

Childhood Poverty in Mozambique

A Situation and Trends Analysis

SUMMARY

Introduction

This document summarises some of the key findings of the report *Childhood Poverty in Mozambique: a Situation and Trends Analysis*. The report provides a comprehensive overview of the socioeconomic situation of the ten million Mozambican children, especially with regard to childhood poverty, and analyses the current situation of children¹ in Mozambique. It also presents an overview of the public policy and service delivery environment for children, identifying areas in which progress needs to be made and making recommendations as to the way forward.

One distinctive contribution of the report is to provide a human rights-based perspective on national efforts to reduce childhood poverty and improve child development outcomes for all children in Mozambique. To this end, a

deprivations-based measure of childhood poverty is presented, complementing the official consumption-based measure of childhood poverty, using a definition that examines children's access to water, sanitation, shelter, education, health, nutrition and information. The disparities and immediate and underlying causes of childhood poverty are explored, drawing on the rich body of data and analytical work that has been conducted in recent years by the Government and its development partners.

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

Childhood Poverty

Childhood poverty examines the poverty specifically experienced by human beings in any society during their childhood. Children experience poverty differently from adults. In addition to having immediate effects on children, childhood poverty is distinctive in that some of its effects are felt throughout the child's life, passing on into adulthood. For example, stunting, reduced mental development, or psychological trauma experienced in childhood affect a person for the rest of her or his life.

Children living in poverty face deprivations of many of their rights: to survive, to develop, to participate, and to be protected. The key international legal instrument on children's rights is the Convention on the Rights of the Child (CRC), to which Mozambique is a signatory. Childhood poverty can therefore be defined as the deprivation of the rights enshrined in the CRC.

In order to operationalise this rights-based approach to childhood poverty, the report uses a series of indicators – known as the 'Bristol Indicators' – to measure children's access to seven rights (nutrition, water, sanitation,

healthcare, shelter, education and information). Where a child does not have access to one of these rights – such as basic education for example – it is described as a 'severe deprivation'. Children are said to live in absolute poverty if they face two or more forms of severe deprivation. This definition of childhood poverty is termed a deprivations-based approach and is presented in conjunction with the standard consumption-based measure of poverty. The two measures are regarded as complementary to one another.

The 'Bristol Indicators' were originally developed to measure childhood deprivations in many different countries. However, developing a universal set of indicators for all poor countries is unrealistic. For the purpose of the report, the indicators have been adapted to reflect the Mozambican context. Table 1 summarises the indicators used in the analysis. No weights have been ascribed to the different deprivations to try to capture their relative importance; the reader is presented with data on the different deprivations and left to decide upon their relative importance in the context of the associated analysis.

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

Table 1: Deprivations-based indicators for Mozambique

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

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

Development Context

The country's performance since the end of the civil war with respect to relative indicators – the development trend – has been strongly positive. Since the end of the 16-year armed struggle in 1992, the country has experienced a relatively smooth transition to political stability and democracy, established macro-economic stability and enjoyed sustained real economic growth.

The economy has grown at a particularly strong pace, averaging about 8.5 per cent per year between 1997 and 2005, with real GDP surpassing its pre-independence level in 2001. This growth has been supported in particular by a rapid and sustained expansion of the education sector and a robust recovery of the agricultural sector, which accounted for 23.6 per cent of real GDP growth between 1991 and 2004, suggesting a relatively broad-based economic recovery with benefits for poor rural families. This is reflected by a downward poverty trend, with significant reductions in the proportion of those living in poverty. The percentage of the population living below the consumption poverty line fell from 69 to 54 per cent between 1996/97 and 2002/03 (see Figure 1), beyond the target of 60 per cent established in the country's first poverty

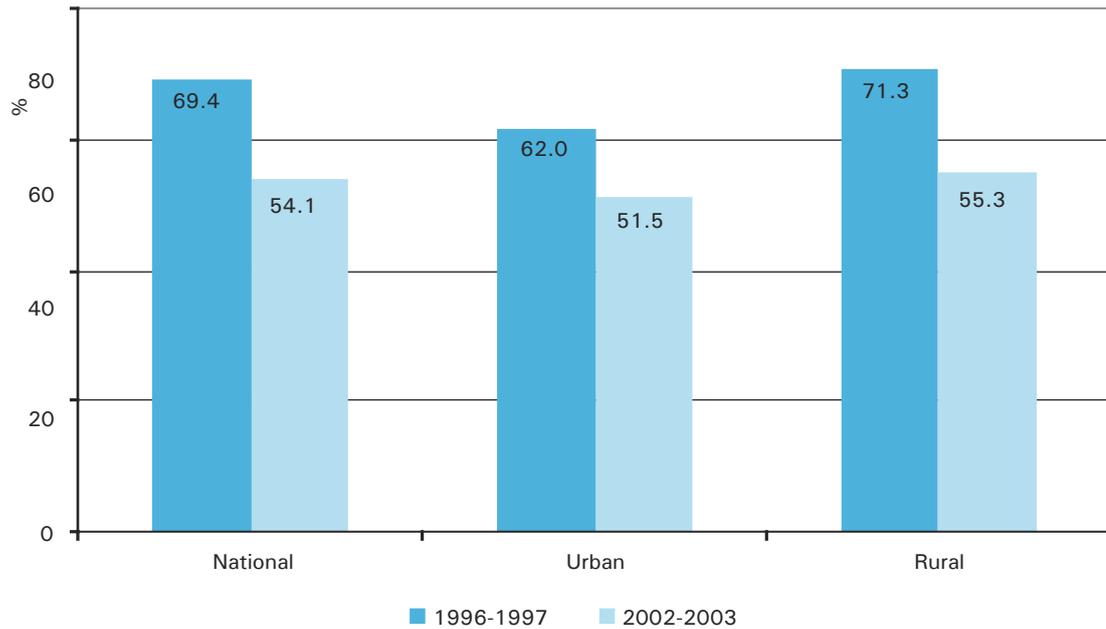
reduction strategy (known as PARPA I). While poverty remains higher in rural areas (55 per cent) than urban areas (52 per cent), it fell more rapidly in rural areas (decrease of 22 per cent) than in urban areas (decrease of 20 per cent).

Despite this impressive progress, the incredibly low base from which progress began – Mozambique was ranked as the poorest country in the world in 1992 – means that there is still a long way to go.

The combination of a very low initial position followed by strong development is reflected in the country's progress towards the Millennium Development Goals (MDGs). Mozambique shows promise of meeting several of the MDG targets that define progress relative to some previous national benchmarks – those on poverty reduction, child mortality and maternal mortality – due to this strong development trend. However, targets that define progress relative to some absolute thresholds, such as universal primary education and gender equality, remain more distant (see Table 2).

As well as working to establish macroeconomic stability, the Government has promoted childhood poverty reduction by targeting public expenditures towards priority public services

Figure 1: Percentage of population living below the poverty line



Source: IAF, 1996/7 and 2002/3

through the State Budget. Public spending as recorded in the state accounts was broadly in line with sectoral targets over the PARPA I period, and in fact probably exceeded those targets considering the large volumes of external assistance that were not captured by Government accounts.

Evidence on the impact of public spending (around half of which is financed by external assistance) suggests that it has been broadly pro-poor, although the report highlights the importance of equitable allocation of resources across provinces and programmes. For example, expenditure per capita in the health sector in 2005 was on average US\$ 2 in Zambezia province, where child well-being indicators are among the worst in the country, compared to US\$ 5 in Maputo City, where child well-being

indicators are far better. Factoring in spending in the country's three central hospitals – likely to be very difficult to access for the poorest – greatly exacerbates such allocative disparities.

Identifying the Most Vulnerable

A crucial demographic element of the development context is that the population is very thinly spread and predominantly rural. Population density is estimated at 25.3 inhabitants per km² (compared to 109 per km² in neighbouring Malawi for example), with around 69 per cent of Mozambicans living in rural areas in households of, on average, 4.2 members (compared to 4.7 in urban areas).

Table 2: Progress towards the Millennium Development Goals

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

Source: GoM/UN 2005

Joining forces in the fight against childhood poverty

While the Government of Mozambique holds the primary responsibility for respecting, protecting and fulfilling the rights of Mozambican children, there are many actors in the fight against childhood poverty and all sectors of society have a role to play in this regard, starting with children themselves.

Children

In recent years, the participation of children and young people has received increased attention in Mozambique. A human rights-based approach to development means that children are viewed as actors in their own development. Children have a right to participate in decision-making processes that may be relevant in their lives and to express their views in all matters that affect them.

Family and community

Families are responsible for the adequate care of children and communities have a responsibility in demanding services for their members and for ensuring that all children in the community are well cared for, protected and have access to the services they need.

Civil society organisations

Civil society organisations, such as non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), religious groups, trade unions, media organisations, private sector associations and academics are the channels through which people participate in the political and social life of their society. They can make demands, advocate for the rights of children at local and national level and engage in policy dialogue with the Government.

Government

As a signatory of the UN Convention on the Rights of the Child (CRC) and other international child and human rights agreements, the Government of Mozambique bears the primary responsibility for the progressive realisation of child rights. The Ministries of Health (MISAU), Education and Culture (MEC), Public Works and Housing (MOPH), Women and Social Action (MMAS) and the National Council for the Fight against HIV/AIDS (CNCS) are of particular importance for children. The Ministries of Planning and Development and of Finance are also of particular importance, as they produce the State Budget and other key planning and budgeting instruments.

Parliament

Parliament is a key duty-bearer for children's rights, not only for ensuring that national legislation is in line with the CRC, but also for fighting childhood poverty through ensuring sufficient and equitable allocation of resources for social services.

International development partners

The Government's international cooperation partners, working at national, provincial and district levels, also have a responsibility for improving the situation of children. In Mozambique, external funding finances about half of the Government's budget. There are at least 44 different international development organisations operating in Mozambique.

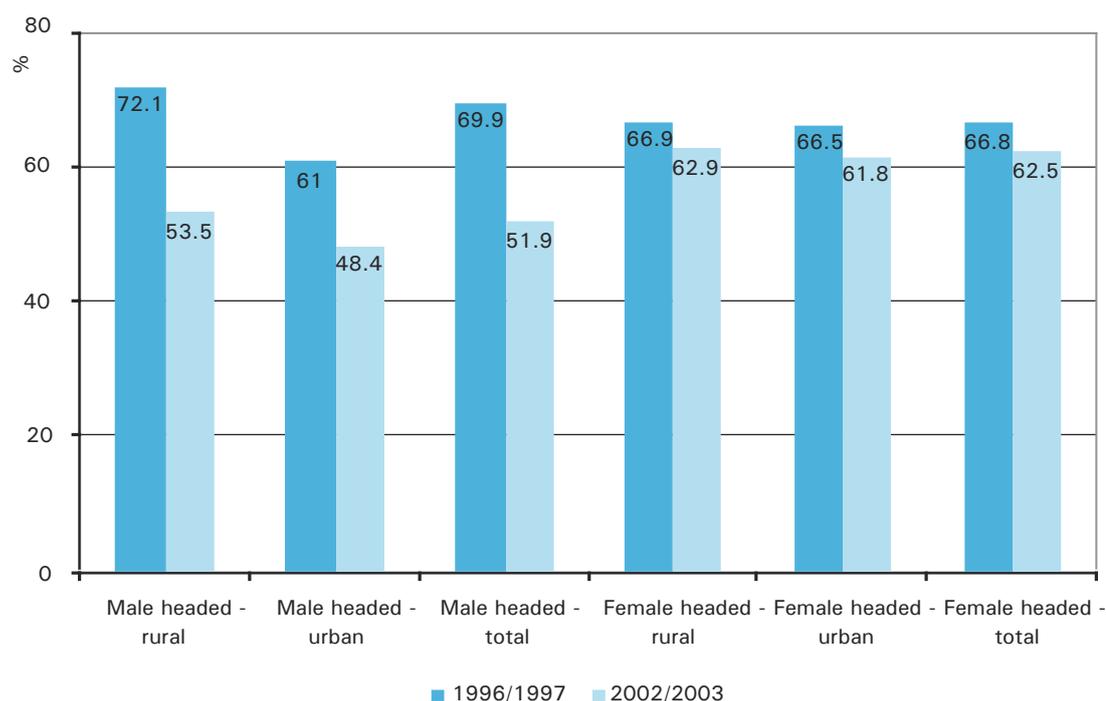
This makes cost-effective delivery of basic services and social support programmes in rural areas very difficult and underlies many of the urban-rural disparities identified in the report. Poverty and inequality are widespread problems: the poor often live alongside the non-poor and most inequality is accounted for by differences within districts. Designing programmes to effectively reach the poorest children is therefore particularly challenging.

