Situation Analysis of Children in Mozambique 2014

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ISBN 978-92-806-4779-2

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Preface

The purpose of the report *Situation Analysis of Children in Mozambique 2014* is to analyse, in an objective manner, the current situation of the more than 12 million children in the country, as well as the progress made in achieving their rights in recent years.

The approach used examines not only the basic indicators related to the welfare of children, but also trends, direct and indirect determinants of advances, and patterns of disparities, as well as the main challenges to that all children enjoy all their rights.

Since the publication of the Child Poverty and Disparities in Mozambique 2010, produced by the United Nations System, significant changes have occurred in both the international and the national contexts. The international financial crisis has increased inequalities and contributed to stagnation in social progress in several countries. This initiated an era of fiscal austerity in many countries which are traditional aid partners. At the same time, several African countries, including Mozambique, saw a great increase in foreign direct investment, and discoveries of large reserves of natural resources opened discussions about new possibilities of inclusive economic development.

Through collaboration between the National Council on Children's Rights and the United Nations Children's Fund, this report brings an opportunity for a reflection on how these contexts have impacted the lives of children. The study shows that over the past decade the situation of children in Mozambique has improved significantly: more children are surviving, are having their births registered, are enjoying access to adequate water sources and sanitation, are entering primary school and are accessing the social protection system. However, there is still a great deal to be done. Chronic under-nutrition still affects a very high percentage of children, many women still die in childbirth, half of all girls still marry before they are 18 years old, and half of the children who begin primary education do not finish it.

The advances of the last decade are encouraging and have created a solid base for greater progress continued investment in human capital is essential for equitable and sustainable development and for poverty reduction. This this begins with investment in children. At the same time, the potential for more consistent and rapid advances in the years to come should be explored. This report aims to be not simply a reference document, but an instrument of advocacy, a platform around which all those who are working for a developed Mozambique for all its citizens can express their vision, their strategy and their policies.

Koenraad Vanormelingen

Representative

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ABBREVIATIONS AND ACRONYMS

ADE	Apoio directo à escolar (direct school grant)
AIAS	Administração de Infraestruturas de Abastecimento de Água e Saneamento (Water Supply and Sanitation Infrastructure Administration)
AIDS	Acquired immune deficiency syndrome
APE	Agentes polivalentes elementares (community health workers)
ARI	Acute respiratory infections
ART	Anti-retroviral therapy
CENOE	National Emergency Operational Centre
CFMP	Cenário Fiscal de Médio Prazo (Medium Term Fiscal Framework)
CLGRC	Comités Locais de Gestão de Risco de Calamidades (Local Disaster Risk Management Committees)
CLTS	Community Led Total Sanitation
CMAM	Central Medical Stores
CNAC	Conselho Nacional dos Direitos da Criança (National Council on Children's Rights)
CRC	Convention on the Rights of the Child
CSO	Civil society organization
C4D	Communication for development
DHS	Demographic and Health Survey, 1996/97, 2003 and 2011
DNA	National Water Directorate
DNRN	National Directorate of Registry and Notary Offices
DPT	Diphtheria, pertussis and tetanus
DRA	Demand-responsive approach
ECD	Early childhood development
EPI	Expanded Programme on Immunization
EP1	1st cycle of primary education (grades 1-5)
EP2	2nd cycle of primary education (grades 6-7)
FIPAG	Water Supply Investment and Assets Fund
GDP	Gross domestic product
HCT	Humanitarian Country Team (of the UN)
HIV	Human immunodeficiency virus
IAF	Inquérito aos Agregados Familiares (Household Survey), 1996/97 and 2002/03
ICS	Mass Communications Institute
IFP	Teacher Training Institutes
IMF	International Monetary Fund
IMR	Infant mortality rate
INAS	National Social Welfare Institute
INCAF	Inquérito Contínuo aos Agregados Familiares (Continual Household Survey)
INE	National Statistics Institute
INGC	National Disaster Management Institute
INSIDA	National Survey on Prevalence, Behavioural Risks and Information about HIV and AIDS
IOF	Inquérito ao Orçamento Familiar (Household Budget Survey), 2008/09
KAP	Knowledge, attitudes and practices
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MINED	Ministry of Education
MIS	Management information system
MISAU	Ministry of Health
MMAS	Ministry of Women's Affairs and Social Welfare
MT	Metical/meticais
NAR	Net attendance ratio
NGO	Non-governmental organization
NUMCOV	Núcleo Multissectorial para as Criança Órfãs e Vulneráveis (Multisector Nucleus for Orphans and Vulnerable Children)
ORT	Oral rehydration therapy
OVCs	Orphans and vulnerable children
PAMRDC	Plano de Acção Multissectorial para a Redução da Desnutrição Crónica (Multi-sector Action Plan for the Reduction of Chronic Under-nutrition)
PARP	Poverty Reduction Action Plan
PASD	Programa de Apoio Social Directo (Direct Social Assistance Programme)
PASP	Programa de Acção Social Produtiva (Productive Social Action Programme)
PESOD	District economic and social plans
PFL	Persons with Functional Limitations
PMTCT	Prevention of mother-to-child transmission (of HIV)
PQG	Programa Quinquenal do Governo (Government 5-Year Programme)
PRONASAR	National Programme for Rural Water Supply and Sanitation
PSSB	Programa de Subsídio Social Básico (Basic Social Grant Programme)
RED	Reach Every District
SACMEQ	Southern African Consortium for Monitoring Educational Quality
SDSMAS	District Health, Women's Affairs and Social Welfare Services
SETSAN	Secretariado Técnico para Segurança Alimentar e Nutricional (Technical Secretariat for Food and Nutritional Security)
SISTAFE	Sistema de Administração Financeira do Estado (State Financial Administration System)
SMoDD	District Development Monitoring System
STI	Sexually transmitted infection
SUN	Scaling Up Nutrition
TFR	Total fertility rate
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNAPROC	Unidade Nacional de Protecção Civil (National Civil Protection Unit)
PRONASAR	National Programme for Rural Water Supply and Sanitation
USD	United States dollar
U5MR	Under-5 mortality rate
WFP	World Food Programme
WHO	World Health Organization

Executive summary

Over the past decade, Mozambique has ranked among the top ten fastest growing economies in the world. Projections for the next decade are of continued high growth. Yet, despite strong economic performance, and two decades of peace and political stability, Mozambique remains one of the poorest and least developed countries in the world, ranking 185 of 187 countries in the 2013 Human Development Index.

When we take stock of how children and women have fared, we see major improvements in child survival and the widening of access to basic social services. More and more children are surviving to their fifth year, as the under-5 mortality rate has gone significantly and steadily down. According to the 2011 DHS, the rate of child mortality has steadily declined, falling to 97 per 1,000 live births for under five mortality, and to 64 per 1,000 live births,for infant mortality, putting the country on track to achieve MDG 4. There has also been notable progress in extending access to improved drinking water sources and sanitation, in extending the testing and treatment of HIV/AIDS (and the prevention of mother-to-child transmission of HIV) and in improving the coverage of birth registration services.

There was also some progress in maternal and neonatal survival in the last 20 years, but concerns remain. From 1990 to 2003 the maternal mortality rate decreased more than 50%, from 1000 maternal deaths per 100,000 live births in 1990 to 408 maternal deaths per 100,000 live births in 2003. However, between 2003 and 2011 the rate remained constant at the still high rate of 408 deaths per 100,000 live births. Neonatal mortality is also decreasing at a slower pace than overall infant (<1 years) and under 5 mortality. Neonatal mortality, although decreasing, is falling much more slowly than infant and under-5 mortality.

Chronic under-nutrition remains at one of the highest levels in the world (affecting 43% of children under 5), with almost no progress in the past decade, posing a serious challenge not only for child survival and development, but also for Mozambique's human capital, long-term productivity, the socio-economic development of the country and poverty reduction.

After an enormous expansion in primary school enrolment, the advances in access to and completion of primary school have stalled in the past few years and the learning achievement of pupils is poor. The gross primary completion rate has fallen slightly since 2008. Falling pass rates and studies on learning achievement show that primary school students are learning little in terms of basic competencies in reading, writing and numeracy.

Large geographic inequities in poverty, human development and child well-being persist, with almost all indicators worse in the rural areas and in the North and Centre of the country, compared with the urban areas and the South – the main exception being HIV prevalence, which shows the opposite pattern. The report highlights the particularly disadvantaged situation of Zambézia, the second most populous

province, across a wide range of social indicators. Some of these disparities are very wide, as in the case of under-5 mortality, which is more than twice as high in Zambézia as in the provinces with the lowest mortality.

Poverty is a key driver of child deprivations. Survey data show the importance of cost and distance barriers to access to health services and birth registration, for example. Many social indicators show large disparities by household wealth quintiles, although in some cases deprivations are high even in the wealthier quintiles. Since the early 2000s, poverty appears to have been declining only slightly, despite high economic growth, although trends in the most recent period (since the last household budget survey in 2008/09) are not yet known. Social protection coverage, as a response to this vulnerability, is still low despite the recent expansion of programmes.

However, child vulnerability is not only determined by the living standards of households. Other key factors include the nature of the family environment (and separation from or loss of parents), the presence of disabilities and gender bias.

There is a synergistic relationship between poverty, climate change, the risks associated with natural disasters and the seasonal fluctuations in food insecurity, which directly and indirectly affect child well-being in many domains. The frequency and impact of natural disasters are being exacerbated by long-term climate change, putting millions at risk of livelihood losses and increases in vulnerability. In a context of high poverty, households' capacity to prepare for, respond to and recover from shocks is limited. For lack of alternatives, the poor engage in environmentally harmful subsistence practices and are also the most exposed to and least able to withstand environmental shocks and cope with their consequences. Children are directly affected in multiple ways. Every year, acute under-nutrition rises during the lean season before harvests. And access to food, safe water, education and adequate care become major problems during disasters.

Deficiencies in knowledge, attitudes and practices, rooted in cultural traditions and unequal gender relations, are another key factor influencing child well-being. This report notes the resilience of traditional institutions and opinion leaders at community level in shaping attitudes and practices, highlighting the continued role of initiation rites, especially for young adolescent girls in the North and Centre, in shaping the expectations of girls about their role in society and shaping reproductive practices. One of the most serious consequences, despite some modest improvement in the last few years, is the still very high incidence of child marriage among girls, which contributes in turn to early sexual activity and a huge problem of adolescent pregnancy, with knock-on effects on child and maternal mortality.

Despite major supply-side advances in recent years, problems persist in the supply of basic social services and there are serious concerns about the quality of services. There are still large shortfalls in the geographical coverage of certain services. Distance is still one of the main reasons for non-utilization of health services. In education, the availability of schools and teachers is still a constraint for upper primary education (EP2) and especially secondary education in remote rural areas. There is increasing concern about the quality of services in all sectors. Health service treatment protocols are not fully respected. There are still large shortfalls in health personnel, especially in rural areas. In primary education, the introduction of fast-track teacher training succeeded in increasing the number of teachers but challenges remain in terms of improving quality.

Despite absolute increases in public expenditure on the social sectors, there has been a decline in their relative share of government expenditure. The analysis of sector expenditure trends is hampered by the lack of comprehensiveness of the expenditure data in the public accounts (and until recently by the failure to classify district-level expenditure by functions). Still, it is evident that in relative terms both health and education have been receiving less priority in resource allocation, compared for example to the expansion of physical infrastructure. This trend is not as obvious because of the continuing rapid increase in expenditure on the social sectors in absolute terms, made possible by the rapid growth of the economy, government revenue and overall expenditure.

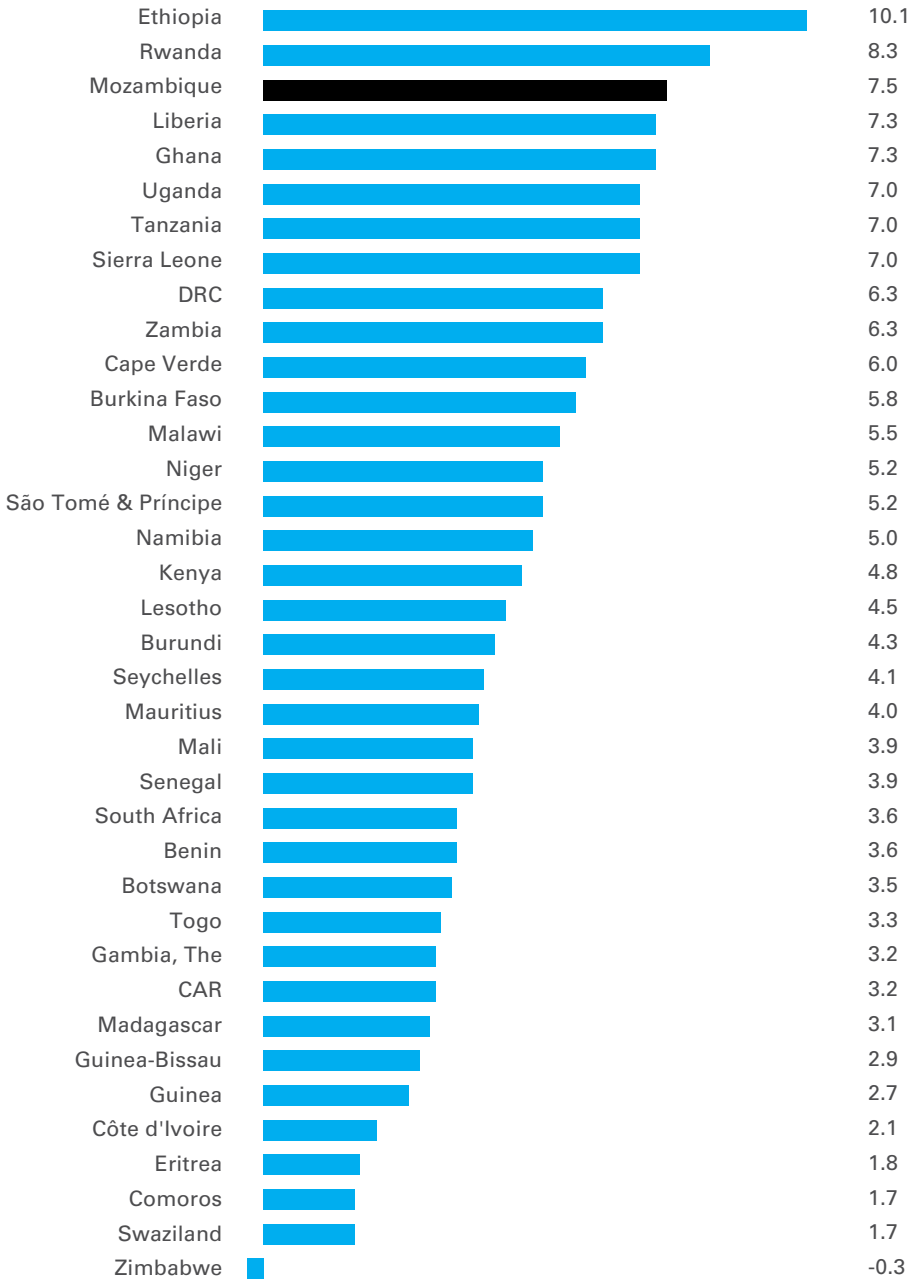
Investing in children is crucial for balanced development and long-term poverty reduction. Mozambique does have large deficits in physical infrastructure that need to be addressed to unlock the country's potential for higher levels of economic growth and development. But investment in human capital is also crucial for balanced development and poverty reduction, and this begins with children. It will be difficult to achieve major improvements in human capital without tackling in a more forthright manner the serious supply and quality deficiencies in the social sectors, including by making a more resolute effort to improve nutrition during the critical period of cognitive development in early childhood. As Mozambique moves into a period of rapid development of its large natural resource deposits, with prospects of generating large additional fiscal resources for the State, starting in the early 2020s, it will be important to give adequate priority to improving the financing of the social sectors and realizing the rights of Mozambique's children.

01 Introduction

1.1 BACKGROUND

Mozambique has been experiencing a rapid improvement in its economic fortunes. Over the past decade, the country has ranked amongst the top ten fastest growing economies in the world, averaging 7.5% a year from 2004 to 2012, more than any other non-oil producing country in Sub-Saharan Africa apart from Ethiopia and Rwanda, as is shown in Figure 1.1. Rising tax revenues and a continuing high level of aid from donors have made it possible to expand government expenditure by more than a third in real terms over the past five years (2008-12) and government spending reached 33% of GDP in 2012 (IMF, 2013).

Figure 1.1 – Mozambique: 3rd fastest growing non-oil economy in Sub-Saharan Africa, 2004-2012 (%)



Source: IMF, 2013.

This high GDP growth and increase in government spending raise the question as to whether the lives and well-being of Mozambicans, particularly of children, who constitute more than half (52%) of the population, have improved at the same pace. Put another way, has the positive economic performance translated into rapid progress in the realization of children's rights to survive, to develop to their full potential, to be protected and to participate in decisions that impact their lives? Exploring the answers to these questions is one of the objectives of this situation analysis, which aims to provide a concise but reasonably comprehensive overview of the degree of progress in realizing the rights of Mozambique's 12.6 million children (INE, 2007), while also analysing the factors that are facilitating or hindering progress.

This situation analysis, produced jointly by the National Council for Children's Rights (CNAC) and the United Nations Children's Fund (UNICEF), focuses particularly on recent trends and developments, taking into account the latest data on a wide range of child-related indicators in the 2011 Demographic and Health Survey (DHS), as well as recent administrative data, policy and planning documents and studies. It also puts the analysis of trends into a longer perspective, notably by drawing on data from successive rounds of national surveys, including the DHS carried out in 1997, 2003 and 2011, the Multiple Indicator Cluster Survey (MICS) in 2008, and the household budget surveys (IAF and IOF) in 2002/03 and 2008/09[1].

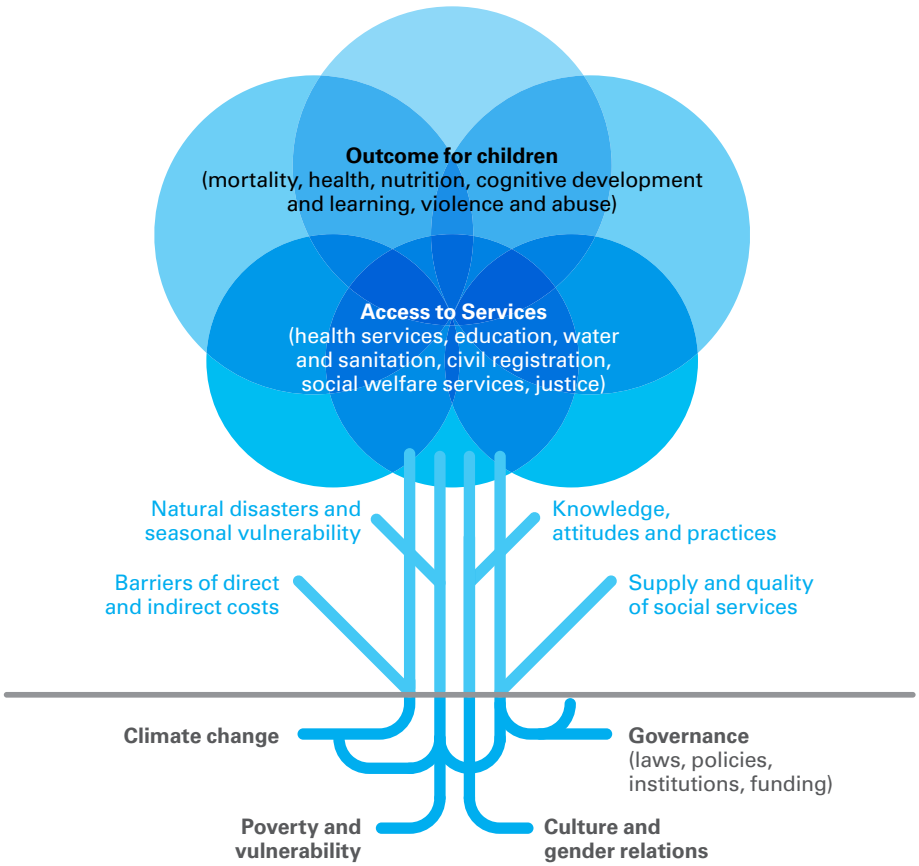
The analysis is anchored within the framework of the Convention on the Rights of the Child (CRC), focusing in particular on Mozambique's progress towards ensuring the rights of Mozambique's children to survival, development and protection. The analysis is presented in an integrated way, rather than sector by sector, in order to build a holistic overview of the country's progress in achieving child rights and of the social, economic, cultural, institutional and other factors that promote or hold back progress. These factors often relate to several dimensions of child well-being, not only to outcomes in particular sectors, such as health or education for example, in an isolated manner.

1.2 CONCEPTUAL FRAMEWORK

The analysis relates child well-being (or 'outcomes' for children) to their immediate and underlying determinants. This is based on a simplified 'problem tree', designed to facilitate a holistic understanding of the factors that affect child outcomes, as shown in Figure 1.2, which has three levels: outcomes (rights or well-being) and intermediate and fundamental determinants.

At the top of the tree is the situation regarding the realization of child rights or child well-being, in which are combined two different types of rights: first, those pertaining to 'final outcomes' or impacts (for example, child mortality, health and nutrition status, cognitive development, learning achievement and literacy, and freedom from violence and abuse); and second, those concerning access to (or use of) basic services, such as preventive and curative health services, education, improved drinking water sources and improved sanitation, birth registration, social care services and the justice system. Although both types of rights feature in the CRC and other human rights instruments, it is important to bear in mind this distinction, which is made throughout this report, since access to services can best be understood as one of the intermediary levels ultimately affecting child outcomes. It may be noted in passing here that some of the indicators in focus here, at both the service and final outcome level, correspond to those used for tracking progress towards the Millennium Development Goals (MDGs).

Figure 1.2 – Conceptual Framework



At the bottom of the tree are a number of fundamental parameters for progress at a 'deep societal level'. These affect the range of child outcomes (and access to services) indirectly and in complex multiple ways through various intermediate levels. **These fundamental parameters have been grouped into four blocs: poverty and vulnerability, the environment (including climate change), culture and gender relations, and governance. These four blocks are not really completely separate, as there are synergistic relations between them, and all together they are both cause and effect of a country's overall level of economic and social development.** Thus, poverty reflects and conditions the level of development, contributes to and results from environmental degradation, and interacts with socio-cultural norms and practices, sometimes through the 'intermediate' level of education. Governance, which is interpreted here as the quality of the 'enabling environment' of laws, policies, institutions and financing, reflects the level of national development while also determining in many respects its pace and nature, as well as progress (or lack of progress) in tackling poverty, vulnerability and environmental degradation.

The middle part of the tree is constituted by a mass of intermediate levels, which link the fundamental societal parameters with access to services and final child outcomes. These intermediate levels have been greatly simplified in Figure 1.2, as the channels of causality are much too complex to represent in a diagram. A more detailed and accurate representation of these intermediate levels and the direction of causality would become an undecipherable mass of elements and arrows, leading not only upwards to affect child rights directly, but criss-crossing in complex ways and with numerous backward loops. In this part of the tree, the big structural 'branches' include, first, the **availability of basic social services**, including the infrastructure, human resources, supply chains and other factors that determine the supply and quality of these services. A second important branch is the **direct and indirect costs that households face in improving their consumption and access to social services, or their 'demand' for these services.** These costs are not only direct, in the sense of prices of goods or charges for the use of services, but also indirect in the case of transport costs when services are distant, or opportunity costs such as the loss of time and income involved in accessing services. Thirdly, practices important for the well-being of children are affected not only by the supply of services and by economic factors (poverty and costs to the household), but also by **knowledge, attitudes and practices**, which sometimes reflect deeper socio-cultural factors at the underlying level, as well as levels of education and access to information. Finally, **climate change and environmental degradation** are leading to the increased incidence and severity of natural disasters, as well as to the more subtle but widespread effects of seasonal food insecurity on a rural population dependent on rain-fed agriculture.

The structure of this analysis follows the logic of the conceptual framework. Following this introduction, Chapter 2 assesses national progress with respect to the headline indicators of child survival, development and protection, as well as the geographical disparities in these indicators between urban and rural areas and among the 11 provinces. The aim of this chapter is to assess the trends, particularly in the period since the 2008 MICS, to identify the most important challenges for improving the situation of children, and to highlight problems of inequity in the achievement of child rights.

Holistic analysis of the determinant factors that affect the achievement of Mozambican child rights

Chapter 3 then turns to the factors that, at intermediate and underlying levels, affect the degree of progress. There are five sections to this chapter. The first focuses on poverty and vulnerability, and their effects with respect to cost barriers and economic disparities in households' access to services and in the realization of child rights. The second examines the problems of climate change and natural disasters, and their effects on children. The third focuses on the socio-cultural factors, including gender relations, and their effects on children through various dimensions of knowledge, attitudes and practices at household and community levels. The fourth turns attention to the supply and quality of basic social services, and their critical inputs (infrastructure, human resources and supply chains). The fifth section examines the enabling environment of laws, policies, institutions and financing that determine the supply and quality of services, and influence many other 'branches' of the problem tree. Finally, Chapter 4 draws out the main conclusions.

Trends and disparities in child well-being

02

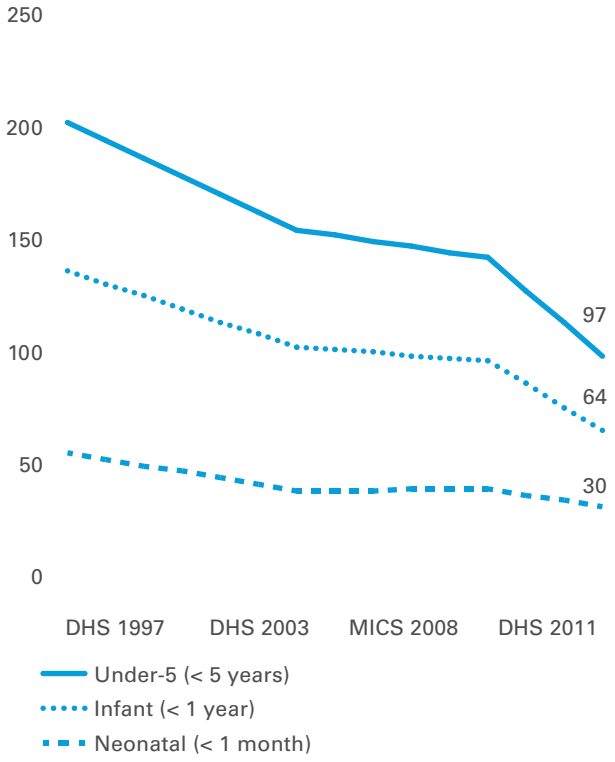
This chapter provides, first, a concise overview of the degree of progress made by Mozambique in recent years to improve the well-being of children, and then assesses inequities in child outcomes by examining the geographical disparities between urban and rural areas and among provinces. Other equity dimensions, such as the disparities between children in poorer and better-off households and gender inequality, are addressed in Chapter 3. Detailed data tables on the trends and disparities in child outcome indicators may be found in the statistical annex at the end of the report.

2.1 THE PACE OF PROGRESS

CHILD SURVIVAL

More and more children are surviving to their fifth year, as Mozambique has made sustained progress in reducing under-5 mortality. Successive national surveys since the late 1990s have shown a continuing downward trend, particularly for under-5 and infant mortality (child deaths within the first year after birth), as Figure 2.1 shows. The mortality has decreased, falling to 97 per thousand live births for under-5 mortality and to 64 per thousand live births for infant mortality in the 2011 DHS, putting the country on track to achieve MDG 4. Progress has been slower, however, in reducing neonatal mortality (mortality within the first 28 days after birth), which, as in other countries moving towards lower levels of mortality, is assuming a larger weight in under-5 mortality (up from 27% in 1997 to 31% in 2011). There is a lot of room for improvement, since, at the national level, almost one in every ten children still die before they reach their fifth birthday, and great disparities exist amongst provinces.

Figure 2.1 – Child mortality rates, 1997-2011 (per 1,000 born alive)

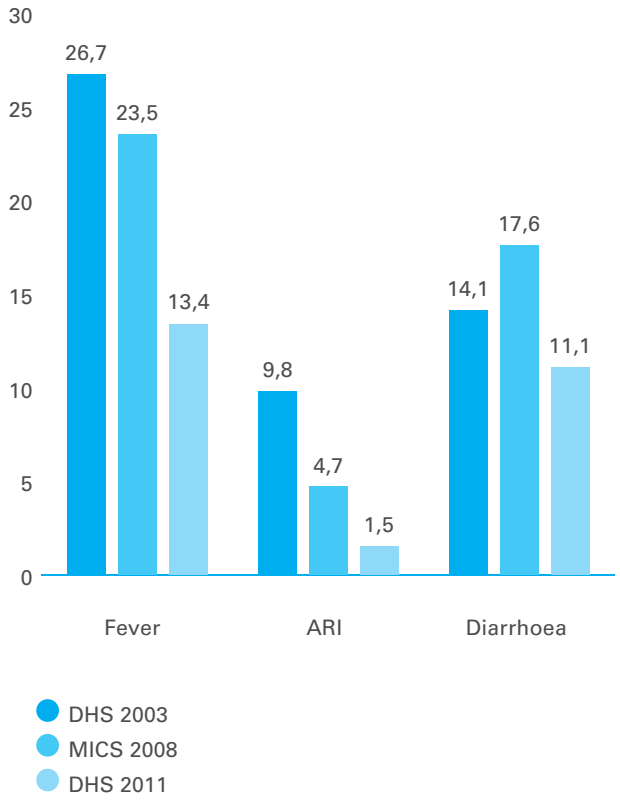


Sources: MICS 2008 and DHS 1997, 2003 and 2011.

CHILD HEALTH

The reduction in child mortality reflects the sharp decrease in the prevalence of fever, acute respiratory infections (ARI) and diarrhoea, observed in the last 14 years (1997-2011) years among children under 5. These improvements are particularly important since malaria (for which fever is a proxy), ARI and diarrhoeal diseases are amongst the biggest killers of children in Mozambique (respectively the first, third and fourth direct causes of mortality in children under 5)[2]. The second leading cause of child mortality in the country is AIDS, for which the mortality rate in young children is also likely to have decreased due to the large expansion in the testing of mothers for HIV and the prevention of mother-to-child transmission (PMTCT). The prevalence of fever (in the 2 weeks preceding the respective national surveys) halved among 0-4 year olds between 2003 and 2011.

Figure 2.2 – Prevalence of fever, ARI and diarrhoea in children under 5, 2003-2011 (%)



Sources: DHS 2003, MICS 2008 and DHS 2011.

The much lower prevalence of fever, which is particularly important given the weight of malaria in under-5 mortality, is likely related to the major progress made in extending ownership and use of bed-nets, in-house spraying and the use of artimisinin for malaria treatment. The proportion of children under 5 sleeping under bed-nets has quadrupled, from less than 10% in 2003 to 39% in 2011. At the same time, the proportion of those sleeping under insecticide-treated nets has continued to rise, reaching 23% in 2008 and 36% in 2011[3]. Administrative health system data indicate that the number of recorded malaria cases (in all ages) declined from 6.3 million in 2006 to 3.9 million in 2013 (MISAU, 2013a). The decline in the prevalence of diarrhoea may be related to the large improvement, from a low base, in the use of improved water sources for drinking and in the use of improved sanitation facilities.

From 1997 to 2011, the under-five mortality rate was reduced by half

While proportionately less children are getting sick or dying, the data about usage of health services by children is not as encouraging. The proportion of children under 5 with fever who were taken to a health provider increased between 2003 and 2011, the proportion receiving anti-malarial drugs more than doubled between 2003 and 2011, reaching 30%. However, the proportion of children under 5 with ARI who were taken to a health facility in 2003 and 2011 is almost the same (51% and 50% respectively). The proportion of children aged 12-23 months with complete EPI vaccination also changed little between 2003 and 2011 (63% and 64 % respectively). However, taken individually, coverage of the different vaccines has improved – measles coverage for example reached 81.5% in 2011[4]. There has also been an increase in the proportion of children under 5 with diarrhoea who received oral rehydration therapy (ORT), which rose from 54.1% in 2008 to 61.5% in 2011.

MATERNAL MORTALITY AND REPRODUCTIVE HEALTH

From the early 1990s, the Government implemented a series of actions aimed to reduce maternal mortality and improve women's health. These efforts resulted in the reduction of maternal mortality from 1000/100,000 live births in 1990 to 408/100,000 live births in 2003. After this, however, the maternal mortality ratio has remained unchanged, at 408 maternal deaths for every 100,000 live births (DHS 2003, 2011). The country is thus not on track to achieve MDG 5 on maternal mortality despite the improvement in the use of reproductive health services over the last years. For example, as per the DHS data, the proportion of deliveries in health facilities rose from 44% in 1997 to 48% in 2003 and to 55% in 2011. There was also an increase in the proportion of pregnant women attending pre-natal consultations between 2003 and 2011. At a more fundamental level, reproductive health in Mozambique is affected by very low contraceptive use, high and rising fertility, high levels of maternal anaemia, high levels of adolescent pregnancy and short birth spacing.

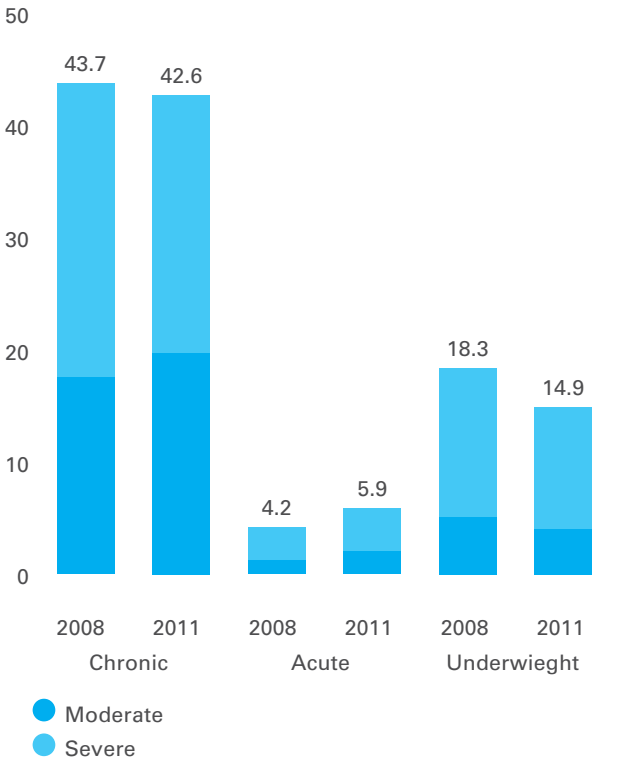
NUTRITION

The prevalence of chronic under-nutrition continues to be a major concern for the Government of Mozambique. However, little progress has been made is the reduction of chronic under-nutrition, which remains at one of the highest levels in the world (and ninth highest in Africa). Chronic under-nutrition, or stunting, begins before a child is even born, and is caused by poor maternal nutrition, poor child feeding practices, poor food quality as well as frequent infections, especially during pregnancy and in the first two years of life (the 'first 1,000 days'). Between 2003 and 2011 (DHS), chronic under-nutrition of children under 5 remained almost unchanged, at 41.0% and 42.6% respectively, thus remaining above the 'very high' threshold defined by the World Health Organization. Nevertheless, wide disparities exist between provinces, with rates ranging from 23% in Maputo City and Province to 55% in Nampula. The proportion of children with severe chronic under-nutrition, that is, children who are three standard deviations below the mean, rose from 18.1% to 19.7%. However, there has been a decline in the proportion of children under 5 who are underweight (i.e. with low weight for their age), from 22.0% in 2003 to 14.9% in 2011. Mozambique has been reported to be on track to meet the MDG 1 nutritional target, which measures the proportion of children underweight. This achievement masks the grave issue of stunting, however, since it includes children who remain too short for their age but

who have gained adequate weight. In these children, the consequences of stunting cannot be undone by gaining weight.

