

# **“Plus 5” review of the 2002 Special Session on Children and World Fit for Children Plan of Action**

## **Report on Progress in Implementing the World Fit for Children Plan of Action in Mozambique**

### **1. Introduction**

Located on the coast of south-east Africa, the Republic of Mozambique covers a total surface area of 799,380 km squared. The country is divided into eleven provinces (Cabo Delgado, Niassa, Nampula, Zambézia, Tete, Manica, Sofala, Inhambane, Gaza, Maputo Province and Maputo City) and the capital of the country is Maputo City. The official language is Portuguese, and there are also several national languages. Demographic data indicate that Mozambique has a total population of 19,888,701, with children accounting for about 50 per cent of the total population<sup>1</sup>.

In 2007, the 62nd Session of the United Nations General Assembly will be held. A plenary session is envisaged to follow up on results and progress in implementing the Declaration and Plan of Action contained in the “World Fit for Children” document (WFFC) and the Millennium Development Goals (MDGs), under the theme “A World Fit for Children”. As a contribution to drawing up the global report to be presented by the UN Secretary General at this meeting, the Government of Mozambique is submitting the present report. The report outlines the results achieved and progress in implementing the WFFC and the MDGs in Mozambique.

The report was produced through analysis of various instruments, including national legislation, policies, programmes and plans of relevance to children and the material and experiences of the various civil society organisations that work in partnership with the Government work to protect and care for children. Development of the report has been informed by the process of developing the country’s second national report to the UN Committee on the Rights of the Child on implementation of the Convention on the Rights of the Child (CRC). Development of the CRC report is ongoing, under the oversight of a CRC Reference Group. A national level civil society consultation was held in 2006, attended by a wide range of civil society organisations active in the area of child rights, at which an initial draft of the report was reviewed and inputs provided. The findings of this consultation provided material for the present report. The CRC report will be submitted to the CRC Committee in 2007 and will provide an excellent basis for disseminating - at national and sub-national levels - the current situation in regard to the MDGs and WFFC targets.

The present report covers the main actions undertaken on behalf of children from 2002 to 2006.

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<sup>1</sup> National Institute of Statistics, population projection for 2006.

## **2. Major national actions taken for children and towards the WFFC targets since 2002**

In Mozambique, the Government, civil society and non-governmental organisations are committed to ensuring and guaranteeing for all Mozambican children the rights to survival, development, protection and participation, in order to attain the full realisation of the rights of children enshrined in the Constitution and in current national legislation.

In order to achieve this aim, a number of plans, policies and programmes of relevance to child rights have been developed:

### ***a) Policies, programmes and plans for the protection and care of children***

The Government of Mozambique has reaffirmed the commitments made by the majority of world leaders, recognising a collective responsibility to promote the principles of human dignity, equality and equity at global level. The Government has made efforts to comply with its commitments under international instruments, in order to achieve the targets of the Millennium Declaration and the MDGs.

At the level of overall policy, this commitment is expressed in the Government's Five Year Plan. The national priorities outlined in the Plan are addressed through a number of instruments, as outlined below:

- The Action Plan for the Reduction of Absolute Poverty (known as the PARPA), which is the main national strategy focusing on the reduction of poverty. The PARPA defines the following as long-term objectives: balanced and sustainable economic and social development; a reduction in absolute poverty; the consolidation of peace, national unity and democracy; the generalised application of justice; improvements in education and health; the encouragement of hard work, honesty and zeal; the guarantee of individual freedoms and social harmony; the imposition of laws against criminals; and the guarantee and effort of international cooperation. In relation to children, the PARPA establishes specific targets for child survival, development and protection, and children's participation in the matters that concern them.
- The Social Welfare Policy guides the interventions of the social action sector, and takes as its objective "promoting the integration of social groups that are on the margins of the normal development process so as to contribute towards full equality of opportunities among citizens, as well as to social stability." These social groups include children, the disabled, the elderly and other vulnerable groups.
- The National Strategic Plan for the Fight against HIV/AIDS (known as the PEN II), the implementation of which is coordinated by the National AIDS Council (NAC), is articulated around seven areas of intervention (Prevention, Advocacy, Stigma and Discrimination, Treatment, Research and Coordination of the National Response) for the effective coordination of activities at national level, and also identifies the expansion of programmes of social support for orphaned and vulnerable children as a priority area of intervention.
- The National Plan of Action for Children (known as the PNAC), which establishes priority interventions to be undertaken by the various stakeholders in the area of children's rights,

and takes as its main strategy support for community-based efforts. The Plan encourages family reintegration rather than institutionalisation. The Plan identifies nine priority areas of intervention fundamental to the realisation of child rights in the areas of child protection, survival and development in Mozambique, namely: legal protection; nutrition; maternal and child health; HIV/AIDS; water and sanitation; basic education and child development; social welfare (family environment, alternative care and social security); leisure, culture and sport; and measures of protection and access to information. For each of these areas, special attention is paid to the needs of children living under difficult circumstances, or who have special needs, such as abandoned children, children living in absolute poverty, children who are victims of abuse and violence of any kind, orphans, disabled children, and children suffering from chronic illnesses.