Female-headed households, which represent a third of all households in Mozambique and carry a disproportionate burden of caring for orphaned children, are also poorer than families headed by men. While consumption-based poverty reduced by 26 per cent in male-headed households (from about 70 per cent in 1996/97 to 52 per cent in 2002/03), it only reduced by 6 per cent in female-headed households (from about 67 per cent to 63 per cent during the same period) (see Figure 2).

The AIDS pandemic is having a dramatic demographic impact. The national HIV prevalence estimate for 2004 was 16.2 per cent among people between 15 and 49 years of age. Out of the country's estimated 1.6 million orphans, more than 380,000 have lost one or both parents to AIDS-related illnesses. The number of orphaned children is expected to rise to 626,000 in 2010. Those orphans that are integrated into other households may face discrimination: amongst poor households there is evidence of biases in the intra-household allocation of resources against children who are not the direct biological descendants of the household head.

Despite a strong overall positive trend in poverty reduction, the poor and many of those assessed to be just above the poverty line remain highly vulnerable to adverse shocks and, as a result, there are likely to be large regional fluctuations in quantitative indicators of poverty from year to year.

Figure 2: Percentage of household living below the poverty line according to male headed and female-headed households



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

The precarious status of many households implies that it is critical that the overall objectives of poverty reduction include direct efforts to protect poor households from shocks, particularly female-headed households, allowing them to maintain an adequate and relatively stable standard of living. The analysis suggests that social protection schemes (e.g. targeted cash transfers) might play an important role in protecting the most vulnerable households from destitution, although careful planning is required if such programmes are to work.

Assessing Childhood Poverty

Two approaches are used to assess childhood poverty in the report: the official consumption-based measure using estimates of childhood poverty drawn from the Household Income and Expenditure Survey; and the deprivations-based approach, using the Bristol Indicators, adapted for Mozambique.

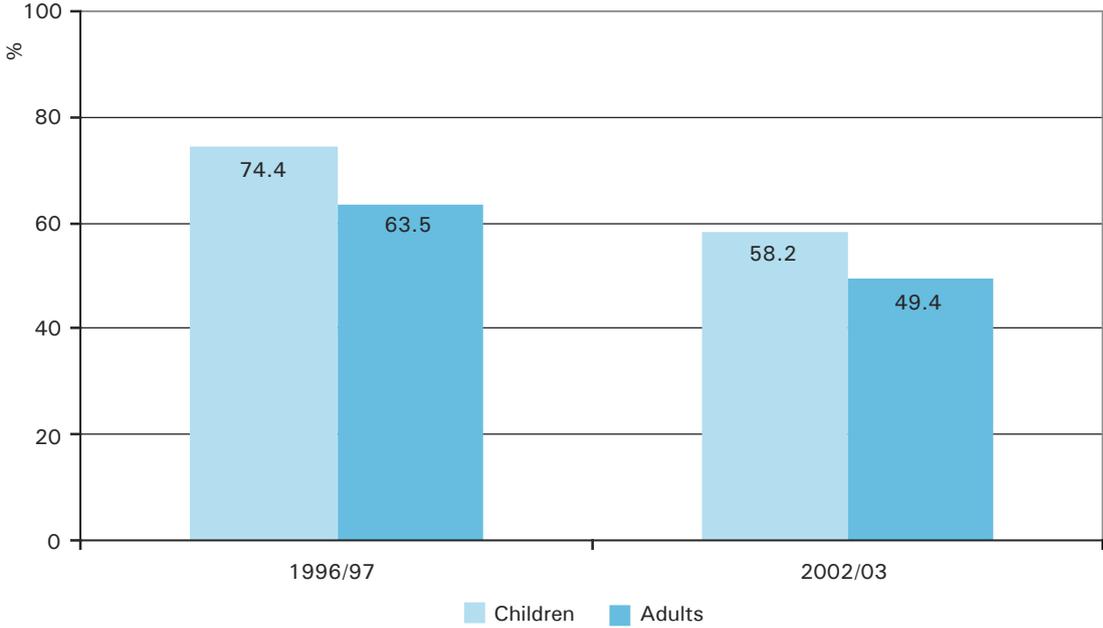
Consumption-based measure

The consumption-based measure is produced according to internationally accepted standards and is based on data collected in the national Household Income and Expenditure Survey ("IAF"). The focus is placed on consumption – rather than income – because it is much easier to measure. Both food and non-food items are included, but public services and home-produced

services are not captured. Due to the fact that consumption is only measured at the level of the household rather than the individual, it can only provide information on the consumption of the average household member rather than for individuals within the household such as women or children. Childhood poverty in the context of the consumption-based measure therefore refers to the percentage of children living in poor households and does not provide a measure of intra-household resource allocation.

The consumption-based measure indicates that the level of childhood poverty in Mozambique decreased by 22 per cent between 1996/1997 and 2002/2003 (see Figure 3). The decrease in poverty levels was more pronounced in rural areas (24 per cent decrease) than in urban areas (16 per cent decrease). Considerable disparities exist between provinces, with childhood poverty levels ranging from 84 per cent in Inhambane to 39 per cent in Sofala in 2002/03. However, the level of poverty among children remains very high, with 58 per cent of children living in poverty in 2002/2003, and the percentage of children living in poor households actually increased over the period 1996/1997 to 2002/2003 in Cabo Delgado province, Maputo province and Maputo City.

Figure 3: Children and adults living below the poverty line



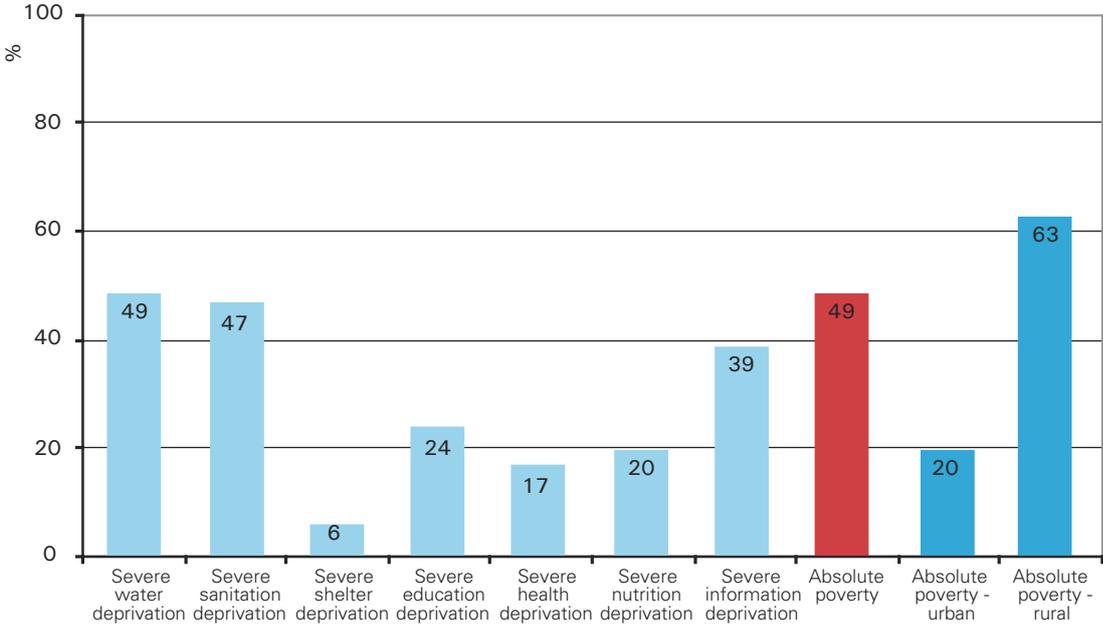
Source: IAF, 1996/7 and 2002/3

Deprivations-based measure

The indicators used to quantify this measure were originally developed for UNICEF by a team at the University of Bristol – hence they are often referred to as the Bristol Indicators. The Bristol Indicators are based on the ‘deprivation approach’ to poverty, drawing upon the definition of absolute poverty agreed at the World Summit for Social Development, as “...a condition characterised by severe deprivation of basic human needs”.

The deprivations-based approach is based upon data collected in the national Demographic and Health Survey (DHS) in 2003. It indicates that the proportion of Mozambican children living in absolute poverty (i.e. with two or more deprivations) in 2003 was 49 per cent, with significantly higher levels in rural areas (63 per cent) than in urban areas (20 per cent) (see Figure 4).

Figure 4: Severe deprivation and absolute poverty among Mozambican children, 2003



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

Breaking the deprivations measure down by province reveals that the proportion of children living in absolute poverty is highest in Zambezia (75 per cent), followed by Sofala (59 per cent), and Nampula and Tete (55 per cent). Maputo City emerges as having by far the lowest levels of poverty, based on this measure (see Figure 5).

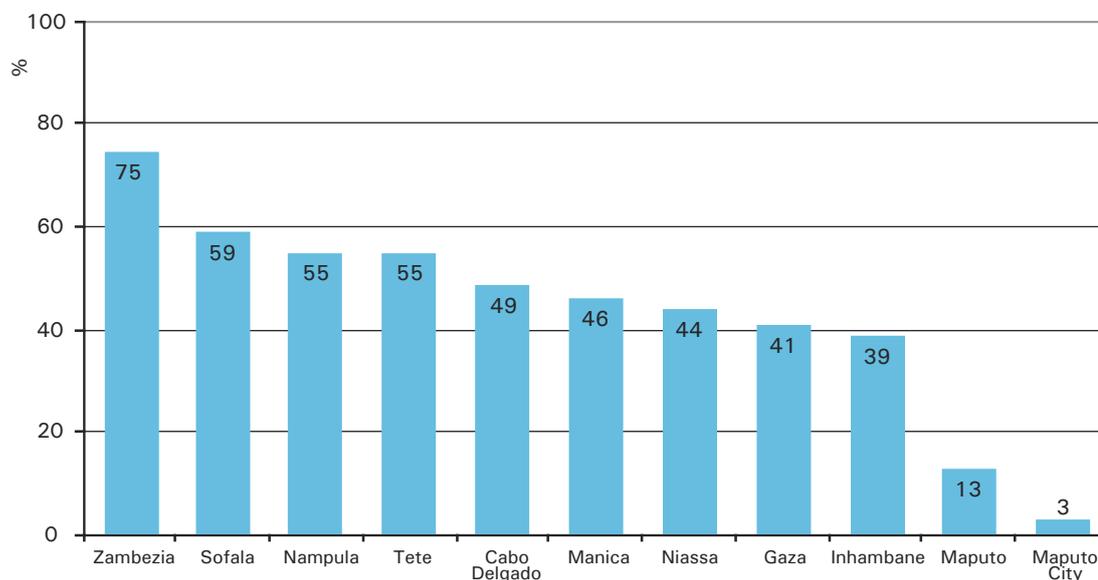
These results contrast strikingly with those produced by the consumption-based measure. Maputo City only records three per cent childhood poverty on the deprivations-based measure, as opposed to 60 per cent under the consumption-based approach. Maputo Province shows a similarly large difference between the two estimates. This is explained by the fact that the consumption-based approach does not directly capture the consumption of public services such as health, education, water and

sanitation, which are likely to be particularly concentrated in urban areas, in particular around the seat of national government.