Chronic under-nutrition not only contributes to child mortality, but, due to its negative effects on cognitive development in early childhood and its irreversible nature, has serious implications for Mozambique's human capital and thus for development more generally. According to a global estimate, under-nutrition causes 45% of deaths in children under five (The Lancet, 2013). Chronic under-nutrition in early childhood diminishes individuals' capabilities during the rest of their lives, due to its negative effects on school participation, learning achievement and, later in life, lower adult productivity. Chronic under-nutrition on the scale seen in Mozambique is therefore a major factor holding back the development of the country. While this has not been estimated specifically for Mozambique, the World Bank (2006) has calculated that globally the productivity losses in adult life from chronic under-nutrition in early childhood reduce GDP by 2-3%.

Figure 2.3 – Child under-nutrition, 2008-2011
(% of children under 5)



Sources : MICS 2008 and DHS 2011.

Chronic under-nutrition has many underlying causes. At a global level, these include inadequate care and feeding practices, low maternal education/high female illiteracy, low female decision-making power, poverty, adolescent pregnancy and short intervals between pregnancies (which affect development of the foetus), as well as constraints on access to health services and, despite some progress, the still low use of improved drinking water sources and safe sanitation facilities. However, to understand better the factors that are associated with chronic under-nutrition in Mozambique, a special study on this subject was commissioned as part of this situation analysis on children. Box 2.1 provides a summary of the main findings.

43% of the 0-5-year-old children suffer from chronic under-nutrition, representing almost no progress since 2008

Box 2.1 – Factors associated with chronic under-nutrition

As part of this situation analysis, a special study[5] on the factors associated with stunting in children under 5 was undertaken. This was a multivariate regression analysis, using data from the 2011 DHS. The results, presented in Table 2.4 control for confounding factors, making it possible to isolate the impact of the variables of interest on the probability of being stunted, assuming that the children being compared are identical in all other respects. All probabilities were estimated, both for children living in very poor households (the bottom 10%) and very rich households (the top 10%), as well as for children living in median households.

Key explanatory factors include region of residence, household wealth, orphanhood, presence of anaemia and hygiene practices in the home. The factors that account for the largest differences in probabilities of being stunted are the region of residence (18 percentage point difference between the North and the South), whether the child is an orphan (9 point difference) and whether the child has anaemia (9 point difference). Children living in the 10% of richest households have a 12 percentage point lower probability of being stunted than comparable children living in the 10% of poorest households. The results also highlight the importance of hygiene as a factor associated with stunting. The availability of hand-washing facilities accounts for a 3 percentage point difference in the probability of a child suffering from stunting. Similarly, children living in households that treat their water before drinking have a 7 percentage point lower probability of being stunted than children living in similar households that do not treat their water.

Table 2.4 – Predicted probabilities of stunting, by categories of children under 5

CRITERIA	CATEGORIES OF CHILDREN UNDER 5	POOREST 10%	MEDIAN	RICHEST 10%
Gender	Girls	0.49	0.45	0.37
	Boys	0.44	0.40	0.32
Region	South	0.37	0.33	0.26
	Centre	0.46	0.41	0.33
	North	0.55	0.51	0.42
Hand-washing	Household does not have any facilities for hand-washing	0.48	0.44	0.35
	Household has hand-washing facilities	0.45	0.41	0.33
Water treatment	Household does not treat water for drinking	0.47	0.43	0.35
	Household treats water for drinking	0.40	0.36	0.28
Literacy	Child's mother is unable to read full sentence	0.48	0.43	0.35
	Child's mother is able to read a full sentence	0.43	0.39	0.31
Anaemia	Child has anaemia	0.50	0.45	0.37
	Child does not have anaemia	0.41	0.37	0.29
Complementary feeding	Child does not receive complementary feeding	0.46	0.41	0.33
	Child does receive complementary feeding	0.47	0.42	0.34
Orphan	Child is not an orphan	0.47	0.42	0.34
	Child is orphan of mother or father	0.56	0.51	0.43
Iodized salt	Household salt is not adequately iodized	0.46	0.42	0.34
	Household salt is adequately iodized	0.48	0.44	0.36
Vitamin A	Child did not receive vitamin A supplement in past 6 months	0.47	0.43	0.35
	Child did receive vitamin A supplement in past 6 months	0.47	0.42	0.34

Source: Silva-Leander, 2014.

Many Mozambican children suffer from an inadequate intake of key nutrients, including crucial vitamins and minerals due to poor dietary diversity, infectious diseases (especially malaria, diarrhoeal diseases and HIV/AIDS) and gastrointestinal parasites. Iron deficiency, for example, can cause anaemia, which affects, often irreversibly, long-term cognitive development and immunity. Anaemia also reduces a child's appetite, prompting a vicious cycle that endangers the child's health (see Kotecha, 2011). In Mozambique, the prevalence of anaemia in children aged 6-59 months (69%) is much higher than the estimated average for developing countries of 40% (WHO, 2013a). In women of reproductive age, the prevalence is also high, at 54%, which is significant because anaemia during pregnancy is associated with infant respiratory health outcomes (Triche et al, 2011), and it is also a major factor in maternal mortality (WHO, 2013a). The special nutrition study carried out as part of this situation analysis, using DHS 2011 data, found that anaemia in children was one of the main factors associated with chronic under-nutrition, accounting for a 9 percentage point difference in the probability of stunting (Silva-Leander, 2014). Iodine deficiency, which can start before birth and jeopardize children's development and survival, is also endemic. Severe iodine deficiency during pregnancy can lead to stillbirth, miscarriage and birth defects. It can lead to pervasive mental impairment that reduces the intellectual capacity of the child (WHO, 2013b). While it can easily and inexpensively be prevented by the use of iodized salt, only 45% of households used iodized salt in 2011, down from 54% in the 2003 DHS Finally, up-to-date data on vitamin A deficiency, which is the leading cause of preventable blindness in children and can increase the risk of disease and death from severe infections (WHO, 2013c), are not available. However, this deficiency affected 69% of children aged 6-59 months and 11% of women of reproductive age in 2002 (RdM, 2010a).

Wasting, or low weight for height, which mainly reflects acute weight loss associated with a recent period of hunger and/or disease, is 5.9% (in the WHO's 'medium' range), according to the 2011 DHS, although there are regional variations. This is an inherently unstable indicator, sensitive to sudden livelihood shocks and generally rising during the lean period before harvests (November-March). The 2008/2009 IOF found that wasting (also referred to as acute under-nutrition) peaked above 8% in February[6].

WATER AND SANITATION

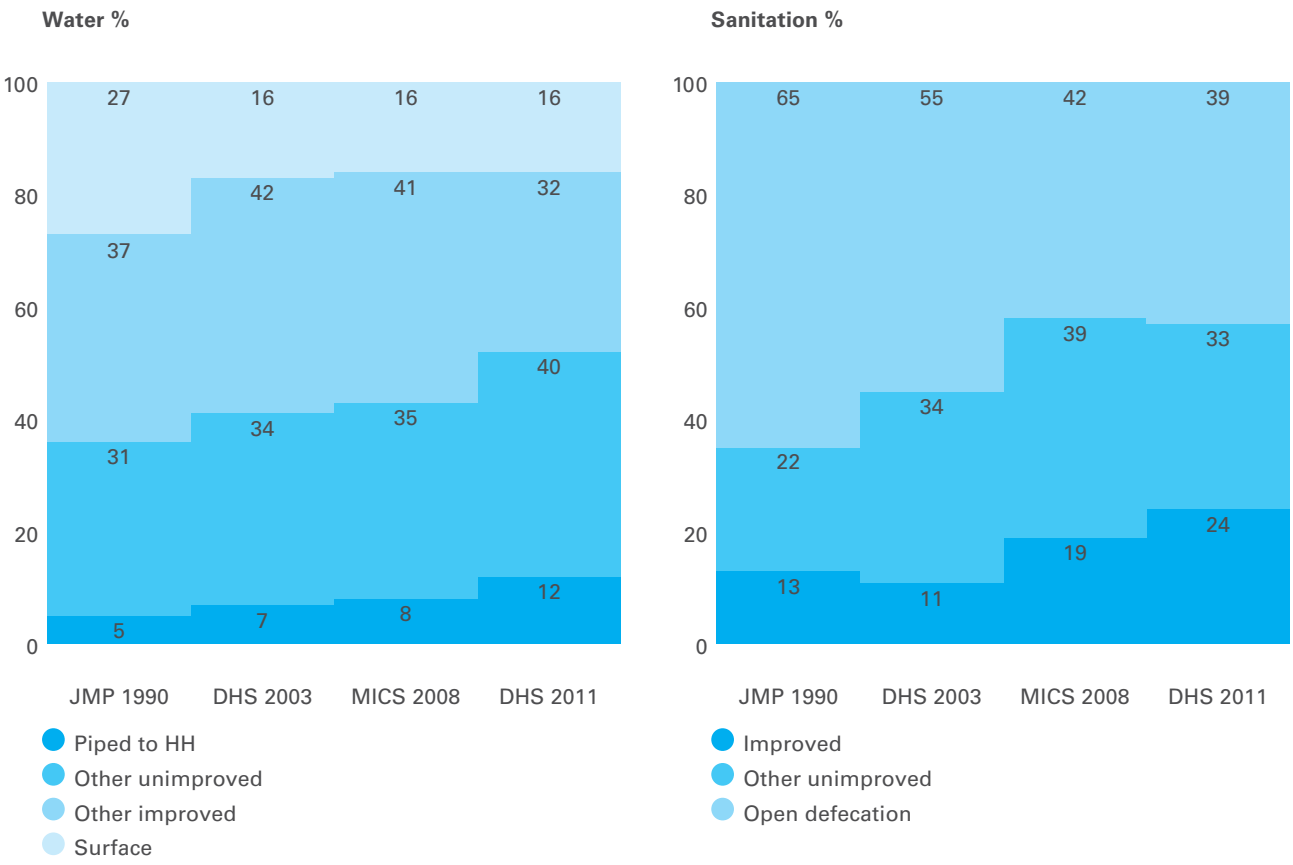
Many more people today are using improved water sources for drinking, that is, those protected against chemical and faecal contamination. While in 2003 only 37% of the population drank water from improved sources, in 2011 53% did so. Nevertheless, Mozambique is still 8 percentage points behind the average for Eastern and Southern Africa. There is also a smaller proportion of the population who spend more than 30 minutes to collect water, which fell from 53% in 2008 (MICS) to 39% in 2011 (DHS). This is much welcomed progress, since often it is children—particularly girls—who must fetch water, being then exposed to several risks, from arriving late at school and missing classes to the health hazards of this onerous task. Despite such improvements, however, it is important to note that 16% of the population still uses surface water for drinking, a proportion that has not changed since the 2003 DHS, suggesting that the overall progress in water access and use has not benefited those in greatest need.

53% of the population drinks water from improved supply sources

39% of the population still practise open defecation.

Progress in the use of improved sanitation is trailing the advances in the use of improved water sources. Less than one in four Mozambicans (24%) uses methods allowing for the separation, in a hygienic way, of human waste from human contact and 39% still practise open defecation. The use of unimproved water supply sources and sanitation methods is a major threat to child health and behind the majority of diarrhoea deaths globally[7]. Although a large improvement has been seen since 2008, when coverage was even lower, Mozambique is off-track, especially for sanitation, with respect to the MDG 7 targets to halve the proportion of the population without permanent and sustainable access to safe drinking water and basic sanitation bt 2015[8].

Figure 2.4 – Use of drinking water sources and sanitation facilities, 1990-2011 (% of population)



Sources: Estimates from JMP 1990, DHS 2003 and 2011, MICS 2008 and IAF 2003.(DHS 2003 and MICS 2008 data refer to households; JMP 1990 and DHS 2011 data refer to % of the population)

HIV/AIDS

Mozambique is still heavily impacted by HIV/AIDS, with the eighth highest HIV prevalence in the world. More than one in ten Mozambicans are infected (UNAIDS, 2013). The first national household HIV/AIDS survey in 2009 (INSIDA) found that HIV prevalence in the population aged 15-49 was 11.5%, with more women infected than men (13.1% and 9.2% respectively). Of every 100 couples in the country, 15 have either both or one partner infected by HIV. INSIDA found a prevalence of 1.4% in children aged 0-11, with rates varying between different age groups. Among children under 1 year old, whose infection is attributed to their mothers, a prevalence of 2.3% was observed. Yet, as most of these children grow without access to treatment, they begin to succumb to the disease, which is reflected in the lower prevalence rate of 1.0% found among 5-9 year olds. From this point onward, there is an upward trend in prevalence, reaching 1.8% in the 12-14 year age group and then rising steeply until it peaks at age 25-29 for women (16.8%) and at age 35-39 for men (14.2%).

Mozambique has the 8th highest HIV prevalence in the world

There has been a decrease in new infections, but the absolute number of people living with HIV has been rising and this trend is likely to continue as higher treatment coverage reduces mortality. UNAIDS (2012) estimates that new infections fell from 140,000 in 2001 to 120,000 in 2011, while the total number of people (of all ages) living with HIV rose from 850,000 to 1.4 million during this period. There have been impressive increases in the coverage of HIV testing (especially of women during antenatal consultations), anti-retroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT), made possible by large-scale project funding by donors. The survey data (DHS, INSIDA and MICS) show that the proportion of women aged 15-49 who were tested within the previous year and who received their results rose from 2.4% in 2003 (IDS) to 17% in 2009 (INSIDA) and 26% in 2011 (DHS). The figures for men (aged 15-49) are lower, but have also risen, from 9% in 2009 (INSIDA) to 14.2% in 2011 (DHS).

There have been impressive increases in the coverage of HIV testing, anti-retroviral therapy and prevention of mother-to-child transmission

Despite strong progress in access to ART and PMTCT services, still very few children who need treatment receive it. There has been a large increase in the proportion of HIV+ pregnant women receiving drugs for PMTCT: 83% in 2013, according to administrative data. In 2003, less than 3,000 patients were receiving ART, but by the end of 2013 this figure had risen to 497,455, with a coverage rate estimated at 63% for adults. Yet, the coverage rate for children is extremely low, at only 36% (CNCS, 2014).

EDUCATION

Over the past decade, Mozambique has made impressive progress in putting more children in school. This achievement has been a result of the abolition of school fees (in 2004), education reforms and large investments in school construction and teacher recruitment. Between 2004 and 2011, the number of pupils in the first five grades of primary education (EP1) increased by 45% from 3.2 million to 4.6 million. In the last two grades of primary school (EP2) enrolment increased by 73% from about 491,000 to 852,000.

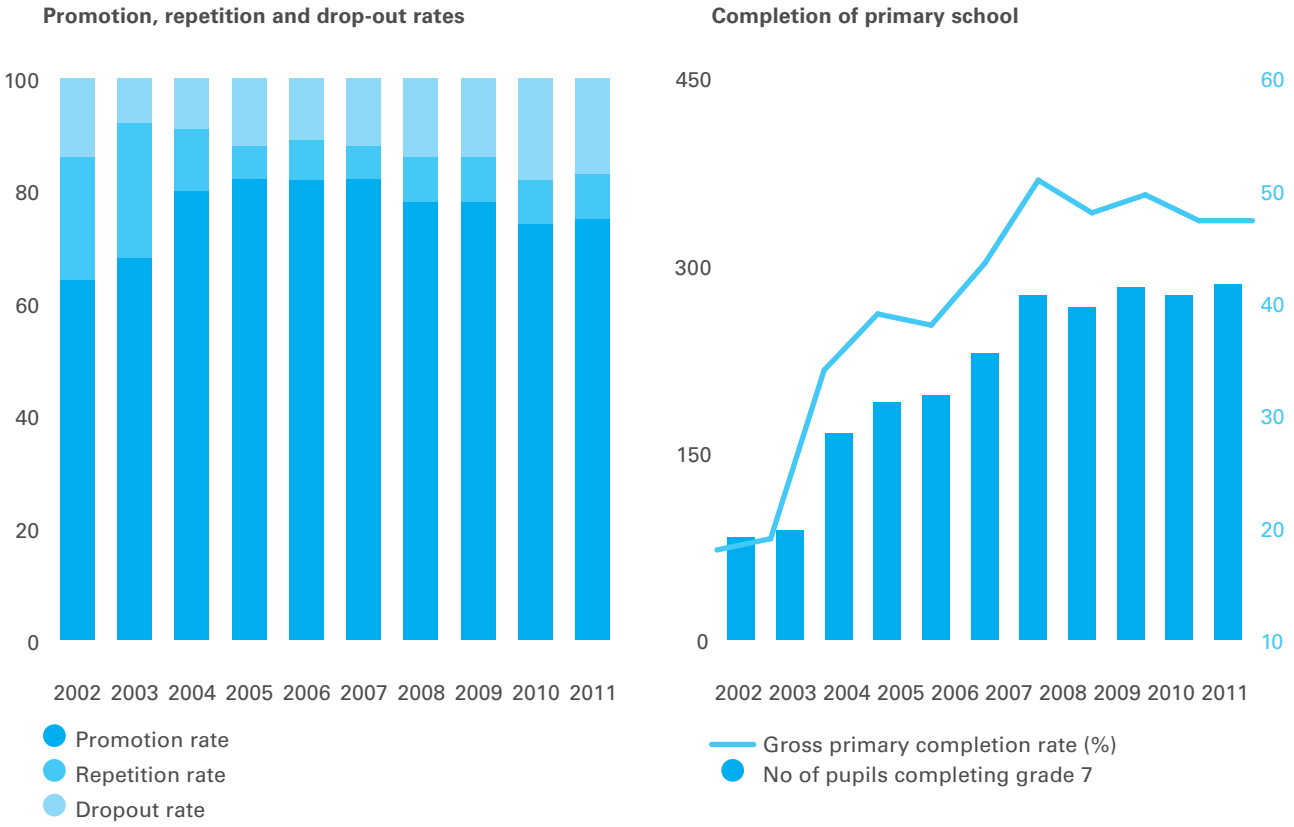
Not only are there more children enrolled in school, but there are more children starting school at the right age (6), actually attending and completing primary school. Substantial improvement has been made in the age of enrolment, which has seen the proportion of 6 year olds in grade 1 rising from 36% in 2002 to 72% in 2012, according to administrative data (MINED, 2013)[9]. Attendance, as measured by net attendance ratio (NAR), in primary education also rose from 59.7% in 2003 to 77.1% in 2011 (DHS, 2003 and 2011). Furthermore, a far higher proportion of children are completing primary school than was the case just a decade ago. Yet the gross primary completion rate (the number of children of any age who reach the last year of primary education as a percentage of the total population

of children aged 12) is still less than 50%. There has also been a rapid expansion in secondary education in this period, but starting from a very low base. While in 2003 only seven out of every 100 children aged 13-17 were attending secondary school, this had risen to 24 in 100 by 2011 (NAR of 23.7%).

However, the rapid expansion in enrolment started to stall after about 2008 and since then has gone into reverse, while low learning achievement has become a matter of growing concern. The survey data (MICS and DHS) show a reversal of the rise in net primary attendance (NAR), which fell from 81.2% in 2008 to 77.1% in 2011. Even the absolute number of pupils in upper primary (EP2) fell in 2011 and 2012 (cumulatively by 5.1%). According to administrative data, the gross primary completion rate (at grade 7), which had risen from less than 20% in the early 2000s to just over 50% in 2008, has declined since then to 47% in 2012 (see Figure 2.5). A UNICEF study (2012) estimates that 1.2 million children of primary and lower secondary age are out of school.

Between 2004 and 2011, the number of pupils enrolled in first level primary school (EP1) increased by about 45% and in second level primary school (EP2) about 73%.

Figure 2.5 – Primary education: repetition, dropout and completion, 2004-2012



Source: MINED, 2013.

Furthermore, those who do go to primary school appear not to be learning much, suggesting that the expansion of the past decade has come at the expense of poor quality (see Box 2.2).

Box 2.2 – Low and declining levels of learning achievement among primary pupils

Falling pass rates in exams are a warning signal that learning achievement is declining. Grade 7 pass rates (in the exam at the end of primary education) stagnated at a level just above 80% between 2004 and 2008 and then declined, falling to 72% in 2011 (Visser, 2013). Pass rates have also shown a generally declining trend since 2008 in the exams at the end of the two cycles of secondary education (MINED, 2013). These trends suggest that learning achievement may be worse now than the already poor performance revealed by the last standardized testing of pupils by the Southern African Consortium for Monitoring Educational Quality (SACMEQ) in 2007. Scores in SACMEQ's grade 5 reading and mathematics tests fell by 8% and 9% respectively between 2000 and 2007, lowering Mozambique's ranking (out of 9 countries in the region) from 5th to 8th place in reading and from 3rd to 6th place in mathematics. These tests found that 22% of grade 5 pupils were functionally illiterate and 33% were not functionally numerate.

Two more recent studies, in selected areas of northern and central Mozambique, confirm that learning achievement is very low. The first study (Raupp et al, 2013), conducted in 180 schools in Nampula and Zambézia, found that only 2% of 2nd and 3rd graders had acquired foundational reading skills. The second study (Adelman et al, 2011), which investigated foundational reading skills among 3rd graders in 60 schools in Cabo Delgado, concluded that 'students in Grade 3 are struggling to read'. Of the 631 grade 3 students sampled, 59% were unable to read a single word in Portuguese.

The following challenges have to be addressed if progress is to be resumed towards the goal of education for all:

- **Increasing coverage of pre-school education.** Coverage of pre-school education is extremely low, around 5%, reducing readiness for school. There are two systems. The first is overseen by the Ministry of Women's Affairs and Social Welfare (MMAS), and is outside the formal school system. This includes both public and private child care centres (centros infantis), for children aged 0-5 (with coverage of only 20,000 children in 2013, according to MMAS data), and community-based 'little schools' (escolinhas) for children aged 3-5, which had an enrolment of approximately 50,000 in 2013. All told, these structures enrolled about 3% of children aged 3-5 . The Ministry of Education oversees the second system, which consists of pre-primary teaching within primary schools, although at present only some private schools offer a pre-primary class and no data is available on the number of children enrolled[10].
- **Increasing the number of children that start primary school at the right age.** Many children still enter late into primary school, despite the substantial improvement in the age of enrolment. The fact that many children still start school late has adverse effects later on. Children who reach adolescence in primary school due to late entry and repetition of classes have a lower probability of completing primary education (Visser, 2013).
- **Sustaining advances made in dropout and repetition rated.** There has been an increase in dropout rates and a reversal of the previous decline in repetition rates at primary level, as can be seen in Figure 2.5. Administrative data show that the year-to-year dropout rate at primary level more than doubled, from 8% in 2003 to 17% in 2011, contributing directly to the reduction in the primary completion rate observed since 2008. Meanwhile, average national repetition rates, which dropped sharply after the introduction of automatic promotion within 3 cycles of primary education (grades 1-2, 4-5 and 6-7) in the education reform in 2004, have risen again slightly, to about 8% (MINED, 2013).
- **Improving access to secondary school.** Secondary school enrolment, despite a major expansion, is still much lower than in most African countries. Of those who complete primary school, about 70% enter the first year of secondary school (grade 8). Overall, the secondary net attendance rates for both boys (25%) and girls (22%) are poor compared to the Sub-Saharan African averages of 31% and 29% respectively (UNICEF, 2013a).
- **Quality of teaching and learning.** A major emphasis needs to be placed on improving the quality of education in order to improve pupils' learning achievement in school (see Section 3.5 of this report).

While rates of adult illiteracy have declined slightly this continues to be a serious concern. The DHS data show that literacy among women aged 15-49 rose only slightly, from 37.5% to 40.2%, between 2003 and 2011. Male literacy is higher, but stagnated in this period around 67-68%. Despite this, the national literacy programme has been in decline, with a fall of 28% in the number of participants between 2010 and 2012 (MINED, 2013).

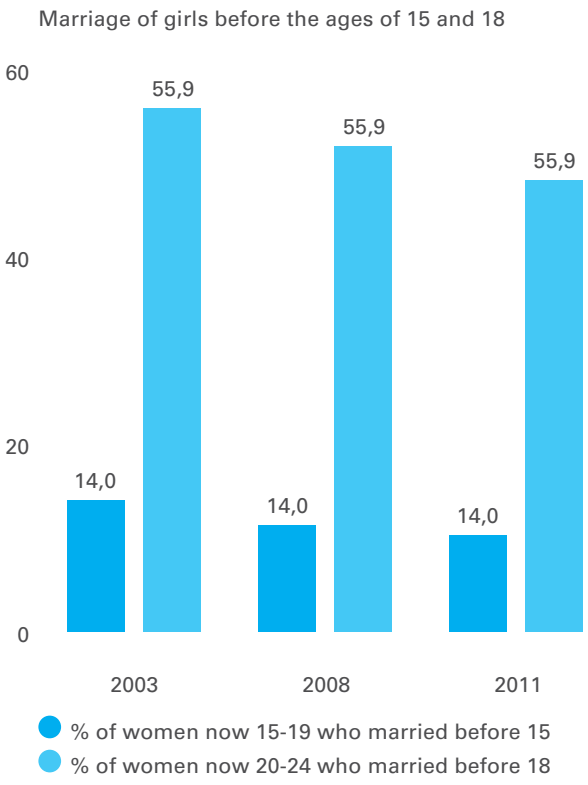
CHILD PROTECTION

The lack of robust time-series data makes it difficult to track progress in the realization of child protection rights, such as the right to protection from all forms of violence, abuse and neglect, the right to protection from harmful and exploitative work and the right to legal identity (through birth registration). The availability of data comparable over time is limited to a few specific dimensions such as early marriage of girls and civil registration.

There has been a rapid advance in birth registration but, despite this, half of all children under 5 years old are still not registered, which is a clear violation of one of the most basic human rights. According to the data from MICS (2008) and IDS (2011), the percentage of children under 5 years old whose birth was registered rose sharply from 31% to 48%, very probably as a consequence of the campaigns held during that period, including campaigns to raise the awareness of households to the need for registration at birth in the posts set up. This rate is now slightly higher than the average for Sub-Saharan Africa (41%) and for Eastern and Southern Africa (37%), according to the data from UNICEF (UNICEF, 2013a). However, increasing the coverage of registration, particularly at birth, which is a basic right of children, remains a challenge.

National surveys show that child marriage is on a declining trend, but still almost one out of every two girls is married before she turns 18 and one out of ten girls is married before she reaches 15. In fact, Mozambique has one of the highest rates of child marriage in the world, violating one of the most fundamental protection rights (and violating Mozambican law). Nonetheless, the DHS data show some progress, as the proportion of women aged 15-19 married before the age of 15 declined from 14% to 10% between 2003 and 2011, and the proportion of women aged 20-24 married before the age of 18 fell from 56% to 48% (see Figure 2.6).

Figure 2.6 – Marriage of girls before their 15th and 18th birthdays



Source: DHS 2003 and 2011; MICS 2008

Violence against children and women is a widespread problem, although there are no national quantitative data regarding the incidence of violence, apart from police administrative data on domestic violence cases reported to the police. The data for 2012 record 24,380 cases, including 6,863 against children (MINT, 2013). However, these reported cases are likely to show only the 'tip of the iceberg'. There is particular concern about sexual harassment of girls in schools, including by teachers[11]. For violence against women, there is more information, due to the coverage of this problem in the 2011 DHS: 1 in every 3 women (33%) aged 15-49 declared that they had been victims of physical or sexual violence at some time in their lives and 28% in the previous year, mainly from husbands and partners. Moreover, 12% of women declared they have been forced to have sexual relations at some time in their lives. Little more than a third (36%) of the women who are victims of physical or sexual violence seek any form of help, which can be related to, among other things, societal attitudes about domestic violence.

Child labour affects more than one in five children aged 5-14. It is difficult to measure the trends in child labour, as comparable data are not available for different years. The 2008 MICS found that 22% of children were working, with slightly more girls than boys involved (24% to 21%) and particularly high rates in Inhambane (39%) and Sofala (30%). A more recent source, the INCAF survey, using a somewhat different definition of child labour that appears not to include child work within the household, found that 12% of children aged 5-17 were working during the final quarter of 2012, with roughly equal proportions of girls and boys involved (INE, 2013). This survey also found high rates in Inhambane and Sofala, but an even higher rate in Tete (40%).

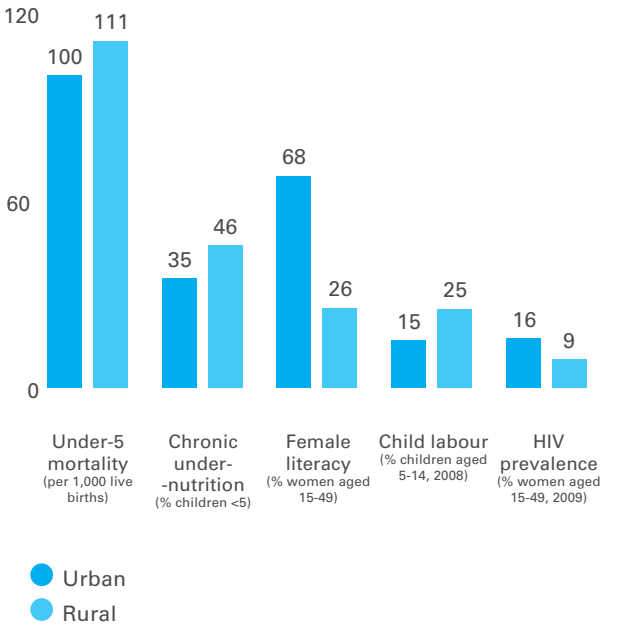
1 out of 2 girls is married before she turns 18; 1 out of 10 is married before she reaches 15

2.2 GEOGRAPHIC INEQUITY

There are large geographic inequities, generally to the disadvantage of rural areas and the provinces in the Centre and North of the country. Administrative data show that there are also considerable disparities between districts within provinces. But, given the large number of districts (141) and the fact that survey data (generally more reliable than administrative data) cannot be disaggregated to this level, district disparities will not be discussed here[12]. In interpreting these disparities, it is important to bear in mind also the distribution of the population. Approximately 30% of the population lives in urban areas. Some of the 11 provinces are much more densely populated than others, with 38% of the national population concentrated in just two provinces, Zambézia and Nampula[13].

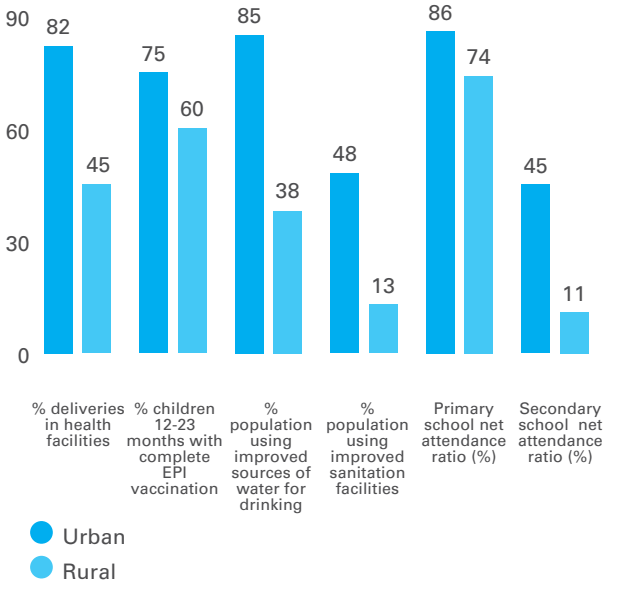
Rural areas are worse off in most domains except HIV prevalence. Using 2011 DHS data, the urban/rural dimension of inequity can be seen both at the level of human and child well-being (including for example child mortality, nutritional status and literacy) and in terms of the utilization of basic social services. In some cases, as Figure 2.7 shows, the disparities are stark at the level of well-being. For example, women are 2.6 times more likely to be literate if they live in the urban areas than in the rural areas. And rural children are 1.7 times more likely than urban children to be working. But, for some other indicators, such as under-5 mortality and chronic under-nutrition, the disparities are less extreme and it is the high level of risk in both rural and urban areas that demands attention. HIV prevalence contrasts with the other well-being indicators in showing a worse situation in the urban areas. This is possibly because of higher population density, migration, the weakening of traditional socio-cultural norms and greater access to HIV testing and treatment (improving the survival of those infected) in the cities.

Figure 2.7 – Urban-rural disparities in human and child well-being, 2011



Sources: DHS 2011, MICS 2008 (for child labour) and INSIDA 2009 (for HIV prevalence).
Note: Disaggregated under-5 mortality rates in the 2011 DHS are for a 10-year period before the survey (2001-2011) and cannot be compared with the national under-5 mortality rate cited earlier (97 per 1,000 live births), which is for a 5 year period (2006-2011).

Figure 2.8 – Urban-rural disparities in use of basic social services, 2011[14]

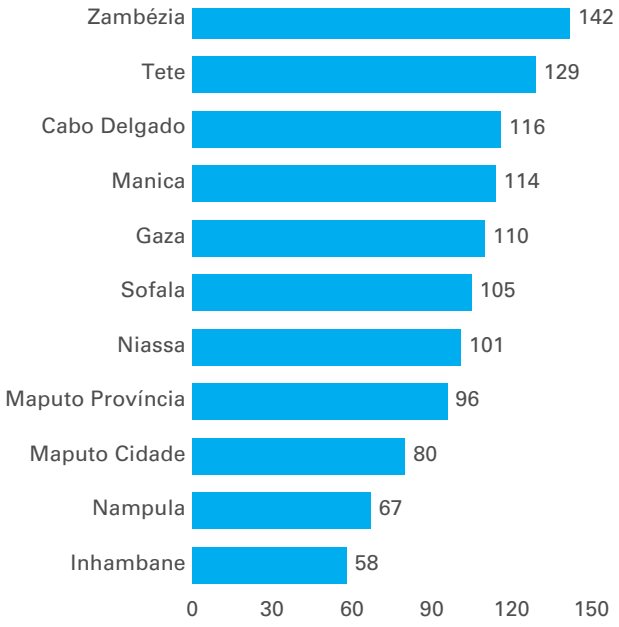


Source: DHS 2011.

The degree of rural/urban inequity in the use of basic social services reflects to a large extent disparities in the supply of services. Thus, as Figure 2.8 shows, there is no difference in the net attendance ratio in primary education between urban and rural areas, due to the substantial progress made in expanding the network of primary schools across the rural areas. There is a large urban-rural difference in the net attendance rate at secondary level (45% compared with 11%), reflecting the supply-side constraints on secondary education in the rural areas. There are also important disparities in the use of health services, particularly in the case of reproductive health services. Expecting mothers in urban areas are almost twice as likely to deliver their babies in health facilities as women in rural areas (82% compared to 45%). Partly because of lower antenatal consultation rates in the rural areas, women are less likely to be tested for HIV in the rural areas (22% compared to 34% in the urban areas). There are also very large inequities in water and sanitation, with people who live in rural areas being four times less likely to use improved sanitation facilities and two times less likely to use improved drinking water sources than people in urban areas. In the rural areas, every other person (51%) practices open defecation and one in five (21%) uses surface water for drinking.[14] There are also large disparities in water access within cities, notably between the modern 'concrete' city and informal peri-urban settlements.