- National Plan of Action for Orphans and Vulnerable Children. This Plan was developed in line with the recommendations of the Rapid Assessment, Analysis and Action Plan for Orphans and other Vulnerable Children (RAAAP) conducted in Mozambique in 2003. The Plan sets out the principles and objectives of intervention for support and care for orphaned and vulnerable children, particularly in the context of HIV/AIDS. In line with the basic principles of the national Constitution relating to children's rights (see below), the strategic areas of intervention set out in the plan are articulated around four key objectives: (i) to establish a protective environment conducive to reducing the impact of HIV/AIDS on orphaned and vulnerable children; (ii) to strengthen the institutional capacity of the government and its partners at all levels; (iii) to strengthen the ability of households and communities to seek local solutions to protect and care for orphans and other children made vulnerable by HIV/AIDS; and (iv) to establish and strengthen the systems for collecting analysis, monitoring and evaluation of the data.

#### ***b) Legislation and defence of children's rights***

During the period covered by the present report, a new Constitution was approved (in 2004), which strengthens the provisions of the previous Constitution concerning the rights of children enshrined in the Convention on the Rights of the Child and in the African Charter on the Rights and Welfare of the Child. Throughout its text, the Constitution establishes the fundamental individual and collective rights of citizens. The Constitution protects unequivocally the rights of children established by the Convention on the Rights of the Child, in the following articles:

##### *Article 47* **(Rights of Children)**

1. *Children have the right to protection and to the care necessary for their welfare.*
2. *Children may freely express their opinions, on the matters that concern them, in accordance with their age and maturity.*
3. *All acts concerning children, whether undertaken by public bodies, or by private institutions, shall mainly take into account the best interests of the child (...).*

##### *Article 120* **(Maternity and paternity)**

1. *Maternity and paternity shall be dignified and protected.*
2. *The family is responsible for the harmonious growth of children, and educates new generations in moral, ethical and social values.*
3. *The family and the state shall guarantee the education of children, training them in the values of national unity, love for the motherland, equality between men and women, respect and social solidarity.*
4. *Fathers and mothers shall provide care for children born within and outside of wedlock (...).*

*Article 121*  
**(Childhood)**

1. *All children have the right to protection by their family, by society and by the state, in order to ensure their all-round development.*
2. *Children, particularly orphans, children with disabilities, and abandoned children, shall be protected by the family, society and the state against any form of discrimination, against ill-treatment, and against the abuse of authority in the family and in institutions.*
3. *Children may not, by reason of their birth, be discriminated against or subjected to ill-treatment.*
4. *Child labour, whether the child is of the age for compulsory education, or of any other age, is forbidden.*

The provisions of the Constitution outlined above reflect the commitment of the Government to comply with its obligations under the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child to harmonise national legislation with international instruments.

In addition to the new Constitution of the Republic, the Government has adopted the Family Law, which strengthens guarantees of women's and children's rights, the Social Security Law, and the Civil Registration Code, which, among other provisions, extended the period of registration free of charge from 30 to 120 days after the birth of the child. A Children's Act on child protection is currently being drafted.

Mozambique's commitment towards children has also been reaffirmed through the ratification of numerous international and regional treaties intended to protect and promote the rights of children. These include the Optional Protocols to the Convention on the Rights of the Child, concerning the sale of children, child prostitution and pornography, and the use of children in armed conflicts, and Conventions 138 and 182 of the International Labour Organisation concerning the minimum age for employment and the elimination of the worst forms of child labour.

### **3. Resource trends for children**

Human capacity is a prime asset for the initiative and action of citizens and of all the institutions of society. This capacity should be permanently enhanced, by strengthening human rights, and particularly the rights of children. To this end, the sectors of particular importance are education, health, water and sanitation, and social welfare.

In order to attain the country's development goals, financial resources must be allocated to the sectors regarded as priority sectors for children. The financial resources allocated to these sectors showed an increasing trend between 2002 and 2006, although the rate of growth varies from sector to sector. Support from international partners should also be recognised, as external assistance currently accounts for an estimated 50 per cent of the state budget.

The financial resources allocated to the water and sanitation sector increased by more than 100 per cent between 2002 and 2006. The water and sanitation sector makes an important contribution to reducing water-borne diseases, such as diarrhoea, one of the main causes of morbidity among the under-fives. The funds allocated to the education sector increased by 95 per cent between 2002 and 2006. Over the same period, the financial resources allocated to the health sector rose by about 89 per cent. The Social Welfare sector shows an increase of 26 per cent in terms of total resources over the past five years. Budget data for the selected sectors are indicated in the table below.