The deprivations-based measure indicates that there is no difference in childhood poverty levels between girls and boys when expressed in terms of the overall number of deprivations. However, analysis of specific severe deprivations shows that girls are more severely deprived than boys in terms of education.

According to the deprivations-based measure, in families where the head of the household has no education, 68 per cent of children were living in absolute poverty in 2003, compared with 11 per cent in households where the head has secondary or higher education.

Figure 5: Absolute poverty among children by province



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

Child Survival and Development

Significant progress has been made in recent years in improving child and maternal well-being in Mozambique, giving hope that the country has the potential of reaching the MDG targets of reducing child and maternal mortality. However, despite these gains and the rapid reductions in both consumption and non-consumption poverty measures between 1997 and 2003, the situation in several areas relating to child survival and healthy development – in particular key anthropometric indicators – saw no significant improvement over the same period.

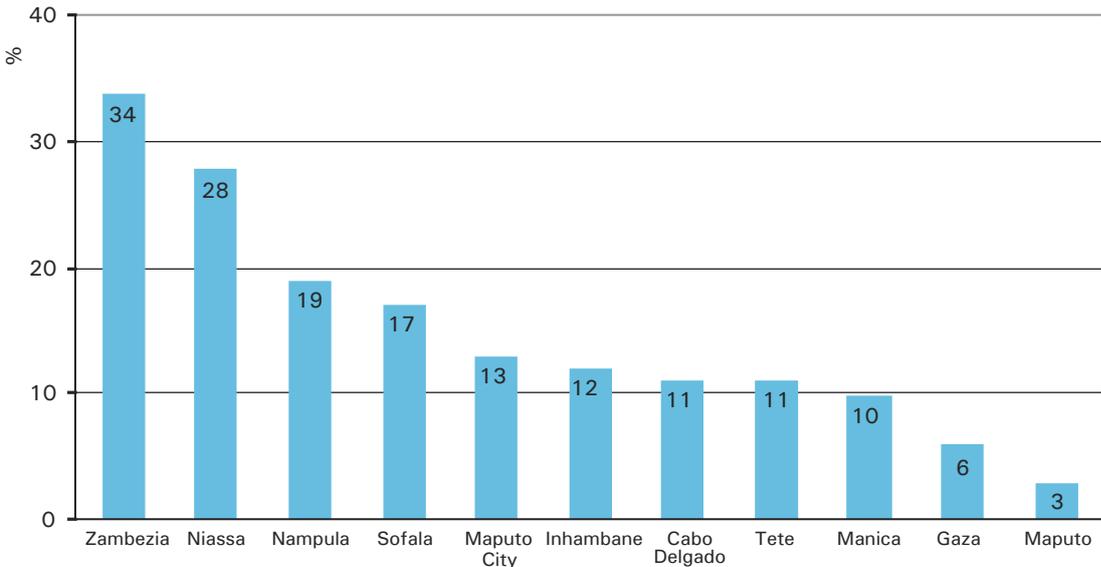
Childhood deprivations of health, nutrition and water and sanitation

Severe health deprivation

The deprivation indicator is the proportion of children under five years of age who have never been immunised against any diseases or young children who have had a recent severe episode of acute respiratory infection (ARI) and did not receive any medical advice or treatment.

- 17 per cent of Mozambican children under five years are experiencing severe health deprivation. There are disparities between provinces, with severe health deprivation ranging from 3 per cent in Maputo province to 34 per cent in Zambezia province (see Figure 6).

Figure 6: Percentage of children with severe health deprivation by province



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

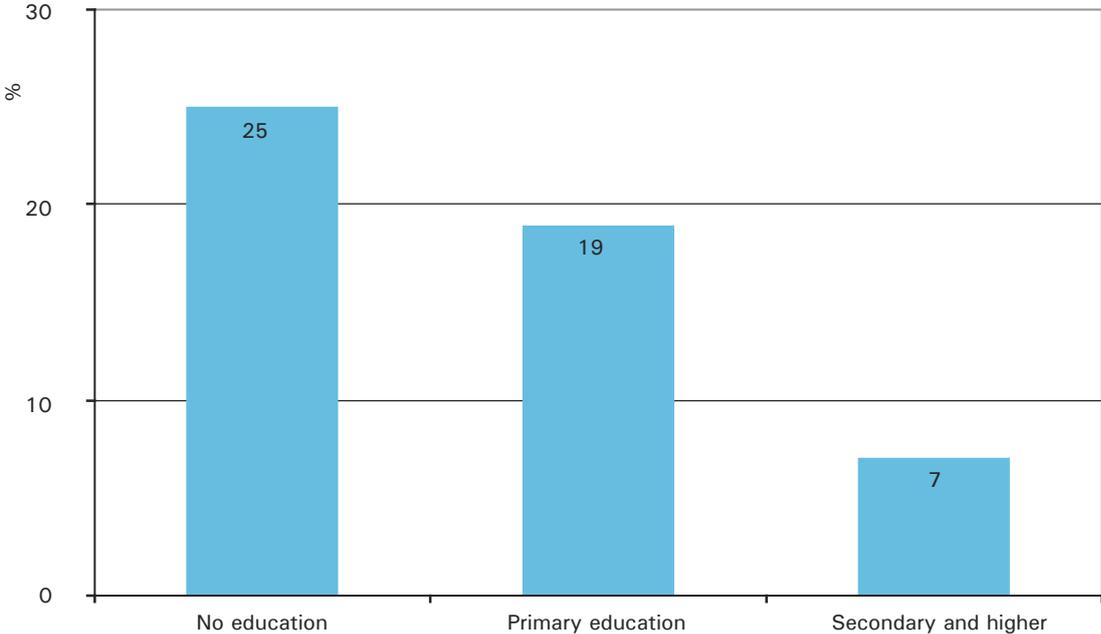
- Children in households headed by a person with no education are three times more likely to face severe health deprivation than children in households headed by a person with secondary level or higher education.
- One in every five children under five years is severely nutritionally deprived.
- Severe nutrition deprivation is twice as high among rural children as among urban children (23 per cent versus 11 per cent).

Severe nutrition deprivation

The deprivation indicator is the proportion of children under five years of age whose heights and weights for their age are more than -3 standard deviations below the median of the international reference population.

- Children whose mothers have no formal education are three times more likely to experience severe nutrition deprivation than children whose mothers have secondary level education or higher (25 per cent and seven per cent respectively) (see Figure 7).

Figure 7: Percentage of children with severe nutrition deprivation by level of education of mother



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

Severe water and sanitation deprivation

The water deprivation indicator is the proportion of children under 18 years of age who only have access to surface water (e.g. rivers) for drinking or who live in households where the nearest source of water is more than 30 minutes away.

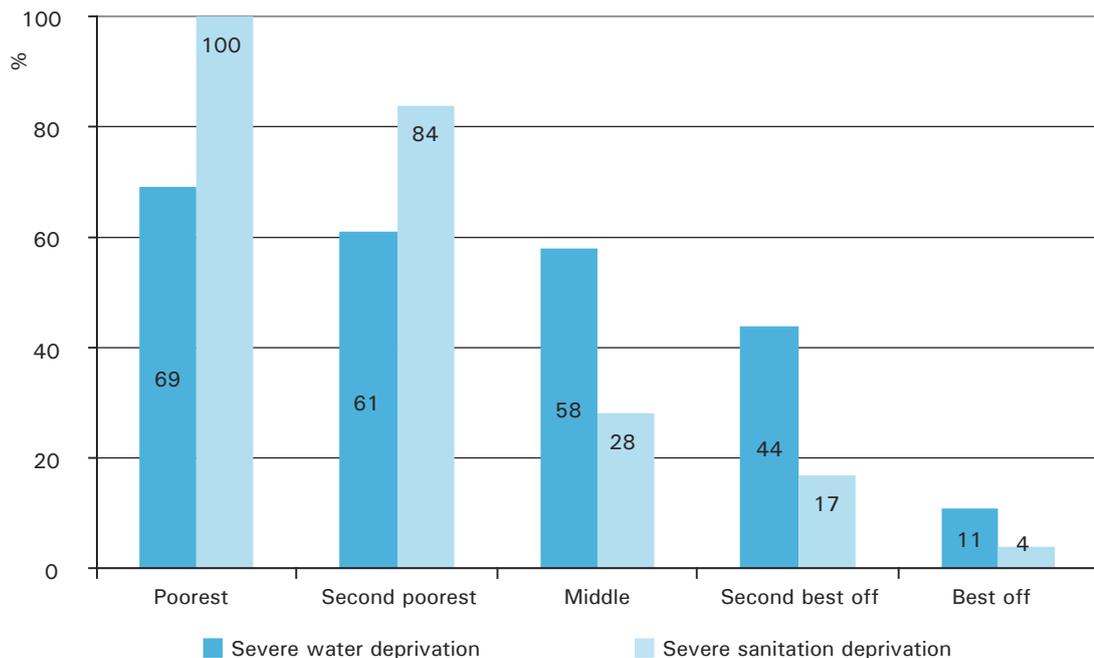
The sanitation deprivation indicator is the proportion of children under 18 years of age who have no access to a toilet of any kind in the vicinity of their dwelling, including communal toilets or latrines.

- 49 per cent of children face severe water deprivation and 47 per cent face severe sanitation deprivation, making water and sanitation the most widespread deprivations faced by children.
- In urban areas, 25 per cent of children face severe water deprivation and 18 per cent face

severe sanitation deprivation. In rural areas, severe water and sanitation deprivation among children reaches 61 per cent.

- 59 per cent of households with children in households headed by a person with no education experience severe water deprivation, compared with 21 per cent among children in households in which the head has a secondary level education or higher.
- 63 per cent of children in households headed by a person with no education face severe sanitation deprivation, as compared to only 10 per cent in households in which the head has secondary education or higher.
- Among the poorest children, severe water deprivation is 69 per cent and severe sanitation deprivation 100 per cent (see Figure 8).

Figure 8: Severe water and sanitation deprivation among children by wealth quintile



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

Maternal survival, health and nutrition

Given the absence of complete and accurate demographic data, it is difficult to determine the maternal mortality ratio (MMR) – the annual number of deaths among women from pregnancy-related causes per 100,000 live births. Mozambique shows promise of reaching the MDG target of reducing the MMR to 250 per 1,000 live births in 2015.

- The MMR appears to have decreased substantially in recent years, from an estimated 1,000 maternal deaths per 100,000 live births in the early 1990s to 408 per 100,000 live births in 2003.
- The main immediate causes of maternal deaths include anaemia, haemorrhage, and rupture of the uterus, eclampsia and sepsis. Nutritional deficiencies, when concurrent with other medical conditions and anaemia, also contribute to maternal death.

One of the most important factors affecting women's health is good nutrition. The most critical factor affecting women's nutrition is their workload – women, especially in rural areas, consistently work long, hard hours and their energy intake is not commensurate with their work output.

- About 9 per cent of women suffer from malnutrition.
- The prevalence of malnutrition is greater among women in rural areas than in urban areas.
- Anaemia and vitamin A deficiency are among the major nutritional problems affecting women, particularly those who are pregnant and lactating.

Antenatal care and childbirth care provide good indicators of maternal health care.

- The coverage of antenatal care has improved significantly in recent years, with the proportion of women attended at least once by skilled health personnel during pregnancy increasing from 71 per cent in 1997 to 85 per cent in 2003.
- Most gains in antenatal care were recorded in rural areas, where antenatal care increased from 65 per cent in 1997 to 79 per cent in 2003. Antenatal care in urban areas remained almost universal, with a slight increase from 96 per cent in 1997 to 97 per cent in 2003.
- Childbirth care shows little improvement. In 2003, the DHS indicated that only 48 per cent of births were attended by skilled health personnel compared to 44 per cent in 1997.
- Disparities in childbirth care remain acute in terms of women's socio-economic status, area of residence and geographical location. Approximately two-thirds of women in rural areas are giving birth without the assistance of skilled health personnel, compared with about one fifth of women in urban areas (66 per cent versus 19 per cent).