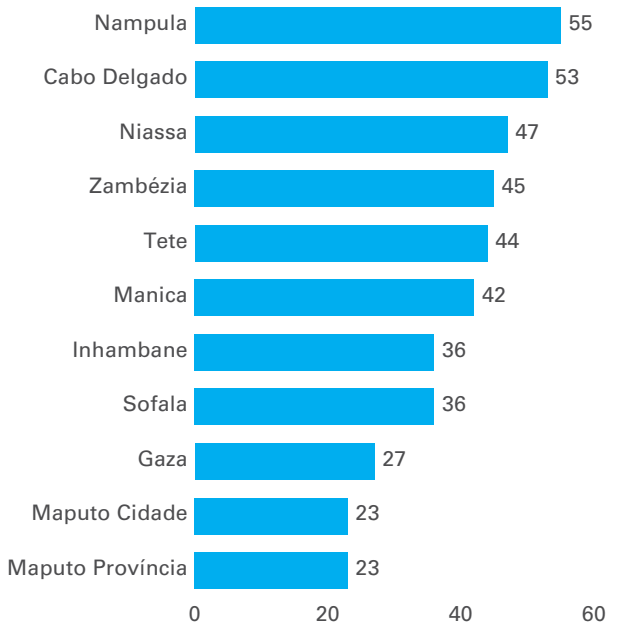
70% of the population lives in rural areas which are the areas with greatest disadvantages in many child well-being aspects

Figure 2.9 – Provincial disparities in under-5 mortality (deaths per 1,000 live births), 2011



Source: DHS 2011

Figure 2.10 – Provincial disparities in chronic under-nutrition (% of children under 5), 2011



Source: DHS 2011

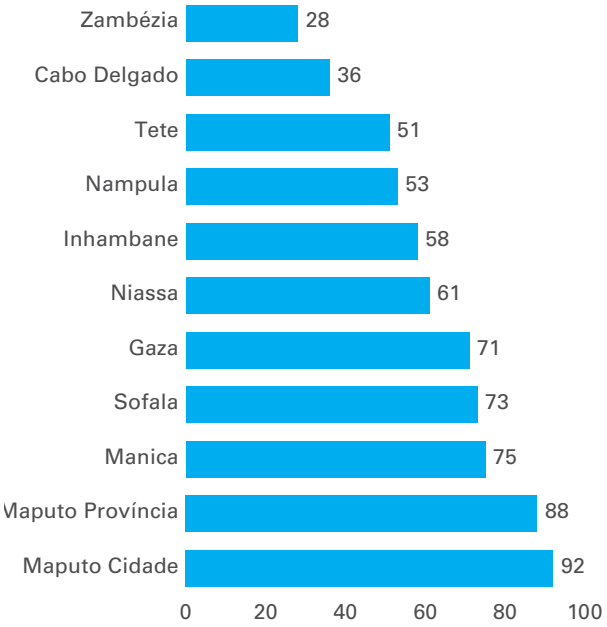
There is a marked north-south divide, with the most recent DHS (2011) data confirming that the northern and central provinces are generally worse off than the southern provinces:

Under-5 mortality is above 100 per 1,000 live births in six central and northern provinces (Zambézia, Tete, Cabo Delgado, Manica, Sofala and Niassa), as well as one southern province (Gaza). However, the northern province of Nampula has one of the lowest under-5 mortality rates. A child born in Nampula has more than twice the chance of surviving to his or her fifth birthday than a child born in the neighbouring province of Zambézia. In contrast, except for Zambézia province which recorded an increase in mortality from 2003 to 2011, from 123 to 142 deaths for every 1,000 live births, this is the region which has made greatest progress in the mortality rate among children under the age of 5. Four provinces (Nampula, Cabo Delgado, Niassa and Sofala), recorded a reduction of more than 100 deaths for every 1,000 live births during this interval.

A child born in the northern provinces is almost twice as likely to suffer from under-nutrition than one born in the southern provinces. The highest rates of chronic under-nutrition are in Nampula, Cabo Delgado and Niassa (in the range of 47-55%), followed by the central provinces (36-45%) and then the southern provinces (23-36%).

Use of health facilities is also generally lower in the North and Centre, compared with the South, although with quite sharp differences between provinces within these regions. For example, the proportion of deliveries in health facilities varies between 28% and 75% in the Centre and North, but overall is considerably higher in the South (in the range of 58-92%). Furthermore, one notes that, with the exception of Zambézia province, which has made little progress in the institutional births indicator, it is in this region that there was the greatest progress in access to institutional births between 2003 and 2011, notably in Sofala, Manica, Nampula and Niassa where the increase was between 15 and 21 percentage points.

Figure 2.11 – Provincial disparities in deliveries in health facilities (% of births), 2011

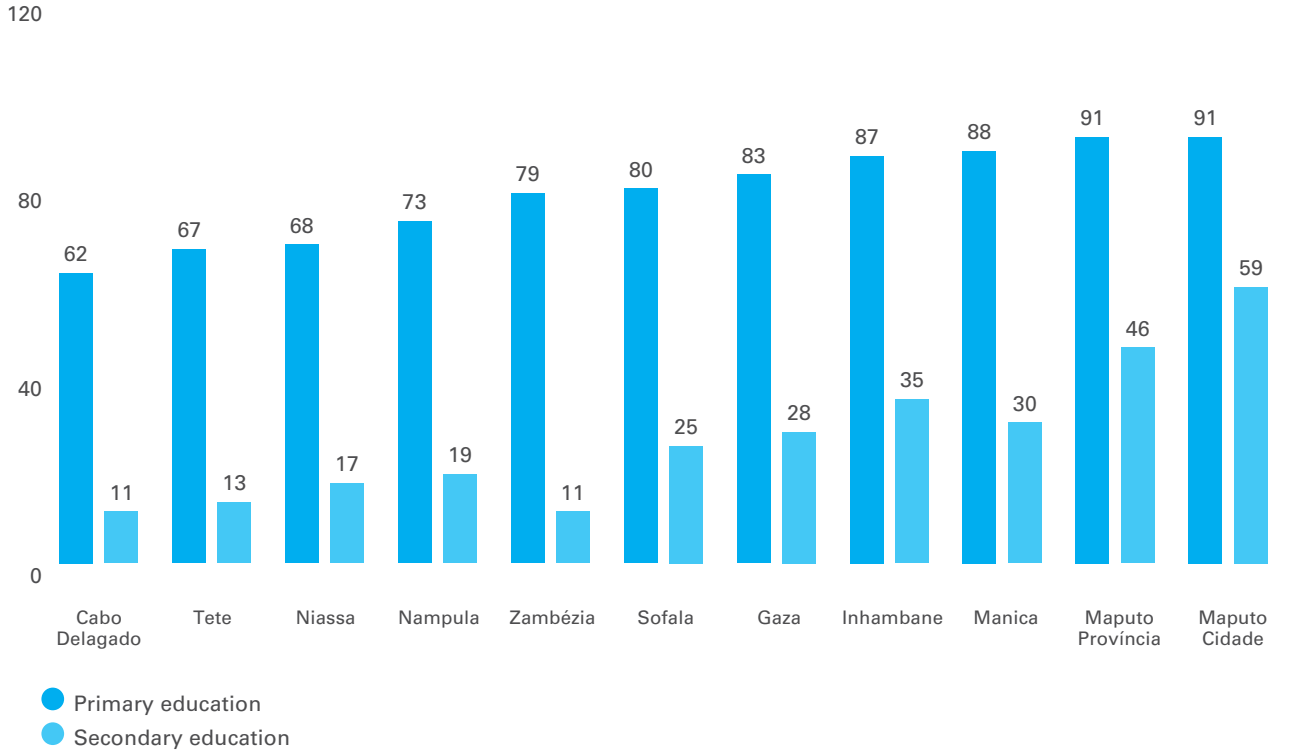


Source: DHS 2011.

There are large regional disparities in access to education, especially at secondary level. In primary education, net attendance rates are 62-73% in the northern provinces, 67-88% in the central provinces and 83-91% in the southern provinces. At secondary level, the net attendance rate is 59% in Maputo city, but less than 20% in all northern provinces and less than 30% in all central provinces (and less than 20% in Zambézia and Tete). The administrative data likewise show large north-south disparities for correct-age enrolment, retention, dropout and completion rates, while the SACMEQ tests have shown similar disparities in learning achievement.

These disparities are evident also for access to water and sanitation. According to the PRONASAR baseline survey in 2011 (MOPH, 2012a), the proportion of the population using both improved drinking water sources and improved sanitation facilities in the rural areas declines from 13% in the South to 11% in the Centre and only 4% in the North.[15]

Figure 2.12 – Provincial disparities in school net attendance ratios (%), 2011

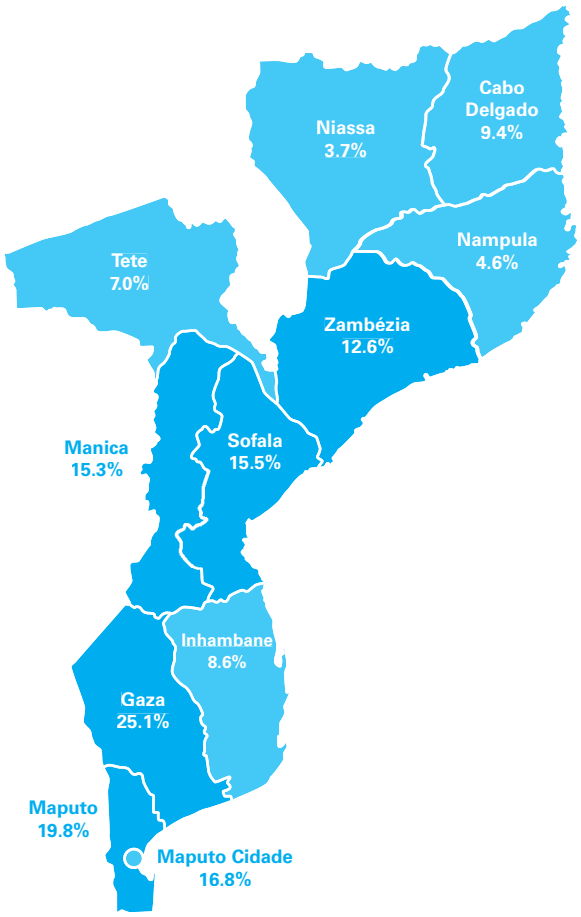


Source: DHS 2011.

The situation in Zambézia is the worst in many respects and this calls for special attention in budgeting, the planning of investment in social infrastructure and the deployment of personnel. This reflects the province's historical legacy of lower levels of development, its high rates of poverty (with the highest provincial poverty incidence of 70.5% recorded in the 2008 IOF) and the large size of its population (almost one fifth of the national total). According to the 2011 DHS, Zambézia has the highest under-5, infant and neonatal mortality rates (142, 95 and 37 per 1,000 live births), the highest rate of acute under-nutrition (9.4%, close to WHO's critical threshold of 10%) and the highest rates of underweight and anaemia in children, the lowest rates (by far) for deliveries in health facilities and assistance at delivery (28% and 26% respectively), the lowest vaccination rates (with only 47% of children aged 12-23 months fully vaccinated), the lowest proportion (by a wide margin) of the population using improved drinking water sources (a mere 26%), the lowest secondary school net attendance rate (just 11%) and the lowest rate of birth registration (27% of children under 5). Given that almost 1 in every 5 Mozambicans lives in the province, the weight of Zambézia in the various dimensions of deprivation is especially high. For example, Zambézia has 32% of the children aged 12-23 months without DTP3 vaccination, followed by the other high-population province, Nampula (21%).

HIV prevalence again shows inverse disparities, with the South worst off. According to the INSIDA data for 2009, prevalence is highest in the South (17.8%), followed by the Centre (12.5%) and then the North (5.6%). HIV risk may be higher in the South because of proximity and migration to South Africa, where the prevalence rate (17.3%) is similar to southern Mozambique. The prevalence rate is exceptionally high for women in the southern province of Gaza, where there is a strong tradition of migration for employment — 1 out of every 3 women are HIV+ (30%). Prevalence rates are also very high (20-21% for women) in Maputo Province and Maputo City (see Map 2.1). Prevalence is lower in one of the southern provinces, Inhambane (10% for women), possibly because this province has a much higher level of male circumcision, which has been shown to be linked to higher protection against HIV infection. Although the Centre has a slightly lower prevalence rate than the South (despite the country's highest rate of 21% in Sofala for young women aged 15-24), the absolute number of persons living with HIV (PLHIV) is highest in the Centre (46% of the national total), due to this region's large population, compared with 38% in the South and 16% in the North. Socio-cultural practices ('closed' polygamy and high levels of male circumcision) and low migration may explain the lower level of prevalence in Northern provinces.

Map 2.1 – HIV prevalence by provinces, 2009
(% of population aged 15-49)



Source: INSIDA, 2009

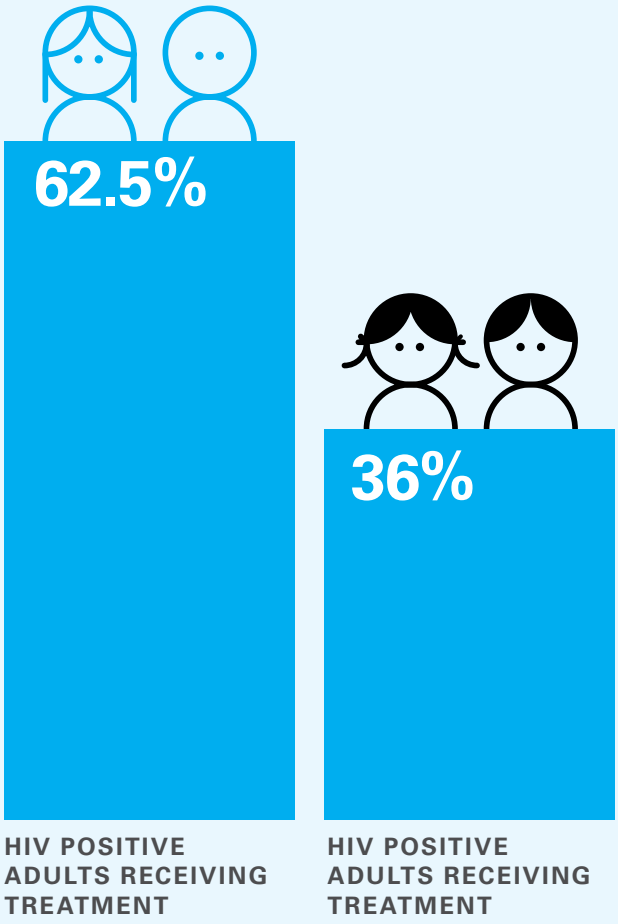
THE SITUATION OF CHILDREN IN MOZAMBIQUE 2014

CHILDREN IN MOZAMBIQUE

The more than 12 million Mozambican children constitute 52% of the population of the country

HIV/AIDS

Mozambique has the 8th highest prevalence in the world. 11.5% of 15 to 49-year-olds are HIV positive



THE SITUATION OF CHILDREN IN MOZAMBIQUE 2014

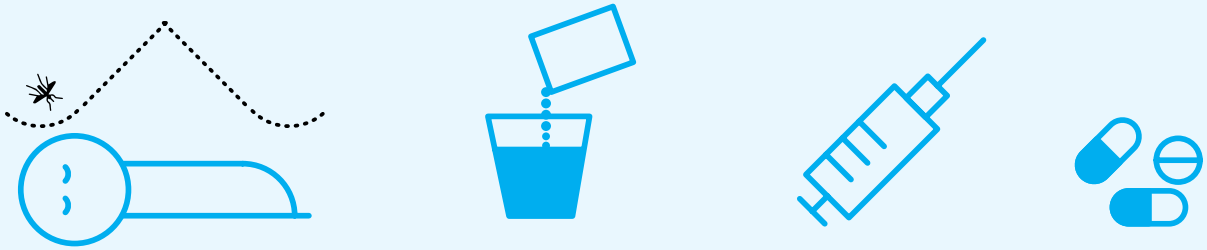
CHILD MORTALITY - 0-5 YEARS

From 1997 to 2011, under 5 child mortality decreased by half.

1997
20 of every 100 children died before their 5th birthday

2011
This proportion is now 10 of every 100

THIS ADVANCE IS IN PART THE RESULT OF INCREASED USE OF MOSQUITO NETS, OF ORAL REHYDRATION SALTS, OF VACCINES AND OF TREATMENT FOR ACUTE RESPIRATORY INFECTIONS



1– For the DHS reports, see INE & Macro DHS (2008), INE, MISAU & MEASURE DHS (2005) and INE, MISAU & MEASURE DHS (2012). For the MICS 2008 report, see INE (2009), and for the results of the IOF 2008/09 (and comparisons with IAF 2002/03), see MPD, 2010. All references are at the end of this report.

2– Malaria is the biggest cause of death in children under five years of age at 33%, followed by AIDS at 10%, pneumonia at 10% and diarrhoea 7%. The breakdown of the causes of mortality is based on 2007 census data.

3– In addition, 18.5% of households in 2011 reported that rooms had been sprayed with insecticide in the previous 12 months.

4– While the initial vaccines have high coverage (about 80% for BCG and DTP1), there is a fall in subsequent coverage (to 69% for DTP3 and 62% for full vaccination), highlighting a failure to sustain compliance with the vaccination schedule.

5– Silva-Leander S (2014) Situation Analysis Mozambique: Multivariate regression analysis on chronic malnutrition (DHS 2011), UNICEF Mozambique, Maputo

6– Data collection for the 2008/09 IOF took place over the course of a full year, from September to August, while data collection for both the 2008 MICS and the 2011 DHS took place in the months immediately preceding and leading into the 'lean period' (August-November for the MICS and June-November for the DHS). Comparing the results of the 2008/09 IOF and the 2008 MICS in their overlapping period (see Azzarri et al, 2011), the differences in stunting and underweight prevalence were very small and statistically not significant, although the IOF did find a statistically significant higher prevalence of wasting (6.3%), which is also close to the prevalence found three years later in the 2011 DHS.

7– WHO, 2009.

8– Based on 1990 estimates, these coverage targets for 2015 are 68% for water and 56% for sanitation. However, it is likely that the base estimates, which were not derived from national surveys, were inaccurate, with a particularly high overestimate for sanitation.

9– According to this source, by the age of 7 almost 100% of children were enrolled in school in 2012.

10– A study in rural Gaza found that children aged 3-5 who had participated in a community ECD programme performed better on measures of cognitive and overall development at age 6 (compared to a control group) and were more likely to enter primary school at the right age (cited by Fox et al, 2012).

11– In a report on field visits to investigate the problem in 2008, the education ministry reported that, in discussions with pupils in primary grades 4-7, 70% of girls said that 'some teachers use sexual intercourse as a condition to move up' (MEC, undated). The girls cited fear of retaliation as one of the main reasons for keeping silent about sexual harassment.

12– A new district level monitoring system, the Sistema de Monitoria do Desenvolvimento Distrital (District Development Monitoring System - SMoDD), has been set up by the Ministry of State Administration, the Ministry of Planning and Development and the National Statistics Institute (INE), to monitor the performance of district administrations. This has been piloted in several districts in Inhambane, but has not yet been expanded nationally.

13– Detailed data on disparities by provinces and by rural and urban areas of residence may be found in Tables A.2 and A.3 in the statistical annex.

14– The 2011 DHS data for water and sanitation in rural areas are similar to the results of the baseline survey of the National Programme for Rural Water Supply and Sanitation (PRONASAR), conducted in the same year (MOPH, 2012a). This found a slightly higher proportion of the rural population using improved water sources for drinking (45%) and slightly less with improved sanitation (12%).

15– However, taken separately, use of improved water sources for drinking in the rural areas is higher in the Centre (52%) than in the South (48%), but still lowest in the North (35%), according to this source.

What is holding back faster progress?

03

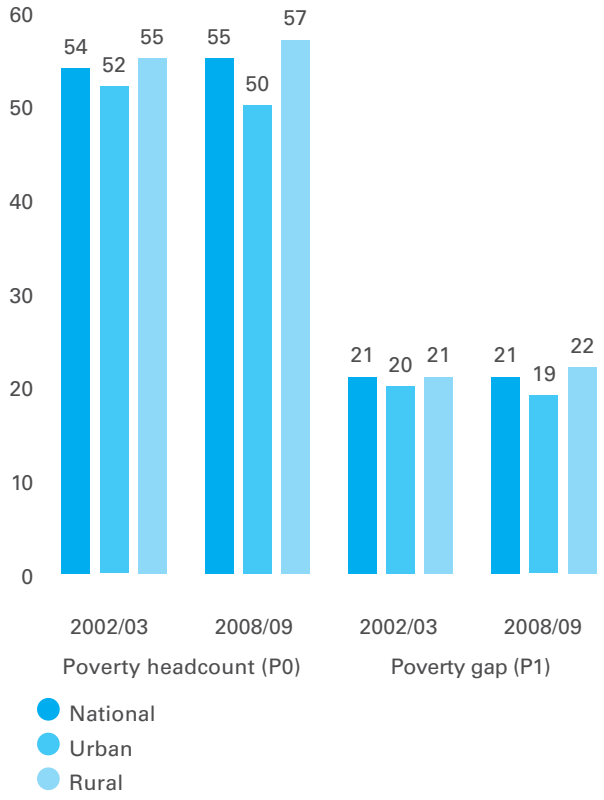
Given the uneven progress shown in the data and illustrated in the previous chapter, it is important to analyse the underlying and intermediate factors which may be influencing the pace of progress, including the 'bottlenecks' that in some cases are hindering the realization of child rights. As explained in the conceptual framework of this analysis, key factors at the underlying level include poverty and vulnerability, climate change, socio-cultural practices and gender relations, and governance. These affect the realization of child rights indirectly in multiple intersecting ways, through a range of intermediate channels.

3.1 POVERTY AND CHILD VULNERABILITY

Child vulnerability is a multi-dimensional phenomenon, in which the high levels of monetary poverty play a particularly important role in Mozambique, alongside other factors such as the quality of the family environment, the presence of disabilities and gender inequality. Monetary poverty has crucial implications for access to social services and child well-being. However, given the immaturity and dependence of the child, the fragility of the family (or in extreme cases the absence of family) can be another critical source of child vulnerability. In Mozambique, such fragility is reflected in particular by the fact that a high proportion of children, including but going far beyond orphans, do not live with their biological parents. Children with disabilities face the added disadvantage of diminished functional capability and discrimination within the family, the community and society, which often leads to a situation of social exclusion. Gender inequality, which is discussed in Section 3.3 of this chapter, increases the vulnerability of girls.

MONETARY POVERTY

Figure 3.1 – Poverty headcount and gap, 2002/03-2008/09



Source: IAF 2002/03 and IOF 2008/09 (INE, 2010).

The high economic growth recorded in recent years has not brought about significant poverty reduction. Although data are not available for the period since the household budget survey (IOF) in 2008/09[16], monetary poverty rates stagnated during the period from 2002/03 to 2008/09, with the poverty headcount 'stuck' at around 54-55% of the population and the poverty gap (the average distance of the poor from the poverty line) also remaining more or less unchanged at around 21% of the poverty line (MPD, 2010). The implication is that, while growth rates have averaged about 7.5%, this has not 'trickled down' to the poor, unlike in the earlier post-conflict period when the return of refugees and the revival of economic activities, especially in the rural areas, brought quick initial gains in poverty reduction. For every 1% increase in real GDP per capita, poverty decreased by 0.86 percentage points between 1996/7 and 2002/3 but by only 0.04 percentage points between 2002/3 and 2008/9. In other words, the most recent growth in the economy has not translated into lifting a larger proportion of Mozambicans out of poverty. Growth has become less pro-poor (Cunha et al, 2013).

This has been attributed to the fact that most of the growth has come from investments in 'mega-projects' and extractive industries that have weak linkages to the rest of the economy, generating few jobs. In the areas most affected by investments in extractive industries, the establishment of concession areas also risks depriving local populations of their livelihoods if they are resettled in areas with inferior farming potential, as appears to have been the case in parts of Tete. By contrast with the high levels of foreign direct investment in mega-projects, there has been little investment to improve the productivity of smallholder agriculture, which affects directly the incomes and food security of the majority of the population of the country, which is engaged in farming. These farmers are highly vulnerable to weather shocks and the seasonality of rural incomes. Living standards and food security have also been affected by the rise of international food and fuel prices, especially in the urban areas. Although urban poverty (with a 50% headcount in 2008/09) is lower than rural poverty (56.9%), the difference is small (see Figure 3.1), and price rises have twice sparked serious urban unrest, in 2008 and 2010.

FAMILY ENVIRONMENT AND CHILD VULNERABILITY

The degree of vulnerability of children reflects not only the income of households and their capacity to withstand economic or climatic shocks, but also the family environment in which they are living. This is because children are not fully mature, either physically or psychosocially, and depend greatly on the positive support and affection of parents and family members. If this is lacking, or the child is entirely deprived of a family environment, he/she is vulnerable to mistreatment and to higher risks of deprivation that compromise the child's well-being and development.

The fact that a very high proportion of Mozambican children do not live with their biological parents, due to orphanhood, separation of parents, migration, informal fostering and other factors, is therefore of particular concern. According to the 2011 DHS, almost 1 in 5 (18%) children are not living with either of their biological parents. In most cases this is despite the fact that one or both of their parents are living. The proportion of children separated from both their parents rises with age, peaking among children 15-17, when 40% are not living with either parent, even though both parents are alive for well over half of these children (23% of all). This is likely to reflect, among other factors, the early marriage of girls, who set up new families with their spouses and are thus not residing with their parents. Child marriage is likely also to be the main reason why about 36,000 children live in child-headed households.[17] The DHS data also show that little more than half of all Mozambican children (52%) live with both their parents, a proportion that falls

to its lowest level in Gaza (28%), in all likelihood because this is a province with a long tradition of economic migration, notably to South Africa. Of those who live only with their mothers, 1 in 5 have living fathers, testifying to the degree of family separation, often due to migration or family instability. There is also a small minority of children living entirely outside a family framework, deprived of the normal affective supports of a family and in some cases exposed to especially high risks. These include children in prisons (2,329, or 14% of the prison population, in April 2013) and, as of the end of 2012, 8,267 children in residential centres (MMAS, 2013; Brown and Winberg, 2013). Although there is very little information on the subject, it appears that some children and young women are trafficked, mainly from rural to urban areas or to neighbouring countries, including for sexual exploitation and domestic service.

Almost 1 in 5 children are not living with either of their biological parents; among children 15-17 years-old this proportion increases to 2 out of 5

The proportion of orphans has risen, due to the ravages of AIDS. The DHS data show that the proportion of children who are orphans of one or both parents has risen by almost a third, from 10% to 13% between 2003 and 2011. Double orphans, who have lost both their parents, constitute only a small subset of these children, but this category has grown in importance too, from 1.3% to 1.7% of children over the same period. These are mainly older children. Although orphans (of one or both parents) are somewhat more likely to be in the upper wealth quintiles, reflecting either the larger impact of HIV/AIDS among the better-off or the greater capacity of wealthier households to foster orphans, or both factors, the 2011 DHS data show that double orphans are particularly vulnerable to deprivation in education. In the age range 10-14, double orphans are 7 percentage points less likely to be in school than children who have lost neither of their parents and who live with at least one parent (74% compared to 81%). A regression analysis of DHS 2011 data (Silva-Leander, 2014) found that, of all the different categories of children under 5, orphans have the highest probability of being stunted (51%), after controlling for all other factors, compared with a 42% probability for non-orphans.

One third of households are taking care of orphans or other children through informal fostering. The 2011 DHS data show that about 19% of households have orphans and that just under one fifth of these households (3% of all households) are caring for double orphans. Furthermore, 28% of households have 'taken in' children, in the sense that these children are living in host households with neither of their parents. This is overwhelmingly a result of informal fostering, showing one of the great strengths of Mozambican society: a high degree of solidarity that, despite the material hardships of everyday life for most households, provides a home for millions of children who are not

living with their biological parents. On the flip side, there is the risk, as the education data for double orphans seem to show, that some of these orphaned or separated children will be disadvantaged compared to 'blood' children in their host families or in the worst of cases may be exploited as a source of labour within the household.

DISABILITY AND CHILD VULNERABILITY

With the prevalence of disability at 2% in the overall population, according to the 2007 census, disability is another driver of vulnerability. A large proportion of the population with disabilities lives in the rural areas in poor households without access to the specialized services they need. The census found that disease (58%) and congenital problems at birth (33%) are the main causes of disability, and that the main types of disability are amputation of the lower limbs (21%), deafness (13%), blindness (9%), mental disability (9%), amputation of the upper limbs (8%) and paralysis (7%).[18]

Other studies have calculated much higher prevalence rates. It is noteworthy that a nationally representative study on the living conditions of the population with disabilities, carried out in 2007-2008, using the criteria in WHO's International Classification of Functionality, Incapacity and Health (ICF), estimated prevalence at 6% (INE, FAMOD and SINTEF, 2009). This would mean that, in 2014, disability affects about 1.5 million people, impeding their full functional capability. The study estimated that about one quarter (26%) of households include at least one member with a functional limitation.

The disability affects 1 out of 15 people

The living conditions of people with disabilities are generally more precarious than for the rest of the population due to the socio-economic effects of the stigma and social discrimination of which they are often victims, as well as the constraints arising from the functional limitations themselves, from their low level of schooling and participation in the labour market and their low access to specialized services and compensatory subsidies. All these factors make it difficult to obtain a decent standard of living. The national study carried out in 2007-2008 used a list of 37 types of household goods to measure the living standards of households with and without persons with functional limitations (PFL) and found that households with PFL possess less types of goods (7.4 on average) than households without PFL (8.2).

Many families continue to have negative attitudes that lead to a situation of social exclusion of people with disabilities from childhood. It appears that attitudes are evolving towards a greater acceptance of people with disabilities and a decline in social discrimination against them. However, stigmatization and discrimination remain widespread in communities and within families, putting at risk the rights of children with disabilities, diminishing their self-esteem and at times marginalizing the family as a whole. Husbands often divorce the mothers of children with disabilities. These negative attitudes have their roots in superstitious beliefs about disability, namely that the birth of a child with a disability is a punishment inflicted on the family by divine powers or ancestors as retribution for sins committed by the parents (UNICEF, 2013, and HI, 2010). Because of this, the child with a disability is often kept shut within the house at the cost of denying his/her right to go to school and to participate in social life within the community, including playing with other children. In the worst of cases, these children can be abandoned or institutionalized in orphanages (Brown and Windberg, 2013).

Children with disabilities have lower school enrolment, despite a likely improvement in the last few years resulting from the general expansion of the school system. The national study in 2007-2008 found that school enrolment of children in households with PFL was much worse than in a control group of households without PFL. In the age group 0-14, the percentages of children not enrolled in school were respectively 43% in the PFL group and 19% in the control group.

The Government, through the Ministry of Education, is trying to ensure that children with special learning needs are integrated into regular schools, instead of being segregated in separate schools or excluded from the education system. Children with severe disabilities are supposed to be taught in special schools, in accordance with the National Education Policy, adopted in 1995. However, the few such schools that are available, overwhelmingly in the urban areas, focus mainly on children with hearing impairments. The ministry is also setting up Inclusive Education Resource Centres (CREI), which provide vocational training courses for children with special learning needs and other vulnerable children. The existence of children with multiple disabilities is a reality in the country, which makes it necessary that specific mechanisms be found to care for these children, raising the awareness of the families and training social welfare staff and teachers so that they can provide the due care for these children.

Many families continue to have negative attitudes that lead to a situation of social exclusion of people with disabilities from childhood.

The implementation of inclusive education faces many constraints. Inclusive education is education that is sensitive to the needs of children with special learning needs, that understands the situation of these children, including psychosocially, and that has adequate capacity to cater to their special needs, wherever possible within the mainstream school system, so that these children can develop to the maximum of their capacity and without stigma, regardless of their differences. A study on access to education in Maputo Province and Zambézia (FAMOD & PI, undated) concluded that 'the majority of schools do not meet the minimum requirements for accessibility'. They do not have ramps or appropriate toilets, nor specialized teaching materials for children with disabilities, such as braille machines. Moreover, the high pupil-teacher ratio and the inadequate training of teachers to teach children with disabilities are serious constraints hindering the implementation of inclusive education. Another study, carried out in three districts of Nampula and Tete in 2012 (UNICEF, 2013), supports this assessment, highlighting the unpreparedness of teachers as the main constraint, along with the lack of specific learning materials for each type of deficiency and the problems of physical accessibility in schools. The study noted that, in both provinces, children with hearing or visual disabilities were those that least attended school. Non-enrolment is also a result of attitudes within the family, including the isolation of children with disabilities at home, as already mentioned, the desire to protect children from the risks of mistreatment at school and the calculation of some parents that it is not worthwhile to invest in the education of a child with a disability.

Various studies also highlight the heightened vulnerability of adolescents, especially girls, with disabilities with respect to their reproductive health and protection against HIV and AIDS (DDP, 2008, Lefèvre-Chaponnière, 2010, and HI, 2013). A large majority of young people with disabilities are sexually active, but they have lower levels of knowledge about HIV and methods of preventing transmission, due to their low levels of education and limited access to information (especially in the case of youth with hearing and intellectual disabilities). Due to their extremely precarious situation, adolescent girls with disabilities are especially vulnerable, due not just to their low levels of knowledge, but also because they are often in unstable, multiple sexual relationships and they have almost no influence over the use of condoms by their partners. These studies concluded that prevention programmes have not adequately taken into account the specific situation of young people with disabilities and the constraints that limit their access to the information channels most used in campaigns.

Children with disabilities who are isolated at home are especially vulnerable to sexual violence and abuse committed by family members (Save & HI, 2011, and HI, 2013). This abuse happens, often over many years, without the knowledge or intervention of neighbours, community leaders or the State (Police and social workers). The low level of education and the high dependence of children with disabilities make it even more difficult for these children to seek help. Abuse in the form of domestic and sexual violence becomes much more extensive in adulthood. According to a study carried out in Maputo and Matola, 75% of women with disabilities have suffered at least once from sexual or domestic violence (HI, 2013).

In the past few years there has been an improvement in the access of persons with disabilities to rehabilitative and medical services, but there are still large shortfalls in the availability and quality of the services provided, including the absence (or distance) of specialized centres providing orthopaedic and rehabilitative services, located in the provincial capitals, and the lack of drugs in public pharmacies. According to the national study in 2007-2008, the gap between needs and access to services is enormous in practically all areas: for example, a gap of 92% in the case of access to professional training (to facilitate the economic autonomy of persons with disability) and a gap of 82% for assistive devices or equipment to compensate disabilities or attenuate their consequences. The devices most widely provided, mainly by specialized NGOs or through the Direct Social Assistance Programme (PASD) of INAS, are those to assist personal mobility (wheel chairs and crutches). The study in 2007-2008 found that less than half of persons with visual disabilities used glasses and no persons with hearing disabilities had hearing aids.