#### **Budget allocations to selected sectors, 2002-2006**

Sectors	Budget in thousands of millions (meticaís)					% increase (2006-2002)
	2002	2003	2004	2005	2006	
Water and sanitation	3,727,130.91	4,247,586.64	3,812,638.44	7,615,398.64	7,493,016.24	101.04
Education	4,120,936.47	4,858,584.49	5,739,859.64	6,446,990.35	8,043,066.66	95.18
Health	3,957,658.23	4,557,743.45	5,415,245.38	5,982,216.82	7,477,586.84	88.94
Social Welfare	211765.44	267394.80	215384.02	230717.42	267717.31	26.42

*Source:* Ministry of Planning and Development (MPD)

#### **4. Development and use of monitoring instruments to track WFFC/MDG targets**

The principal planning document in Mozambique is the Government Five Year Plan, which under the Constitution must be produced by each new Government upon entering office. The Five Year Plan is operationalised through the national poverty reduction strategy, or PARPA, which focuses only on key sectors for economic growth and poverty reduction and goes into far greater depth with regard to resource allocation and the setting of time bound targets for monitoring and evaluation of performance.

Following the approval of the PARPA II, a PARPA Strategic Matrix was developed, which now serves as the key monitoring framework for the implementation of the PARPA (and consequently the national child related targets in line with the WFFC targets). The matrix consists of approximately 200 indicators and introduces a distinction between medium-term results-based indicators and annually measured product-based indicators. The former will be measured in 2009, while the latter will measure progress against targets for annual actions aimed at achieving the medium-term objectives and associated results. The Strategic Matrix includes key child development indicators and related targets, which is of strategic importance, as all PARPA targets will be costed and directly linked to the MTEF.

PARPA activities are implemented on an annual basis through the government's Economic and Social Plan (PES) and the State Budget, which is the financial translation of PES activities.

These two instruments are approved annually by the Assembly of the Republic. The degree of implementation of the activities envisaged under the PES is assessed through the PES Balance-Sheet, an instrument that is also approved every year by the Assembly of the Republic. A reduced version of the PARPA matrix, known as the Performance Assessment Framework, or PAF, has been adopted as an annual monitoring tool and integrated into the PES.

The data to be used in assessing progress towards achieving the national targets for children are obtained from a variety of sources, including household surveys conducted by the National Institute of Statistics and routine monitoring systems of sectoral ministries<sup>2</sup>. The National Institute of Statistics conducts a number of household surveys, including Demographic and Health Surveys every six years (the latest in 2003), household surveys on income/living conditions used to produce the official consumption-based measure of absolute poverty (the latest in 2002/3), and core welfare indicator surveys (the latest as part of a nationwide Labour Force Survey conducted in 2004/2005). With regard to monitoring the AIDS pandemic, which is becoming the single greatest threat to development in Mozambique, HIV prevalence is monitored through the epidemiological surveillance rounds conducted by the Ministry of Health in sentinel sites, the latest being in 2004 and indicating an HIV prevalence among 15-49 year-olds of 16.2 per cent.

In 2002, the National Institute of Statistics launched 'ESDEM' (Estatísticas Sociais, Demográficas e Económicas de Moçambique), the national database on social, demographic and economic statistics in Mozambique. The ESDEM database contains key statistics on the socio-economic situation, including data from household surveys (DHS, Household Income Surveys, Labour Force Survey); data from the routine monitoring systems of sectors; and information on the geographic location of water points, schools and health centres collected using a Global Positioning System. The database therefore constitutes an important resource to inform planning, programming and policy development. In 2005, the ESDEM database was disseminated in all of the 11 provinces in order to facilitate evidence-based provincial level planning. In 2007, a new version of ESDEM (version 4) will be launched. This latest version has been adapted to include all of the PARPA II indicators/targets and therefore provides a useful tool for monitoring progress towards attainment of national targets, in addition to international targets such as the Millennium Development Goals and the UN General Assembly Special Session on HIV/AIDS (UNGASS).

Much of the available information is being to inform the development of the country's second report to the UN Committee on the Rights of the Child, which is currently being finalised and will be submitted in 2007. This report will provide an excellent basis for disseminating - at national and subnational levels - the current situation in regard to the MDG and WFFC targets.

## **5. Enhancing partnerships, alliances for children and participation**

The WFFC and MDG targets have been integrated into the country's main planning instruments, such as the PARPA, ensuring that children's issues remain high on the agenda. Under the framework of the PARPA, a number of strategic partnerships and partnership coordination fora have been established that allow Government, development partners and civil society to work

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<sup>2</sup> The means of verification for each of the PARPA II indicators are outlined in the Strategic Matrix.

together more effectively to influence progress towards achievements of WFFC and child related MDGs.