Child mortality

The principal indicator used to measure the level of child well-being and its rate of change in a country is the under-five mortality rate (U5MR). The U5MR is the result of a wide variety of factors: the nutritional health and the health knowledge of mothers, the availability, use and quality of maternal and child health services, income and food availability in the family, the availability of clean water and safe sanitation, and the overall safety of the child's environment. Mozambique shows promise of reaching the MDG relating to child mortality by 2015.

The under-five mortality rate measures one end result of the development process and therefore presents a good overall picture of the health status of Mozambican children and of Mozambican society as a whole.

- Mozambique has achieved a continual decrease in child mortality. Between the periods 1987-1997 and 1993-2003, the U5MR decreased by around 19 per cent, from 219 to 178 per 1,000 live births. The infant mortality rate decreased by about 16 per cent, from 147 to 124 per 1,000 live births (see Figure 9).
- The under-five mortality rate decreased more in rural areas than in urban areas, falling by about 20 per cent in rural areas compared with 5 per cent in urban areas.
- However, current child mortality rates remain high, with about one in every six children dying before she or he reaches their fifth birthday. In 2004, it was estimated that the total number of deaths among children under the age of five was 117,000. This is about 320 child deaths every day and represents a U5MR of 152 per 1,000 live births.
- Malaria and acute respiratory infection (ARI) are the two major immediate causes of mortality among young children, with AIDS emerging as a major killer. Malnutrition is a significant underlying cause of child mortality.

Childhood illnesses

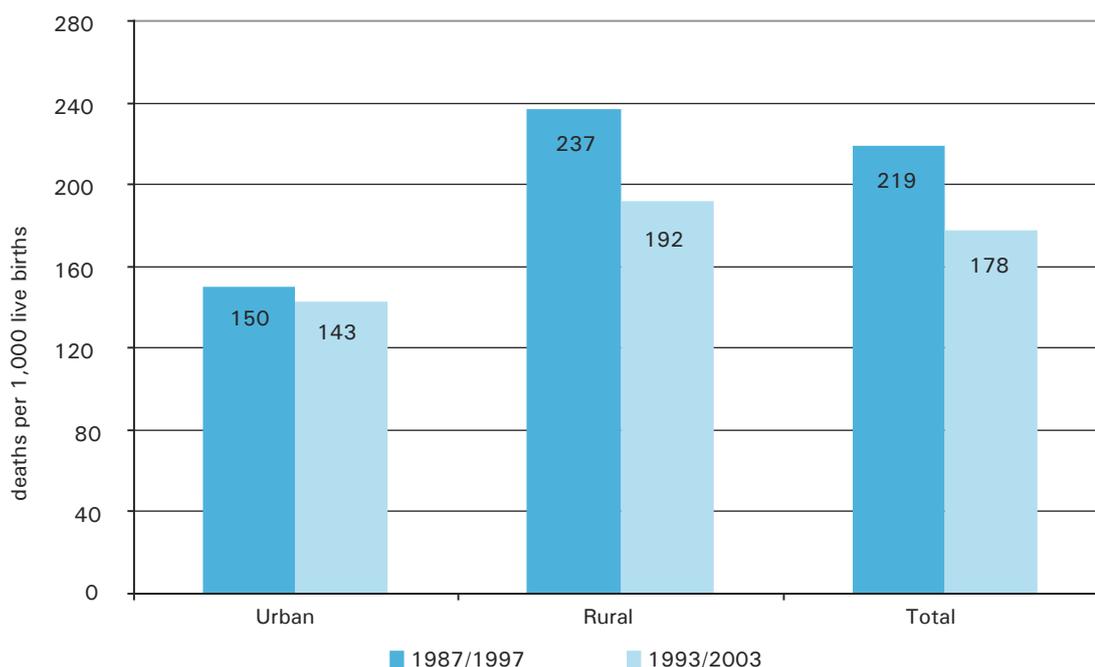
Malaria

- Malaria is the leading killer of children despite the fact that it is both preventable and can be treated. It is estimated that more than one in four deaths among under-five children is due to malaria.
- The 2003 DHS indicated that while 18 per cent of women with children owned a bednet, only 13 per cent of women and 10 per cent of children were using the net (i.e. were reportedly sleeping under the net the night prior to the survey).
- Disparities between provinces and areas of residence were significant. In rural areas, only 7 per cent of children were using a bednet compared to 16 per cent in urban areas.

Acute respiratory infection (ARI)

- Acute respiratory infection (ARI) is among the leading causes of morbidity and mortality among young children, with pneumonia being the most serious infection.

Figure 9: Under-five mortality rate: comparison between 1987/1997 and 1993/2003



Source: DHS, 2003

- According to the 2003 DHS, about 10 per cent of children under five had shown symptoms of ARI in the two weeks preceding the survey, with children aged between 6-11 months being the most affected (39 per cent).

compared to only 56 per cent in rural areas. Coverage among children of mothers with no education was 49 per cent compared to 98 per cent among children of mothers with secondary education.

Diarrhoea

- Diarrhoea is another major cause of child morbidity and mortality, particularly in children six months and older, when they begin to crawl and eat complementary food.
- According to the 2003 DHS, 14 per cent of children under the age of five had experienced diarrhoea in the two weeks preceding the survey.

Vaccine preventable diseases and immunisation

- The national Expanded Programme of Immunisation (EPI) for improving immunisation coverage among children against vaccine preventable diseases has made substantial progress in recent years.
- The proportion of one-year-old children fully immunised against the six main vaccine preventable diseases (diphtheria, pertussis, tetanus, polio, measles and TB) increased from 47 per cent in 1997 to 63 per cent in 2003.
- However, coverage remains low and highly unequal. The 2003 DHS indicated that full immunisation coverage among one-year-old children was 81 per cent in urban areas

Malnutrition

Malnutrition is the main underlying cause contributing to the high level of child mortality. It is also closely linked to future educational outcomes, as malnutrition seriously impacts on the immediate and future cognitive development of the child. The major manifestations of malnutrition are macronutrient deficiencies and micronutrient deficiencies.

Macronutrient deficiencies

In order to measure macronutrient deficiencies among children, three standard anthropometric indicators from the 2003 DHS are used: stunting (height-for-age), wasting (weight-for-height) and underweight (weight-for-age). While direct comparison between different household surveys is fraught with methodological difficulties, research correcting for differences in survey design confirms that there has been little substantive progress with regard to these standard anthropometric indicators in recent years.

- Based on international standards developed by the World Health Organisation, stunting prevalence among Mozambican children is very high (41 per cent), underweight prevalence is high (24 per cent), and wasting prevalence is low (4 per cent).

- In rural areas, where about 70 per cent of children live, malnutrition levels are substantially higher than in urban areas, reaching 46 per cent for stunting and 27 per cent for underweight.
- The high prevalences of stunting and underweight malnutrition in Mozambique have enormous social and economic implications and constitute one of the main challenges for public health interventions.

Stunting prevalence (chronic malnutrition)

Stunting, or chronic malnutrition, shows malnutrition resulting from cumulative inadequacies in the child's nutritional status. Stunting is a good indicator for the general well-being of a population, as it reflects the structural context surrounding malnutrition.

- The national stunting prevalence in 2003 was 41 per cent among children aged 0-59 months. The prevalence of severe stunting was 18 per cent.
- Children living in rural areas show a much higher prevalence of stunting than those living in urban areas (46 per cent versus 29 per cent).

Wasting prevalence (acute malnutrition)

Wasting or acute malnutrition, defined on the basis of weight to height, shows malnutrition resulting from excessive loss of weight that occurred in a recent period due to severe illness or lack of food.

- In 2003, the DHS indicated that wasting prevalence among children under the age of five was 4 per cent.
- There was little difference between urban and rural areas (3.1 per cent versus 4.3 per cent).

Underweight prevalence

Being underweight shows past nutritional or health deficits experienced by a child, in a similar way to stunting.

- Comparison between 1997 and 2003 indicates that the underweight prevalence among children under three years of age remained at 26 per cent.
- Children living in rural areas are almost twice as likely to be underweight as those living in urban areas (27 per cent versus 15 per cent).

Micronutrient deficiencies

The other major manifestation of malnutrition is micronutrient deficiency. The lack of two minerals (iodine and iron) and one vitamin

(vitamin A) plays a particularly important role in these deficiencies.

- The October 2004 national survey of iodine deficiency among primary school children indicated that the overall prevalence of goitre among children was 15 per cent. Iodine deficiency remains the single greatest cause of preventable brain damage and mental retardation worldwide.
- In 2002, the National Survey on Vitamin A Deficiency and Anaemia indicated that 69 per cent of children 6-59 months were suffering from vitamin A deficiency, 14 per cent in a severe form. Vitamin A improves children's resistance to infection such as diarrhoeal diseases, ARI, measles and malaria. Severe Vitamin A Deficiency (VAD) can also lead to poor eyesight and blindness.

Breastfeeding

Mothers' practices related to infant and child feeding have an important bearing on the nutritional status of young children, both in terms of macronutrient and micronutrient deficiencies.

- Although the vast majority of children are breastfed, with 92 per cent of mothers initiating breastfeeding during the first day of life, the rate of abandoning exclusive breastfeeding is very high. By three months of age, only 38 per cent of infants are exclusively breastfed.
- The 2003 DHS reveals poor breastfeeding practices among women, with only 30 per cent of children exclusively breastfed during the first six months of life.
- Exclusive breastfeeding is higher in rural areas than in urban areas (32 per cent versus 25 per cent).

HIV and AIDS

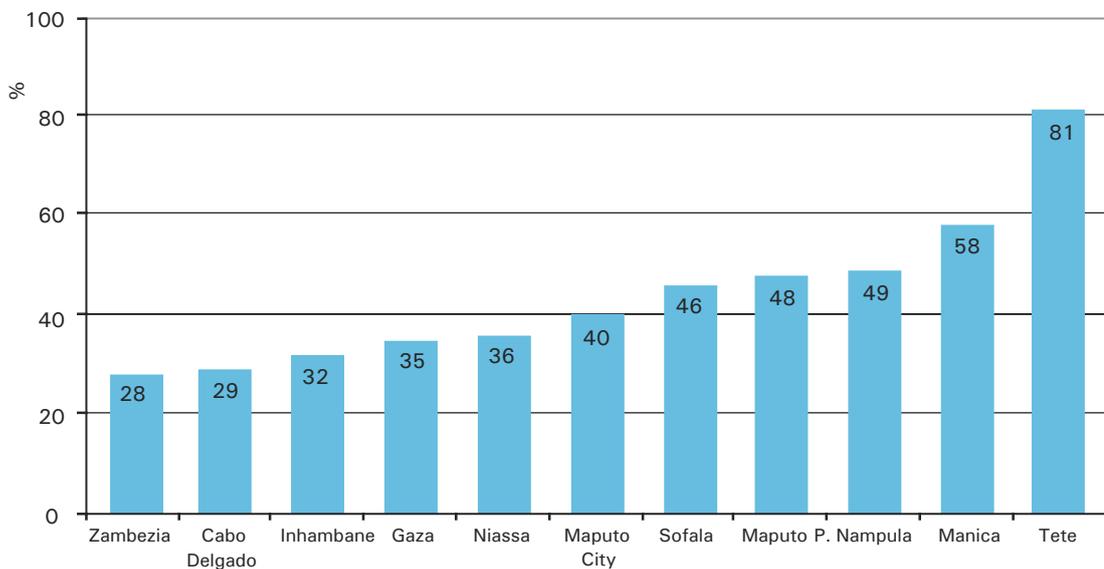
By 2006, over 1.6 million Mozambicans were estimated to live with HIV or AIDS – 58 per cent were women and 5 per cent were children under five. AIDS is fast becoming a major cause of mortality among children, with an estimated 20,000 children under five dying from AIDS related illnesses in 2006.