Despite the improvement in the access of persons with disabilities to rehabilitative and medical services, there are still large shortfalls in the availability and quality of the services provided

In the last few years there has been major progress in establishing a favourable legal, policy and planning framework for respect of the rights of people with disabilities, including children. Mozambique has established a legal framework that protects the rights of citizens with disabilities, notably by including this guarantee in the national Constitution (in article 37) and by ratifying the International Convention on the Rights of Persons with Disabilities in 2012. The Government adopted a Policy on Persons with Disabilities in 1999 and, in order to make it operational, adopted two successive national plans on disability (PNAD I and II) for 2006-2010 and 2012-2019. The goal of PNAD II is to 'promote the full participation, equality and empowerment of persons with disabilities and ... to uphold the principle of equal rights and opportunities for this social group' (RdM, 2012a). It includes, among other components, the expansion of inclusive basic education, the provision of rehabilitative medical services, social assistance to families and institutional capacity building for organizations of and people with disabilities. The monitoring of PNAD II is coordinated by the National Council on Disability (CNAD), set up in 2009 as a multi-sector body in which various ministries, associations of persons with disabilities and other actors are represented.

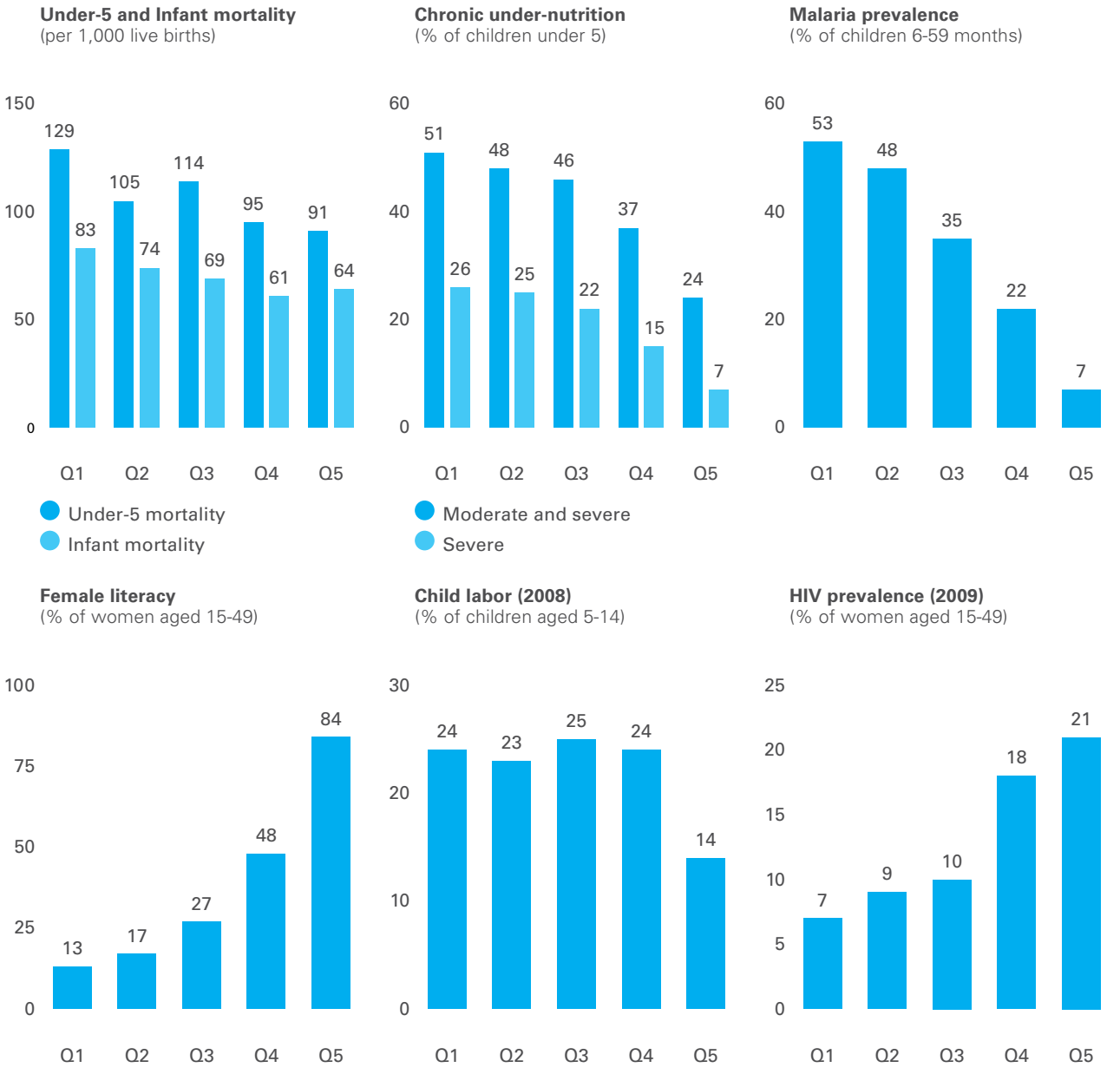
Much still needs to be done to translate these principles and intentions into practice. The progress achieved has not been as much as hoped for. The evaluation report of PNAD I noted the 'scarcity of trained human resources and of financial and material resources to implement fully the measures envisaged in the Plan' (RdM, 2012a). Persons (including children) with disabilities are still not effectively integrated in many of the sector plans and programmes. There is still the challenge of the prevalence of negative attitudes from families and communities which impact the survival, protection and development of children with disabilities.

EQUITY ANALYSIS BY QUINTILES

Many of the dimensions of well-being or deprivation are correlated with the material wealth (or poverty) of households. The following analysis employs the DHS 2011 data disaggregated by wealth quintiles, which have been constructed by dividing the population into five groups of equal size based on an index of assets owned by households. These groups of 20% of the population go from the lowest (poorest) quintile to the highest (richest) quintile. The analysis examines inter-quintile inequities first with respect to human or child wellbeing indicators and then in terms of access to basic social services. Figures 3.2 and 3.3 present the data by quintiles for some key indicators, while more comprehensive data may be found in Table A.4 in the statistical annex. It is important to point out that to a considerable extent the distribution of the population by wealth quintiles overlaps with the urban-rural distribution previously discussed. In the DHS data set, about 80% of the urban population is in the top two quintiles, with almost the entire population of Maputo City (96%) in the richest quintile. On the flipside, only 4% of the rural population is in the richest quintile, and 22% in the richest two. It is also worth noting that in the poorest province, Zambézia, 43% of the population is in the first (poorest) quintile and 70% is in the two poorest quintiles.

Although under-5 and infant mortality rates show a correlation with wealth, it is striking that mortality is high even in the wealthiest quintile. The differentiation by quintiles is quite shallow, but most striking is the fact that the risks are high even for children in the richest quintile, where nine out of every 100 children do not survive to their fifth birthday (see Figure 3.2). Household poverty appears to put children at higher risk of early death, but other factors are clearly also involved. These include the unhealthy environment in which children grow up and the poor quality of health services, which affects all quintiles, as well as various socio-cultural factors affecting reproductive behaviour and hygiene, feeding and child care practices.

Figure 3.2 – Inequities in human and child well-being, by wealth quintiles, 2011



Sources: DHS 2011, MICS 2008 (for child labour) and INSIDA 2009 (for HIV prevalence).

This pattern can be seen for chronic under-nutrition as well, although economic factors do seem to predominate, especially for severe stunting. Children in the poorest quintile are almost four times more likely to suffer from severe chronic under-nutrition than children in the richest quintile. Nonetheless, it is still worthy of note that almost a quarter of children in the richest quintile are chronically malnourished and that 7% are severely chronically malnourished. Two studies of the variables associated with chronic under-nutrition, using multivariate regression, both came to the conclusion that poverty is the key root cause of chronic under-nutrition. The first, using the 2008/09 IOF data (Azzarri et al, 2011), found a strong relation between consumption expenditure and the height-for-age of children[19], while other important (but lesser) factors included household size and birth spacing. The second, using the 2008 MICS, found that household wealth[20] was so much more important than other factors such as education and quality of water and sanitation facilities, that these 'became non-significant' (Martel, 2009).

The association with poverty is particularly striking in some specific dimensions, such as malaria prevalence and female literacy, as can also be seen in Figure 3.2. Only 13% of 1st quintile (poorest) women and 17% of 2nd quintile women are literate, compared with 84% of 5th quintile (richest) women, according to 2011 DHS data. However, even in this case it is remarkable to find that 42% of the 'richest' (5th quintile) women cannot read. Prevalence of malaria in children aged 6-59 months rises eightfold from 6.5% in the richest quintile to 53.2% in the poorest quintile, according to the same source.

HIV prevalence is the big exception, rising with the level of wealth. HIV prevalence is far higher in the 4th and 5th quintiles (18-21%) than in the three poorer quintiles (7-10%), seemingly contradicting the received wisdom that there is a synergistic relationship between the HIV/AIDS pandemic and poverty. The explanation may in part be geographical in the sense that the richer southern provinces with high prevalence are closer to and more integrated with the high prevalence countries of southern Africa, partly through migration.

The relatively small differences across quintiles for some indicators and the high level of deprivation even in the richest quintile suggest that universal rather than 'poverty targeted' approaches may be most appropriate, although they are more costly. The use of a 'poverty filter' for access to benefits such as social transfers or fee waivers is difficult to justify in this context, where, across the spectrum, people are faring poorly. Targeted approaches are also likely to be subject to large inclusion and exclusion errors (where people who should be benefitting are not, and people who should not be benefitting are) because of the technical difficulties of identifying the poorest when relatively little distinguishes households across the first few deciles in terms of assets, income or human development. Moreover, due to changing weather conditions or price movements, many households are 'transitory poor', moving in and out of poverty. The main argument for poverty targeting in such an environment is a fiscal one – the simple fact that public resources are constrained and have to be rationed, even though needs are extensive and targeting methods are unlikely to prove accurate.

At the level of service utilization, inter-quintile disparities reflect the relative importance of cost barriers as well as indirectly some supply-side factors (see Figure 3.3). Services with high direct, indirect and opportunity[21] costs for households tend to show greater inequity in access between the poorest and the wealthiest quintiles. However, other factors such as the availability and quality of services also affect inter-quintile disparities, especially if public services are disproportionately located in and better resourced in the urban areas, which are also 'wealthier-quintile' areas.

Many social indicators show large disparities by household wealth, although in some cases deprivations are high even in the wealthiest household

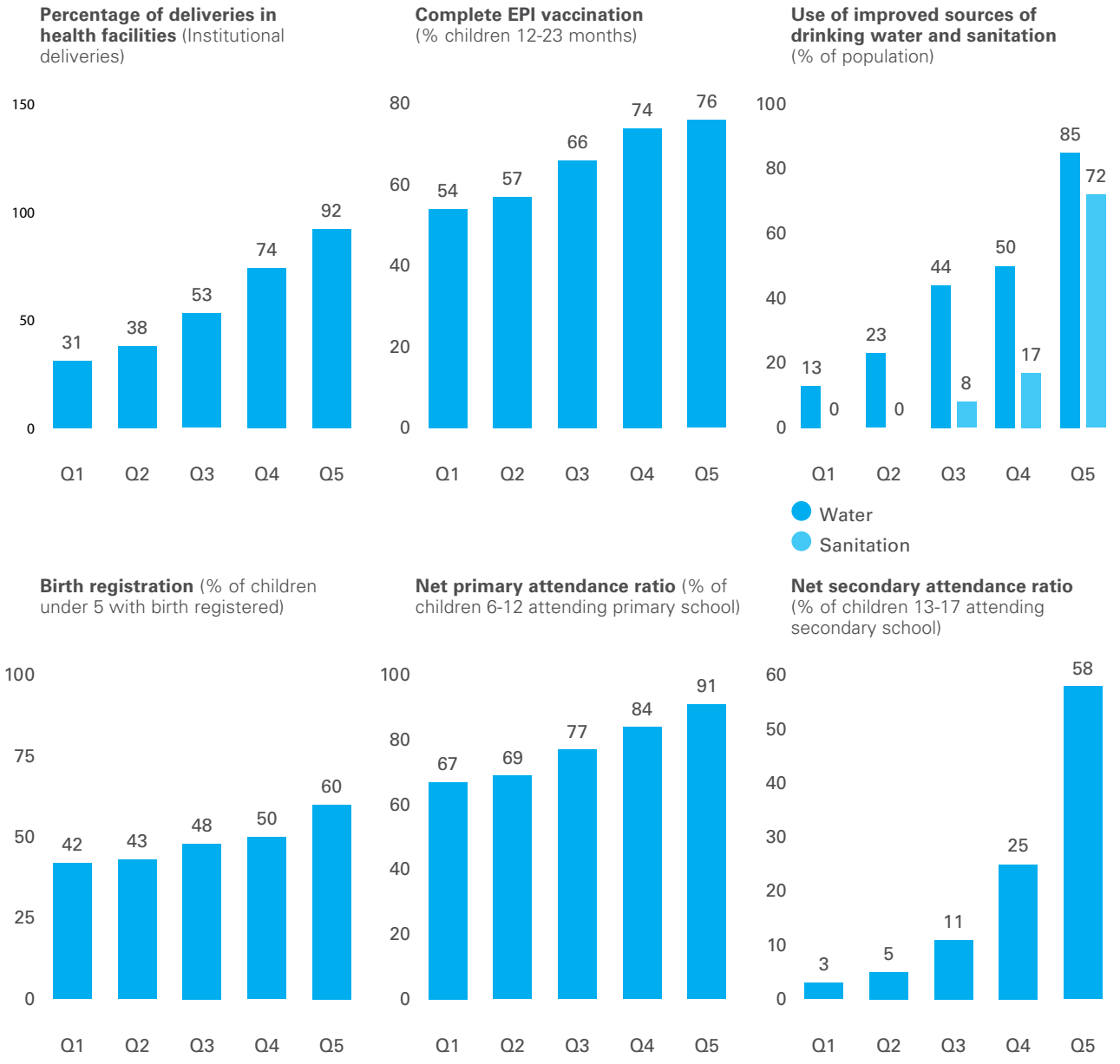
There is extreme inequity in the use of improved sanitation and drinking water sources. The MICS 2008 data show that virtually no one at all uses improved toilets/latrines in the two poorest quintiles. Although there may have been some improvement since then, 93% of people in the first quintile and 60% in the second quintile practiced open defecation. Even in the third and fourth quintiles, use of improved sanitation facilities is very low, with a large increase only in the fifth (richest) quintile (to 72%). The situation is slightly better for use of improved water sources, but this is still only 13% in the poorest quintile and 23% in the second poorest, rising steadily to reach 85% in the richest quintile. One in three people in the poorest quintile (29%) uses surface water (from rivers and lakes) for drinking.

In lower primary education, poverty leads to delayed enrolment, even though direct and indirect costs are low at this level of the education system. The primary net attendance rate rises from 67% in the poorest quintile to 91% in the richest quintile, according to the 2011 DHS data. This suggests that economic factors create barriers for demand from the poorer households, in a context where supply constraints are no longer a barrier to access, except at EP2 level in the more remote rural areas. Direct costs were reduced by the abolition of national school fees in 2004, but were not entirely eliminated because schools continue to charge various informal levies and families also have to meet the costs of school materials and sometimes uniforms.[22] Although household expenditure on these direct and indirect costs is in general very low at EP1 level (Fox & Santibañez, 2011), poverty holds back the enrolment of children in EP1 in another way. Qualitative research in Gaza (Visser, 2013) and Tete (PMA & DPE Tete, 2012) found that food insecurity is a key reason for the delayed enrolment of children in grade 1. Since the majority of primary age children do not receive breakfast (a finding also of the SACMEQ research), many parents consider children aged 6-7 as being too 'small' to go to school, especially as they will not be fed there. Mozambique has one of the lowest levels of coverage of school feeding in southern Africa, with only 72,000 children (1.3% of primary pupils) benefiting in 2012.

In 2008, practically no one in the poorest two quintiles used bathrooms/improved latrines

There are much starker economic disparities in access to upper primary and secondary education. Due to late enrolment and repetition in EP1, many children reach an age where opportunity costs (competition with work) become one of the main factors driving dropout towards the end of EP1 and especially in EP2 (Visser, 2013). At secondary level, where school fees have not been abolished and costs to households are much higher, including costs for children from more remote rural areas to travel to and live in towns where there are schools, there is extreme inequity in access. In fact, very few children from the poorest quintiles get this far in the education system. In 2011, according to the DHS, only 3% of poorest quintile children aged 13-17 were in secondary school compared with 58% of richest quintile children.

Figure 3.3 – Inequities in use of basic socials services, by wealth quintiles, 2011 (% of children 6-12 years)



Sources: DHS 2011 and MICS 2008 (for water and sanitation).

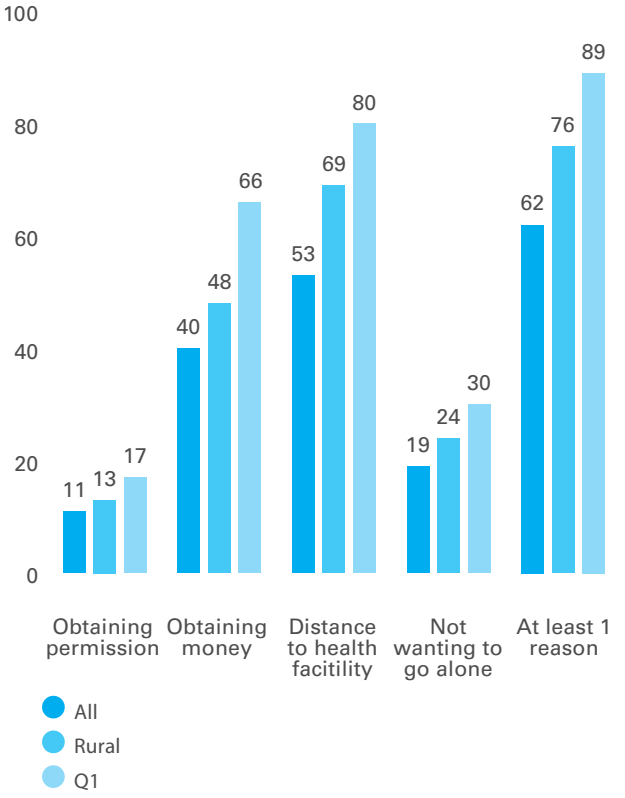
There are wide economic disparities in utilization of health services by both children and women. The large disparities in the proportions of women who give birth in health facilities and whose deliveries are assisted by health personnel provide the most extreme example of inequity in health service utilization. Women in the richest quintile are almost three times more likely to deliver in health facilities than women in the poorest quintile (92% compared to 32%), as Figure 3.3 shows, although there has been a slight reduction in inequality when compared with 2003 when this probability was 3.6 times greater (89% compared with 25%). The disparities for children are smaller, but not unimportant, with children under 5 in the richest quintile 1.4 times more likely to be fully vaccinated than children in the poorest quintile, 1.5 times more likely to receive oral rehydration therapy if they have diarrhoea and 1.2 times more likely to sleep under an insecticide-treated bed-net. Surprisingly, however, there is no correlation between household wealth and the proportion of children under 5 with fever receiving anti-malarial drugs. This follows no clear pattern, reaching its highest level in the 3rd quintile and falling sharply to the richest quintile (see Annex Table 4).

Box 3.1 – Cost and distance as barriers to access to health facilities and birth registration

The 2011 DHS shows that just over half of women (53%) cite distance as a reason for not using health facilities when ill, slightly ahead of the need to 'obtain money', cited by 40% of women. Direct costs for patients in the government health system are very low, with charges that have not changed for many years (MT 1 for a consultation, MT 5 per day for hospitalization and MT 10 for prescriptions) and exemptions for children under 5. However, direct costs are much higher in practice when drugs are not available in government health facilities, and there are also indirect (travel) and opportunity (time) costs, especially for patients in rural areas. In practice, the distance factor is partially a financial barrier, in so far as transport and time costs are incurred when health facilities are far away. The DHS findings therefore reflect both the financial constraints on households and the continuing problem of physical access. It is noteworthy that both cost and distance are more important for rural households and for the poorest households, as Figure 3.4 shows. A voucher mechanism to facilitate and encourage institutional deliveries is to be piloted with donor support.

There are similar cost and distance barriers for birth registration, according to the 2008 MICS. Costs were cited by 20% of mothers and distance by 23% as reasons for non-registration. Again, distance is itself partly a cost issue. Both problems were again cited more in the rural areas and in the poorest quintiles.

Figure 3.4 – Reasons cited by women for not going to health facilities, 2011 (% of women aged 15-49)



Source: DHS, 2011.

SOCIAL PROTECTION

The stalling of progress in reducing poverty has stimulated policy interest in the role of social transfers as a means of boosting the consumption and well-being of the poorest. The legal, policy and planning framework in this area has been strengthened by the adoption of the Social Protection Law in 2007, a new regulatory framework for non-contributory social protection in 2009, a national strategy for 2009-2014 and an operational plan for expansion of the system. This has led to modest but sustained increases in government expenditure, complemented by increased donor involvement, and investments in improving the operational systems (targeting, Management Information System, payments, case management) of the institution responsible for social transfer programmes, the National Social Welfare Institute (INAS).

Box 3.2 – Social transfers, children and human capital

The largest social protection programme, the Basic Social Grant Programme (PSSB), has a narrow focus that indirectly benefits only a small minority of the most vulnerable children. This programme, which currently accounts for over 80% of INAS beneficiaries, provides regular cash transfers to households with a permanent labour constraint, headed by old people and, to a more limited extent, by persons with disabilities or chronic diseases. Some children, including orphans, benefit indirectly in so far as they live in these highly vulnerable households. However, these households have an abnormally low number of children. With an average household size of only 2.3 (compared with a national average of 4.7), permanently labour constrained households have far fewer children than the average household (about 1.0 compared to 2.5). Furthermore, the fact that many of the children in these marginalized households do not have birth certificates prevents or delays their registration as secondary beneficiaries with a supplement to the base transfer.

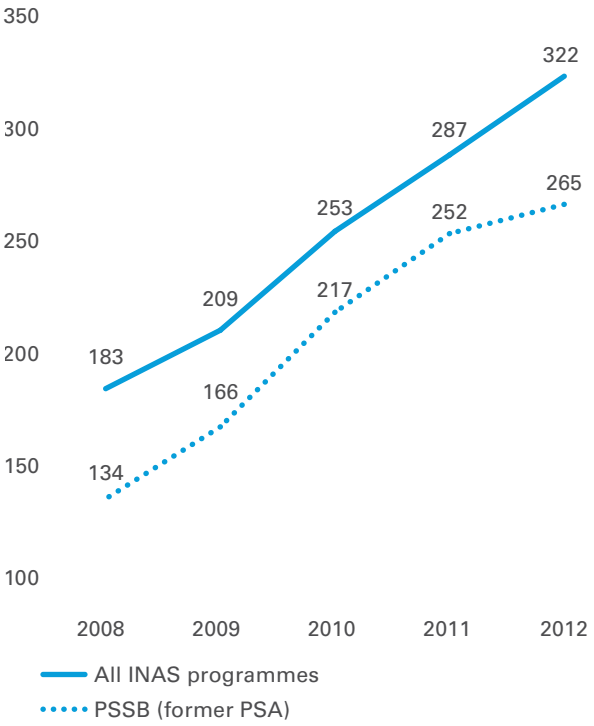
The second programme, the Direct Social Assistance Programme (PASD), is more child-focused but much smaller (36,831 beneficiaries in 2012) and provides only short-term 'bridging' support for households that are temporarily labour constrained or have been affected by shocks. This programme provides in-kind assistance to, among others, child-headed households, households with children suffering from severe acute under-nutrition and households with malnourished AIDS patients on ART.

The third programme, the Productive Social Action Programme (PASP), may also benefit children indirectly. PASP provides short-term employment (of 4-6 months) in labour-intensive public works, notably during the lean period before harvests in rural areas when food insecurity is highest, and facilitates access to micro-finance, as a 'first step in the ladder out of poverty' (Cunha et al, 2013) as well as other government initiatives for income generation. This is still a small programme, but will expand with support from the World Bank and the World Food Programme.

Mozambique does not yet have a social transfer programme that specifically targets children (like the child grants established in South Africa and Namibia) and, in contrast with many other social transfer programmes in the developing world, the existing programmes do not explicitly aim to use transfers as a means of promoting investment by poor households in the human capital of their children as a long-term pathway out of poverty. A recent study simulating the impacts and costs of different options for the future development of INAS programmes (Hodges and Tiberti, 2013) shows that, if cost-effectiveness is measured by the cost of a 1 percentage point reduction in the poverty gap, a child grant would be considerably more cost-effective than the existing PSSB. Child grants would have statistically significant positive effects across a range of human development indicators, including on sanitation, education, nutrition and use of health services, although the effects are small, possibly because of the importance of supply side constraints in basic social services and the weight of socio-cultural factors in the Mozambican context.

The coverage of social transfers doubled between 2008 and 2011, but still cover only about 15% of the poor households

Figure 3.5 – Coverage of social transfer programmes (thousands of households), 2008-2012



Sources: UNICEF, 2013c; Cunha et al, 2013.

Social transfers have expanded rapidly, but still cover only about 15% of poor households. Mozambique lags far behind the middle-income countries in southern Africa that have invested heavily in their social protection systems, but is doing well compared to other low-income African countries. The coverage of INAS programmes almost doubled from 183,131 to 322,075 households between 2008 and 2012 (see Figure 3.5). In 2011 and 2013, there were also sizable increases in the transfer amounts of the main programme, the Basic Social Grant Programme (PSSB), which were previously too low to have much impact.

3.2 CLIMATE CHANGE AND NATURAL DISASTERS

The frequency and impact of natural disasters are being exacerbated by long-term climate change, putting millions of Mozambicans at risk of livelihood losses and increases in vulnerability. Mozambique ranks third amongst the African countries most exposed to risks from weather-related disasters, and worldwide is placed 43rd out of 173 countries (ADW, 2012). Floods and cyclones are the most frequent disasters, but droughts affect by far the largest number of people. Mozambique is extremely sensitive to these shocks, which cause loss of life, damage crops, destroy economic and social infrastructure and disrupt social services and productive activities. The National Disaster Management Institute (INGC) has defined six high-risk, high-impact zones, which together have a population of 7 million people (INGC, 2013). The incidence of natural disasters seems to be rising, with eight such events recorded in the 1980s, seven in the 1990s and 30 in the 2000s, with nine so far recorded in the present decade (one drought, four floods and four storms/cyclones), according to INGC data.

Poverty limits households' capacity to prepare for, respond to and recover from natural disasters. These adverse climatic trends interact with poverty, since, for lack of alternatives, the poor engage in environmentally harmful subsistence practices, including slash-and-burn agriculture and the use of wood fuel, and are also the most exposed to and least able to withstand environmental shocks and cope with their consequences. Data from the 2008/09 IOF show that agricultural pests, drought, cyclones and floods affect poorer households more than richer households. Damaged or destroyed harvests contribute to the high food insecurity in Mozambique.

Mozambique ranks third amongst the African countries most exposed to risks from weather-related disasters

As the vast majority of rural households depend on rain-fed agriculture, droughts have a serious impact on their livelihoods. Even though environmental conditions in drought-prone parts of Mozambique are not comparable to those in the Sahel or other extremely arid regions of the world, droughts are a major constraint on overall development and poverty reduction in Mozambique since 81% of the population relies on agriculture and over 95% of the food crops are produced under rain-fed conditions[23]. Vulnerability is exacerbated by the fact that very little farmland is irrigated. Mozambican droughts are a consequence of environmental degradation and inadequate use of land (INGC, 2009) and are inter-linked with desertification (MICOA, 2007). They result from low levels of rainfall or changes in its spatial and temporal distribution (thus from climate driven causes) combined with human activities, such as the overuse of agricultural land, over-grazing, bush fires, fire wood gathering, charcoal production and industrial forestry[24]. Occurring every three to four years, droughts mainly affect the southern provinces of Gaza and Maputo, along with adjoining districts in southern Manica and Inhambane (see Map 3.1), as well as several districts in northern Manica, southern Tete and to a lesser extent parts of Cabo Delgado and northern Nampula.

Poor rural households are also vulnerable to seasonal food insecurity during the 'lean' period prior to harvests. The 2008/09 IOF data on household perceptions of food inadequacy show the seasonal nature of food insecurity, with the proportion of households reporting inadequate food consumption rising gradually from almost zero immediately after the harvest period (May-June), reaching about a quarter of households by November and affecting over 40% of households at the peak of the lean period in January-February (Azzarri et al, 2011[25]). According to a WFP assessment, around 25% of the population

The incidence of natural disasters seems to be rising, with 8 events recorded in the 1980s, 7 in the 1990s and more than 30 in the 2000s

suffers from acute food insecurity at some point in the year and approximately 34% remains chronically food-insecure and lacks an adequate diet. The majority of food-insecure households are located in the arid and flood-prone areas of the South and Centre (WFP, 2010).

The low-lying coastal plains are repeatedly exposed to extensive flooding, with devastating consequences. Several large rivers that reach the Indian Ocean from the inland high plateaux of southern Africa periodically burst their banks when rainfall is high in the interior. Floods occur every two to three years along these major river basins, in the low coastal plains and in areas with drainage problems. The risk is highest in the central and southern regions. Floods in early 2013 affected almost 480,000 people, caused 117 deaths and displaced about 172,500 people (MPD, 2013). While an initial assessment mission by the World Bank (2013a) estimated short and medium term funding needs of USD 260 million, the Government declared that reconstruction would cost USD 517 million (MPD, 2013). The 2013 floods were the most destructive since the floods in February 2000, the worst in 150 years, which caused 699 deaths, displaced 540,000 people and in total affected 2.5 million people.

Cyclones, which form in the Indian Ocean, are a third major risk, particularly along the northern coast during the rainy season (October to March). There are on average one or two cyclones every four years, damaging infrastructure and crops.

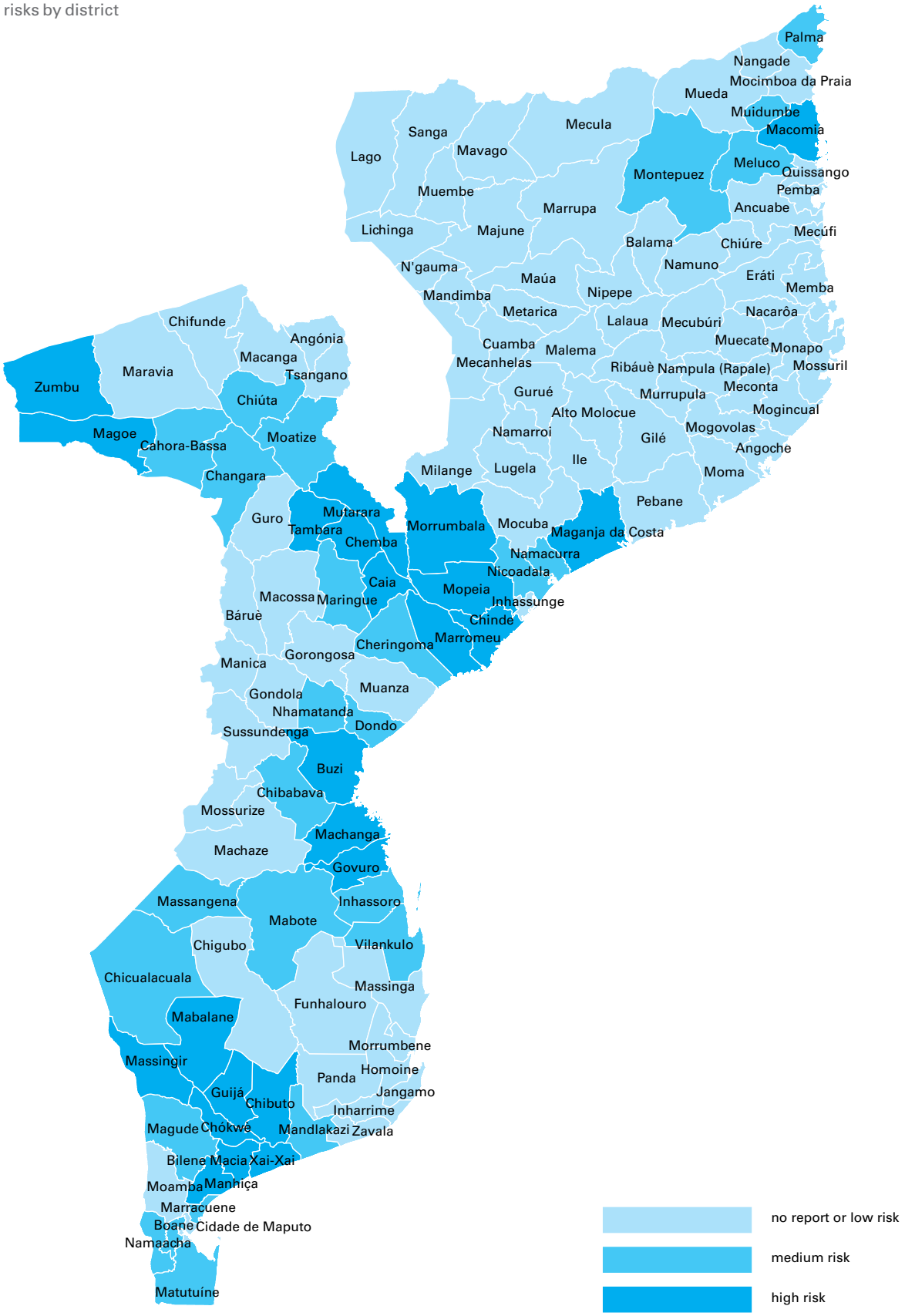
Children are directly affected in multiple ways. The effects of long-term climate change, natural disasters and seasonal vulnerability on food security and poverty indirectly affect children's nutritional status. Access to safe water is a major problem during and following floods and droughts, leading to outbreaks of water-borne diseases, such as diarrhoea and cholera. Children are also at risk of trauma, inadequate care and protection during disasters due to the lack of counselling services, the fragility of many families and the high proportion of single-parent households. In addition, social infrastructure such as schools and health facilities are lost during severe floods and cyclones. The floods in early 2013 destroyed 212 classrooms, resulting in 20% of students in Gaza not being able to attend school for a number of weeks, while also losing learning materials. The disruption arising from disasters also leads to non-compliance with anti-retroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) schedules.

The situation will worsen in the decades to come. Since the 1960s, mean rainfall has decreased by an average of 3.5 mm/month or 3% per decade, while the proportion of days with heavy rainfall events rose by 2.6% per decade, and these trends are expected to intensify in the years to come as a result of global warming (World Bank et al, 2011). A study by the World Bank (2010) predicts that by 2050 GDP will be between 4% and 14% lower than baseline projections if no adaptation measures to respond to climate change are undertaken. Flood peaks in the Limpopo and Save Rivers are expected to rise in magnitude by 25%. Some areas in the North will experience floods more frequently. However, with population growth, per capita water availability is expected to decline in the major river basins, by 15% in the case of the Zambezi river flow. Tropical storms and cyclones are likely to become less frequent, but their intensity and associated rainfall are expected to increase. Especially when combined with cyclones, seawater surges will likely increase and threaten the livelihoods of those living along soft coastlines, which are already vulnerable to erosion under normal conditions. The temperature is projected to increase between 1o and 2.8o C by 2060 and the warming will be more rapid in the interior of the country[26]. There are also likely to be major changes concerning the start, the end, the duration and the intensity of the rainy season.