In 2004, a Memorandum of Understanding was signed between the Government and the **Programme Aid Partners** (PAPs), the group of bilateral and multilateral donors - currently numbering 18 - providing General Budget Support (GBS) to the State Budget. The dialogue between the Government and the PAPs focuses in particular on the Performance Assessment Framework (PAF), which, as outlined in Part 4, is a multi-annual matrix of priority targets and indicators based on the PARPA, updated on an annual basis through the PES process and agreed through cross-governmental dialogue. Review of performance against the PAF targets, and therefore performance in achievement of the WFFC targets, is undertaken through various coordination mechanisms. Under the framework of the main 'pillars' of the PARPA (Governance, Human Capital and Economic Development), 24 **PARPA Working Groups** have been established, comprising representatives of Government, development partners and civil society and mandated with reviewing progress in implementing the PARPA II, based on the PAF, through joint Mid Year and Annual Reviews.

In 2003, the country held its first **Poverty Observatory** (PO, known in Portuguese as Observatorio da Pobreza), a consultative and participatory forum coordinated by Government (led by a Technical Secretariat in the Ministry of Planning and Development) for monitoring PARPA implementation, considering Government and civil society evaluations and producing recommendations for improvement. Civil society involvement in the PO process has been coordinated through the '**Grupo 20**', a group of NGOs formed in 2003, now comprising over 20 organisations including religious groups, trade unions, private and financial sector groups and other NGOs, including those concerned with gender, HIV/AIDS and the environment.

In 2005, the national PO met twice to discuss and contribute to the PARPA II elaboration process, and provincial POs were also held in all but one of the provinces in order to provide national consultation on PARPA II. Young people and children were supported by the National Youth Council to participate in four of the provincial POs. A national PO was held in June 2006 in order to launch the PARPA II following its approval by the Council of Ministers in May 2006. The POs will continue to meet in order to monitor implementation of the PARPA and as such, provide an additional platform through which Government and civil society can, in partnership, review implementation of the WFFC and MDG targets integrated into the PARPA, at both national and subnational levels. It is envisaged that young people will continue to be supported to participate in POs in all of the provinces, providing further opportunities for the voice of young people to be heard in discussion fora.

In addition, formal **sector wide approaches** (SWAps) have been established in several sectors (e.g. Education, Health, HIV/AIDS), in order to enable partners to collaborate in support of government-led programmes for a particular sector in a comprehensive and coordinated manner. The SWAps have provided an important forum for advocacy around children's issues and technical discussion between all partners on issues relating to child rights and development, in addition to providing a basis for capacity building efforts.

Efforts have been made in recent years to facilitate the **participation of children in decision-making processes**, although ensuring meaningful participation of children in the national development agenda remains an ongoing challenge. Some positive steps include the

establishment of a national Child Parliament in 2002 and subsequent provincial Child Parliaments in all provinces; roundtable events held in three provinces bringing together parliamentarians, '*municipios*' and children to discuss the way forward in the national response to HIV/AIDS; the active involvement of over 350 children and adolescents in national child to child media programmes; and the provision of peer counselling by young people under the Youth Friendly Health Services programme.

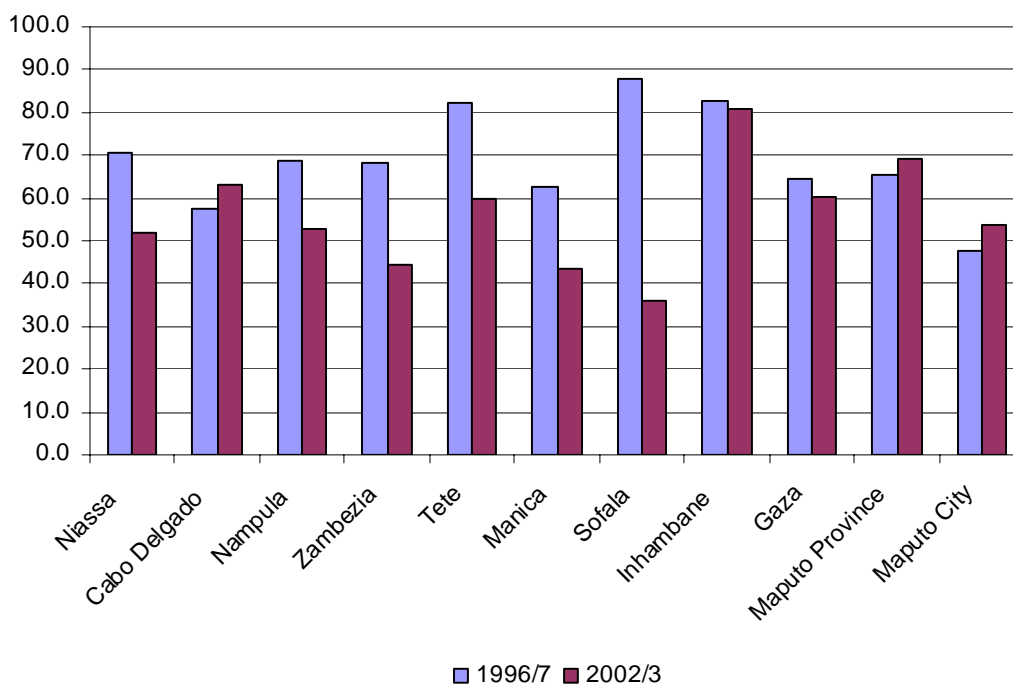
## **6. Achievement of WFFC Plan of Action and related MDG targets**