Prevention of mother-to-child transmission

- There were about 146,000 HIV-positive pregnant women in 2006, almost half of whom lived in the four central provinces of the country.
- The level of knowledge about mother-to-child transmission of HIV is low. The 2003 DHS

- indicated that only 44 per cent of women and 43 per cent of men in the age group 15 to 49 had knowledge that HIV can be transmitted from mother to child during pregnancy, delivery and breastfeeding. There are also massive disparities in knowledge by province, from 28 per cent in Zambezia province to over 80 per cent in Tete province (see Figure 10).
- Since the establishment of a national prevention of mother-to-child transmission (PMTCT) programme in 2002, the number of health facilities offering PMTCT services has expanded rapidly, from eight in 2002 to 113 in mid-2006.
 - However, coverage remains very low and highly unequal. By mid-2006, only five per cent of the total estimated HIV-positive pregnant women in the country received PMTCT prophylaxis.
 - Prioritising access to Anti-Retroviral Therapy by eligible pregnant women is critical, both for their own health and also to reduce the risk of post-natal transmission in breastfeeding mothers with low CD4 and high viral load, and in the context of the challenges faced by mothers in implementing recommended infant feeding options.

Figure 10: Knowledge of mother-to-child transmission of HIV among Mozambicans (15-49 year-olds)

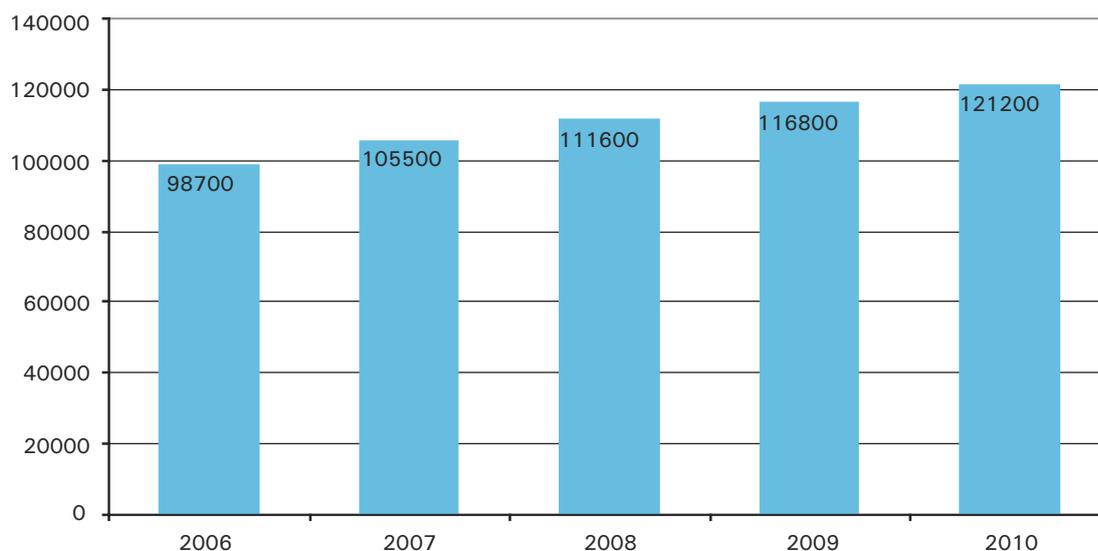


Source: DHS, 2003

Paediatric AIDS

- There were about 99,000 children under the age of 15 living with HIV or AIDS in 2006, a number expected to increase to over 121,000 by the year 2010. One in two infected children live in the four central provinces of the country.
- The number of new infections among children has steadily increased over the years, from an estimated 23,400 in 2000 to 37,300 in 2006, representing about 102 new infections every day. Projections indicate that this number will increase to over 40,000 by the year 2010, with 110 children becoming infected each day.
- AIDS is fast emerging as a major cause of mortality among children, with an estimated 20,000 child deaths due to AIDS in 2006 (or about 17 per cent of all deaths). More than half of children living with AIDS die before reaching their second birthday.
- The Ministry of Health estimates that 75 per cent of children under 15 living with HIV/AIDS require ARV treatment, compared to an average of 15 per cent of HIV positive adults. By mid-2006, of an estimated 74,000 infected eligible children, only about 2,300 were receiving treatment, representing less than three per cent.
- The distribution of children accessing treatment is highly inequitable, with 68 per cent of all children under treatment in 2005 living in the four southern provinces of the country, and 55 per cent alone living in Maputo City.

Figure 11: Children living with HIV/AIDS: projection until 2010



Source: *Demographic Impact of AIDS, Multisectoral Technical Group of Support to the Fight against HIV/AIDS, 2004*

Water and sanitation

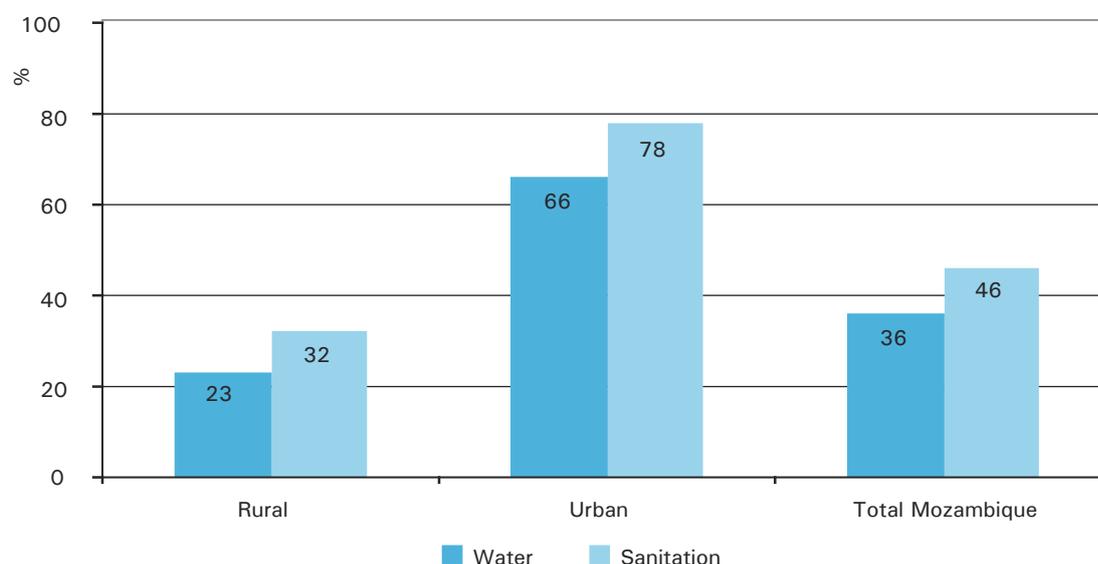
Access to clean, safe water and adequate sanitation are vital for the survival and healthy development of children, reducing sickness and death due to diarrhoeal diseases and other major causes of child mortality. It is estimated that over 300,000 Mozambican children would need to gain access to an improved water supply and improved sanitation every year if the MDG target of reducing by half the number of people without sustainable access to safe drinking water and adequate sanitation is to be met by 2015.

- Use of a safe water source is defined as the proportion of households that use any of the following types of water supply for drinking: piped water, public tap and borehole/well

with a hand pump. The 2004/2005 Labour Force Survey ("IFTRAB") indicates that only 36 per cent of the population use a safe drinking water source, with massive disparities between urban areas and rural areas (66 per cent with safe water in urban areas and 23 per cent in rural areas) (see Figure 12). Data from all household surveys conducted since the year 2000 show no improvement in the use of safe water sources, with measures of 37 per cent in 2000 (QUIBB), 36 per cent in 2002/2003 (IAF) and 37 per cent in 2003 (DHS).

- The IFTRAB survey indicates that the use of sanitary means of excreta disposal was 46 per cent at national level, with significant disparities between urban areas and rural areas (78 per cent versus 32 per cent).

Figure 12: Use of safe water source and sanitary means of excreta disposal



Source: *IFTRAB 2004/5, National Institute of Statistics*

Underlying causes of the child survival and development situation

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

- **Inequitable access to and funding of social services**

The lack of access to public services –both in terms of physical and economic access– and the poor quality of these services are significant barriers, particularly for poorer households, for people living in rural areas and for those with less education.

- **Economic accessibility**

The mortality rates among children from poorer families are significantly higher than those from better off families. The Expenditure Tracking and Service Delivery Survey showed that nearly half of Mozambicans questioned found it ‘difficult’ or ‘very difficult’ to find money to pay for healthcare, with 52 per cent in rural areas and 32 per cent in urban areas.

- **Physical accessibility**

The 2004/2005 IFTRAB survey indicated that 56 per cent of households were one hour or more on foot from the nearest health facility, with a significant disparity between urban areas and rural areas (18 per cent versus 72 per cent).

- **Low levels of education among mothers**

The education level of mothers is strongly correlated with children’s well-being. The 2003

DHS indicated that children of mothers with no education were 130 per cent more likely to die before reaching the age of five than children of mothers with secondary level education (see Figure 13).

- **Weak human resource capacity**

The health sector is faced with an acute shortage of human resources –particularly at the sub-national levels. The situation is further exacerbated by the AIDS pandemic. There is currently one doctor per 44,000 inhabitants, compared to the average for sub-Saharan Africa of one doctor per 22,000 inhabitants.

- **Poor quality infrastructure**

Many existing health facilities are without electricity, adequate water supplies or basic equipment. In the water sector, although poor coverage remains the main problem, a major barrier to access and use of safe water is the frequency with which existing water points break down. DNA estimates that approximately 30 per cent of the water supply facilities that have been constructed in recent years are non-operational.

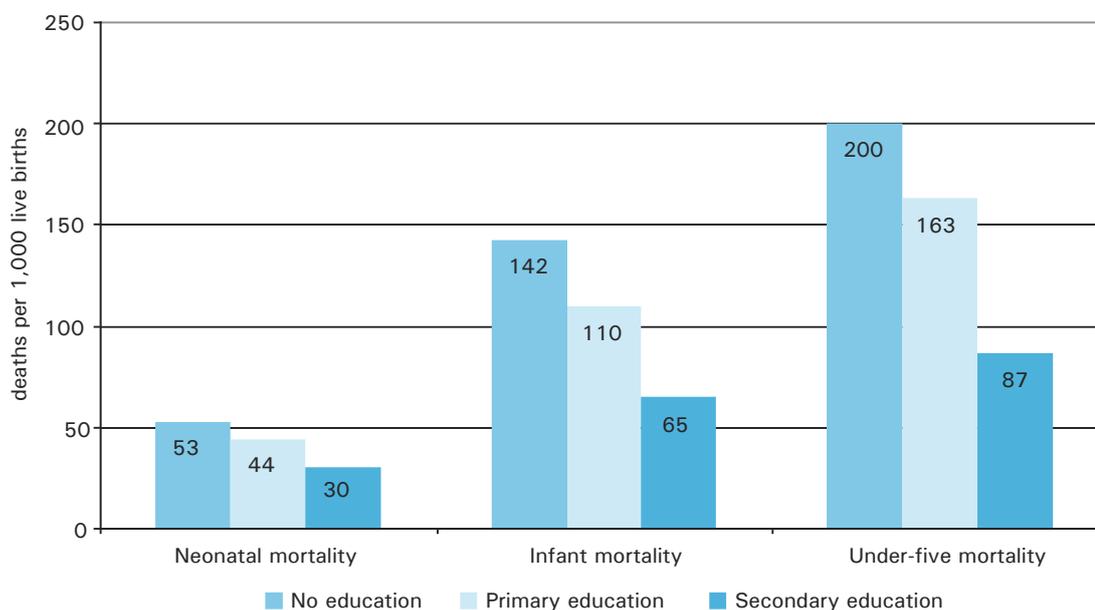
- **Natural disasters**

Mozambique is a country prone to natural disasters, including cyclones, floods and repeated drought. In rapid onset emergencies, health infrastructure is damaged and roads or paths made inaccessible, reducing people’s already limited access to health services.