These changes will have significant implications for agriculture and rural livelihoods. According to the World Bank (2010), without adaptation measures, the impacts of climate change in the next 40 years would decrease the yields of major crops by 2-4% and, combined with the effects of more frequent flooding on rural roads, reduce agricultural GDP by 4.5% to 9.8%. INGC (2012) has forecast that crop yields could fall by up to 30% in the most affected areas.

Map 3.1 – Climate-related risks in Mozambique

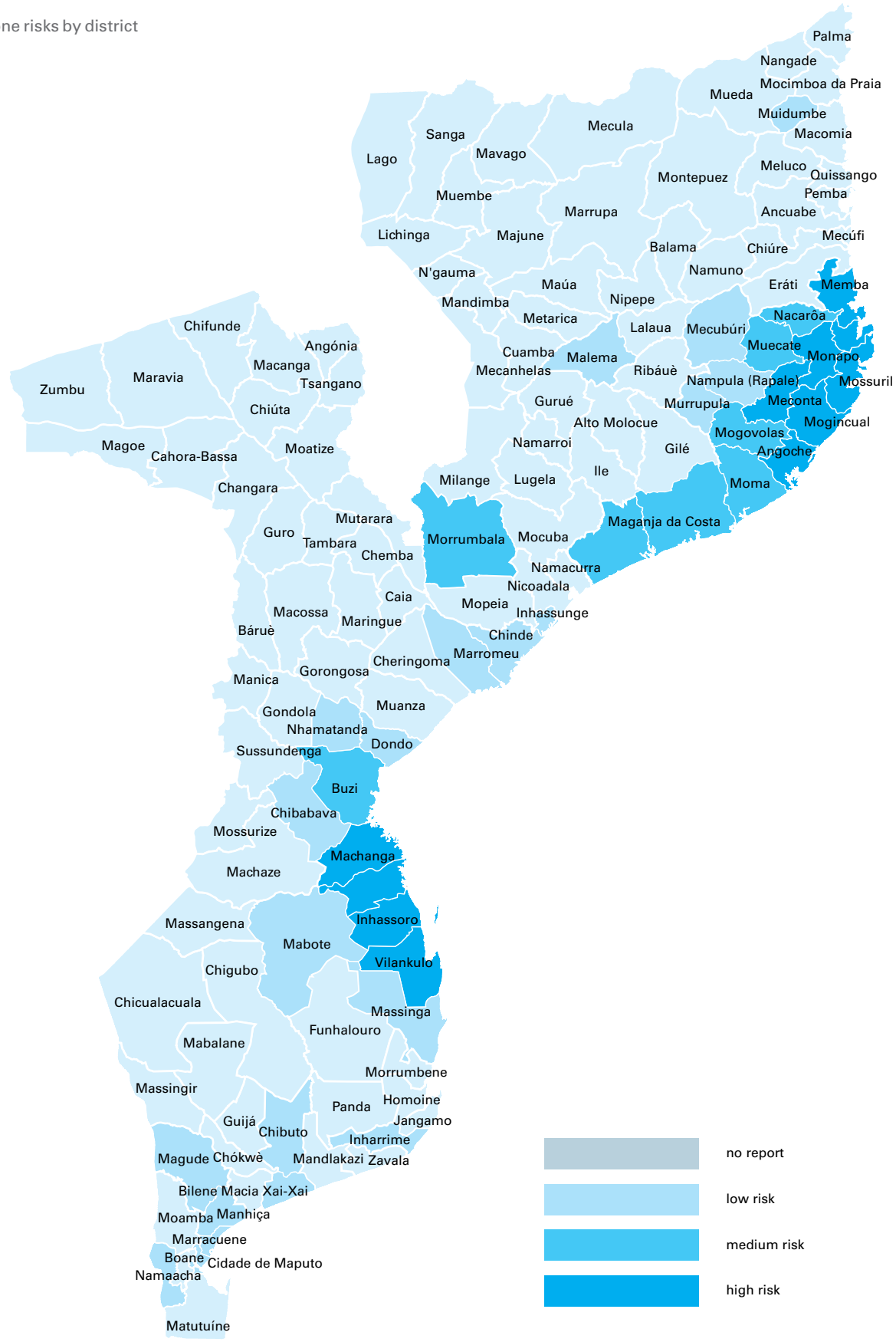
Flood risks by district



Fontes: Disaster Information Management System, www.desinventar.net

Map 3.1 – Climate-related risks in Mozambique

Cyclone risks by district



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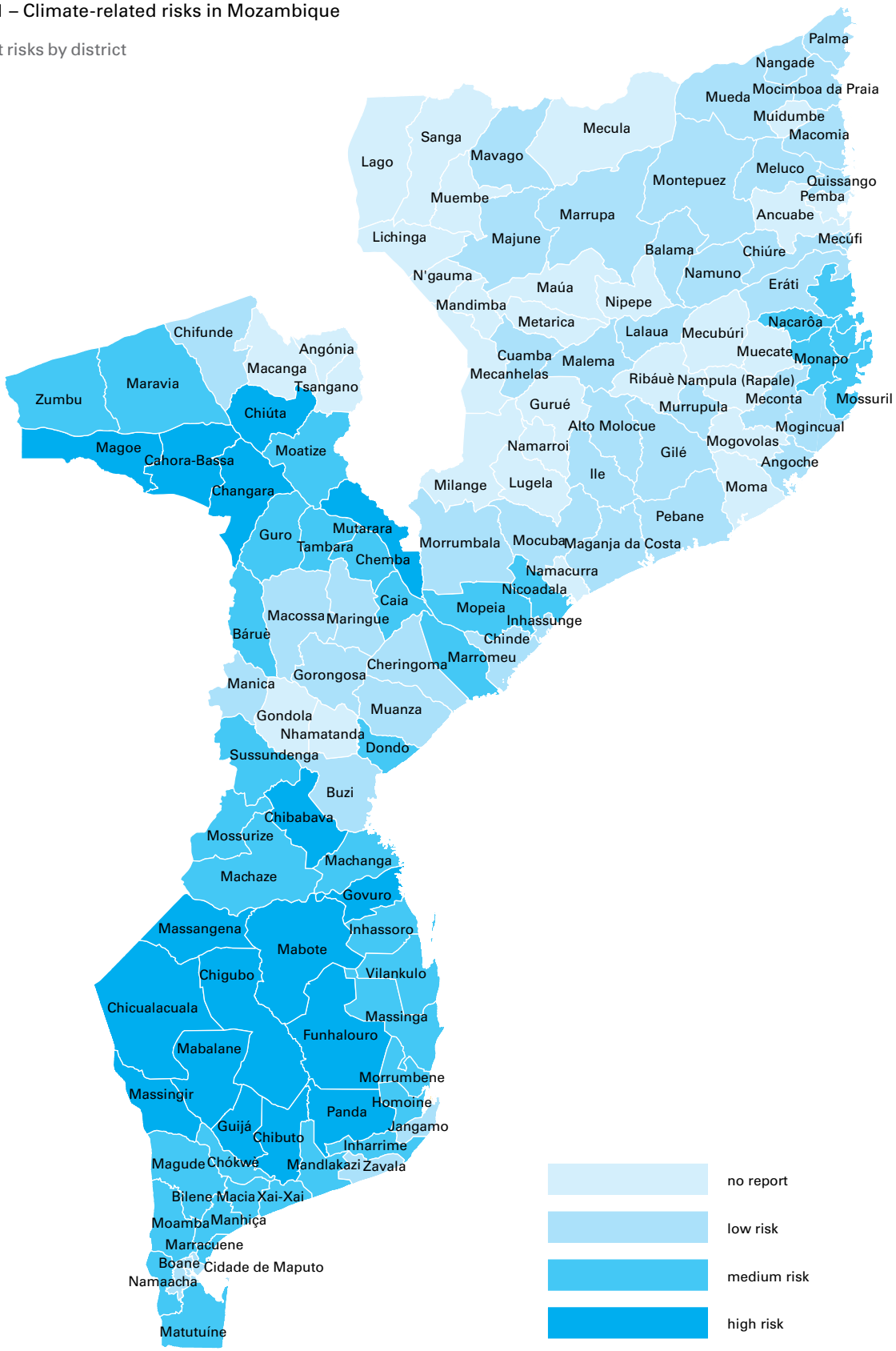
Map 3.1 – Climate-related risks in Mozambique

Drought risks by district

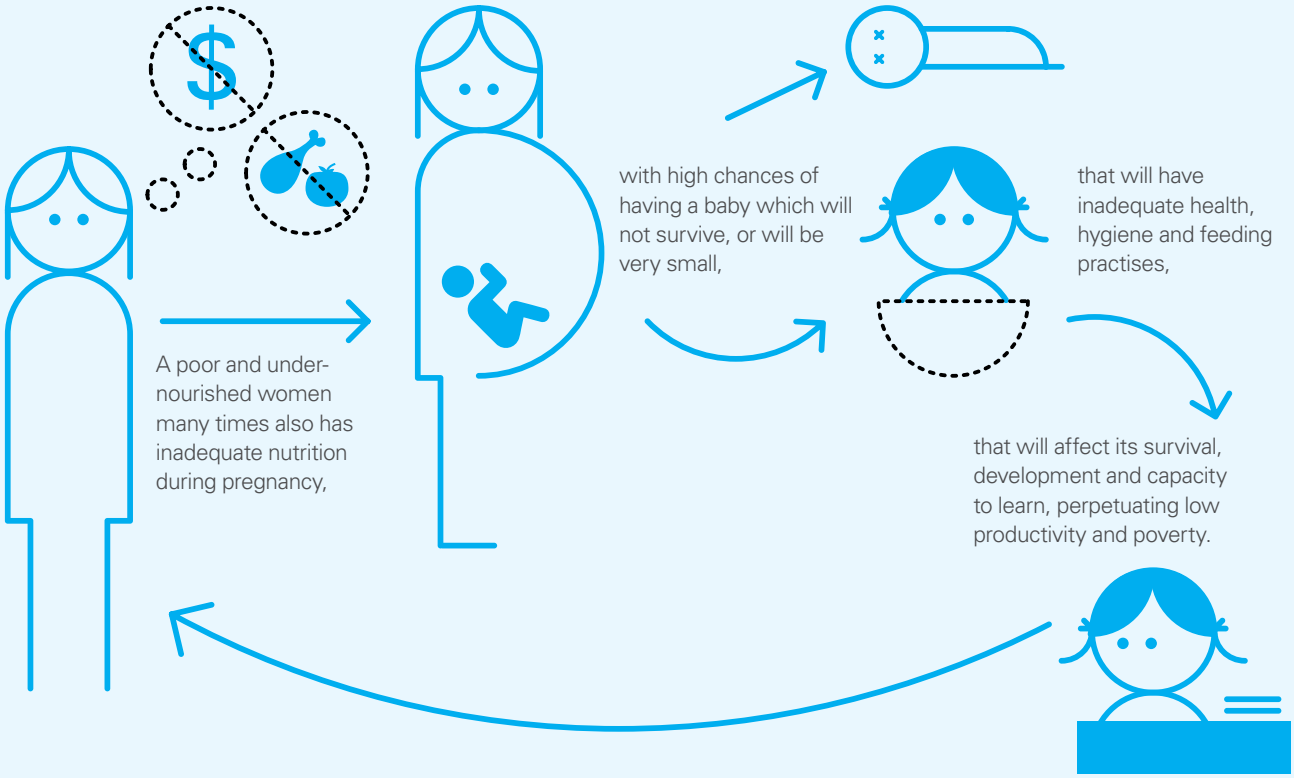


Fontes: Disaster Information Management System, www.desinventar.net

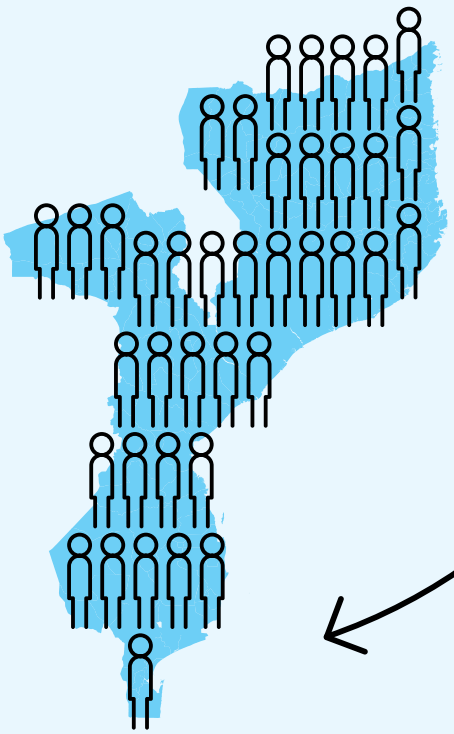
THE SITUATION OF CHILDREN IN MOZAMBIQUE 2014: A SNAPSHOT

THE CYCLE OF UNDER-NUTRITION

43 % of Mozambican children (0-5 years) suffer from chronic under-nutrition



WITH NEGATIVE CONSEQUENCES FOR THE DEVELOPMENT OF THE WHOLE COUNTRY

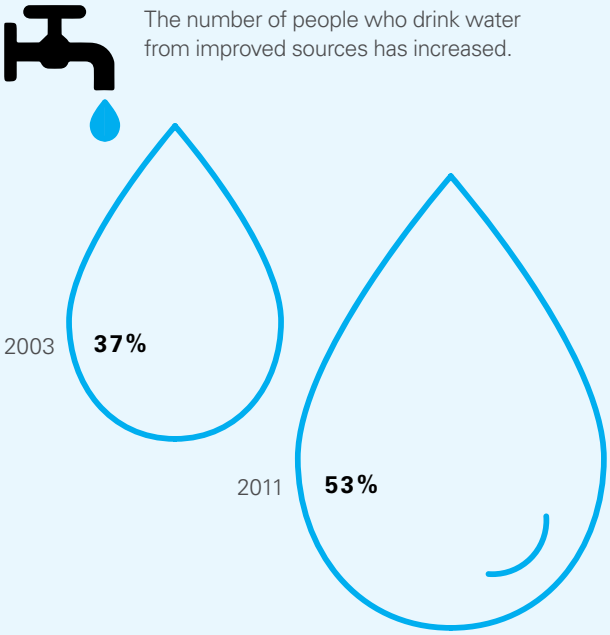


THE SITUATION OF CHILDREN IN MOZAMBIQUE 2014: A SNAPSHOT

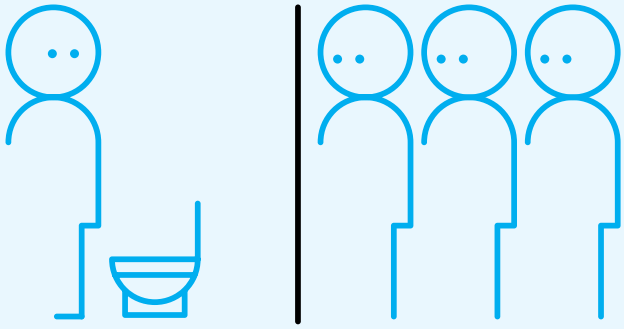
WATER AND SANITATION

Significant progress has been made in access to improved sources of water and in sanitation, but from a very low starting point.

The number of people who drink water from improved sources has increased.



Less than 1 in 4 Mozambicans has access to improved sanitation infrastructure.

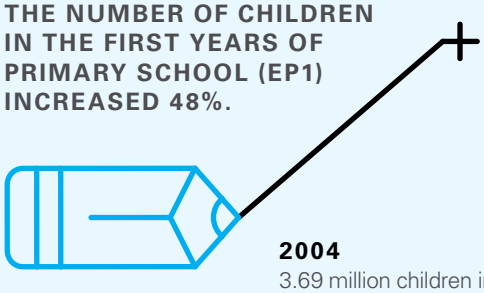


2 of every 5 Mozambicans practise open defecation

EDUCATION

Since 2004 there has been impressive progress in the construction of schools and access to education, and in the recruitment of teachers. However, still half of children who start primary school do not finish it, and there are increasing concerns about learning quality.

THE NUMBER OF CHILDREN IN THE FIRST YEARS OF PRIMARY SCHOOL (EP1) INCREASED 48%.

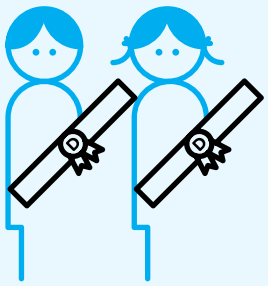


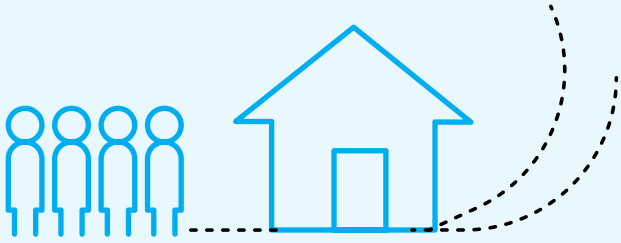
2011
5.45 Million

2004
3.69 million children in primary school

+ MORE SCHOOLS CONSTRUCTED
+ MORE TEACHERS RECRUITED

IN ALL, HALF OF THE CHILDREN THAT START PRIMARY SCHOOL DO NOT COMPLETE IT

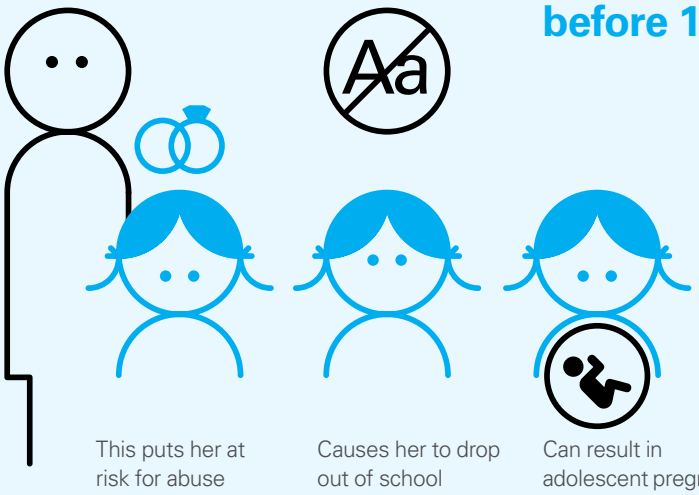




THE SITUATION OF CHILDREN IN MOZAMBIQUE 2014: A SNAPSHOT

EARLY MARRIAGE

1 in every 2 girls is married before 18



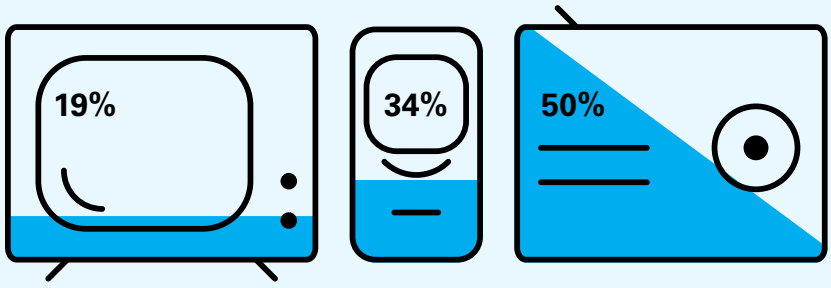
This puts her at risk for abuse

Causes her to drop out of school

Can result in adolescent pregnancy and high risk of death for both mother and baby

PERPETUATING AN INTER-GENERATIONAL CYCLE OF POVERTY, AND LIMITING THE DEVELOPMENT OF THE COUNTRY.

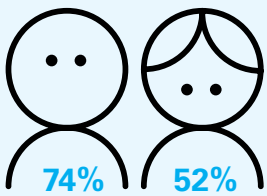
ACCESS TO INFORMATION



Access to television

Access to mobile phones

Access to radio



GENDER DIFFERENCES

Only 52% of women have access to some kind of communication, compared to 74% of men

THE SITUATION IN ZAMBÉZIA

1 IN EVERY 5 MOZAMBICANS LIVE IN THIS PROVINCE

Highest rate of under-5 mortality

Highest incidence of poverty

Lowest rate of birth registration

Lowest level of institutional deliveries and of assistance during births

The Government is increasingly focusing on reducing vulnerability to natural disasters and strengthening resilience to climate change, while also building capacity to manage disaster response. Long-term vulnerability reduction requires the integration of disaster management and climate change adaptation into broader policies and planning instruments, at both sector level (in sector strategic plans and policies) and at the macro level (PARP, Government 5-Year Programme and medium-term budget planning). INAS's new Productive Social Action Programme (PASP) provides a good example of this integrated approach. This programme aims to reduce the vulnerability of the poorest to climate-related shocks and seasonal food insecurity both by providing a short-term increase in household resources (from employment in public works, especially during the lean period in rural areas) and by focusing much of the public works projects on soil and water conservation and the rehabilitation of degraded areas in order to promote long-term adaptation and resilience (World Bank, 2013b).

3.3 INFORMATION DEPRIVATION, SOCIO-CULTURAL FACTORS AND GENDER RELATIONS

Access to information contributes to postivie social change and promotes practices which will in turn affect child well-being. Information deprivation sustains harmful attitudes[27] and practices, rooted in cultural traditions and gender relations, holding back progress in several dimensions of well-being such as reproductive health, HIV/AIDS, nutrition and domestic violence. Information deprivation refers to the shortfalls in access to information and knowledge, through the mass media or through more localized, community-level mechanisms of communication, and the resulting deficits in knowledge and awareness. Access to the formal mass media remains quite low, especially in the rural areas and among women, limiting access to information critical for health and broader wellbeing. The low levels of literacy (and proficiency in the official language) further impede access to knowledge.

THE CULTURAL CONTEXT AND ITS IMPLICATIONS

Knowledge in such fields as health, nutrition, gender roles, sex and reproduction, and the beliefs and attitudes that shape behaviours, are to a large extent rooted in local cultures and traditions and transmitted and sustained by community institutions and opinion-leaders (the madrinhas and matronas involved in girls' initiation rites, traditional birth attendants, traditional medical practitioners, chiefs and régulos, among others), as well as the churches and mosques. While some of the teachings and advice proffered are beneficial, an example being the promotion of male circumcision in some ethnic groups and especially in Muslim areas, reducing the risk of HIV infection[28], some others are far less so. This is particularly worrying in the case of the initiation rites for young adolescent girls that are common in ethnic groups in much of the North and Centre of the country. Besides inculcating a general sense of female submissiveness to men, these important life-cycle events constitute a rite of passage to adulthood, endorsing as a social norm the idea that, once initiated in their early teens, girls are ready for marriage and procreation (Matsinhe et al, 2010). This underpins the widespread practice of child marriage, followed by adolescent pregnancy and all its accompanying risks of low birth weight, foetal obstruction and maternal and neonatal mortality. In addition, although very little is known scientifically, there may be risks with respect to sexually transmitted infections (STIs), including HIV, arising from customs such as the elongation of the vaginal labia minora and intra-vaginal cleansing, which are widespread in the North and Centre (Bagnol and Mariano, 2012). In the case of boys, initiation rites are less widely held than for girls. However, where these involve scarification, the process of cutting, scratching, etching or burning designs into the skin, there could be risks of HIV infection. Regression analysis of INSIDA data shows a strong association between the HIV+ status of a child and the practice of scarification and tattoos, and suggests that about 9% of HIV+ children aged 5 11 might be positive because of that exposure (Martel, 2011).

Ethnographic studies suggest that traditional institutions and actors continue to exert a strong influence in many rural areas. They appear to outcompete 'modern' actors at community level such as school teachers and health workers, although those who are most deeply embedded in communities, such as the agentes polivalentes elementares (community health workers), appear to be more successful in raising awareness. Partly as a result of these barriers and bottlenecks, improvements in health-related knowledge, attitudes and practices (KAP) have been patchy at best, as Box 3.3 discusses. To be successful, communication for development initiatives clearly need to build alliances with traditional institutions and community opinion-leaders as well as with the churches and mosques.

By 2050 GDP will be between 4% and 14% lower than baseline projections if no adaptation measures to respond to climate change are undertaken

Box 3.3 – Knowledge, attitudes and practices (KAP) in health, hygiene and nutrition

The 2011 DHS and other recent surveys suggest that there has been only limited progress in improving knowledge, attitudes and practices regarding health, hygiene and nutrition. This is illustrated by the data discussed below on water treatment, breastfeeding, knowledge about HIV/AIDS and sexual behaviour.

With regard to hygiene, the proportion of households not treating water before drinking remained essentially unchanged (close to 90%) between 2003 and 2011, according to DHS data. Only 6% of households use an appropriate treatment method, a proportion that falls below 3% in the rural areas. The DHS and PRONASAR surveys in 2011 concur in showing that only about 1 in 20 rural households treat water in any way before drinking. Only 26% of households use water and soap for hand-washing, with another 6% using ash or other local materials. A regression analysis of DHS 2011 data (Silva-Leander, 2014) found that these factors were especially important determinants of stunting in children under 5, with water treatment in the household decreasing the probability of stunting by 7 percentage points and the availability of hand-washing facilities reduces this probability by 3 percentage points.

There has been progress in increasing the proportion of children who are exclusively breastfed, although the overall rate is still low due to widely held erroneous beliefs. Exclusive breastfeeding before the age of 6 months is one of the key practices for reducing the risks of child under-nutrition, infection and mortality. The proportion of children aged 0-5 months who are exclusively breastfed rose from 30% in 2003 to 37% in 2008 and 43% in 2011, according to the DHS and MICS surveys, and the median length of exclusive breastfeeding rose from 0.7 to 1.3 months in this period. However, this still means that introduction of foods and liquids other than breast milk starts at an extremely young age. Qualitative research (Arts et al, 2010) has found a widespread belief that children need to drink water from a very early age, and that traditional medicines are given to children of all ages, mainly orally as a 'tea', to prevent and cure common illnesses and afflictions caused by spirits. Porridge is introduced at the age of 4-6 months, or even earlier, due to the belief that young children need these foods in addition to breast milk to grow well.

In 2009, the Ministry of Health began implementing a communication and social mobilization plan for the promotion, protection and support of breastfeeding. This includes the establishment and training of peer groups of mothers to spread knowledge and good practices on breastfeeding to women in their communities (RdM, 2010a). However, the study by Arts et al, based on focus group discussions, noted that young mothers, especially first-time mothers are not empowered to make their own decisions and recommended a broader approach, extending awareness-raising beyond mothers to mother-in-laws, grandmothers and fathers, since they were found to be less well informed and influence decisions on feeding practices.

There has been only a very small improvement in knowledge on key ways of reducing the risk of HIV infection, according to data from the 2003 and 2011 DHS as well as the national AIDS survey (INSIDA) in 2009. Women remain generally less knowledgeable than men, with the 2011 DHS finding that less than one third of women (15-49) and one half of men (49.7%) have a 'comprehensive' knowledge of HIV/AIDS, with knowledge lower in rural than urban areas and also varying substantially between provinces. Compared with the data obtained by INSIDA in 2009, there seems to have been some improvement in knowledge by men, but not by women. While men are more knowledgeable than women about HIV/AIDS, this does not mean that they engage in less risky behaviour. The 2011 DHS found high proportions of men in multiple sexual relations (30%) and paying for sex (14%), with a slight increase in both indicators since the 2003 DHS.

HUMAN CAPITAL – IMPLICATIONS OF ILLITERACY AND LOW LEVELS OF EDUCATION

Illiteracy and inability to speak the official language are major barriers to information and knowledge for many Mozambicans, especially women. These two linguistic barriers are closely related, since literacy is acquired almost entirely in the Portuguese language and both skills are obtained mostly in school. According to the 2007 census, 49% of the population is unable to converse in Portuguese, with more women (58%) than men (39%)[29] disadvantaged in this way. Most non-Portuguese speakers (88% of the total) live in the rural areas. As has been previously noted, women are also much less likely to be literate than men (40% compared to 68% according to the 2011 DHS) and, despite the large expansion in school participation, there has been very little improvement in literacy (by just 3 percentage points for women and not at all for men) **in the period 2003-2011, confirming the low learning achievement of pupils at school.** Female illiteracy is highest in the rural areas (74% compared to 32% in the urban areas), in the northern and central provinces (being above 71% in Cabo Delgado, Nampula, Tete and Zambézia) and in the poorest quintiles (87% in Q1, 83% in Q2 and 73% in Q3, compared to 16% in the richest Q5).

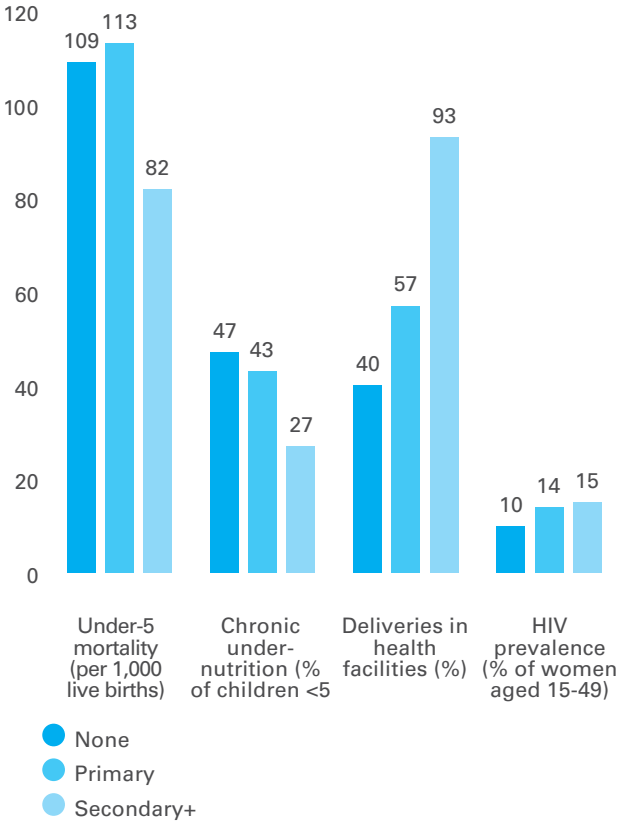
49% of the population is unable to converse in Portuguese, with more women (58%) than men (39%) disadvantaged in this way

Considerable progress has been made towards gender parity in education, although the low level of learning achievement raises doubts about the impact on female literacy, knowledge and gender relations. The 2011 DHS showed a gender parity index (GPI), measured by net attendance ratios (NARs), of 1.0 in primary education, meaning that equal proportions of boys and girls aged 6-12 were in primary school. Based also on NARs, the GPI was 0.9 in secondary education, meaning that a slightly lower proportion of girls than boys aged 13-17 were attending secondary school. In terms of gross attendance rates, there appear to be slightly larger disparities in favour of boys at primary level, but these small differences seem to reflect the problem that boys are failing exams and repeating classes more than girls, and so are more likely to be above the correct age for the grade. This is reflected in the higher primary gross completion rate for boys, although the gap narrowed from 15 to 6 percentage points between 2002 and 2011, mainly because of a decline for boys (MINED, 2013, and Visser, 2013). At primary level, girls are at a slight disadvantage to boys in parts of the North and Centre, but these differences are extremely small. The opposite is true in the South, which has slightly higher NARs for girls than boys at both primary and secondary levels. At secondary level, the GPI is very low in the bottom quintiles and in certain central and northern provinces. However, the dominant reality at this level is that very few children of either sex in the first two to three quintiles succeed in reaching secondary school.

It is unclear to what extent formal education is really improving child and human well-being via its impact on knowledge, attitudes and practices. The survey data appear to show a correlation between the level of education (especially of women or mothers) and many social indicators (see Figure 3.6). However, this association is often most evident at the higher levels of education (secondary and above), which, as noted above, benefit only a very small minority, mainly in the top two quintiles. It should be noted here that, in the household surveys, 'primary education' means attending at least some primary education, not necessarily completing primary education. Many of those 'with secondary education' will have completed primary education and had some secondary education, again without necessarily completing this stage of education.

- In the case of infant and under-5 mortality, it is interesting to note (and quite puzzling) that mortality rates are actually higher for children whose mothers had some primary education than for those whose mothers had no education at all, and only decline more sharply for the small minority of children whose mothers have some secondary education.
- HIV prevalence is inversely related with level of education. In other words, the better educated are more likely to be infected, although the opposite is true for HIV-related knowledge (albeit with a large difference only at secondary education level) and for HIV testing. The Ministry of Education has introduced HIV/AIDS education in the school curriculum at both primary and secondary levels.
- For chronic under-nutrition, the difference by level of education of mothers is minimal between no education and some primary education, but again much larger when mothers have some secondary education.
- For some other indicators, such as the percentage of deliveries in health institutions, there is a sharper differentiation across the spectrum of education levels.

Figure 3.6 – Social indicators by women's or mothers' level of education, 2011



Source: DHS, 2011.

To some extent, the weak impact of the level of education (below secondary level) may be attributable to the low quality of primary education, which is one of the main issues of concern in this analysis of the situation of children in Mozambique. However, it also reflects the fact that many of those 'with primary education' have in fact dropped out before completing primary education, and in many cases after only one or two grades. Given that little teaching is taking place in many schools, and that pupils lose a large part of the potential learning time as a result of late start times, early closing and extended recesses, as observed in a study in Cabo Delgado (Adelman et al, 2011), the simple fact of having attended school, especially for only a couple of grades, does not guarantee learning, and thus any positive impact on a future mother's competency levels for caring for herself and her children.

There are more than 90 community radio stations, which broadcast entirely in local languages and cover almost half of all districts.

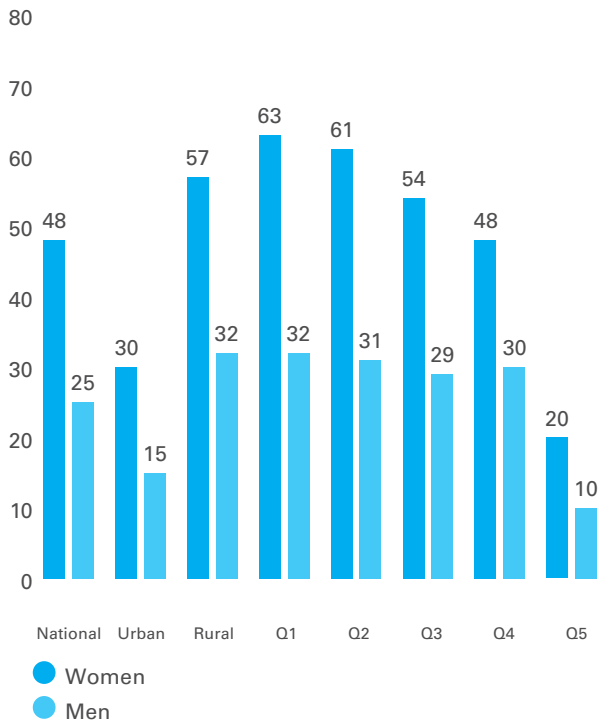
In addition, parental education level is linked to many other factors, such as income and area of residence, which makes it difficult to affirm with certainty its direct impact on child well-being. Multivariate regression analyses based on data from the 2008/09 IOF (Azzarri et al, 2011) and from the 2008 MICS (Martel, 2009) have found that, controlling for some of these other variables linked to education (in particular the strong correlation between mothers' education, per capita consumption and residence), mother's education does not have a statistically significant impact on chronic under-nutrition, which is determined primarily by levels of household wealth or income. It is quite possible that this would also be true in several other areas.