### **MDG 1 / WFFC Promoting Healthy Lifestyles**

Since the signing of the 1992 Peace Agreement, Mozambique has been viewed as one of Africa's most successful stories of post-war reconstruction and economic recovery. The country held its third peaceful and democratic legislative and presidential elections in December 2004, reaffirming its commitment to political stability, democratic governance and national reconciliation. An ambitious economic, social and political reform agenda is underway, and efforts have been made to consolidate macro-economic stability, as a result of which the country is experiencing strong economic growth, averaging 7-8 per cent over the past five years.

Significant progress has been made in reducing overall poverty, with the proportion of people living below the poverty line decreasing from 69 per cent in 1997 to 54 per cent in 2003 (putting the country on track to reach the Millennium Development Goal (MDG) target related to poverty reduction). Graph 1 shows the poverty headcount by province in 1997 and 2003.

### Percentage of the population living in poverty by province, 1996/7 and 2002/3



Source: Household Income and Expenditure Surveys, MPD, 1996/7 and 2002/3

The second national MDG progress report was produced in 2005. The report found that Mozambique has the potential to achieve several targets that define progress relative to previous national benchmarks (i.e. those on poverty reduction, child mortality and maternal mortality) due to the strong development trend.

More generic targets that define progress relative to absolute thresholds such as universal primary education and gender equality remain more distant prospects due to the sheer depth of poverty and underdevelopment from which the nation is emerging. The table below, taken from the MDG report, presents the current status in regard to the 11 MDG targets for which data were available.

#### Progress towards attainment of the MDGs

Target for 2015	Potentially on Track?
Halve the proportion of people living in extreme poverty	Yes
Halve the proportion of people who suffer from hunger	No
Ensure that all boys and girls are able to complete a full course of primary schooling	No
Eliminate gender disparity in all levels of education	No
Reduce by two-thirds the under-five mortality rate	Yes

Reduce by three quarters the maternal mortality ratio	Yes
Have halted and begun to reverse the spread of HIV/AIDS	No
Have halted and begun to reverse the incidence of malaria and other major diseases	Yes
Integrate principles of sustainable development into country policies and reverse loss of environmental resources	No
Halve the proportion of people without access to safe drinking water and sanitation	No
Develop further an open, ruled based, predictable, non-discriminatory trading and financial system	Yes

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*Source:* National MDG Progress Report, Government of Mozambique/UN, 2005

In spite of the rapid poverty reduction by both income and non-income measures in recent years, there has been no significant change in the nutritional status of children and the MDG target relating to hunger is considered unlikely to be achieved. Protracted drought, combined with the AIDS pandemic and limited coping capacities, has resulted in persisting pockets of high malnutrition, particularly among orphaned children<sup>3</sup>, and malnutrition remains the main underlying cause of child mortality.

The 2003 Demographic and Health (DHS) survey indicated a high prevalence of underweight among children under five, 24 per cent, ranging from less than 8 per cent in Maputo City to 34 per cent in Cabo Delgado province<sup>4</sup>. Micronutrient deficiencies including iron-deficiency anaemia, vitamin A deficiency, and iodine deficiency are also serious health issues affecting child morbidity and mortality.

### **MDGs 2 & 3 / WFFC Promoting Quality Education**

Significant progress has been made in improving access to education, and both the Gross Enrolment Ratio (GER) and Net Enrolment Ratio (NER) in public schools have continuously increased since the end of the civil war, for both primary and secondary education. The net enrolment ratio at lower primary level (grades 1-5) increased from 69 per cent (66 per cent girls/72 per cent boys) in 2003 to 88.3 per cent in 2006 (90.3 per cent boys/86.3 per cent girls). This rapid increase in enrolment, or ‘access shock’, however, has impacted negatively on the quality of education. As a result, the status against indicators on the quality of schools remains poor, such as the high learner/teacher ratio (76:1 in 2006). The primary completion rate is 39 per cent, making attainment of the MDG relating to education improbable.