- **Involving service users**

Relatively low levels of satisfaction among health service users have been registered in several surveys. The 2002/2003 IAF survey

Figure 13: Mortality level among children by type of mortality and level of education of the mother



Source: DHS, 2003

indicated that 38 per cent of the population was not satisfied with the health services provided. The first reason cited was the long waiting time, the second was the lack of treatment and the third was unsuccessful treatment. The 2004/2005 IFTRAB survey confirmed these findings, with a slight decrease in the level of dissatisfaction.

Education, Information and Child Development

Education is one of the most powerful instruments for reducing childhood poverty and inequality. The importance of education –particularly primary education– in advancing economic and social development and in reducing poverty is well documented. Recent findings suggest that educational improvements over the period 1999-2004 accounted for 13.9 per cent of economic growth in Mozambique. Girls’ education is particularly important, as it is highly correlated with reduced child mortality and improved child health and nutrition for subsequent generations of children.

Childhood deprivations of education and information

Severe education deprivation

The deprivation indicator is the proportion of children aged between 7 and 18 who have never been to school and are not currently attending school.

- About one in five children are severely deprived of education, with massive disparities by province, area of residence, sex, level of education of the household head and wealth.

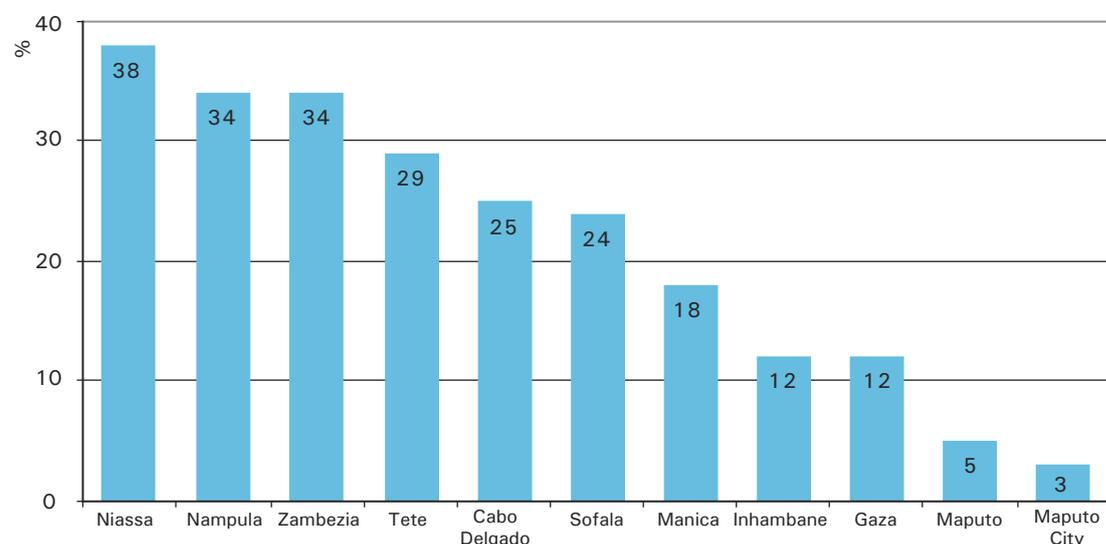
- There are massive variations in education deprivation by province, particularly affecting children in Niassa, Nampula and Zambezia provinces, where over one-third of children between 7 and 18 years have never been to school (see Figure 14).
- There is a direct correlation between severe education deprivation and whether the head of the household in which the child lives has an education. Among households in which the household head has no education, 38 per cent of children are severely deprived of education, compared with 20 per cent of children in households in which the household head has a primary education and 4 per cent of children in households in which the household head has a secondary level or higher education.

Severe information deprivation

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

- 39 per cent of children in Mozambique are facing severe information deprivation and significant disparities exist by province, area of residence, sex, wealth and level of education of the household head.
- Almost twice as many children living in rural areas face severe information deprivation as in urban areas (46 per cent versus 24 per cent).
- Among children in the poorest households, 64 per cent are facing severe information deprivation, as compared with 11 per cent in the best off households.

Figure 14: Severe education deprivation by province



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

- There is a direct correlation between the level of education of the head of the household in which a child lives and the level of information deprivation. Fifty three per cent of children living in households in which the household head has no education are experiencing severe information deprivation as compared with 10 per cent of children in households in which the household head has a secondary level or higher education.

Access to schooling and attendance

In the period 1992 to 2005, the number of pupils in the primary school system tripled, from approximately 1.3 million to over 3.8 million. The number of pupils in the secondary system increased from about 45,000 to 245,000.

The massive increase in the number of students has been driven by an expansion of the public school network at primary and secondary levels, from around 3,600 schools in 1992 to over 10,200 in 2005. On average, each year around 500 new schools have been constructed and 3,500 new teachers recruited. In 2004, enrolment fees were suspended and have now been abolished for primary education. The education sector accounted for 19 per cent of the total expenditures recorded in the State Budget Execution Report in 2005.

However, significant inequalities persist in terms of access to education, based on where a child lives, whether the child is a boy or a girl and on the level of poverty in his or her household. There are currently approximately 660,000 primary school age children (6-12 years) who are not attending primary school. Using the age range permitted under education legislation (6-15 years) this number rises to around 1.3 million children.

Gross and net enrolment ratios

The Gross Enrolment Ratio (GER) and the Net Enrolment Ratio (NER) in public schools have continuously increased since the end of the civil war, both at primary and secondary education levels.

- The GER in the lower level of primary education (EP1) increased from 60 per cent in 1992 to 131 per cent in 2005 and the NER increased from 32 per cent to 83 per cent over the same period.
- Access to secondary education follows a similar pattern of increase, with the absolute number of students enrolled in secondary education more than trebling between 1999 and 2005. In the lower level of secondary education (ESG1), student enrolment (excluding nocturnes) increased from about 64,006 to 210,128 and in the upper level of secondary (ESG2) the number of children

enrolled increased from 8,368 in 1999 to 25,737 by 2005.

- However, access to secondary education remains the privilege of very few children, mostly those in urban areas and from the wealthiest quintile of the population. In 2005, GER in ESG1 and ESG2 were 17 per cent and four per cent respectively, while NER in ESG1 was four per cent and in ESG2 only one per cent.
- This rapid increase in enrolment has not been matched by increases in investment in the quality of education or by adaptive strategies for such massive increases in students. In the lower level of primary education, there was on average 1 teacher for every 74 pupils in 2005.

Repetition, dropout and completion rates

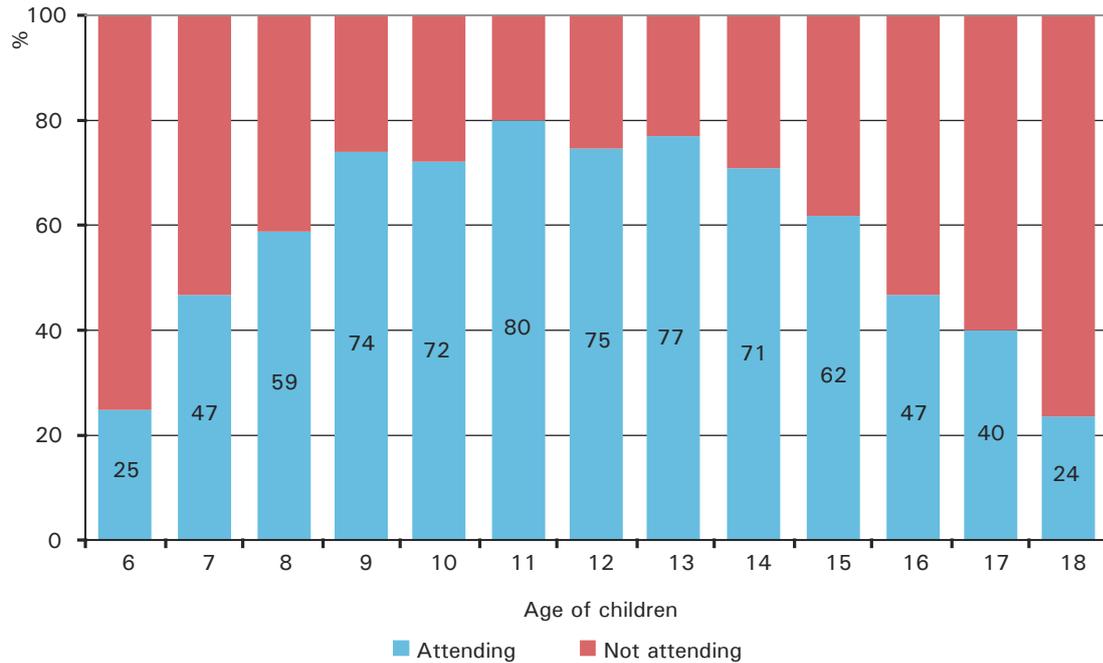
- Despite a slight decrease during the period 1999 to 2005, repetition and drop-out rates at EP1 level remain high, at 11 per cent and 8 per cent respectively. In upper primary level (EP2), repetition rates and drop out rates also indicate a downward trend. Repetition rates decreased from 25 per cent in 1999 to 6 per cent in 2005 and drop-out rates decreased from 9 per cent to 8 per cent for EP2 during the same period.
- Completion rates in both EP1 and EP2 show a marked improvement over the period 1999 to 2004. In EP1 completion rates increased from 27 per cent to 48 per cent. In EP2, completion rates increased from 11 per cent to 29 per cent by 2004. However, under half of children complete the lower level of primary education and less than one third of children complete EP2.
- Completion rates in EP1 are substantially lower for girls than for boys. In 2004, the completion rate for EP1 was 39 per cent for girls compared to 57 per cent for boys. The gender gap is slightly less at the upper level of primary education, where the EP2 completion rate for girls was 23 per cent compared to 35 per cent for boys.

Attendance

Analysis of attendance rates provides a more informative picture of the education sector since they indicate whether a child is actually attending school, as opposed to simply being enrolled in school. Attendance figures are measured by household surveys while enrolment data is compiled by the Ministry of Education and Culture (MEC).

- Trends in school attendance over time confirm the positive trends in school enrolment. However, a much smaller proportion of children are attending school than are enrolled

Figure 15: Children attending primary education (grade 1 to 7) by age



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

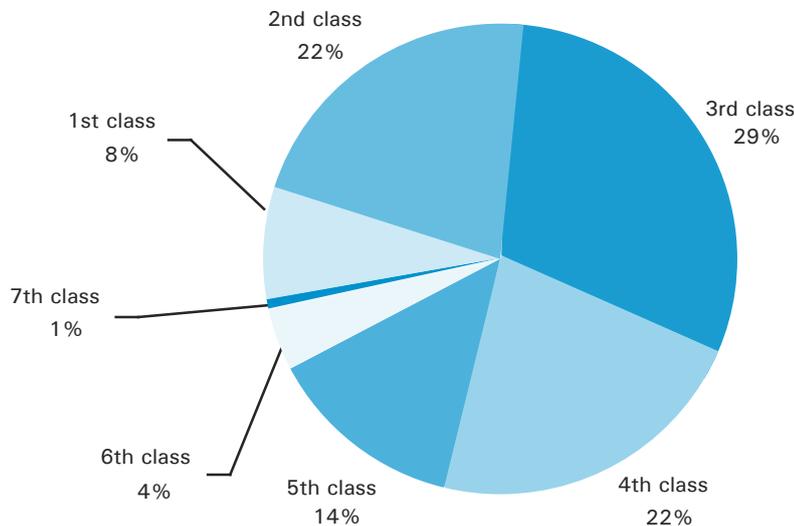
in school. For example, while NER in EP1 was 69 per cent in 2003, the DHS conducted in 2003 indicates that the net EP1 attendance rate for that year was 54 per cent.