ACCESS TO INFORMATION

The low level of literacy means that access to information is mainly oral, highlighting the importance of community-level communication, especially radio broadcasts in local languages. In addition to state-owned Radio Moçambique, which broadcasts in both Portuguese and local languages, there are more than 90 community radio stations, which broadcast entirely in local languages and cover almost half of the 141 districts.[30] These broadcasters produce locally generated programming that speaks to the interests and concerns of local listeners and thus provide a valuable platform for the dissemination of information and knowledge, including on topics such as health, nutrition and HIV/AIDS. As a vehicle for participatory communication, closely linked to communities, they could become important agents of social change. However, they also face serious technical and financial constraints and depend heavily on unpaid volunteers and external assistance, which put at risk their long-term sustainability.

Access to information through the mass media remains low, even in the case of radio. The 2011 DHS found that only 50% of households own a radio set (57% in urban areas and 47% in rural areas), indicating a slight decline from 53% nationally in the 2003 DHS. The proportion of households owning TV sets has more than doubled, but from a very low base, reaching 19% in 2011. TV ownership is almost entirely restricted to the urban areas, where 49% of households owned TV sets in 2011, compared with 6% in the rural areas. The DHS data also indicate that, especially in the case of radio, men listen to broadcasts more than women (66% compared to 43% at least once a week), possibly because the radio sets are portable and may often belong to men within the household. Overall, half (48%) of all women aged 15-49 do not have any access to mass media (radio, TV or newspapers), compared to 26% of men (see Figure 3.7). There are marked disparities by area of residence, province and quintile.

Figure 3.7 – Population with no access to mass media, 2011 (% of men and women aged 15-49)



Source : DHS 2011.

Growing mobile telephone coverage is providing a new cost-effective means of disseminating information, although coverage is still lower than in most other southern African countries. In March 2013, the Ministry of Health, UNICEF and MCel (the largest mobile telephone operator) launched 'SMS for Life' to disseminate health and other information, through monthly text messages, to all 4.5 million MCel subscribers (UNICEF, 2013b). Nonetheless, only 34% of households own a mobile phone, according to DHS data for 2011, and this proportion is much less in rural than urban areas (20% compared with 67%). According to the National Communications Institute of Mozambique (INCM), 70% of all mobile phone users are concentrated in and around Maputo.

GENDER RELATIONS

Mozambique remains fundamentally a patriarchal society, in which men make the main decisions, especially within the family and in the community, and women and girls are expected to be submissive. Women are also overburdened by their reproductive functions in a context of very high fertility, child-care and work in and outside the home. Women are less integrated into the labour market and the formal economy than men: According to the 2011 DHS, only 39.4% of women 15-49 were employed in the previous 12 months, compared with 82.3% of men. Employed women are overwhelmingly involved in unskilled activities, mainly farming (63%) and trade (24%). Less women than men own homes or land, due to their lower levels of earnings as well as inheritance practices[31]. In addition, as has been discussed, women have high levels of illiteracy. These multiple disadvantages interact with and are reinforced by a culture of male supremacy within the household, inculcated during childhood within the family, in the community and, in some parts of the country, through rituals such as initiation rites.

Women are less involved than men in the major household decisions, especially (according to the 2011 DHS data) when women are not in paid employment. This has many ramifications, including with respect to the ability of women and especially adolescent girls to influence decisions on reproductive and sexual behaviour, contributing to their vulnerability to HIV infection and unwanted pregnancies. Data in the DHS 2011 show that the ability of a woman to control her fertility and choice of contraceptive is affected by her degree of independence. The patriarchal culture also leads to widespread acceptance, especially by women themselves, of the practice of wife beating. The 2011 DHS found that 23% of women and 20% of men (aged 15-49) believe that, under certain circumstances, it is justifiable for husbands to beat their wives[32]. Male dominance within the family is sometimes enhanced by a large age difference between spouses, resulting partly from the widespread practice of early marriage of girls (see Box 3.4) and by the practice of polygyny, that is, men having more than one wife: Approximately one fifth (19.5%) of married women are in marriages with one or more co-wives, according to the 2011 DHS.

Incidents of domestic violence, including child abuse, are rarely reported to the judicial authorities or social care services due to a cultural preference to find solutions within the family or community, as well as lack of information about the state mechanisms and their slowness, ineffectiveness and high transaction costs, including for travel to the district capitals. Furthermore, the legal framework (the penal code in place since 1886) allows for perpetrators of violence to escape punishment through dowry or marriage (referred to locally as: "*dote da ofendida*" and "*efeitos do casamento*"). In cases of rape the perpetrator is obliged to pay dowry to the victim/survivor and if the perpetrator marries the victim his pre-trial detention is waived and he can await trial in freedom. If the perpetrator who marries the victim continues married with her for five years (without divorce or judicial separation) the sanctions applied to the perpetrator are suspended.

However, the social position of women is changing in some important respects. Practices such as polygyny and the cultural acceptance of wife beating appear to be in historical decline. For example, by 2011 the proportion of women in polygynous marriages had diminished by more than one third from its level of 31% in the 2003 DHS[33]. The approval of wife beating fell by 31 percentage points in this period, from 54% to 23% of women. The proportions of girls marrying before the ages of 15 and 18 have also declined, as previously noted. Another trend, which merits further research to understand its causes and consequences, is the large increase in the proportion of female-headed households, from 26% in 2003 to 36% in 2011, according to DHS data.

Box 3.4 – Child marriage – a fundamental rights violation on a large scale

Child marriage affects approximately half of girls before they reach 18 and one tenth before they are 15. The 2011 DHS found that 10% of women currently aged 15-19 had been married (legally or de facto) by the age of 15 and 48% of women now aged 20-24 were married by the age of 18. The legal age of marriage is 18 under the Family Code and the Law on the Protection and Promotion of Child Rights, but this is not enforced, due partly to the fact that the vast majority of marriages are de facto unions, even if formalized through customary procedures including the payment of dowry (lobolo) rather than legally registered marriages.

The highest rates of underage marriage are found in the North, with one in five girls married before the age of 15 in Niassa. Zambézia and Nampula are the provinces with the highest absolute numbers of girls married before the ages of 15 and 18. A regression analysis using DHS 2011 data (Silva-Leander et al, 2014) found that, apart from geographical differences, rates of child marriage varied little according to household characteristics, although they were lower in households with older heads. Marriage before the age of 18 was negatively associated with household wealth, but fell only slightly before the top quintile. In terms of education, early marriage (before 15 and before 18) was significantly lower only for girls with secondary education, but the direction of causality appears to run from marriage to education, rather than the other way round – early marriage being an important cause of dropout from school.

Child marriage disempowers girls and deprives them of other rights. When teenage girls are married, their aspirations and opportunities for further development immediately close off. They become subordinate to their husbands, who in many cases are much older than them (about a fifth of married girls aged 15-19 have husbands who are 10 or more years older according to the 2008 MICS). In some cases they are also second or third spouses, with the DHS data showing that about 9% of married girls aged 15-19 have co-wives.

Child marriage is one of the main causes of school dropout among teenage girls. Analysis of data from a national panel survey in 2008 (covering a sub-sample of the 2002/03 IAF) found that, for adolescents, marriage and pregnancy are two of the main reasons cited for not being enrolled in school, with the proportion rising from 11% at age 13 to 15% at age 14, 18.5% at age 15 and over 20% from age 16 onwards (Fox et al, 2012). For girls, these proportions are much higher, as almost no boys are married before the age of 18. The analysis of DHS 2011 data (Silva-Leander et al, 2014) likewise found that child marriage is associated with statistically significant reductions in the likelihood of girls finishing primary school (-11.7% if married before 15 and -5.5% if married before 18) and starting secondary school (-12.9% and -6.4% respectively).

Since sexual activity is much higher in married than unmarried adolescent girls, child marriage also leads to teenage pregnancy and indirectly to higher risks of maternal and child mortality. As Azarri (2011) has documented, the risk of under-nutrition (stunting, wasting and underweight) is significantly higher when mothers are under 19 years of age at the time of delivery. The study using DHS 2011 data came to a similar conclusion, finding that children under 5, when born to mothers below 18 years old, were likely to be at least one third of a standard deviation further away from the WHO mean for height-for-age (Silva-Leander et al, 2014).

A major effort is required to change social norms on this critical and sensitive cultural matter. Graça Machel, the former first lady of Mozambique and a renowned social activist for the rights of women and children, has shown the way forward by launching a national campaign against child marriage.

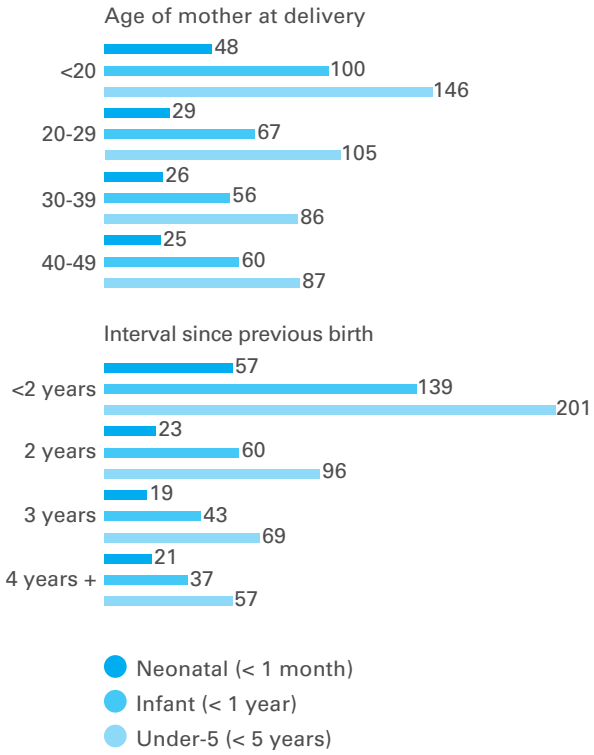
SEXUAL AND REPRODUCTIVE PRACTICES

Sexual activity starts very young, resulting in high rates of adolescent pregnancy, which greatly increases the risks of maternal and child mortality. Between the DHS in 2003 and 2011, there was a slight reduction in the proportion of 15-19 year old girls who had their first sexual relations before the age of 15, but no change in the proportion of 20-24 year olds who had sexual relations before the age of 18. The median age of first sexual relation for girls in 2011 (16.1) was almost unchanged from 2003 (16.0). The age of sexual début is young in all provinces and quintiles and does not vary with the level of education. But it is particularly low in the northern provinces of Niassa (14.6) and Cabo Delgado (15.2) and in the central province of Zambézia (15.5). It is only slightly higher in urban areas (16.6) than in rural areas (15.9). Given the low use of contraceptives, this leads to high rates of adolescent pregnancy. The proportion of women aged 20-24 who first gave birth before the age of 18 declined from 47% to 40% in this period, but this is still a very high percentage, which in turn has serious implications for child survival, since the rates of neonatal, infant and under-5 mortality are much higher for children born to mothers aged less than 20 (see Figure 3.8).

Further analysis of the DHS has highlighted the very high risks of mortality when the two high-risk factors of young age of mother (below 18) and short birth interval (below 24 months) are combined. For example, the risk of death before the age of 5 is 4.35 times higher in this dual high-risk category than for children born with three low-risk characteristics (mother aged 18-34, birth interval above 24 months and birth order below 4).[34]

The early start to sexual activity and the very low contraceptive use by couples contribute to high fertility, which appears to have risen over the past 15 years. According to the 2011 DHS, only 11.3% of women aged 15-49 who are married or in a de facto union use modern contraceptives, a proportion that is basically unchanged from the 2003 DHS (11.7%). This proportion is particularly low in the rural areas (7.2%), among women with no education (5.3%), in the bottom three quintiles (2.9%, 5.4% and 6.9% respectively) and among married women aged 15-19 (5.8%). Despite falling child mortality, which might be expected to reduce fertility by improving the survival chances of children, the total fertility rate (TFR) was higher in 2011 (5.9 children per woman) than in 1997 (5.6). The TFR has risen most in the rural areas, from 5.8 in 1997 to 6.6 in 2011, according to DHS data (see Figure 3.9). The largest increases in fertility have been in the northern and central provinces, which have the highest TFRs, peaking at 7.1 in Niassa. Fertility is also negatively correlated with wealth, with the TFR reaching 7.2 in the two poorest quintiles.

Figure 3.8 – Neonatal, infant and under-5 mortality rates by age of mother and birth intervals, 2011

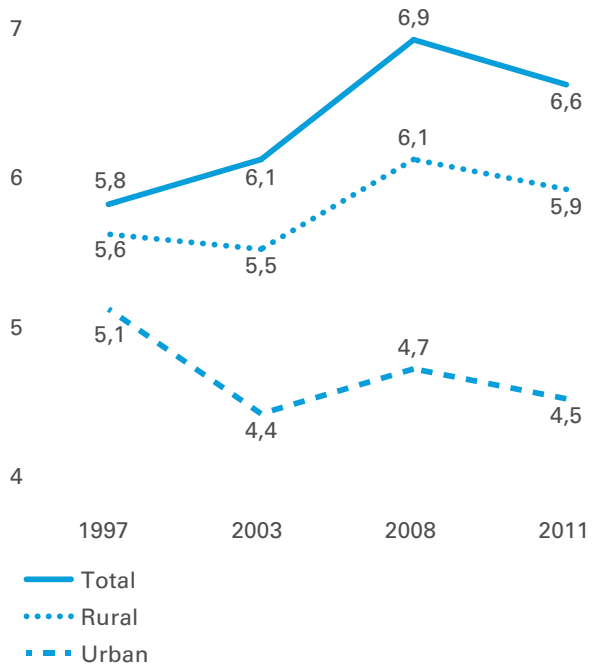


Source: DHS 2011.

The proportion of women aged 20-24 who first gave birth before the age of 18 declined

In 2011 the number of children per woman was higher than in 1997

Figure 3.9 – Total fertility rate, 1997-2011



Sources: DHS, 1997, 2003 and 2011; MICS 2008.

3.4 WEAKNESSES IN THE SUPPLY AND QUALITY OF BASIC SOCIAL SERVICES

Although there has been a large expansion in the supply of basic social services over the past two decades, there are still major deficiencies, limiting access to some services and affecting their quality.

HEALTH

The policy environment is conducive for a stepped-up effort to reduce child and maternal mortality, but faster progress is being held back by bottlenecks in the health system. In May 2010, the First Lady and the Ministry of Health launched a Partnership for the Promotion of Maternal, Newborn and Child Health. The Integrated Plan for the Achievement of MDGs 4 and 5 in Mozambique, adopted by the Ministry of Health in 2008, defines the objectives and targets for improvements in child and maternal health by 2015. However, serious constraints regarding financing, infrastructure, human resources and drug procurement have resulted in the stalling or partial reversal of progress in several critical areas since 2008.

There has been a large expansion in health infrastructure, but still only 65% of the population has access to health services within 45 minutes' walk from home. As has already been noted, distance is the main barrier cited by women (in the 2011 DHS) as a reason for not going to a health facility when ill. An immunization study in Zambézia, in 2012, likewise found that the main barrier to vaccination is distance (59%), followed by the non-availability of vaccines (11%) or vaccinators (5.5%) and waiting time (9%) (cited in UNICEF, 2013e). There are large geographical disparities in the availability of health infrastructure, ranging from about 1 health facility for 10,000 people in Gaza and

Niassa to 1 per 20,000 people in the three most underserved provinces: Nampula, Tete and Zambézia (UNICEF, 2013e). Only 63% of primary health care facilities have maternity services, although a positive development is that almost half (47%) of those facilities that do offer maternity services have 'waiting houses' (casas de espera) for women about to deliver, as a mechanism to facilitate access.

Active outreach to communities is limited in scope. Given the deficit in health facilities, expansion of services requires mobile services to reach communities, especially in the more remote areas. To extend vaccination coverage, the Ministry of Health made outreach a pillar of its delivery strategy for the expanded programme on vaccination (EPI) by adopting the Reach Every District (RED) approach in 2008. However, due to financial, human resources and logistics constraints, the outreach approach only accounts for a small proportion of vaccinations in practice – just 15% in 2012 in Zambézia, which has the lowest vaccination coverage in the country (UNICEF, 2013e).

Child and maternal health services are often lacking in quality. Some important advances have taken place, notably the introduction of new vaccines in the EPI and mass distribution of long-lasting treated mosquito nets to children. In the EPI, Hepatitis B vaccine was introduced in 2001, Hib vaccine (against Haemophilus Influenza B) in 2009 and pneumococcal vaccine – PCV10 (against pneumonia) in April 2013. Rotavirus vaccine (against rotavirus, the main common cause of diarrhoea) will be introduced in 2015. PCV10 could greatly reduce the incidence of acute respiratory infections (ARI, the third leading cause of child mortality in the country). However, the health system faces serious shortages of qualified human resources, drugs and equipment, all of which affect service delivery and the saving of lives. Additionally, policies, norms, guidelines and protocols are not always respected for some services. Regarding malaria treatment, for example, the 2011 DHS found that, while 56% of children with fever were taken to a health facility, only 30% had a blood test (as per the national malaria policy). Regarding maternal health, services provided during antenatal visits likewise diverge from established norms: Only 59% had their blood pressure tested, 50% provided a urine sample and 85% provided a blood sample (reflecting the fact that not all facilities have the capacity for testing urine and blood samples).

One of the major bottlenecks for reducing maternal mortality is the small number of health facilities offering emergency obstetric care (78 according to the Ministry of Health) and the fact that the referral system does not ensure the timely access of women with obstetrical complications to these facilities (MISAU 2013b).

There has been a large expansion in health infrastructure, but still only 65% of the population has access to health services within 45 minutes' walk from home

Drug stock-outs are one of the recurring deficiencies of the health system. Since 2008, the Central de Medicamentos e Artigos Médicos (CMAM – Central Medical Stores) has been responsible for managing drug procurement, but without adequate capacity and systems. The lack of clear criteria for prioritizing the drugs to be purchased and the absence of any real analysis of needs based on epidemiological data or the actual consumption of drugs by health facilities means that the annual tender process is flawed, leading to drugs running out and frequent recourse to emergency procurement. Distribution to health facilities is managed on an equally ad hoc and emergency-driven basis, with no real analysis of requirements. There are large gaps in cold storage capacity, especially in Nampula and Zambézia. While the procurement and distribution procedures for drugs and equipment are weak, it has to be acknowledged that the whole system of procurement, warehousing and distribution has also become more demanding due to the rapid expansion of the National Health Service and the massive requirements for treatment of HIV/AIDS. In an attempt to address these weaknesses and challenges, the Ministry of Health has drafted a new strategic plan for pharmaceutical logistics (CMAM, 2013).

Although the number of health workers more than doubled in 2000-2010, the ratios of health workers to population remain far below international norms. Health personnel assigned to maternal and child health (MCH) almost tripled in this period, and accounted for about 12% of total health sector staff in 2010. The Ministry of Health projects that there will be 65 generalist and MCH doctors and nurses per 100,000 inhabitants by 2015, but this would still be only about a quarter of the ratio of 240 recommended by WHO (MISAU, 2013b). There are also large disparities in medical personnel by provinces, with more than three times more population per health worker in Zambézia than in Maputo City (UNICEF, 2013f).

Long waiting times and the disagreeable attitude taken by health workers to patients discourage use of health services. A qualitative study in Zambézia (De Maria, 2013) indicates that this is one of the main reasons for non-adherence by mothers to the vaccination schedule for infants, leading to much lower immunization rates for the later vaccines.

WHAT IS BEING DONE

Revival of the Community Health Workers (Agente Polivalentes Elementares) programme

Increased availability and quality of the Family Planning and Contraception services.

Expanion of the Model Maternity Facilities initiative, in the perspective of improving the quality of maternal and child care (humanised childbirth).

Construction of waiting houses for pregnant women, in order to reduce the obstetruic complications and maternal and neonatal deaths that occur in the communities.

Formation of National Audit Committees on Maternal, Perinatal and Neonatal Deaths

Strategy for strengthening the interventions of traditional midwives and training them to promote the health of mothers and newborn infants in the community ,

Screening and treatment for cervical and breast cancer (CACUM)

Campaign to treat women with obstetric fistulas

Strengthening the management, logistics, monitoring and evaluation system.

Strengthening the coordination mechanisms

HIV/AIDS

There has been a large expansion in the availability of HIV testing and treatment of AIDS over the past decade, covering all districts, although still only about one quarter of health facilities (316 out of 1,414) currently provide anti-retroviral therapy (ART) services to adults and children. PMTCT services are now available in 99% of health facilities providing antenatal care. Early infant diagnosis has been slower to expand, reaching 475 health facilities by 2013 (MISAU, 2013c). Only about 42% of women who gave birth in the two years prior to the 2011 DHS received HIV counselling, took a test and received the results.

The Ministry of Health's Accelerated HIV/AIDS Response Plan for 2013-2015 aims to scale up ART coverage to 80% by 2015, which in turn would greatly reduce transmission. According to long-term modelling, it would cut incidence and mortality by more than 50% by 2025, regardless of other preventive measures such as the scale-up of male circumcision[35] and changes in sexual knowledge and behaviour (MISAU, 2013c). Achievement of this ambitious goal depends, however, on the continuation of high levels of financing (95% of which has come from donors) and, given the serious human resource constraints in the health sector, the transfer of ART services to lower level health personnel and the redistribution of trained personnel to AIDS-priority districts[36]. The strengthening of the drug procurement and distribution system, as discussed, is also crucial, to avoid the frequent shortages of testing kits and drugs experienced to date.

WHAT IS BEING DONE

The Government recently adopted "Option B" for the prevention of mother-to-child transmission

Health services are free of charge, particularly those related to HIV/AIDS

NUTRITION

Many of the challenges in the health sector, discussed above, apply also to the nutrition-related services delivered by the Ministry of Health. Some nutrition services are heavily dependent on donor funding, with limited allocation of domestic resources. Low priority is given to the procurement and distribution of nutrition products, including therapeutic products for the treatment of acute under-nutrition. The training of nutrition staff (técnicos de nutrição) was interrupted from 2005 to 2010, creating a shortage of staff with nutrition qualifications within the health system. In 2009 there were only 90 nutrition technicians in the health system (RdM, 2010a). However, this number is now increasing again, with the first new batch of nutrition technicians having graduated at the end of 2012.

Counselling on infant feeding in health facilities is weak. The Ministry of Health revived the Baby Friendly Hospital Initiative (BFHI) in 2010 and to date hospitals in five provinces and Maputo City are implementing the BFHI. However, no facility has yet been certified as 'baby friendly'. The Ministry of Health introduced community-based infant and young child feeding counselling at the end of 2011. Community workers have been trained in these skills and the work is being scaled up by both the Ministry of Health and some NGOs. The Ministry of Health has a breastfeeding communication strategy in place and is developing a comprehensive Social and Behaviour Change Strategy on Nutrition.

Legislation relevant for nutrition is in place but enforcement is lacking. Mozambique has a National Code on the Sale of Breast-milk Substitutes, which came into force in 2008, but the legal instrument to regulate implementation of the Code is still not in place. To ensure a sufficient intake of iodine, a Ministerial Diploma approved in 2000 states that all salt for human and animal consumption needs to be iodized, but there has been very little enforcement to date. In 2011, only 45% of households used iodized salt. Finally, in terms of maternity protection, legislation has been in place since 2007 (in the Labour Law), but very few women benefit from it in practice.

WHAT IS BEING DONE

Revival of the Child Friendly Hospitals Initiative (IHAC) which is so far being implemented in hospitals in five provinces and in Maputo City

Strategy of counselling on infant feeding at community level and training of the APE in these matters

Implementation of breastfeeding communication strategy

Development of a Strategy for Social and Behavioural Change in Nutrition

Implementation of the Multi-sector Plan of Action for the Reduction of Chronic Under-nutrition (PAMRDC)

Campaign approaches, through national health weeks, have been used to expand micro-nutrient supplementation and deworming, with considerable success. The 2011 DHS found that 75% of children aged 6-59 months had received vitamin A supplementation, compared to 72% in the 2008 MICS and 50% in the 2003 DHS.

New community-based approaches to the treatment of acute under-nutrition are being scaled up rapidly. The Ministry of Health approved an updated protocol for the treatment of acute under-nutrition in August 2010. This includes community-level diagnosis, referral and follow up, and the outpatient treatment of children with severe acute under-nutrition without complications. Outpatient treatment is now available in all districts in the country and has helped reduce overcrowding of hospitals. However, inadequate supply forecasting and management of therapeutic products and, in various places, the low capacity of health workers to apply the treatment protocol, remain serious bottlenecks.

The implementation of the Multi-sector Action Plan for the Reduction of Chronic Under-nutrition (PAMRDC), approved in August 2010, is advancing in implementation. The Technical Secretariat for Food and Nutrition Security (SETSAN), in the Ministry of Agriculture, is tasked with coordination of the PAMRDC. SETSAN also acts as the focal point in Mozambique for the Scaling Up Nutrition (SUN) global movement. However, unlike neighbouring countries, Mozambique does not yet have a high-level government focal point for SUN. SETSAN's capacity to coordinate the multi-sector response to under-nutrition is being strengthened with support from several development partners. The provinces are drafting their own versions of the PAMRDC, based on the national plan, with Tete becoming the first province in, 2012, to have a finalized plan. The number of development partners supporting implementation of the PAMRDC is growing, but a remaining challenge is to increase domestic financing on nutrition.

WATER AND SANITATION

The large investments in expanding water services have brought to the fore the challenge of ensuring sustainability, especially in rural areas. The PRONASAR baseline survey in 2011 found that 18% of water points are out of operation in the rural areas, with the proportion rising to 26% in the North (DNA, 2012). This is an improvement on the situation only a decade ago, when nationally about 30% of rural water points were not functioning, according to an inventory in 2002-03. However, there is a risk that the requirements for rehabilitation of these out of operation water points will take resources away from further expansion. The demand-responsive approach (DRA), a key plank of the national water policy, aims at improving the sustainability of the investments in water supply sources in the rural areas, of which about 90% are hand-pump operated. However, in addition to the problems of weak institutional capacity (especially at district government level) and inadequate budgets for investment and maintenance, DRA has been inconsistently applied, with many investments still implemented as top-down supply-driven initiatives. As a result, communities have been insufficiently motivated, organized or financially able to repair pumps when they break down. Nevertheless, a trend towards the deconcentration of responsibilities and financial resources to district level has been observed. PRONASAR reported an average of 2.1 water and sanitation technicians per district in 2011 and further recruitment is continuing, combined with increases in the number of districts with water and sanitation projects in their district economic and social plans (PESOD). Other challenges are limited technical options in often-difficult hydro-geological areas and maintenance costs beyond the reach of remote, poor rural communities.

In the urban areas, the main challenges are to improve piped water supply to the peri-urban areas, ensure the long-term financial solvency of the water supply systems and regulate the operators and small-scale independent providers. In the main cities, covering about 80% of the urban population, considerable progress has been made in delegating responsibilities for management of urban water supplies to the private sector, under the supervision of a public body, the Water Supply Investments and Assets Fund (FIPAG), which is also responsible for investments. Operational performance has improved, making water services more reliable, and the water systems in the largest cities are now generating small operating surpluses. A social tariff policy is applied to consumers using public standpipes and pre-financing is provided to facilitate new household connections to the piped water system. As for water supply in the smaller towns, the separate Water Supply and Sanitation Infrastructures Administration (AIAS), set up in 2009, is in charge of a new national programme to rehabilitate and develop these small systems, many of which have been functioning only sporadically after years of unsustainable finances and neglect. There are as yet no clear financing mechanisms to support the development of these systems and the small towns also lack trained technical staff.

In view of the still alarmingly high rate of open defecation, the improvement of sanitation is a high priority, requiring stronger leadership, rationalization of institutional mandates, larger financing and a viable model for sanitation marketing. Although the promotion of the concept of community-led total sanitation (CLTS), which emphasizes community mobilization and behaviour change to eradicate open defecation, is an approach making steady gains in rural areas, as the data trends shown in Figure 2.4 testify, various institutional and financing weaknesses remain. Leadership on sanitation is fragmented across a range of institutions (AIAS, MISAU, district administrations and municipalities) and the limited financing available is directed mainly to improvement of high-cost sewer networks benefiting a small proportion of the urban population. Given the low level of sanitation coverage and its implications for child health and mortality, sanitation needs a much greater degree of policy attention and commitment than is currently the case. The World Bank has estimated that the cost of poor sanitation (including opportunity costs) in Mozambique is equivalent to 1.2% of GDP (WSP, 2012). The depth of poverty in rural and peri-urban areas makes it crucial to develop affordable models to facilitate household investment in sanitation, in conjunction with the emphasis on behaviour change through CLTS.

Deficiencies in water supplies and sanitation facilities in schools and health facilities represent additional although unquantified challenges. Besides their importance for the health of children, the availability of drinking water and sanitation facilities within schools influences school attendance and retention, especially for girls. The real scale of the problem is not known, as coverage information for planning, financing and programming is inadequately collected in both the education and water/sanitation sectors. The weak enabling environment, in particular the lack of institutional leadership and guiding policies, hinders progress. Similarly, water, sanitation and hygienic practices are often neglected in health facilities, both large and small, urban and rural, and not adequately monitored, with large impacts on children.

WHAT IS BEING DONE

Noteworthy improvements in water supply: 53% of the population was using improved water supply sources in 2011 (38% in the rural areas and 85% in the urban areas) compared with 37% of the population in 2003. There has also been an improvement in the percentage of the population who need to spend more than half an hour to fetch water, from 53% in 2008 (MICS) to 39% in 2011 (DHS).

Sanitation also recorded improvements although progress is slow: 24% of the population (DHS) was using improved sanitation facilities in 2011 (13% in the rural areas and 48% in the urban areas) compared with 12 % of the population in 2004 (QUIBB).

The instruments and methodologies for planning and calculating the water supply and sanitation coverage have been harmonised, aligning them with the instruments of the INE and those in use internationally (WHO/UNICEF Joint Monitoring Programme).

EDUCATION

The supply side is no longer a real constraint on access to lower primary school (EP1). There has been a large expansion in school infrastructure and a reduction in the pupil-teacher ratio, which, although still very high (compared with the 'Education for All' target of 40), declined from 73 to 63 between 2007 and 2012 (MINED, 2013). Inter-provincial disparities in the pupil-teacher ratio have declined, although some northern and central provinces (in particular Nampula and Zambézia) still have higher than average ratios. Investments in teacher training have reduced the number of untrained teachers (from 44% to 21% of EP1 teachers between 2004 and 2011) and increased the proportion of female teachers to 45% by 2012 (Visser, 2013; MINED, 2013).

Supply-side shortfalls remain a barrier to access in EP2, although much less so than a decade ago, and are a binding constraint on access to secondary education. The percentage increases in numbers of schools and teachers have been highest at EP2 and secondary levels, but from a very low starting point. The number of schools teaching grades 6-7 (EP2) tripled and the number of teachers at this level doubled between 2004 and 2011, increasing the proportion of primary schools offering EP2 from one in eight in 2004 to one in three in 2012. There is still a longer average travel time for pupils to reach these schools in rural areas. In terms of secondary education, the shortage of schools is acute, blocking the transition of many children who manage to complete EP2, especially in the more remote rural areas.

The pre-school education system is still in its infancy, with only a few community-based *escolinhas* (583 in 2013) apart from some private fee-paying child care centres and pre-primary inception classes in private primary schools in the cities. As has been noted above, this is one of the factors that delays school readiness, contributing to the late enrolment in primary school. The community-run *escolinhas* receive almost no State funds, depending on contributions from parents to pay their staff (animadores). The very small number of trained ECD personnel is an important constraint. There has been growing interest in addressing this major gap in service provision, reflected in the establishment of a multi-sector commission in 2010, the approval of an ECD strategy in 2012, and increasing donor support. MMAS adopted new regulatory procedures and developed new pedagogical manuals for ECD centres.

Mozambique has managed an extremely rapid expansion in pupil numbers, but at the cost of placing a large burden on the education system, compromising quality and learning. The shortage of teachers and classrooms forces most primary schools to operate a double shift system and in some cases triple shifts. And, although large numbers of new teachers have been hired, these teachers' low level of education, low morale and poor teaching skills and methods compromise the quality of teaching, and ultimately learning achievements. Teachers have to cope with large classes and the challenge of teaching children of widely varying ages in the same class, in a language that is not their mother tongue. The rapid expansion seems also to have undermined implementation of the education reform of 2004, which was introduced without adequate preparation and is poorly understood by teachers. The objective of the reform is to promote 'pupil-centred learning', but this has been difficult to put into practice in a context of large class sizes and minimal training of teachers on how to implement it. Focus group discussions with teachers have also revealed almost universal disapproval of the policy of automatic promotion of pupils within the three primary education cycles (grades 1-2, 3-5 and 6-7), which was intended to reduce repetition, but is widely seen by teachers as degrading quality (Beutel, 2011).

There are also concerns about teacher absenteeism and poor learning conditions. According to a study of schools in Cabo Delgado (Adelman et al, 2011), the recorded average teacher attendance rate was 87%, but appeared from observation to be considerably lower, and pupils were losing more than 50% of the potential learning time as a result of late start times, early closing and extended recesses. Some of these problems could be reduced by engaging the community to become more directly involved in the management of schools, through the school councils, which function poorly in most schools (Monjane et al, 2011)[37]. However, other problems are resource-related. The Cabo Delgado study found that only 68% of 3rd grade pupils had notebooks and 73% had pens or other writing materials. Textbook possession was higher (over 80%), reflecting the large investments made nationally, with donor support, to produce and distribute textbooks. A similar study in Nampula and Zambézia (Raupp et al, 2013) found that children were sitting on the bare ground in 65% of classes in Nampula and 63% of classes in Zambézia, and that 15% of classes in Nampula were held under a tree. The grants provided to schools for local running costs through the Apoio Direto à Escola (ADE – Direct School Grant) programme are very small, equivalent to just over USD 1 per pupil in 2013 (Visser, 2013), allowing for only minimal improvements in the teaching environment.

Improving learning achievement is one of the three focus areas of the Education Strategic Plan for 2012-2016 and some important measures are now being taken to improve quality

Improving learning achievement is one of the three focus areas of the Education Strategic Plan for 2012-2016 and some important measures are now being taken to improve quality. In 2012, the Ministry of Education (MINED) established quality standards for primary education and a system for monitoring their implementation. MINED is also conducting reforms in teacher training and piloting the introduction of bilingual education.