The gender gap is gradually closing at the lower primary education level: the absolute gender gap in enrolment in EP1 decreased from a 25 percentage point difference in GER in 1999 to 17 a percentage point difference in GER in 2005, although girls remain disadvantaged in the central and northern regions. Recent studies have indicated a number of barriers to education in Mozambique, including poverty (inability to afford direct and opportunity costs of education); the low importance given by many parents to education, due to either cultural factors or the poor

<sup>3</sup> The 2003 Vulnerability Assessment showed that while overall stunting prevalence in the 29 surveyed districts was 38 per cent, the level was 56 per cent among maternal orphans.

<sup>4</sup> National Institute of Statistics, Ministry of Health and Measure DHS, *Demographic and Health Survey*, 2003.

quality of education; the distance from schools and the impact of HIV/AIDS<sup>5</sup>. Additional barriers have been identified that affect girls disproportionately, including cultural practices, such as premature marriage.

Data from the 2004/2005 Labour Force Survey indicated that slightly over half (52 per cent) of the Mozambican population is not literate, with significant disparities between rural and urban areas (66 and 26 per cent not literate respectively) and between women and men (67 per cent non-literacy among women compared with 34 per cent among men). A positive trend was confirmed, however, whereby a greater proportion of younger Mozambicans are literate: 80 per cent of Mozambicans over 65 years of age are not literate compared with 34 per cent of young people aged 15-19 years. The gender gap in terms of literacy is also lower among young people, reflecting progressively more equitable access to education by sex.

#### **MDG 4/ WFFC Promoting Healthy Lifestyles**

The under-five mortality rate remains high, at 178 per 1,000 live births in 2003, although this represents a significant decline since 1997, when the rate was 219 per 1,000 live births<sup>6</sup>. If this trend continues, the MDG target relating to under-five mortality has the potential to be met. The infant mortality rate also fell during this period, from 147 in 1997 to 124 in 2003<sup>7</sup>.

Malaria remains the primary cause of under-five mortality, and in 2003 only 9.7 per cent of children under five were sleeping under a mosquito net<sup>8</sup>. Acute respiratory infections are the next most common cause of child mortality, although data on the causes of child mortality are currently incomplete and unreliable. AIDS is also emerging as a major killer, accounting for about 17 per cent of all deaths among under-five children. Immunisable diseases such as measles remain an important cause of child morbidity. While the 2003 DHS showed that the proportion of children under one immunised against measles increased from 58 per cent in 1997 to 77 per cent in 2003, residential disparities remained (71 per cent in rural areas/91 per cent in urban areas) and this substantial increase was not sufficient to prevent a particularly severe measles epidemic in 2003, when over 25,000 measles cases were reported, with a fatality rate of 8/1,000.

One of the main underlying causes of the high levels of child morbidity and mortality is the limited access, in terms of both physical and economic accessibility to quality health services by much of the population. For example, the Labour Force Survey indicated that 56 per cent of households live one hour or more on foot from the nearest health facility, with significant disparity between urban areas (18 per cent) and rural areas (72 per cent)<sup>9</sup>. Additional causes include the weak capacity of the health sector in terms of human and financial resources, limited knowledge of appropriate family care practices, often due to the low level of education among mothers, and inequitable allocation of resources from the central level, both in terms of bias towards tertiary over primary healthcare and disparities between provinces<sup>10</sup>. A comprehensive Child Health Policy has been drafted, with a strong newborn care component, which, together

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<sup>5</sup> For example, Justiniano, M., Oksanen P., Steen Nielsen, N. and Xerinda, H., *A Study on the Barriers to Girls' Education, Zambezia Province, Mozambique*, 2005.

<sup>6</sup> National Institute of Statistics, Ministry of Health and Measure DHS, *Demographic and Health Survey*, 2003.

<sup>7</sup> National Institute of Statistics, Ministry of Health and Measure DHS, *Demographic and Health Survey*, 2003.

<sup>8</sup> National Institute of Statistics, Ministry of Health and Measure DHS, *Demographic and Health Survey*, 2003.

<sup>9</sup> National Institute of Statistics, *Labour Force Survey*, 2004/5.

<sup>10</sup> See Bergström, S., Costa, J., Hämäläinen, R., Hellström, P., *Provincial Study: To Evaluate the Approaches to Supporting Health Sector Development at Provincial Level, Mozambique, 2001-2005, Mozambique*, 2006, page 86.

with the recently approved Code on Marketing Breastmilk Substitutes and Nutrition Strategy, provides a solid foundation to accelerate interventions in the area of child health and nutrition.