- There was almost no difference in urban areas between the proportion of girls and boys attending school. The gender gap in rural areas was marked, with only 48 per cent of girls attending primary school compared to 57 per cent for boys.
- There is a phenomenon of late entry into school. For example, only 25 per cent of 6-year-old children are attending EP1 level (see Figure 15). A child's area of residence has a

huge impact on the age at which he or she begins school. Children in rural areas enter school much later than children in urban areas. At 6 years of age, only 19 per cent of children in rural areas attend primary school compared to 43 per cent of urban children. At 7 years of age, the gap widens, with 39 per cent of rural children being in school compared to 68 per cent in urban areas.

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

Figure 16: Distribution of 11-years old children by class attended



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

education (EP1), with most in grade 3 (see Figure 16). This 'over-age' phenomenon in the lower level of primary education is the result of late entry into the education system and high levels of repetition. It has serious implications for children's learning outcomes, as the same curriculum is taught at the same pace to learners of very different ages and levels of cognitive development.

Literacy

- The 2004/2005 Labour Force Survey shows that slightly over half (52 per cent) of the population is not literate, with significant disparities between rural and urban areas (66 per cent versus 26 per cent) and between women and men (67 per cent versus 34 per cent).
- A greater proportion of younger Mozambicans, particularly women, are literate. While 80 per cent of Mozambicans over 65 years of age are not literate, the figure is 34 per cent among young people aged 15-19 years (see Figure 17).

Children and HIV Prevention Education

- Knowledge about HIV and HIV prevention greatly improved between 1997 and 2003. In 2003, the DHS indicated that over 95 per cent of young people 15 to 24 years of age had heard about AIDS. However, knowledge about means of transmission is low. Only 47 per cent of young women and 63 per cent of young men of 15-24 years of age knew about

the two main ways to protect themselves from contracting HIV (using condoms or having sex only with one faithful uninfected partner).

- Young people hear about HIV/AIDS from a variety of sources. The primary source is radio, followed by friends and relatives, teachers, health workers, television and brochures/pamphlets.

Immediate and underlying causes of education deprivation

• Lack of relevance

The 2005 World Bank Poverty and Social Impact Assessment (PSIA) found that 32 per cent of those interviewed considered the current school curriculum to be lacking relevance.

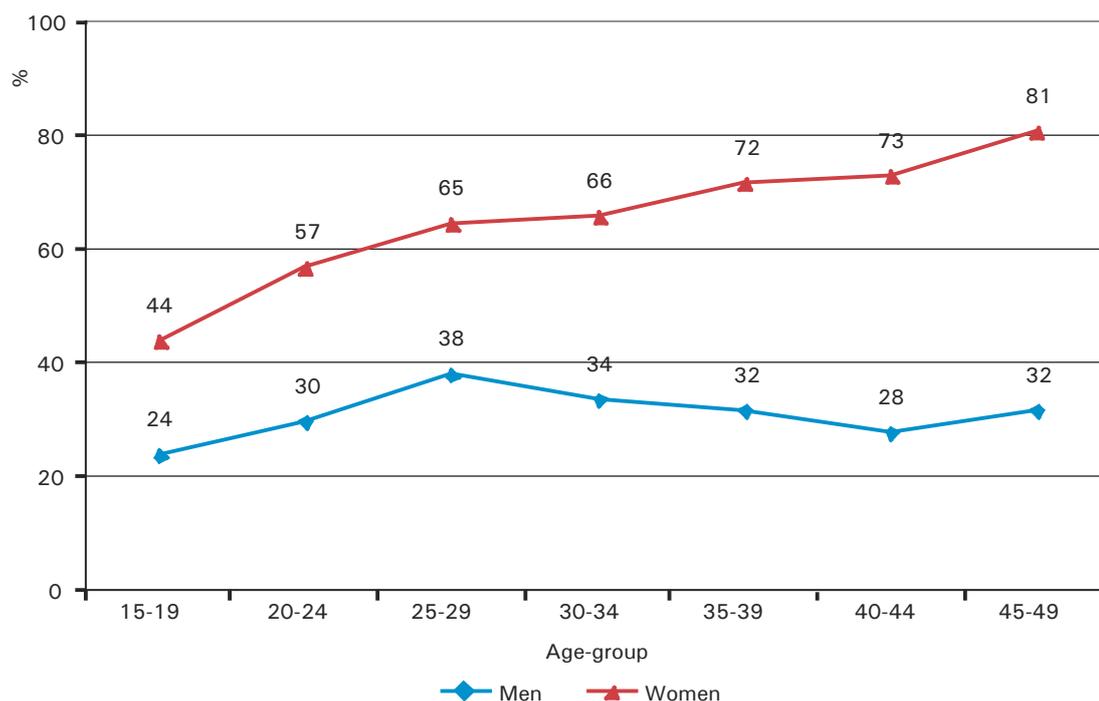
• Distance from school

Proximity to school has been identified as a key determinant of primary school enrolment and retention: the further a child lives from a school, the less likely they are to attend.

• Poor quality of teaching and learning processes

Poor teacher training, insufficient materials and lack of pedagogical support have meant that most teachers rely on teacher-centred didactical methods, emphasising repetition and memorisation over pupil-centred approaches that encourage creative thinking and skills-based learning.

Figure 17: Illiteracy rate by age group



Source: IFTRAB 2004/2005, National Institute of Statistics

- **Lack of materials**

A major barrier to quality education often cited is the lack of basic school materials – text books in particular.

- **Poor condition of school infrastructure**

The construction of schools and classrooms has not kept pace with the rapid increase in enrolment, and there is a chronic shortage of schools across the country. In 2005, there were 70 students for every classroom. Few schools currently provide a school environment conducive to learning.

- **Lack of teachers**

The lack of teachers has led to a rapid increase in pupil-teacher ratios in recent years. In 2005, the pupil-teacher ratio was 74:1, up from 65:1 in 2000.

- **Lack of qualified teachers**

With the rapid increase in primary school enrolment over the past decade, the demand for qualified teachers has increased dramatically. In 2005, at primary level, only 58 per cent of teachers at EP1 level were qualified, and 68 per cent at EP2 level.

- **Lack of female teachers**

Women teachers provide valuable role models to young girls to encourage them to continue with their education and lessen the probability of abuse of pupils. In 2005, only 31 per cent of all EP1 teachers were women and 23 per cent at EP2 level.

- **Violence and abuse in schools**

The prevalence of violence, sexual abuse and harassment in schools has been identified by parents as a factor influencing their decision not to send their children to school and a factor influencing attendance, particularly for girls.

Child Protection

The physical and psychological effects of violence, abuse and exploitation affect a child's well-being and development and are likely to influence the child's behaviour and attitudes throughout their childhood and into adulthood. Significant steps have been taken by the Government of Mozambique to improve policy and legal instruments for the protection of children from violence, abuse and exploitation and to ensure access by the most vulnerable children to basic social services.

Protection of children from violence, abuse and exploitation

Children in conflict with the law

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

- A Save the Children Norway study carried out in 2003 in the provinces of Nampula, Sofala and Maputo showed that at least 25 per cent per cent of all prison inmates interviewed were under the age of 18. The main underlying reason identified in the study for children being in conflict with the law was poverty. A number of additional reasons were given, including a decline in moral values, increased access to violent films, the breakdown of families, lack of education and lack of employment.
- The 2004 Annual Statistical Report on the Prison System in Mozambique reported that 17 per cent of the prison population was comprised of adolescents between 16 and 19 years old.
- The Save the Children Norway study found that an effective institutional framework to support the enforcement of international and national laws relating to the protection of children was not in place at any stage of the legal process.

Violence, sexual exploitation and abuse

The information available raises concern over the incidence of domestic violence and sexual abuse, including sexual abuse in schools.

- As a child or teenager, 30 per cent of women and 37 per cent of men had directly witnessed violence between their parents and 15 per cent of women and 20 per cent of men had suffered physical abuse from a relative in their youth (National Survey of Reproductive Health and Sexual Behaviour of Young People, 2001).
- As many as 34 per cent of women who participated in a study carried out for MMAS in 2004 reported having been beaten. The perpetrator of the violence was most frequently the husband or a close relative or acquaintance. Ten per cent of respondents reported having been subjected to some form of sexual abuse. Women in rural areas reported higher levels of violence than women in urban areas.

- Case studies suggest that there is a high level of sexual abuse in the school system. In a recent study supported by Save the Children, CARE International, MEC and Rede-CAME/FDC, it was estimated that at least 8 per cent of school children had suffered physical sexual abuse.
- In a 2004 Youth Profile commissioned by the Ministry of Youth and Sport and UNICEF, 20 per cent of girls who participated in the study reported that abuse was a problem in schools. Students reported that they were forced to choose: provide sex, pay money or face expulsion from school.
- Married girls are much less likely than their unmarried peers to attend school, and girls are often removed from school to marry.
- A family's decision to have a child married – girl or boy – is often a survival strategy to relieve the family of what they perceive to be a financial burden in the face of acute poverty. Girls are considered to be ready for marriage on reaching puberty. DHS data indicate that girls aged 15-19 in the poorest quintile of the population are more likely to be married than girls from the better off households.

Trafficking in children

The trafficking of children removes them from the protective environment of their family and increases their vulnerability to child labour, violence, sexual exploitation and abuse. There have been numerous reports of the trafficking of women and children, especially between Mozambique and South Africa for purposes of labour and sex work.

- A study on trafficking in Southern Africa conducted in 2002/3 by the International Organisation on Migration found that Mozambique is both a source country and a transit country for trafficking activities in Southern Africa. The study found that approximately 1,000 Mozambican women and children are trafficked to South Africa every year.
- Studies from Save the Children UK also point to the importance of the broader issue of cross-border migration of children. Children who migrate are then much more vulnerable to trafficking, both in their home and destination countries, having little access to social protection mechanisms or public services.

Child marriage

The Population Council has noted that Mozambique has one of the most severe child marriage crises in the world today.

- DHS data from 2003 indicate that 18 per cent of girls aged 20-24 had been married before the age of 15 and 56 per cent before the age of 18.
- The average age at first marriage among girls varied among provinces, from 16 years in Nampula province to 20 in Maputo City. Girls living in rural areas tend to get married earlier than their peers in urban areas. The percentages of men who had been married before the ages of 15 and 18 were considerably lower (one per cent and 14 per cent respectively), suggesting that young girls tend to marry older men.
- The survey indicates that 32 per cent of children between seven and 17 years old are engaged in some form of economic activity, with significant difference between urban areas and rural areas (16 per cent versus 40 per cent).
- The survey shows that the vast majority of children working are doing unpaid work for the family and that girls and boys are involved in equal proportions. At seven years of age, six per cent of children are already engaged in productive activity. Around half of children 14 years and older are economically active.
- There is a strong correlation between the probability of a child working and the level of education of the household head. 40 per cent of children in households where the household head has no formal education are economically active, compared with 15 per cent of children in households where the household head has secondary level education or higher.
- Over two thirds of children between seven and 17 years old who are working attend school, which reflects the fact that most of the work undertaken by children is unpaid work for the family carried out in addition to schooling activities.

Working children

The most recent data on children in work come from the Labour Force survey conducted by National Institute of Statistics (INE) in 2004/2005. However, the survey has not yet been fully analysed. Results presented here refer to children involved in economic activities defined as "working on the machamba, selling products or other economic activity." They do not provide an indication of the proportion of children involved in domestic work, which evidence suggests is a significant proportion of the work undertaken by children. Also, they do not distinguish between child labour and child work (the latter refers to children that are working but not in exploitative situations and who are attending school).