It is critical to break the cycle of poorly trained teachers delivering low quality primary teaching. A recent study (Beutel, 2011) has highlighted the drawbacks of the fast-track training model (known as 10+1) used to boost the number of trained teachers as quickly as possible, as well as the related problem of low teacher morale, resulting from low pay, the diminished social status of teachers and the high proportion of teachers on temporary contracts (58.5% in 2009)[38]. To meet the need for rapid expansion of the teaching cadre, the Ministry of Education at first employed large numbers of untrained teachers, a practice that was widely used up to 2008, when it was phased out. The Ministry then increased the number of places in teacher training colleges (the Institutos de Formação de Professores or IFPs) by expanding the network of colleges and halving the length of the training courses, from two years to one (in 2007). Most of these new teachers have been hired as contract teachers and kept in this status for as long as possible, to cut costs. This has helped to 'solve' an immediate problem (the acute shortage of teachers), but at the long-term cost of low teacher skills, large needs for in-service training and low levels of teacher motivation. The government has recognised these drawbacks of the fast-track approach and, now that some progress has been made in reducing pupil-teacher ratios, is preparing to restore a two-year cycle of teacher training. Another priority is to strengthen in-service training, particularly for the fifth of EP1 teachers who were recruited without any pre-service training at all. Places in short-term courses (capacitações) are limited, estimated to cover less than 13% of primary teachers annually.

Delays in the introduction of bilingual education have also made it harder for children to learn. Research on 3rd graders in Cabo Delgado (Adelman et al, 2011) has shown that pupils who do not speak Portuguese at home (the vast majority of children) are struggling to acquire even the most basic pre-reading skills. Despite the extensive international experience that mother tongue education gives children the best chance in their first years at school, and in contrast with the practice of teaching in African languages in the first years of primary school in many other African countries, children are still taught exclusively in Portuguese. It is government policy to introduce bilingual education, mainly in the first two years of primary school, but this is still at an early pilot stage. Progress has been held back by the complexity of developing textbooks and training teachers to teach in local languages, of which there are 17 main ones.

WHAT IS BEING DONE

- Training of teachers and school managers
- Short in-service courses for teachers
- Capacity building for members of the School Councils for undertaking their tasks better
- Expansion of distance learning in secondary education
- Construction of classrooms which also provide access for disabled children
- Support for orphaned and vulnerable children through the ADE including retaining girls at school
- National School Feeding Programme in drought-stricken areas
- Monitoring and supervision of the work of teachers and school managers
- Awareness raising in communities to support children's entry into technical and vocational training opportunities
- Awareness raising about the need for children to enter school at the right age
- Free enrolment in primary education and the distribution of school books

CHILD PROTECTION

There is not yet an integrated system of social care services at local level with trained social workers[39] who are able to play an effective role in preventing abuse, violence and social exclusion and in referring victims to the services they need. Although data are lacking to quantify the needs for social care services or the actual extent of these services at present, it is generally acknowledged that there are large unmet needs, including for counselling and therapy, due to the high levels of violence, neglect and abuse (in communities, families and schools) and the large number of children living separated from their biological parents (in some cases as orphans). The sector is fragmented, with overlapping and ambiguous mandates (for example between the provincial and district social care services and those of the municipalities) and many non-state actors (NGOs and churches), many of which are highly dependent on short-term donor funding, making it difficult to sustain or scale up services. Coordination is generally considered to be weak (MMAS, 2013), although there are multi-sector technical groups and 'nuclei' (NUMCOV) to coordinate services for orphans and vulnerable children (OVCs) at national, provincial and district levels and these are functioning well.

The system is weakest at the district level, where social welfare is part of a combined district structure responsible also for health, the District Health, Women's Affairs and Social Welfare Services (SDMAS). Social care services seem to be eclipsed within the SDSMAS, which in most cases have only one or two social workers, with minimal qualifications, covering an entire district (MMAS, 2013). The scale of services provided is inevitably very limited, given the distances involved and the individual, time-intensive nature of social care work, involving home visits, counselling, case management and referral to complementary services.

A network of community child protection committees complements the formal social care services, although these committees do not exist everywhere and they may be difficult to sustain. These informal community child protection committees have a greater presence in some provinces (notably Zambézia) than in others. Usually including community leaders and some child members, these committees provide a critical link between communities and state services. They identify children at high risk of mistreatment or deprivation of access to key services and refer them to the competent state institutions (SDSMAS, schools, health and nutrition services, the police and judicial system) or to NGOs, among others. Their role has not yet been formalized (for example with respect to case management and linkages with the SDMAS), although MMAS has developed guidelines for strengthening the committees. Most committees have been set up with the support of NGOs, which have provided guidance and training, but they depend on unpaid volunteers, which may make these structures difficult to sustain, especially as they lack funding to carry out their functions.

One of the biggest challenges is to reduce the institutionalization of children and improve the protection of children in alternative care. The legal framework clearly supports the placement of orphans and other children unable to live with their biological parents in alternative families, institutionalization being seen as an option of last resort and, wherever possible, only as a temporary measure. There is also a regulatory framework for the accreditation and inspection of childcare and residential care centres. However, narrow interests seem to be driving the opening of more and more residential care centres, which in many cases are admitting children who have at least one living parent (usually the father) or who could be adopted or fostered by another family. This is prejudicial to the interests of the child and diverts resources away from family-based solutions. At present there are 120 registered centres (and probably many others operating illegally), most of them in the private/faith-based sector, although about 14% of children are in eight state-run institutions (Brown and Winberg, 2013). A decree to regulate the provision of alternative care for children has been drafted. However, capacity is extremely limited for individual case management by social workers, the identification and vetting of alternative families and the judicial processing of cases, and this is exacerbated by the lack of a computerized database to record and monitor the situation of children requiring or already placed in alternative care (Brown and Winberg, 2013). In 2008-12, the judicial system approved 1,500 legal guardianships[40] and 184 adoptions – a tiny drop in the ocean compared with the 700 thousand children facing the risk of abandonment.

Efforts have been stepped up to combat violence against children and women, but there is still a climate of silence and impunity, and redress through the judicial system is rare and costly. Since 2000, the Ministry of the Interior, through the Police, has set up specialized centres, the *gabinetes e secções de atendimento*, to assist women and children who are victims of violence, and also to engage in outreach to communities. As of 2012, there were 260 of these units, including 22 'model' offices, across the country (MINT, 2013), up from 204 in 2008. An evaluation of this system (Ernst and Young, 2010) has noted the professionalism of the police working in these units, the rising number of cases they handle (currently about 6,000 a year), and the links to related services (health, social action, the Attorney General's Office and the judicial system), although these specialized units are mainly located in provincial and district capitals, limiting access. It appears that very few perpetrators of violence are prosecuted and sentenced (about 20%), and there are few specialists available to provide therapy or counselling to victims. Meanwhile, the Ministry of Education has established a policy of 'zero tolerance' of sexual violence and harassment in schools, including by teachers[41], in an attempt to stamp out this widespread problem. But, while much has been done to raise awareness among school directors, teachers and pupils, it is still rare for sanctions to be taken against offenders. More recently, five ministries (health, education, social welfare, interior and justice) have come together to endorse a Multi-Sector Plan of Action to Accelerate Prevention and Response to Violence against Children, covering the period 2012-2017, and to adopt a protocol on case management and referral for child victims of abuse, which is currently being tested.

Despite the adoption of the Juvenile Justice Law (law 8/2008), which brings Mozambique into formal compliance with core international norms and standards, the juvenile justice system remains extremely weak. In practice, the deprivation of liberty is not used as a measure of last resort and pre-trial detention is frequent. As of April 2013, over 2,300 children were in prisons, amounting to 14% of the prison population in the country (MMAS, 2013). There are only two courts for minors, one in Maputo city and another (under construction) in Cabo Delgado.

The Ministry of Education has established a policy of 'zero tolerance' of sexual violence and harassment in schools, including by teachers

Very little action has been taken to combat child labour. There appears to be a general acceptance that little can be done about this widespread phenomenon, given the context of widespread poverty. The Labour Law allows children aged 15-17 to perform 'non-hazardous' work and even allows children aged 12-15 to work under certain conditions. However, the types of work considered non-hazardous are yet to be defined, and neither the

labour inspectorate nor the police have adequate staff, training and funds to inspect work places and intervene to protect children engaged in dangerous work.

The success in increasing birth registration has been due mainly to campaigns for free birth registration organized by the National Directorate of Registry and Notary Offices (DNRN) in the Ministry of Justice, under the Action Plan for Birth Registration, adopted in 2004, although this aims also to strengthen routine registration systems. Since 2012, the campaigns have been widened by including birth registration as an activity during the national health weeks.

Furthermore, attention is turning to the modernization of the routine civil registration system to make it more accessible, secure and efficient. This involves moving from an old-fashioned paper-based system, which is inefficient and insecure, to an electronic civil registry. This reform is linked to the issuance of biometric identity cards, through the new e-NUIC system, which has been piloted in Maputo and Matola and is soon to be rolled out nationally. This is intended also to improve the management of vital statistics. A key challenge is to simplify the registration process and reduce the distance to registry services, so as to cut transaction costs for poor households, primarily through deepened collaboration with health facilities and local chiefs, but also possibly by using mobile technology to transmit data on births, marriages and deaths from remote rural areas to the civil registry offices in district capitals. The 2008 MICS found that, for children whose births were not registered, the main reasons cited were the complexity of the procedures (25%), distance (23%) and expense (20%). It will be important also to abolish or reduce the fines for late registration, remove restrictive barriers such as the requirement for both parents to be present at registration, and improve cross-sector linkages, so that for example births can be registered through a one-stop process at health facilities, where birth registration is currently almost negligible. Likewise, efficient procedures need to be put in place between DNRN and INAS to facilitate the registration of children in highly vulnerable households receiving cash or in-kind transfers, who are at especially high risk of non-registration.

WHAT IS BEING DONE

The efforts of the Government and its partners guaranteed that 797,298 children were registered in 2013

In 2013, 304,576 households benefitted from the PSSB and 11,345 from the PASP

In 2013, 317,657 children received mutiple forms of support (education, health, nutrition, psycho-social support, protection, etc.)

There now exist 1,420 Community Child Protection Committees

In 2013, 1,208 children were reunited with their families or integrated into foster or adoptive families.

DISASTER RISK REDUCTION AND RESPONSE

The Government has made considerable progress in improving the framework for disaster risk management since the adoption of the Disaster Management Policy and the establishment of the National Disaster Management Institute (INGC) in 1999. The Policy became the country's operative strat-

egy for disaster risk management, emphasizing the linkages between development policies, vulnerability reduction and disaster preparedness, prevention and mitigation[42]. The INGC, which since 2009 has been under the Ministry of State Administration, has overall responsibility for coordinating disaster management activities at national, provincial and district levels, including the coordination of relief activities during and after disasters, raising public awareness on disaster prevention and coordinating the early warning system.

The INGC has improved considerably its response mechanisms since the devastating floods of 2000. It has invested in strengthening data collection and analysis, and in training its staff, and has developed a reasonably well functioning early warning system. It prepares an annual contingency plan for floods and cyclones in coordination with the UN Humanitarian Country[43] Team and organises simulation exercises. The INGC operates during emergencies through the National Emergency Operational Centre (CENOE) and its provincial delegations, coordinating with other actors, including the National Civil Protection Unit (UNAPROC), the Mozambique Red Cross, UN agencies and other ministries and NGOs. At the district level, since 2005, the INGC, with the support of the Mozambique Red Cross and NGOs, has been establishing, equipping and training local committees, the Local Disaster Risk Management Committees (CLGRC), which are responsible for all activities related to disaster risk management and response in the communities, although they do not yet exist in all districts. In its Contingency Plan for 2012-2013, the INGC indicated that there were already 760 of these committees, including 206 in high-risk areas.

In March 2013, Parliament adopted a new Disaster Management Law. The law sets out principles for prevention and preparedness and establishes a legal requirement to develop early warning systems and maps that identify areas and populations at risk of being affected. The law demonstrates strong government commitment to the strengthening of disaster risk management and a desire to integrate climate change considerations into national development policies and strategies.

WHAT IS BEING DONE

The National Emergency Operational Centre (CENOE) was set up in 2006 to operate during emergencies

The Law on Disaster Management was approved in 2014

Simulation exercises have been held

The Local Disaster Risk Management Committees (GLGRC) have received training

3.5 THE ENABLING ENVIRONMENT OF LAWS, POLICY, INSTITUTIONS AND FINANCING

The quality of governance is one of the key underlying factors determining the pace of progress in realizing child rights. This concerns the enabling environment of laws, policy, institutions, planning mechanisms and public financial management (PFM), which affect the supply and quality of basic social services, as well as other determinants of child outcomes such as the degree of progress in poverty reduction.

THE LEGAL AND POLICY FRAMEWORK

Mozambique has ratified most of the major international conventions regarding the protection of child rights, including the Convention on the Rights of the Child (CRC) and its optional protocols. The CRC does not prevail over domestic legislation[44] and is thus not justiciable, but the Law on the Protection and Promotion of Child Rights, enacted in 2008, does translate the principles and main provisions of the Convention into domestic law. In accordance with this law, the government has set up the National Council for Child Rights (CNAC) and similar bodies at provincial level.

Important progress has been made in establishing a comprehensive legal and policy framework for children that is largely consistent with the CRC. The legal framework includes the Law on the Protection and Promotion of Child Rights (Law 7/2008), the Family Law (Law 10/2004), the Juvenile Justice Law (Law 8/2008), the Law on Prevention and Response to Human Trafficking, Particularly of Women and Children (Law 6/2008), the Labour Law (2008), the Domestic Violence Law (2009) and the Civil Registration Code of 2004, as well as legislation on education, health, social protection and other relevant fields. It should be noted, however, that the child rights law has not yet been regulated, and there are also deficiencies regarding the provisions on sexual violence against children in the criminal code, which dates from 1886 and is currently under revision.

However, law enforcement is often weak. For example, as has been highlighted in this report, the legal age of marriage has been set at 18 in the Family Code, but in fact about half of Mozambican girls are married before the age of 18. Likewise, perpetrators of sexual and physical violence against women and children are very rarely prosecuted and convicted, and the legislation against hazardous child labour and the employment of children below the age of 15 is not effectively implemented. These deficiencies reflect not only a culture of silence or tacit acceptance of these violations of rights, but also the weak capacity of the police (including the gabinetes de atendimento), social workers, labour inspectors and the judicial system, and the high transaction costs for victims.

THE INSTITUTIONAL FRAMEWORK

Accountability to parliament (the Assembly of the Republic) suffers from a number of weaknesses, including with respect to the control of public expenditure. Despite its formal role in the planning and budget process (approval of the State Budget and the Economic and Social Plan and approval of the General State Accounts after auditing by the Administrative Tribunal), Parliament's degree of real influence over public finances is limited by the short length of the parliamentary year, gaps in its role (for example its lack of involvement in debate or approval of the medium-term fiscal framework, the CFMP), the latitude given to the executive to make budget revisions without returning to Parliament for approval[45], the deputies' weak technical capacity and the fact that some expenditure is off-budget or 'off-Treasury' and thus outside the purview of parliament. Parliament has a strategic plan for its long-term development and is receiving capacity-building assistance from the UN and donors.

Civil society organizations (CSOs) have a narrow social base and only limited influence. Although the democratic reforms introduced by the 1990 Constitution opened the way for the formation of a wide range of CSOs, an analysis of their role in Mozambican society (FDC, 2008) found that they are weak in breadth, depth and diversity of citizen participation. Most CSOs act as donor conduits for service delivery, although a few also engage in policy advocacy, and are heavily dependent for their survival on donor financing. Very few have a membership base, the main examples being professional associations, employers' organizations or trade unions, and these are small and largely limited to the cities. At the grass-roots level, there are no real social movements, although faith-based organizations and traditional authorities both have a wide social base. These weaknesses may be attributed to structural factors such as the dispersed and predominantly rural nature of the population, the small size of the formal sector of the economy and the high levels of poverty and illiteracy (Hodges and Tibana, 2005).

The audio-visual and written press play a limited role in informing and educating the population, and as a forum for debate, partly because of the limited access of the population (in particular in the rural areas) to the media, as well as capacity constraints. The low level of access to the media, including even radio in the rural areas, has been discussed previously in this report. The public radio and TV have the largest coverage. The development of the private media has been hindered by unfavourable market conditions (low levels of literacy, weak purchasing power, low levels of electrification for television access, limited advertising revenue and difficulties in obtaining bank credit for expansion). The community radios, which are notable for their proximity to grass-roots populations, are perilously dependent on donor assistance. Finally, the low salaries paid to journalists make it difficult for media houses to recruit and retain well-educated and professionally trained journalists, limiting the quality of reporting (Hodges and Tibana, 2005).

Donors have assumed a large deal of influence, due to the scale of government dependence on external assistance, which has distorted the nature of accountability. The procedures set up over the past decade for government-donor dialogue on general budget support, linked to a performance assessment framework (PAF) with mutually agreed indicators and targets, and similar processes for the SWAPs and common funds, have ended up making accountability to donors more formalized than to parliament or the public (De Renzio, 2011).

The process of deconcentration has modified slightly the system of public administration. The only truly autonomous decentralized bodies are the municipalities (autarquias), established in the urban areas and to which a few limited powers have been devolved. However, they accounted for only 1.4% of total government expenditure in 2013. More important has been the 'deconcentration' of central government responsibilities to the 11 provincial governments, headed by centrally appointed

governors, and the 141 district administrations. There are still no elected government structures at provincial and district levels, apart from consultative bodies. Almost two thirds of public expenditure is carried out by the central government, and this has changed only marginally during the past few years, although there was a process of devolution of part of the provincial-level expenditure to the districts, which increased the share of district expenditure by about 10% between 2008 and 2013 (see Table A.9 in the statistical annex). There has been a higher level of devolution of expenditure to sub-national levels in some specific sectors, especially in the social sectors. For example, 30% of general (non-tertiary) education spending in 2013 was managed at provincial level and 53% at district level.

PLANNING AND PUBLIC FINANCIAL MANAGEMENT

Strategic planning has been greatly strengthened by sector-wide approaches (SWAPs), of which Mozambique was one of the pioneers, beginning in the late 1990s. There are now second or third generation strategic plans in several of the sectors directly relevant to children, linked to the Action Plan for Poverty Reduction (PARP) and the Government's 5-Year Plan (PQG). These include:

- The Education Strategic Plan 2012-2016 (MINED, 2012);
- The Health Sector Strategic Plan 2014-2019 (MISAU, 2014);
- The National Basic Social Protection Strategy 2009-2014 (RdM, 2009);
- Two separate water and sanitation strategies – the first for rural areas covering the period 2006-2015, with a related programme document (MOPH, 2009), and the second for urban areas in 2011-2025 (MOPH, 2012b), as well as a long-term investment plan for small towns, which is currently under preparation.

Mozambique also has strategic plans or similar planning documents in cross-cutting areas like climate change, disaster management, nutrition, HIV/AIDS and disability, where many different sectors are involved. These include:

- The National Master Plan for the Prevention and Mitigation of Natural Disasters, adopted in 2006, which is to be replaced soon by a new national strategy;
- The Multi-Sector Action Plan for the Reduction of Chronic Under-nutrition in Mozambique 2011-2015(20) (RdM, 2010a);
- The National Strategic HIV and AIDS Response Plan 2010-2014 (RdM, 2010b);
- The second National Plan of Action for Children, adopted in 2012 for the period 2013-2019 (RdM, 2012b);
- The second National Plan in the Area of Disability (PNAD II), for the period 2012-2019 (RdM, 2012a).

However, coordination among the wide range of actors in these fields is complex, so that it becomes difficult to make these plans operational except in so far as their content is also well integrated into sector-specific strategies or plans. In the case of HIV/AIDS, for example, the health sector's interventions for prevention and treatment are the subject of a separate planning document, the HIV Accelerated Response Plan for 2013-2015 (MISAU, 2013b).

Mozambique has made great progress in the area of public finance management (PFM) in recent years, including the establishment and implementation, since the early 2000s, of an integrated electronic system for PFM, the State Financial Administration System (SISTAFE). However, challenges remain, and one of the major challenges is the strengthening of the linkages of sector and macro planning instruments to the annual preparation of the State Budget, through robust medium-term budget planning so that budget allocations reflect policy priorities. The key instrument for this is the Cenário Fiscal de Médio Prazo (CFMP – Medium Term Fiscal Framework). However, the CFMP still needs to be strengthened so that it can effectively be used as a strategic instrument for policy-driven allocation of resources and to orient the annual budget (see Hodges and Tibana, 2005).

Concerns about fiduciary risk[46] and the need to provide evidence of results to home constituencies have made it increasingly challenging for donors to maintain programmatic support (through common funds and budget support), running the risk of a return to project-based aid. This can be seen most clearly in the case of the health common fund, PROSAÚDE, whose share of the overall health budget has diminished since 2010, mostly due to the withdrawal of the Global Fund to Fight AIDS, Tuberculosis and Malaria since 2009. Some other donors, in particular the USA, have never provided aid in the form of budget support or disbursed aid through government PFM systems. Given the scale of these parallel resource flows, which have also been associated with the use of NGOs as contractors, three major difficulties have arisen: difficulties in planning and the rational allocation of resources; inequalities created by distortions in the channelling of resources to vertical programmes for specific diseases and services (in particular to HIV/AIDS treatment and prevention); and an 'internal brain drain' from the public health service to NGOs and autonomous project units, due to salary distortions (Mussa et al, 2013).

The shift from sector to territorial planning and budget management has made it more complex and challenging to ensure the coherence of public expenditure in the social sectors. As a result of reforms to the system of 'dual subordination' (to vertical line ministries and horizontal levels of government), provincial governments and district administrations have assumed primary responsibility for the preparation of plans and budgets at sub-national level, reducing the role of the line ministries. The latter now have less leverage over territorial budget allocations, although they retain control over substantial centrally allocated resources, as indicated above. This has made sector planning, including for the correction of historical patterns of territorial inequity, more complex and difficult (MISAU, 2013a).

GOVERNMENT EXPENDITURE ON THE SOCIAL SECTORS

Analysis of the structure and trends of public expenditure is beset with methodological difficulties due to substantial extra-budgetary resource flows and expenditures, as well as classification weaknesses (including the lack of a programme-based budget classification) and the fact that district-level expenditures have not (until very recently) been included in sector breakdowns in the published budget law, budget execution reports or the public accounts (the Conta Geral do Estado or CGE). Although progress has been made in bringing a substantial part of donor resources (in particular GBS, most of the common funds and even some project financing) into the PFM system, this is not the case for much of the project financing, which, at different points in the budget cycle, may be off-budget, off-Treasury and/or off-accounts (i.e. not recorded in the CGE). These parallel resource flows include the substantial aid from the USA in particular, notably for HIV/AIDS. Some locally collected and retained revenues (receitas próprias), in sectors such as health, are likewise not captured in the state accounts (or the budget). The fact that district expenditures are made by multi-sector 'district services' (such as DSMAS for health, women's affairs and social welfare) means that a significant part of the 'on-accounts' public expenditure has not been disaggregated by sectors (until 2012), making it even more difficult to form a comprehensive and accurate picture of sector expenditure. This was a particularly serious limitation given the increasing share of the budget being allocated to and executed at the district level, as noted above. In 2013, 53% of education expenditure and 17% of health expenditure was executed at district level (MINFIN, 2014).

Notwithstanding these data limitations, there appears to have been a decline in the relative share of the social sectors in executed government expenditure, but an increase in real per capita spending in these sectors (see Figure 3.10). In other words, a rapid increase in government expenditure (by 152% in real terms between 2008 and 2013), made possible by the fast growth of GDP and government revenue (and a recent widening of the fiscal deficit), brought about a large expansion in social sector expenditure at constant prices on a per capita basis (despite the fast population growth), even though the relative priority given to the social sectors, compared to other areas of spending, declined slightly. This can be seen most clearly in education, where the sector's share of government expenditure has been on a gradual declining trend, from 23.3% in 2008 to 18.5% in 2013, even though per capita expenditure on education has risen in real terms by 72% over this period. The trends in health are more difficult to interpret, due to the large proportion of unstable donor-financed project spending in this sector and the time lag in incorporating data on expenditure from these

projects into the government accounts. The health expenditure in 2013, which shows a sharp decline (in both relative and per capita terms) in Figure 3.10, may later be adjusted upwards, as happened to the 2012 data. Nonetheless, Mozambique appears to be far from achieving the target of 15% government expenditure on health adopted by the African Union in the Declaration of Abuja in 2001, making it difficult to address the serious supply and quality problems in the health sector.

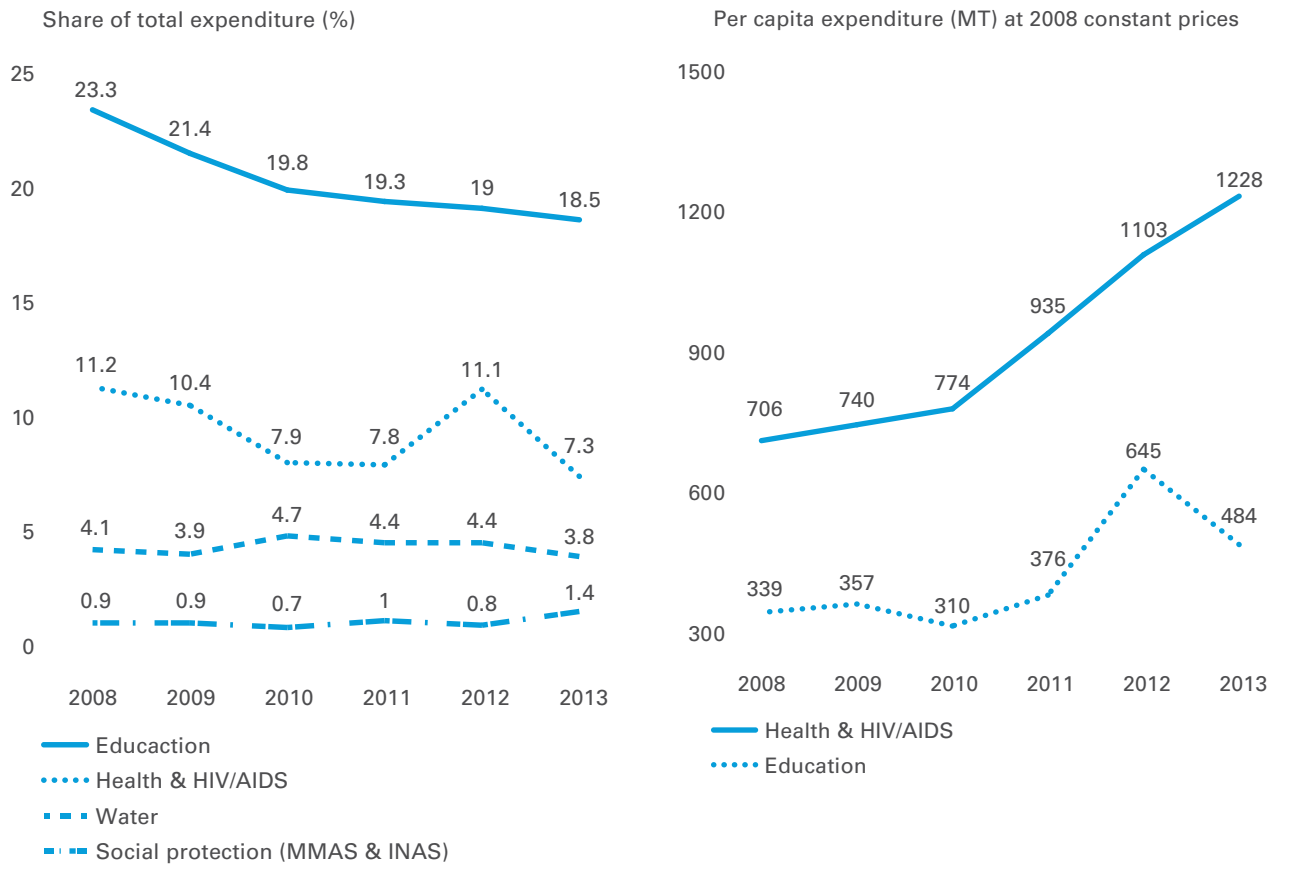
Some other aspects of public expenditure on the social sectors are worth noting here:

- Within the education sector, the spending on secondary education grew particularly fast, cumulatively by 226% in 2008-12 (at current prices), reflecting the expansion at this level of the system, while spending on primary education grew by 77%. It is pertinent to note, given the concerns about teacher quality previously discussed, that expenditure on teacher training remained almost unchanged between 2007 and 2012 in nominal terms, implying a decline at constant prices.
- Financing of the water sub-sector has remained around 4-5% of total government expenditure, with consistently less than 1% of domestically financed government expenditure since 2009, the balance being financed by donors.
- As for social protection (excluding price subsidies), there has been an increase in expenditure, starting from a very low base and rising to about 1.4% of government expenditure in 2013. Almost all of this is for the social transfer programmes of INAS, leaving few resources for the social care services provided by MMAS. More than 90% of expenditure is domestically financed.

There also appear to be large disparities in social sector expenditure per capita by provinces, although the data should be interpreted with caution, being limited to the expenditure made directly by the provincial governments. In other words, this excludes the substantial central level expenditure that benefits provinces, as well as the growing share of expenditure by districts. Nonetheless, it is striking that the provincial per capita budget allocations for health vary widely and do not seem to reflect an attempt to overcome the disparities in access to health services or in health outcomes. For example, the 2013 per capita health allocation for Zambézia was the lowest for any province, despite the fact that Zambézia has some of the worst health indicators and has the highest under-5 mortality rate. This can be seen in Figure 3.11, which plots, by provinces, the under-5 mortality rate (from the 2011 DHS) and the per capita allocations to provinces for health from the 2013 budget.

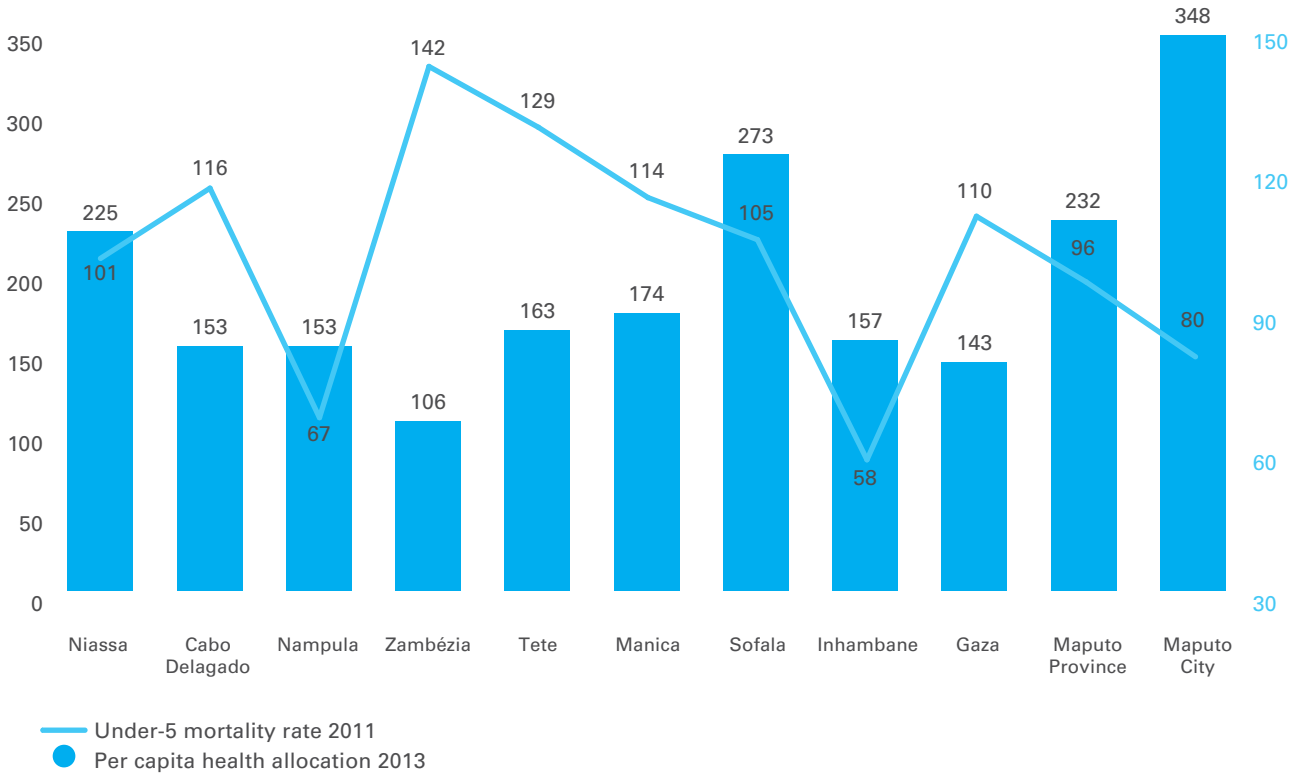
Despite absolute increases in public expenditure on the social sectors, there has been a decline in their relative share of government expenditure.

Figure 3.10 – Trends in executed social sector expenditure, 2008-2013



Note: Exclude the management of dams and irrigation systems.
Source: CGE 2008-2012, REO 2013.

Figure 3.11 – Health budget allocations per capita, 2013, and under-5 mortality, 2011, by provinces



Sources: UNICEF, 2013b, and DHS 2011.

16– The National Statistics Institute (INE) plans a new IOF in 2014.

17– Calculated from MICS data and INE population projections for 2010.

18– The distribution of types of functional limitation was similar in the national study in 2007-2008 on the population with disabilities: amputation of the lower limbs (23%), deafness (13%), blindness (12%), mental disability (9%), amputation of the upper limbs (11%) and paralysis (10%). About half of the persons surveyed with functional limitations (52%) attributed their disability to disease and a quarter (26%) said that originated at birth.

19– An elasticity of 1.286 for the child height-for-age z-score with respect to per capita consumption expenditure.

20– Measured by a wealth score.

21– The cost of what must be given up, such as work, in order to access the service.

22– Uniforms are not officially compulsory but are sometimes required in practice by schools, especially above EP1 level.

23– FAO (2011).

24– Shifting cultivation through slash and burn is the traditional farming method. Trees are cut to the extent needed by the extended family for cultivation to ensure adequate food supply. The timber is a by-product used for cooking and, in some areas, construction of shelters for people and animals. The increase of population has reduced the time available for the vegetation to re-grow on fallow land, resulting in soil erosion.

25– For analysis on the impact of climate related hazards on agriculture and food security, see INGC (2012), World Bank (2010) and FAO (2011).

26– See World Bank/GFDRR Mozambique Dash Board, at http://sdwebx.worldbank.org/climateportalb/home.

27– The deprivation of information refers to the deficiencies of knowledge generated by the non-existent or poor access to information, whether through the media or by Community mechanisms at the local level.

28– Analysis of provincial data in the 2009 AIDS survey (INSIDA) points to a negative correlation between male circumcision and HIV prevalence. Inhambane, which has one of the highest rates of male circumcision (83.6%), has a relatively low level of HIV prevalence (8.6%), contrasting with other southern provinces where male circumcision rates are much lower and HIV prevalence rates are much higher.

29– These proportions were respectively 60% and 32% in the 2011 DHS.

30– These radio stations are supported either by the National Community Radio Forum (FORCOM), an independent NGO, or by the state-run Instituto de Comunicação Social (ICS – Mass Communications Institute).

31– For example, only 13% of women aged 15-49 are sole owners of land, compared with 25% of men in the same age group, according to the 2011 DHS.

32– This view is most widespread among women who are without education and who live in the poorer households and in the rural areas.

33– This decline has been partially offset, however, by a large increase in the proportion of married women who do not know whether their husbands have additional wives (up from 0.3% to 6% in this period), especially in the southern provinces. In Maputo City, this proportion is as high as 24%.