### **MDG 5 / WFFC Promoting Healthy Lifestyles**

The maternal mortality ratio decreased from over 1,000 per 100,000 live births in the early 1990s to 408 in 2003, putting the country on track to attain the MDG target. The development and implementation of the National Strategy for Maternal Mortality Reduction - which began in 2000 and led to improved access to health services, particularly family planning and antenatal care - played an important role in this decrease<sup>11</sup>. The coverage of antenatal care improved significantly over the same period, with the proportion of women attended at least once by skilled health personnel during pregnancy increasing from 71 per cent in 1997 to 85 per cent in 2003. Despite improvements made in the quality of obstetric care, however, the main causes of maternal deaths are due to direct factors (75 per cent), such as haemorrhage, rupture of the uterus, eclampsia and sepsis, while a quarter of deaths (25 per cent) are due to indirect causes such as malaria and AIDS<sup>12</sup>. A contributing factor to maternal morbidity and mortality is the high prevalence of anaemia among mothers (48 per cent, and 70 per cent among pregnant women)<sup>13</sup>.

### **MDG 6 / WFFC Promoting Healthy Lifestyles**

AIDS is fast emerging as a major cause of child mortality. In 2006, approximately 99,000 children under the age of 15 were living with HIV or AIDS, over 80 per cent below the age of five<sup>14</sup>. The HIV prevalence among 15-49 year-olds increased from 8.2 per cent in 1998 to 16.2 per cent in 2004, with the highest rates in the central and southern regions of the country, reaching 26.5 per cent in Sofala province<sup>15</sup>. Access to paediatric treatment remains at less than three per cent and although mother-to-child transmission is the main cause of infection among young children, access to anti-retroviral drugs for the prevention of mother-to-child transmission remains low, at less than five per cent in mid 2006. Among adolescents, the gender disparity is acute, with three times as many girls as boys aged 15-19 living with HIV or AIDS. The 2003 DHS showed that 48 per cent of girls aged 15-19 as compared with 60 per cent of boys of the same age knew the two main ways to prevent against HIV infection<sup>16</sup>.

The AIDS pandemic continues to compound the crisis of increasing numbers of orphaned and vulnerable children. In 2006, there were estimated to be 1.6 million orphaned children (aged 0-17), of which 382,000 had been orphaned as a result of AIDS. With the growing number of children in need of care, traditional community support systems are coming under increasing pressure and the trend is set to continue: the National Institute of Statistics (INE) estimates that the total number of children orphaned by AIDS will reach almost 630,000 by 2010<sup>17</sup>. In addition

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<sup>11</sup> See Government of Mozambique and UN Agencies, *Report on the Millennium Development Goals*, Mozambique, 2005 and National Institute of Statistics, Ministry of Health and Measure DHS, *Mozambique Demographic and Health Survey 2003*, Mozambique, 2005.

<sup>12</sup> See Government of Mozambique and UN Agencies, *Report on the Millennium Development Goals*, Mozambique, 2005.

<sup>13</sup> Ministry of Health/UNICEF, *National Survey on Vitamin A Deficiency, Anaemia and Malaria in Children 6 to 59 Months and their Mothers* (December 2001 to February 2002), 2005.

<sup>14</sup> National Institute of Statistics, *Demographic Impact of HIV/AIDS in Mozambique*, Mozambique, 2004.

<sup>15</sup> Ministry of Health, *Report on the Update of the HIV Epidemiological Surveillance Data – 2004 Round*, Maputo, 2005.

<sup>16</sup> National Institute of Statistics, Ministry of Health and Measure DHS, *Demographic and Health Survey*, 2003.

<sup>17</sup> Multi-Sectoral Technical Group for Support to the Fight against HIV/AIDS, *Demographic Impact of HIV/AIDS in Mozambique – 2002 HIV Surveillance Round*, 2004.

to the increased vulnerability of orphaned and vulnerable children to abuse and exploitation, evidence indicates that orphaned children, particularly maternal orphans, are discriminated against in terms of access to education<sup>18</sup>. The 2003 DHS indicated that the rate of primary school attendance among maternal orphans (10-14 years old) was 62 per cent, as compared with 78.4 per cent among non-orphaned children. A second national strategic plan for the period 2005 to 2009 (known as the PEN II) was approved in 2004, offering a comprehensive multi-sectoral strategic framework articulated around the priority areas of prevention, advocacy, stigma and discrimination, treatment, mitigation of consequences, research and coordination.

## **MDG 7 / Promoting Healthy Lifestyles**

The water and sanitation sector in Mozambique is characterised by low coverage, weak capacity and poor sustainability. The Labour Force Survey indicated that only 36 per cent of the population uses a safe drinking water source, with massive disparities between urban areas and rural areas (66 per cent with safe water in urban areas and 23 per cent in rural areas). The use of sanitary means of excreta disposal is 46 per cent, with significant disparities between urban (78 per cent) and rural areas (32 per cent).