Strengthening legal protection

Comprehensive legal framework

Effective legal protection is an integral part of a protective environment for children. The absence of an adequate legal framework exacerbates a child's vulnerability and increases the likelihood that he or she will be denied a range of rights beyond those strictly associated with protection.

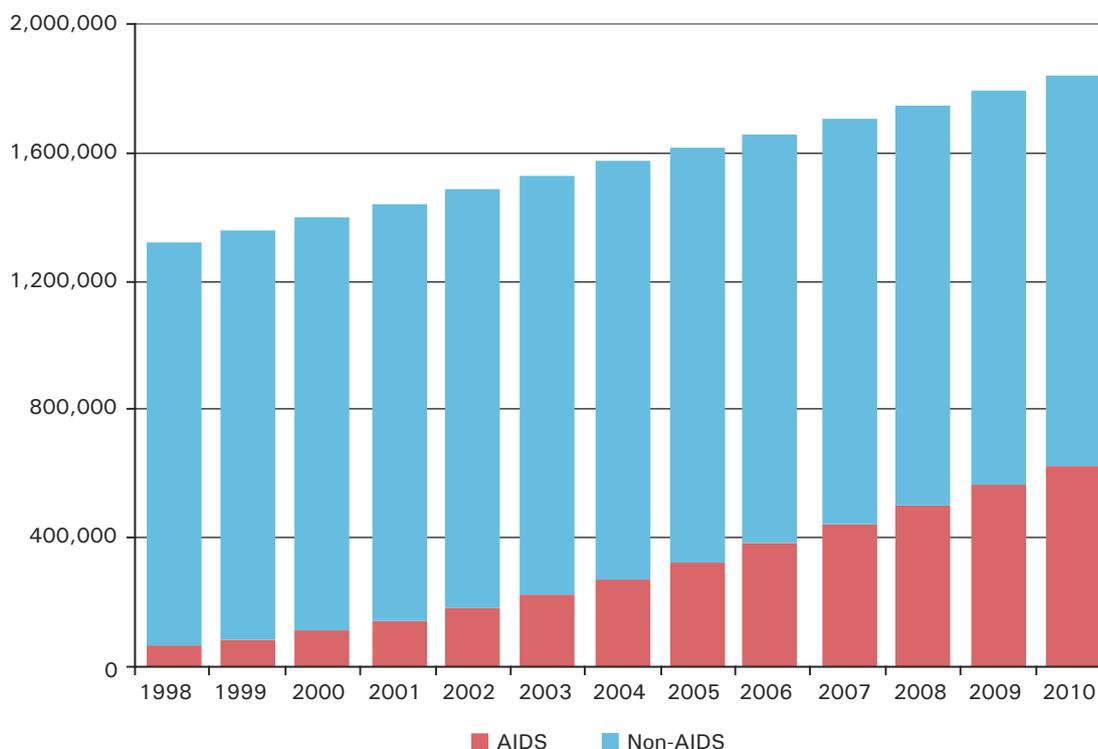
- Mozambique has ratified international and regional human rights instruments relating to the protection of children, including the UN Convention on the Rights of the Child, the UN Convention on the Elimination of All Forms of Discrimination against Women and the African Charters on Human and People's Rights and on the Rights and Welfare of the Child.
- The Ministry of Justice has developed a draft Children's Act with the twofold objective of establishing a comprehensive legal framework for children and harmonising national law with Mozambique's obligations as a State party to international human rights instruments. It is anticipated that the Act will be approved by the Parliament in 2006.

Access to basic services and social assistance for the most vulnerable children

There were about 1.6 million orphaned children under 18 years of age in 2006. Data on the proportion of children who are orphaned (defined as having lost one or both parents), vary from one source to the other, with estimates ranging from about 12 per cent to 16 per cent of the total population.

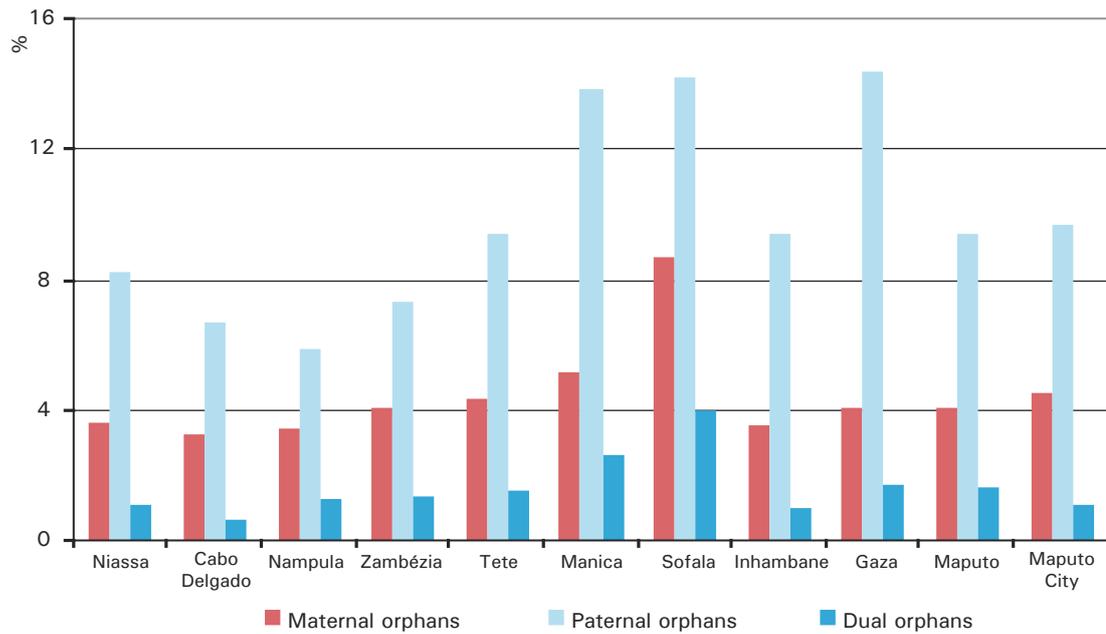
- It is estimated that 380,000 children have been orphaned due to AIDS, which account for more than 20 per cent of the total of orphaned children. The total number of children orphaned by AIDS is expected to reach 630,000 by the year 2010 (see Figure 18).
- In 2006, it was estimated that 54 per cent of maternal orphaning was due to AIDS compared to 35 per cent for paternal orphans. Among children who had lost both parents, 60 per cent had lost their parents due to AIDS.
- In addition to being affected by AIDS through the loss of their parents, an increasing number of children are themselves living with HIV or AIDS.

Figure 18: Total orphans 0-17 - Projection from 1998 to 2010



Source: Demographic Impact of AIDS, Multisectoral Technical Group of Support to the Fight against HIV/AIDS, 2004

Figure 19: Orphaned children by province



Source: IFTRAB 2004/2005, National Institute of Statistics

- Results from the 2004/2005 Labour Force Survey indicate that the proportion of orphaned children is the lowest in the provinces with the lowest HIV prevalence, namely Niassa (HIV prevalence 11.1 per cent; orphaning rate 10.8 per cent), Cabo Delgado (HIV prevalence 8.6 per cent; orphaning rate 9.3 per cent) and Nampula (HIV prevalence 9.2 per cent; orphaning rate 8.2 per cent). The proportion of orphans is highest in Sofala province, where almost one in five children is an orphan (19 per cent) and where HIV prevalence is the highest in the country (estimated at 26.5 per cent in 2004) (see Figure 19).
- The proportion of orphaned children is slightly higher in urban areas than in rural areas (13.8 per cent versus 11.1 per cent).
- 16.6 per cent of children living in families where the head of household has had no education are orphans. This proportion decreases steadily as the education level of the household head increases. 10.8 per cent of children are orphans in households where the head has reached EP1 level; 9.1 per cent where the head has reached EP2 level; and 9.9 per cent where the head has reached secondary or higher education.
- Orphaned children are also disproportionately living in households headed by women. Female headed households make up only 30 per cent of all households, but over half of orphans (54 per cent) live in households headed by women.
- The 2005 national OVC Situation Analysis conducted in all provinces by the Ministry of Women and Social Action found that 0.2 per cent of all OVC households surveyed were headed by a child under the age of 18, with the figure slightly higher for orphan households (0.3 per cent) compared to vulnerable children households (0.2 per cent).
- Children heading households are more likely than other children to work in exploitative situations, to be stigmatised, to be at risk of being trafficked, to be subjected to violence, abuse and neglect or to be forced to make a living on the streets.

Conclusions

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

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

In addition, there is a danger that some groups are not benefiting from growth and poverty reduction. Children in rural areas, for example, are consistently worse off than their peers in urban areas and additional groups of children are particularly marginalised, such as orphaned and vulnerable children. Underlying the many urban-rural disparities is the very low population density in rural areas, one implication of which is that delivering a given level of public services is considerably more costly in rural areas than in urban areas.

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

- **Ensuring adequate and equitable resource allocation.** Ongoing analysis of budget mechanisms, allocations and expenditures and specifically the development of an efficient method for tracking expenditures in key sectors for children are imperative to ensure sufficient investment for children and inform the equitable allocation of the available resources.
- **Strengthening Government capacity at national and sub-national levels.** Often the key constraint to delivery is not lack of funds but limited institutional capacity. Increased investment for children must therefore be matched by sufficient Government capacity for the efficient utilisation of available resources. It is therefore critical to ensure significant, sustained investment in strengthening the institutional capacity of Government at the national and sub-national levels. Particular focus needs to be placed on developing capacity for planning, monitoring and evaluation and financial management at the provincial and district levels, and strengthening the capacity for coordination of agencies responsible for multi-sectoral interventions benefiting children, especially in the area of nutrition and child protection.
- **Targeting the most vulnerable.** Understanding the situation of the most vulnerable children and the factors behind their marginalisation and then targeting initiatives towards these children needs to be an integral part of the national development agenda. Efforts need to be placed on ensuring the availability and use of reliable and up-to-date data on vulnerable children and the causes of their vulnerability and supporting them to access basic services and social protection programmes, particularly through the scaling of cash transfere schemes. The broad distribution of childhood poverty and inequality and the very low population density in rural areas mean that policies targeting the poorest and most vulnerable children need to be designed carefully.
- **Accelerating the response to the AIDS pandemic.** It is critical that interventions in the areas of paediatric AIDS and the prevention of mother to child transmission are significantly accelerated and scaled up, in order to reduce the impact of AIDS on infant and child mortality, thereby helping to sustain recent improvements in the rates of infant and child mortality.

- **Managing aid inflows for improved child outcomes.** As PARPA II stresses, aid flows ideally need to be tailored to promote long-term Government-led objectives such as capacity strengthening efforts. However, it also recognises that there is a need to manage potential additional inflows of finite duration. These need to be targeted towards programmes that can deliver a ‘step-change’ in development outcomes for children. Large-scale vaccination or malaria campaigns, which deliver clear benefits for children, are natural candidates, particularly because childhood diseases can undermine development for life and should therefore be addressed as soon as possible.
- **Strengthening the capacity of civil society and promoting community participation.** It is critical that the capacity of civil society is strengthened, in order to ensure enhanced and expanded support for Government in terms of demand creation, alternative mechanisms for service delivery and the targeting of development programmes towards the most vulnerable children. In addition, active and informed participation of communities in the design, implementation and monitoring of development programmes needs to be promoted and facilitated in order to increase their impact and sustainability.
- **Implementing social communication strategies.** Social communication strategies, tailored to the local context and employing a variety of communication channels need to be supported, in order to enhance the sharing of information and knowledge, promote social and behaviour change and mobilise communities in the fight against childhood poverty. This is potentially a very important tool in making progress on anthropometric measures, which the evidence suggests are closely linked to cultural practices and attitudes (such as those regarding breastfeeding).