34– Taken alone, the risk of mortality is 2.05 times higher for children born to mothers less than 18 years old and 2.30 times higher for children born less than 24 months after a previous birth, compared with the low-risk category. These 2 high-risk categories account for 9.2% and 4.1% of births respectively, while the third high risk category (birth order of 4 or more) is larger (25.2% of births) but with a lower risk ratio (1.13) compared to the other two.

35– The health service has also adopted a national plan to expand male circumcision, given its high impact on men's probability of HIV infection. Following a pilot scheme in 2009-2012, the programme is now at rollout stage in several provinces.

36– According to the Ministry of Health, the proportion of ART services provided at primary health care level rose from 21% in 2005 to 78% in 2011.

37– This is one of the main objectives of the child friendly school initiative supported by UNICEF in selected schools.

38– Contract teachers have lower job security, no pension rights and reduced opportunities for in-service training and career advancement. Conversion to civil servant status, after the minimum 2-3 years of successful service, is beset by complex bureaucratic procedures, high transaction costs and long delays, further demoralising teachers (Beutel, 2011).

39– As of 2011, MMAS, which has the core mandate for social care services, had 1,534 staff, of which only 28% had specialized qualifications in social action or early childhood development, the two main areas of work of this ministry. The Ministry adopted a Human Resource Development Plan in 2011, which aims in particular to improve the technical competence of its staff, including through in-service training courses, for which it has developed new curricula.

40– Legal guardianship (tutela) requires a court decision to assign guardianship of a minor to designated persons, but does not alter permanently the legal ties between the minor and his/her natural family as occurs in adoption.

41– Dispatch no. 39/GM/2005 of 5 December 2005.

42– For a review of Mozambique's legislative framework on disaster management and recommendations for improvement, see IFRCRCS (2012).

43– The UN Humanitarian Country Team (HCT) is supporting disaster response at the national level. Led by the UN Resident Coordinator, it consists of the UN agencies, national and international NGOs and the Red Cross. The HCT is organised into clusters (Education/Protection, Health, Nutrition, Food Security, Shelter, Logistics, Emergency Telecommunications and Initial Recovery), which are integrated into the four sectors of CENOE (Planning and Information, Infrastructure, Social and Communication) and are aligned with their respective ministerial counterparts.

44– However, there are some gaps such as the absence of an explicit prohibition on corporal punishment in the home and in schools.

45– Only when aggregate revenue and expenditure figures increase does the Government have to return to Parliament for approval of a budget revision. In recent years this happened in 2002, 2007 and, most recently, in 2013.

46– Fiduciary risk is the risk that resources are not used for their intended purposes, fail to achieve their objective or are not properly accounted for.

Conclusions

04

There have been major advances in improving child well-being, especially with regard to child survival and access to basic social services. There has also been real progress in extending access to improved drinking water sources and sanitation, albeit from a low base, in extending the testing and treatment of HIV/AIDS (and PMTCT) and in improving the coverage of other services such as birth registration.

However, improving maternal and neonatal survival remains a major challenge and virtually no headway has been made in reducing chronic under-nutrition. The past decade has seen no reduction in the maternal mortality rate and since 2008 there has been a slight reversal in the use of reproductive health services, including the proportions of deliveries that take place in health facilities or are attended by health personnel. This is closely related to the performance on neonatal mortality, which is falling much more slowly than infant and under-5 mortality. With respect to nutrition, the fall in the proportion of underweight children under 5 (one of the MDG indicators), which appears to show progress, masks the fact that stunting (low height for age) remains at one of the highest levels in Africa, with almost no progress in the past decade. This poses serious challenges not only for child survival, given the contributory role that under-nutrition plays in child mortality, but also for Mozambique's human capital, poverty reduction and long-term socio-economic development.

Advances in the last decade are encouraging, however, the potential to advance more consistent and rapidly in the coming years should be explored

Advances in school enrolment and completion, which appear to have stalled since about 2008, have come at the cost of low learning achievement. Up to the late 2000s, there were major advances in school enrolment and completion at both primary and secondary levels, although from a very low base in the case of secondary education (and even in EP2). However, this has gone into reverse at primary level, with a slight fall in the primary net attendance ratio and primary gross completion rate since 2008 and an absolute decline in the number of children in EP2 in 2011 and 2012. Inter-annual dropout rates have been rising, and repetition rates, which fell sharply after the education reforms in 2004, have been rising again. Falling pass rates and several studies on learning achievement show that primary pupils are learning little in terms of core literacy and numeracy skills. Along with early dropout, this poor learning achievement explains the limited progress made in improving adult literacy, which remains low, especially among women.

Large geographic inequities in poverty, human development and child well-being persist, with almost all indicators worse in the rural areas and in the North and Centre of the country, compared with urban areas and the South – the main exception being HIV prevalence, which shows the opposite pattern. Some of these disparities are very wide, as, for example, in the case of under-5 mortality in Zambézia, which is more than twice as high as in the provinces where this indicator is lowest. The report has highlighted the particularly disadvantaged situation of Zambézia, which not only has the highest under-5, infant and neonatal mortality ratios, but also the highest rate of acute under-nutrition, the lowest proportions of deliveries in health facilities, the lowest vaccination rates, the lowest use of improved drinking water sources, the lowest secondary school net attendance ratio and the lowest rate of birth registration. This poor performance in relative terms is made all the more serious by the large size of Zambézia's population, which gives the province a large weight in many dimensions of child deprivation. Resource allocation does not yet show a determined effort to redress these imbalances.

Returning to the conceptual framework presented at the onset of this analysis, it can be seen that poverty remains a key driver of child deprivations. Regression analysis has shown, for example, that poverty is by far the dominant factor associated with chronic under-nutrition. Survey data show the importance of cost and distance barriers to access to health services and birth registration. Inter-quintile disparities are large for many indicators, although in some cases deprivations are high even in the wealthier quintiles. Economic inequities are exceptionally large for access to ECD centres, secondary education and use of health facilities for deliveries. Given this context, it is a matter of concern that, since the early 2000s, poverty has been declining only slightly, despite high economic growth, although poverty trends in the most recent period (since the 2008/09 IOF) are not yet known. Social protection coverage is still very low despite the recent expansion of INAS programmes.

However, child vulnerability should not be understood in a purely economistic sense. The large proportion of children who do not live with either of their biological parents, in some cases due to orphanhood but in many more because of poverty, family instability or migration, testifies to the strength of the extended family, but also increases the risks of inadequate care, disadvantage in access to education and in the worst cases exposure to abuse. The strengthening of social care services, including through community mechanisms, is crucial for protecting the rights of these children.

There is a synergistic relationship between poverty, climate change, the risks associated with natural disasters and the seasonal fluctuations in food insecurity. Environmental degradation and the increasing risk of extreme weather events reinforce the vulnerability of poor households, particularly in the rural areas, and affect children through their effects on households' livelihoods and food security, as well as the direct damage to social infrastructure and disruption to social services resulting from disasters. Adaptation to climate change and disaster risk management need to be better integrated into broader development policy. On the positive side, Mozambique is making progress in developing systems and capacity for disaster risk reduction and relief.

Child outcomes are also affected by deficiencies in knowledge, attitudes and practices (KAP), rooted in traditions and unequal gender relations, as well as low access to information through the mass media. This report has noted the resilience of traditional institutions and opinion leaders at community level in shaping attitudes and practices, highlighting in particular the role that initiation rites play, especially for young adolescent girls in the North and Centre, in shaping their expectations on the role of women in society and shaping reproductive health behaviours. One of the most serious consequenc-

es, despite some modest improvement in the last few years, is the still very high incidence of child marriage among girls, which contributes in turn to early sexual activity and a huge problem of adolescent pregnancy. Along with inadequate birth spacing, this is one of the key factors increasing the risks of maternal and child mortality, and contributing to the high and (in rural areas) rising fertility rate. Furthermore, female submissiveness and weak bargaining power, which are deeply rooted in cultural attitudes and economic disadvantage, underlie the widespread problem of domestic violence and contribute in particular to the vulnerability of young girls in sexual relations, exacerbating the risks of HIV infection. To be effective, KAP strategies need to go beyond formal 'modern' channels, such as schools, health facilities and the mass media, to build partnerships with key community opinion-leaders in order to influence the messages conveyed in traditional practices such as initiation rites.

Despite major supply-side advances in recent years, problems persist in the supply of basic social services and there are serious concerns about their quality. There are still large shortfalls in the geographical coverage of certain services, especially in the availability of health facilities. Distance is still cited in surveys as the main reason for non-utilization of health services. In education, the availability of schools and teachers is no longer a barrier at the lower level of primary education. However, despite rapid progress in increasing the number of schools offering grades 6 and 7, access to EP2 is still a problem in remote rural areas. At secondary level, supply remains a binding constraint, even though this has seen some of the largest increases in investment and pupil numbers. There is increasing concern about the quality of services in all sectors. Health service treatment protocols are not fully respected, often due to the endemic drug stock-outs. A fundamental reform of the pharmaceutical procurement and distribution system is a top priority. There is also grave concern about human resources. While the numbers of health workers and teachers has rapidly expanded, there are large shortfalls in health personnel (relative to global norms for ratios to population) and deficits in training, especially in primary education, where the introduction of fast-track teacher training seems to have succeeded in increasing the number of teachers but at the cost of undermining quality. The serious deficiencies in quality affect the impact of these services (for example on health outcomes and learning achievement) while also diminishing the credibility and take-up of services.

An enabling environment for the realization of child rights is largely in place at the level of laws and policy, although law enforcement is weak, due mainly to capacity constraints. Although access to the justice system is improving on the margins, for the vast majority of Mozambicans redress for rights violations through the courts is effectively impossible due to distance, costs and the weak capacity of the police and judicial system.

Investing in children is critical to unlock the country's potential for higher levels of development

Mozambique has advanced further than most African countries in developing a strategic planning framework at both macro and sector levels, but linkages to resource allocation remain problematic. Despite the SISTAFE reforms, the translation of policy objectives and strategic plans into appropriate public expenditure allocations through the budget system is hampered by the weakness of the CFMP, and has been made more complex by the shift towards planning and budgeting at horizontal levels of territorial administration. There are also signs of a partial retreat of donors from budget support and common funds, seen most notably in the case of the PROSAÚDE common fund, which risk making it still more difficult to ensure the overall coherence of resource allocation, while also raising the transaction costs of aid for the Government.

The decline in the relative share of the social sectors in government expenditure is a cause for concern. Although the analysis of sector expenditure trends is hampered by the lack of comprehensiveness of the data available in the public accounts (and until recently by the non-classification of district expenditure by functions), there is little doubt that in relative terms the social sectors are receiving less priority in resource allocation, compared for example to the expansion of physical infrastructure. This is masked somewhat by the continuing rapid increase in expenditure on the social sectors in absolute terms, made possible by the rapid growth of the economy, government revenue and overall expenditure.

Investing in children is crucial for balanced development and long-term poverty reduction. Mozambique does have large deficits in physical infrastructure that need to be addressed to unlock the country's potential for higher levels of economic growth and development. But investment in human capital is also crucial for balanced development and poverty reduction, and this begins with children. It will be difficult to achieve major improvements in human capital without tackling in a more forthright manner the serious supply and quality deficiencies in the social sectors, including by making a more resolute effort to improve nutrition during the critical period of cognitive development in early childhood. As Mozambique moves into a period of rapid development of its large gas and mineral deposits, with prospects of generating large additional fiscal resources for the state from the early 2020s onwards, a high priority should be given to improving the financing of the social sectors and the realization of Mozambican children's rights.

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Table A.1 – Well-being of children and mothers, 1997-2011

	DHS 2003	MICS 2008	DHS 2011
Child and maternal mortality			
Under-5 mortality (per 1,000 live births)	153	141	97
Infant mortality (per 1,000 live births)	101	95	64
Neonatal mortality (per 1,000 live births)	37	38	30
Maternal mortality (per 100,000 live births)	408	…	408
Child under-nutrition (%)			
Chronic under-nutrition (moderate and severe, children <5)	48.0a	43.7	42.6
Severe chronic under-nutrition (children <5)	…	17.6	19.7
Acute under-nutrition (moderate and severe, children <5)	5.0a	4.2	5.9
Underweight (moderate and severe, children <5)	22.0a	18.3	14.9
Households with iodized salt	53.7	58.4b	44.8
Children 6-59 months receiving vitamin A supplements	49.8	71.5	74.6
Children 6-59 months dewormed	…	…	46.3
Children 6-59 months with anaemia	…	…	68.7
Reproductive health (%)			
Total fertility rate	5.5	6.1	5.9
Women in marital union using modern contraceptives	11.7	12.2	11.3
Women delivering in health facilities	47.6	58.0	54.8
Deliveries assisted by health personnel	47.7	55.3	54.3
Pregnant women receiving antenatal care (1 visit +)	84.6	92.3	90.6
Pregnant women receiving preventive malaria treatment	…	43.1	19.6
Pregnant women receiving 2+ vaccinations against tetanus	57.2	66.5	55.9
Pregnancies protected against neonatal tetanus	…	79.3	66.9
Child health (%)			
Children 12-23 months with complete EPI vaccination	63.3	60.3	64.1
Children <5 with ARI taken to health facilities	51.4	65.4	50.2
Children <5 with diarrhoea receiving ORT	54.1	53.9	61.5
Children <5 with fever receiving anti-malarial drugs	14.9	36.7	29.9
Children <5 sleeping under bed-nets	9.7	42.1	38.9
Children <5 sleeping under insecticide treated bed-nets	…	22.8	35.7
HIV/AIDS (%)			
HIV prevalence (adults aged 15-49)	…	11.5c	…
Women 15-49 tested (with results) for HIV in past 12 months	2.4	15c	25.9
PMTCT coverage (% of pregnant women HIV+) d	1	49	72
Water and sanitation (%)			
Population using improved sources of water for drinking	36.6	43.0	52.5
Population using improved sanitation facilities	…	19.3	23.8

Table A.1 – Well-being of children and mothers, 1997-2011

	DHS 2003	MICS 2008	DHS 2011
Education (%)			
Female literacy (women aged 15-49)	37.5	35.5c	40.2
Net attendance ratio, 1st grade of EP1	20.8	64.5	…
Primary net attendance ratio (NAR)	59.7	81.2	77.1
Gender parity index (primary NAR)	0.9	1.0	1.0
Net secondary attendance ratio	7.6	20.4	23.7
Violence and abuse (%)			
Women aged 15-19 married by age 15	14.0	11.4	10.3
Women aged 20-24 married by age 18	55.9	51.8	48.2
Children engaged in child labour	…	22.2	…
Civil registration			
Children < 5 with birth registered	…	30.8	47.9

Notes: a Recalculated rates for 2003 on basis of WHO reference population of 2006. b 21.8% adequately iodized. c INSIDA 2009 data. d Administrative data. e Women aged 15 and above.
Sources: DHS, 2003, MICS 2008 and DHS 2011.

Table A.2 – Well-being of children and mothers by areas of residence, 2011

	URBAN	RURAL	TOTAL
Child and maternal mortality			
Under-5 mortality (per 1,000 live births)	100	111	97
Infant mortality (per 1,000 live births)	69	72	64
Neonatal mortality (per 1,000 live births)	34	31	30
Child under-nutrition (%)			
Chronic under-nutrition (moderate and severe, children <5)	35.0	45.5	42.6
Severe chronic under-nutrition (children <5)	15.4	21.3	19.7
Acute under-nutrition (moderate and severe, children <5)	3.8	6.7	5.9
Underweight (moderate and severe, children <5)	9.8	16.9	14.9
Households with iodized salt	53.9	40.9	44.8
Children 6-59 months receiving vitamin A supplements	85.0	70.6	74.6
Children 6-59 months dewormed	58.2	41.7	46.3
Children 6-59 months with anaemia	59.7	72.0	68.7
Reproductive health (%)			
Total fertility rate	4.5	6.6	5.9
Women in marital union using modern contraceptives	21.1	7.2	11.3
Women delivering in health facilities	81.8	44.5	54.8
Deliveries assisted by health personnel	80.3	44.3	54.3
Pregnant women receiving antenatal care (1 visit +)	96.3	88.2	90.6
Pregnant women receiving preventive malaria treatment	26.9	16.8	19.6
Pregnancies protected against neonatal tetanus	76.1	63.0	66.9
Child health (%)			
Children 12-23 months with complete EPI vaccination	75.0	60.0	64.1
Children <5 with ARI taken to health facilities	64.4	44.0	50.2
Children <5 with diarrhoea receiving ORT	69.8	57.9	61.5
Children <5 with fever receiving anti-malarial drugs	24.9	31.7	29.9
Children <5 sleeping under insecticide treated bed-nets	42.2	33.1	35.7
HIV/AIDS (%)			
HIV prevalence (adults aged 15-49, 2009) a	15.9	9.2	11.5
Women 15-49 tested (with results) for HIV in past 12 months	34.0	21.7	25.9
Water and sanitation (%)			
Population using improved sources of water for drinking	84.6	37.8	52.5
Population using improved sanitation facilities	47.8	12.8	27.8
Education (%)			
Female literacy (women aged 15-49)	67.8	40.2	40.2
Primary net attendance ratio (NAR)	77.2	77.1	77.1
Gender parity index (primary NAR)	1.0	1.0	1.0
Secondary net attendance ratio	25.0	22.4	23.7
Violence and abuse (%)			
Children engaged in child labour b	20.5	23.8	22.2
Civil registration			
Children < 5 with birth registered	47.8	42.2	33.1

Notes: a INSIDA 2009 data. b MICS 2008 data.
Source: DHS 2011.

Table A.3 – Well-being of children and mothers by provinces, 2011

	NIASSA	CABO DELGADO	NAMPULA	ZAMBÉZIA	TETE	MANICA	SOFALA	INHAMBANE	GAZA	MAPUTO PROVINCE	MAPUTO CITY
Child and maternal mortality											
Under-5 mortality (per 1,000 live births)	101	116	67	142	129	114	105	58	110	96	80
Infant mortality (per 1,000 live births)	61	82	41	95	86	64	73	39	63	68	61
Neonatal mortality (per 1,000 live births)	28	31	15	37	48	23	41	16	34	37	33
Child under-nutrition (%)											
Chronic under-nutrition (children <5)	46.8	52.8	55.3	45.2	44.2	41.9	35.7	36.0	26.8	22.7	23.2
of which, severe	24.0	26.8	30.0	21.0	19.3	18.2	14.8	15.8	8.5	6.0	7.4
Acute under-nutrition (children <5)	3.7	5.6	6.5	9.4	5.6	6.7	7.4	2.2	1.0	2.1	2.2
Underweight (children <5)	18.2	20.6	15.5	21.3	17.0	10.8	11.3	6.9	6.3	7.4	5.4
Households with iodized salt	52.7	6.5	26.1	18.0	59.4	81.3	55.6	74.4	76.3	63.7	73.0
Children 6-59 months receiving vitamin A supplements	69.0	62.4	78.4	57.6	78.8	91.6	78.7	81.7	77.2	93.7	87.6
Children 6-59 months dewormed	46.0	52.9	48.8	27.9	28.6	79.9	58.2	35.8	41.6	73.2	67.4
Children 6-59 months with anaemia	64.1	75.8	72.6	79.2	67.6	67.5	62.6	62.1	58.9	51.7	54.5
Reproductive health (%)											
Total fertility rate	7.1	6.6	6.1	6.8	6.8	5.8	6.1	4.9	5.3	4.1	3.1
Women delivering in health facilities	61.4	36.2	53.3	27.8	50.7	75.3	73.4	57.7	70.7	88.3	91.8
Deliveries assisted by health personnel	60.5	35.3	55.3	26.4	51.7	74.0	71.1	59.4	71.1	84.0	90.8
Pregnant women receiving antenatal care (1 visit +)	90.0	96.1	92.9	73.7	90.1	99.2	95.2	96.4	96.6	99.0	97.4
Pregnant women receiving preventive malaria treatment	3.6	24.8	36.1	7.7	8.7	32.5	31.9	11.9	20.3	27.7	16.6
Pregnancies protected against neonatal tetanus	77.6	65.5	75.5	51.7	50.8	70.4	81.4	75.1	65.0	78.6	78.5
Child health (%)											
Children 12-23 months with complete EPI vaccination	77.2	58.5	66.3	47.3	58.0	64.6	78.4	64.7	76.3	87.9	76.7
Children <5 with fever receiving anti-malarial drugs	43.5	12.7	42.9	35.4	16.8	40.1	33.1	34.2	23.6	2.7	7.0
Children <5 sleeping under insecticide treated bed-nets	38.9	49.7	51.1	31.6	31.5	38.0	39.9	24.3	9.7	21.8	30.9
HIV/AIDS (%)											
HIV prevalence (women 15-49, 2009) a	3.3	9.5	5.5	15.3	8.0	15.6	17.8	10.0	29.9	20.0	20.5
Women 15-49 tested (with results) for HIV in past 12 months	28.4	12.8	19.9	14.2	39.1	38.5	18.6	29.1	29.8	42.1	33.7
Water and sanitation (%)											
Households using improved sources of water for drinking	43.5	37.1	38.5	25.5	43.5	84.2	65.6	60.3	70.1	85.1	98.9
Households using improved sanitation facilities	28.8	6.1	21.5	6.2	17.0	20.1	22.3	16.7	33.1	46.7	74.2
Education (%)											
Female literacy (women aged 15-49)	31.1	25.0	28.2	24.6	23.8	49.4	39.6	51.7	55.8	76.8	85.7
Primary net attendance ratio	67.9	61.7	73.2	78.9	67.3	87.6	79.8	87.0	83.0	90.6	91.3
Secondary net attendance ratio	17.2	11.4	18.6	11.1	13.4	29.5	24.9	34.6	27.7	45.8	59.4
Violence and abuse (%)											
Children engaged in child labour b	8.9	25.7	16.3	25.1	24.2	25.5	30.1	39.4	26.7	9.6	10.6
Civil registration											
Children < 5 with birth registered	35.1	43.6	59.0	26.8	76.3	67.1	40.2	43.2	31.2	57.3	54.8

Notes: a INSIDA 2009 data. b MICS 2008 data.
Source: DHS 2011.

Table A.4 – Well-being of children and mothers by wealth quintiles, 2011

	Q1	Q2	Q3	Q4	Q5
Child and maternal mortality					
Under-5 mortality (per 1,000 live births)	129	105	114	95	91
Infant mortality (per 1,000 live births)	83	74	69	61	64
Neonatal mortality (per 1,000 live births)	33	32	31	31	33
Child under-nutrition (%)					
Chronic under-nutrition (moderate and severe, children <5)	51.1	48.0	46.4	37.4	24.1
Severe chronic under-nutrition (children <5)	25.7	24.5	21.8	14.9	7.4
Acute under-nutrition (moderate and severe, children <5)	9.6	6.1	5.3	4.0	3.2
Underweight (moderate and severe, children <5)	23.0	17.2	15.2	9.7	6.4
Households with iodized salt	27.0	31.9	44.8	58.6	65.9
Children 6-59 months receiving vitamin A supplements	65.4	66.3	75.5	81.7	89.9
Children 6-59 months dewormed	37.6	37.4	48.1	51.3	63.4
Children 6-59 months with anaemia	77.8	76.3	68.3	62.7	51.5
Reproductive health (%)					
Total fertility rate	7.2	7.2	6.3	5.6	3.7
Women in marital union using modern contraceptives	2.9	5.4	6.9	13.8	29.5
Women delivering in health facilities	31.2	38.2	52.9	74.4	91.5
Deliveries assisted by health personnel	31.5	37.7	52.6	74.2	89.5
Pregnant women receiving antenatal care (1 visit +)	82.8	87.4	90.7	96.2	97.5
Pregnant women receiving preventive malaria treatment	17.6	15.6	18.4	22.8	26.1
Pregnancies protected against neonatal tetanus	59.9	63.1	63.8	71.5	78.1
Child health (%)					
Children 12-23 months with complete EPI vaccination	53.8	57.3	66.3	73.5	75.5
Children <5 with diarrhoea receiving ORT	48.9	57.8	67.4	66.6	72.6
Children <5 with fever taken to health facilities	47.6	42.7	59.5	69.7	68.0
Children <5 with fever receiving anti-malarial drugs	36.1	23.7	41.2	26.9	17.1
Children <5 sleeping under insecticide treated bed-nets	32.4	35.7	35.9	36.1	39.6
HIV/AIDS (%)					
HIV prevalence (women aged 15-49, 2009) a	6.6	8.6	9.9	18.3	20.6
Women 15-49 tested (with results) for HIV in past 12 months	16.6	17.5	22.2	31.1	38.7
Water and sanitation (%)					
Population using improved sources of water for drinking b	12.6	22.8	44.4	49.9	85.1
Population using improved sanitation facilities b	0.0	0.1	7.7	17.1	71.6
Education (%)					
Female literacy (women aged 15-49)	12.7	17.0	27.1	48.1	83.9
Primary net attendance ratio	66.6	69.2	76.5	84.4	90.7
Secondary net attendance ratio	3.4	5.2	11.2	24.5	57.8
Violence and abuse (%)					
Children engaged in child labour b	24.0	22.8	25.4	23.6	14.3
Civil registration					
Children < 5 with birth registered	42.3	43.1	47.8	50.2	60.2

Notes: a INSIDA 2009 data. b MICS 2008 data.
Source: DHS 2011.

Table A.5 – Well-being of children and mothers: international comparisons

	MOZAMBIQUE (DHS 2011)	SUB-SAHARAN AFRICA	EAST & SOUTHERN AFRICA	LEAST DEVELOPED COUNTRIES
Child and maternal mortality (per 100,000 live births)				
Under-5 mortality rate	97	109	84	98
Infant mortality rate	64	69	55	65
Neonatal mortality rate	30	34	29	33
Maternal mortality ratio	408	500	410	430
Child under-nutrition (<5, moderate and severe, %)				
Chronic under-nutrition (stunting)	43	40	40	38
Acute under-nutrition (wasting)	6	9	7	10
Underweight (weight for age)	15	21	18	23
Reproductive health (%)				
Women delivering in health facilities	55	47	43	44
Deliveries assisted by health personnel	54	49	44	48
Prenatal consultation rate (1 visit +)	91	77	81	74
Total fertility rate	5.9	4.9	4.5	4.2
Child health (%)				
Children 12-23 months with DPT3 immunization	76	71	79	78
Proportion of children <5 with fever receiving anti-malarial drugs	30	38	31	36
Proportion of children <5 sleeping under insecticide treated bed-nets	36	38	41	41
HIV/AIDS (%)				
HIV prevalence rate (adults 15-49)	11.5	4.8	7.0	1.9
Water and sanitation (%)				
Population using safe sources of water for drinking	53	61	61	63
Population using improved sanitation facilities	24	30	35	35
Education (%)				
Primary net attendance ratio, boys	77	72	75	76
Primary net attendance ratio, girls	77	70	75	75
Secondary net attendance ratio, boys	25	31	23	27
Secondary net attendance ratio, girls	22	29	23	24
Violence and abuse (%)				
Women aged 20-24 married by age 15	14	12	9	16
Children engaged in child labour	22	27	27	23
Civil registration				
Children < 5 with birth registered	48	41	37	35

Sources: DHS 2011 and UNICEF State of the World's Children 2013.

Table A.6 – Access to information and knowledge, attitudes and practices

	DHS 2003	MICS 2008	DHS 2011
Access to information			
Ownership of radio set (% of households)	53.2	…	50.0
Ownership of TV set (% of households)	8.6	…	18.6
Ownership of mobile phone (% of households)	…	…	34.1
Women aged 15-49 with no access to mass media (%)	50.4	…	47.6
Men aged 15-64 with no access to mass media (%)	22.0	…	25.6
Hygiene (%)			
% of households not treating water before drinking	88.8	…	89.9
Nutrition (%)			
% of children 0-5 months exclusively breastfed	30	36.8	42.8
Reproductive health (%)			
Median age of 1st sexual relation (women aged 20-49)	16	…	16.1
Use of modern contraceptives (% of women aged 15-49 married or in union)	11.7	12.2	11.3
HIV/AIDS (%)		INSIDA 2009	
Women who know 2 key ways of reducing risk of HIV infection a	45	60	52
Men who know 2 key ways of reducing risk of HIV infection a	61	63	74
Women with comprehensive knowledge on HIV/AIDS b	…	32	31
Men with comprehensive knowledge on HIV/AIDS b	…	35	50
Men with 2 sexual partners or more in previous 12 months	33	20	30
Men who paid for sexual relations in previous 12 months	13	9	14

Notes: a Use of condom and limiting sexual partners to 1 person who Is not infected. b Knowledge of the following: HIV/AIDS can be prevented by use of condom and by limiting sexual partners to 1 uninfected person; an apparently healthy person can be infected with HIV; and HIV/AIDS cannot be transmitted by mosquito bites or by supernatural powers. Sources: DHS 2003, MICS 2008, INSIDA 2009 and DHS 2011.

Table A.7 – Monetary poverty indices, 2002/03 and 2008/09

	POVERTY HEADCOUNT (P0)		POVERTY GAP (P1)	
	2002/03	2008/09	2002/03	2008/09
National	54.1	54.7	20.5	21.2
Residence				
Urban	51.5	49.6	19.7	19.1
Rural	55.3	56.9	20.9	22.2
Province				
Niassa	52.1	31.9	15.8	12.3
Cabo Delgado	63.2	37.4	21.6	11.5
Nampula	52.6	54.7	19.5	20.0
Zambézia	44.6	70.5	14.0	27.9
Tete	59.8	42.0	26.3	16.5
Manica	43.6	55.1	16.8	21.1
Sofala	36.1	58.0	10.7	27.0
Inhambane	80.7	57.9	42.2	20.9
Gaza	60.1	62.5	20.6	28.3
Maputo Province	69.3	67.5	31.1	25.6
Maputo City	53.6	36.2	20.9	11.8

Source: IAF 2002/03 and IOF 2008/09 (INE, 2010).

Table A.8 – Population by provinces: official projections for 2013

	NUMBER	% OF TOTAL
Niassa	1,531,958	6.3
Cabo Delgado	1,830,124	7.5
Nampula	4,767,442	19.6
Zambézia	4,563,018	18.7
Tete	2,322,294	9.5
Manica	1,800,247	7.4
Sofala	1,951,011	8.0
Inhambane	1,451,081	6.0
Gaza	1,367,849	5.6
Maputo Province	1,571,095	6.4
Maputo City	1,209,993	5.0
Total	24,366,112	100

Source: INE.

Table A.9 – Distribution of executed government expenditure by levels of government, 2008-2013 (%)

	2008	2009	2010	2011	2012	2013
Central government	63.7	63.7	65.4	66.0	65.7	64.8
Provincial governments	31.2	29.4	27.0	19.6	19.5	20.3
District administrations	4.1	5.9	6.5	13.0	13.5	13.5
Autonomous municipalities	1.1	1.1	1.0	1.3	1.3	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Conta Geral do Estado, REO 2013.

Table A.10 – Externally financed expenditure as % of total executed expenditure, by sectors, 2008-2012a

	2008	2009	2010	2011	2012	2013
Total expenditure	25.9	27.7	23.0	23.9	36.8	17.0
Education	29.4	29.1	25.4	22.5	16.7	14.3
General education	31.4	31.4	28.1	23.6	16.3	16.1
Higher education	15.8	15.7	12.8	17.0	20.0	3.7
Health & HIV/AIDS	52.3	58.8	44.4	43.0	51.1	24.4
Health	49.5	57.8	43.4	42.7	55.6	24.2
CNCS	88.8	83.2	74.8	57.1	93.3	37.8
Water	82.4	83.0	87.0	85.6	86.9	85.3
Disaster management (INGC)	0.5	0.6	0.1	4.1	2.4	4.2
Juvenile justice	0.0	0.0	0.0	0.0	0.0	0.0
Social protection (MMAS & INAS)	37.6	45.1	44.8	25.1	8.7	8.9

Note: a Data excludes some district level expenditure prior to 2013 and some off-accounts externally financed expenditure.
Source: Conta Geral do Estado, REO 2013.

Table A.11 – Executed government expenditure on social sectors, 2008-2012a

	2008	2009	2010	2011	2012	2013
In million MT at current prices						
Education	14,976	16,673	19,871	24,031	26,803	31,290
General education	13,047	14,194	16,390	24,031	23,384	26,757
Higher education	1,929	2,479	3,481	3,874	3,418	4,533
Health & HIV/AIDS	7,181	8,052	7,965	9,670	15,660	12,345
Health	6,677	7,737	7,708	9,491	15,555	12,205
CNCS	504	315	257	179	104	140
Water	2,623	3,066	4,694	5,464	6,265	6,464
Disaster management (INGC)	280	286	305	463	487	331
Juvenile justice	13	14	13	15	18	…
Social protection (MMAS & INAS)	593	706	719	1,232	1,150	2,384
Price subsidies (fuel and others)	0	0	4,692	4,354	2,781	2,372
In % of total government expenditure (excluding debt service)						
Education	23.3	21.4	19.8	18.8	19.0	18.5
General education	20.3	18.3	16.3	15.8	16.6	15.8
Higher education	3.0	3.2	3.5	3.0	2.4	2.7
Health & HIV/AIDS	11.2	10.4	7.9	7.6	11.1	7.3
Health	10.4	9.9	7.7	7.4	11.0	7.2
CNCS	0.8	0.4	0.3	0.1	0.1	0.1
Water	4.1	3.9	4.7	4.3	4.4	3.8
Disaster management (INGC)	0.4	0.4	0.3	0.4	0.3	0.2
Juvenile justice	0.0	0.0	0.0	0.0	0.0	0.0
Social protection (MMAS & INAS)	0.9	0.9	0.7	1.0	0.8	1.4
Price subsidies (fuel and others)	0.0	0.0	4.7	3.1	2.0	1.4
In % of GDP						
Education	6.2	6.5	6.1	6.6	6.6	6.8
General education	5.4	5.5	5.1	5.5	5.8	5.8
Higher education	0.8	1.0	1.1	1.1	0.8	1.0
Health & HIV/AIDS	3.0	3.1	2.5	2.6	3.9	2.7
Health	2.8	3.0	2.4	2.6	3.8	2.6
CNCS	0.2	0.1	0.1	0.0	0.0	0.0
Water	1.1	1.2	1.5	1.5	1.5	1.4
Disaster management (INGC)	0.1	0.1	0.1	0.1	0.1	0.1
Juvenile justice	0.0	0.0	0.0	0.0	0.0	0.0
Social protection (MMAS & INAS)	0.2	0.3	0.2	0.3	0.3	0.5
Price subsidies (fuel and others)	0.0	0.0	1.5	1.1	0.7	0.5
Memorandum items (billion MT)						
GDP	239.8	256.0	323.2	365.3	406.4	463.4
Total government expenditure (excluding debt service)	64.3	77.8	100.3	124.4	141.1	168.9
Debt service	1.3	1.4	2.7	3.5	4.1	4.0
Total government expenditure (with debt service)	65.5	79.1	103.0	127.9	145.2	172.9

Note: a Data excludes district level expenditure and off-accounts externally financed expenditure.
Source: Conta Geral do Estado.

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Situation Analysis of Children in Mozambique 2014

ISBN: 978-92-806-4779-2

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