School sanitation is a particular problem: it is estimated that only around 30 per cent of primary schools in Mozambique currently have water and sanitation facilities, mainly in urban and peri-urban areas. It is estimated that over 600,000 people (half of them children) would need to gain access to an improved water supply and improved sanitation every year if the MDG target of reducing by half the number of people without sustainable access to safe drinking water and adequate sanitation is to be met<sup>19</sup>. It is therefore unlikely that Mozambique will achieve its MDG targets relating to water and sanitation without considerable investment of resources in the sector.

## **MDG 8 / WFFC Mobilising Resources**

Mozambique is Africa's single biggest recipient of international development assistance. External aid flows have a substantial bearing on child development outcomes. About 50 per cent of annual government spending is financed from external assistance. In 2005, external assistance in the State Budget represented over US\$ 877 million, of which about US\$ 500 million was in grant. The way this assistance is delivered has changed considerably, with a clear and concerted move towards increased harmonisation and alignment of donor activity centred on the PARPA, together with an interrelated move towards more flexible aid modalities such as sector Common Funds and Government-wide General Budget Support (GBS).

## **Millennium Declaration / WFFC Child protection against abuse, exploitation and violence**

The available evidence indicates a number of child protection concerns in Mozambique, such as domestic violence and sexual abuse and exploitation. In order to respond to violence against

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<sup>18</sup> National Institute of Statistics, Ministry of Health and Measure DHS, *Demographic and Health Survey*, 2003.

<sup>19</sup> A WHO/UNICEF survey in 2005 found that 600,000 Mozambicans would need to gain access to improved water and sanitation if Mozambique is to meet the MDG. The estimate of 300,000 children is based on an estimate that at least half the population is children.

women and children, services have been set up in police stations to attend to women and child victims of violence. There are currently 21 such centres covering all provinces of the country, administered by duly trained police officers. As part of the provision of psychological, social and legal support for child victims of violence, there are also centres to care for women and children who have suffered violence set up by civil society organisations. In order to prevent violence, the Government, in coordination with civil society organisations, is undertaking awareness-raising activities among households and communities to protect children against violence, as well as to denounce abusers.

The vulnerability of households and the lack of resources to guarantee the basic needs of children mean that children, particularly in rural areas, are often forced to work, notably in commercial agriculture, in domestic chores, and in prostitution. This is often as a result of household poverty, the lack of employment for adults, the lack of educational opportunities, persisting gender inequalities and the impact of HIV/AIDS. In order to prevent children from being exploited at work, the Ministry of Labour regulates child labour, both in the formal and the informal sectors, through the labour inspectorate. Furthermore, a National Employment and Professional Training Strategy has been approved, which seeks to attain the objectives of reducing absolute poverty through employment, which should help to eliminate child labour, and to implement the principles and objectives established by the Government in its Labour Policy.

## **7. Lessons and initiatives to speed up compliance with the WFFC and MDG targets**

In spite of various challenges, progress has been made in developing an enabling national policy and legislative framework to prioritise child development concerns. The PARPA II sets out time-bound and quantifiable targets for the further realisation of child rights, many of which contribute directly towards attaining the MDGs. Other important frameworks include the National Plan of Action for Children, which includes a costed Plan of Action on Orphaned and Vulnerable Children, and the comprehensive Children's Act, due to be approved in 2007, which will provide an important basis through which the national legislation will be brought further into line with the Convention on the Rights of the Child.

As a result of the implementation of national policies guided by the international WFFC and MDG targets, the incidence of poverty has reduced: the poverty headcount fell from 64 per cent in 1996-97 to 54 per cent in 2002-03, representing a reduction of 15 per cent. This indicates that one of the PARPA I targets, which was to reduce the poverty rate to 60 per cent by 2005, was surpassed by more than 5 per cent. Furthermore, the depth of poverty fell from 29 per cent in 1996-97 to 21 per cent in 2002-03 (a reduction of one third). These results mean that: (i) there has been a fall in the percentage of the population living below the poverty line, and (ii) the average consumption of those living below the poverty line increased between the two periods.

In addition, comprehensive revisions of a number of sectoral plans have been undertaken, including the Health Sector Strategic Plan (2000-2005-2010) and the National Water Policy, both of which placed increased emphasis on the reduction of disparity in terms of access to basic services, and the Education and Culture Strategic Plan (2006-2010/11), which includes strategies for disparity reduction and a Gender Framework for Action and Policy Reform. These policies and plans provide a solid framework for the acceleration of efforts for the attainment of the

MDGs, although focus will need to be placed on ensuring equitable budget allocation among provinces and sufficient capacity to operationalise these instruments.

In order to accelerate implementation of actions aimed at attaining the WFFC and MDG targets, the United Nations should play a significant role in mobilising resources that make it possible to meet the needs of children in developing countries.