REPORT ON THE MILLENNIUM DEVELOPMENT GOALS

REPUBLIC OF MOZAMBIQUE

2010

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Table 1: Overview of the Progress of Mozambique towards the Millennium Development Goals

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

Source: MPD, UNDP

PREFACE

The September 2000 Millennium Declaration and Millennium Development Goals (MDGs) reiterated that the development of our countries depends on a variety of factors influencing each other mutually. In this sense, the way in which the selected 8 goals interact shows the structural nature and inherent complexity of the current challenges. Indeed, it is not possible to talk about the promotion of gender equity and the autonomy of women without recognizing and giving due attention to universal basic education, which in its turn contributes to the reduction of child mortality and to the improvement of mother health. Similarly, the fight against HIV and AIDS cannot be separated from the improvement of food and nutrition security, as anti-retroviral treatment does not save an undernourished patient, who doesn't even know where to get his or her next meal. Still in the field of evidence, environmental sustainability cannot be fully guaranteed when factors outside the MDGs, such as the lack of consensus about the adoption of an international regime for climate change, also aggravate environmental degradation and erosion, turning the soils poorer for agricultural production, our countries, even the most developed ones, more vulnerable to the effects of extreme natural phenomena, and sanitation interventions for the fight against malaria and diarrhoeas more difficult to carry out. Finally, we should mention the role of the global partnership in favour of development, which should assume greater expression through the implementation of the commitments assumed in September 2000, as well as through the adoption of harmonized interventions, integrated and aligned with national, regional and international policies. The Paris Declaration on Aid Effectiveness, the emergent United Nations "Deliver as one" Programme and the direct budget support programmes are a few examples of this coordination. Though not having achieved its primary goal, Copenhagen played a very important role in awakening global consciousness regarding the negative impact of climate change on the MDGs. Taking into account that the targets of the Millennium summit were adopted by consensus, to us it does not appear curial to reach the year 2015 without having met them, with extreme poverty and hunger fustigating millions of men and women on our planet.

In Mozambique we have done our part to reach the commitments assumed in this international road map, integrating it in our National Agenda for the Fight against Poverty, which has a holistic character with the various indicators influencing each other mutually. In this Report, the fourth of this kind after those of 2002, 2005 and 2008, emphasis is given to the important progress achieved, particularly in the expansion of education and health services, as well as in the promotion of gender equality. This Report also reflects Mozambique's commitment to control the negative effects of climate change that, through changes in the

planting seasons and cycles, the increase of the average seawater level, impoverishment of the coastal and marine ecosystems and change of disease vectors and spread, may undermine our engagement in the reduction of poverty and in achieving food security. This commitment is reflected in our 2010 Gender, Environmental and Climate Change Strategy and Action Plan.

In the course of this period we have launched three Presidential Initiatives to crystallize the challenges of the MDGs. Thus, in 2008 we launched the Presidential Initiative on Maternal and Child Health, a theme stimulating us to carry out many activities in favour of women and children. We congratulate ourselves that, on our proposal, the 15th Conference of the Heads of State and Government of the African Union, held in July this year in Kampala, adopted Maternal and Child Health as its official theme. The debate produced recommendations which we in Mozambique have already started to implement.

We also launched the "one student, one tree per year" and the "one leader, one community forest" Presidential Initiatives and we exhorted each Mozambican citizen to use every available opportunity to plant another tree and relate it to specific occurrences. These are programmes aimed at instilling new values about the environment, mitigating the effects of climate change and ensuring that the trees provide what they are capable of giving us: shade, fruits, construction and therapeutic material, purification of the air and landscape beauty, to give a few examples.

Special reference should be made to the 7 million that are annually allocated to the rural areas for the production of more food and the generation of more jobs. These resources create, among others, conditions for those belonging to the poorer population groups, who would otherwise have no way to finance their economic initiatives, to have the possibility to be real actors in the country's economic life.

More than merely describing, in a systematic way, progress in the implementation of our Programme for the achievement of the MDGs, this Report is also a contribution to the debates of the Special Session on this theme, in the scope of the 65th Session of the General Assembly of the United Nations.

To conclude, we would like to thank all national and foreign actors who made the preparation and edition of this Report possible. We thank the United Nations Development Programme (UNDP), our partner in this endeavour, for its technical and financial contribution.

Maputo, September 2010

Armando Emílio Guebuza
President of the Republic of Mozambique

INTRODUCTION TO THE MDGs

In the beginning of the 90s, the United Nations organised a series of international conferences aimed at the establishment of a common global development agenda. The agenda contained quantitative objectives, with defined deadlines and numerical monitoring indicators. These efforts culminated in the September 2000 meeting, in which 147 Heads of State met and adopted the Millennium Declaration.

The Millennium Declaration is a reassurance of the world leaders regarding their collective responsibility to support the principles of human dignity, equality and justice at global level. The Declaration defines a series of interrelated and mutually reinforcing objectives, and which serve as a basis for a global development agenda. It presents concerns related to peace, security and development, and brings together the areas of the environment, human rights, democracy and good governance, also emphasizing the specific development needs of the African continent. The Declaration recognises that, though the developing countries have the responsibility to introduce policy reforms and to strengthen governance, they will not be able to achieve the objectives without support from the international community, through new aid commitments, fair trade rules and debt relief.

The Millennium Declaration establish the Millennium development Goals (MDG), which constitute a framework for monitoring human development. There are eight main objectives, most of which should be met in the course of a 25-year period (1990-2015):

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a Global Partnership for Development

The countries agreed on a list of 21 targets (previously 14) and 60 indicators (previously 48)[1] to guarantee a common evaluation of MDG progress at global, regional and national level.

[1] Official list of MDG Indicators, effective from 15 January 2008.

This report basically intends to evaluate progress achieved in Mozambique to meet the MDGs and identify the main challenges and priorities for action at policy or implementation level to accelerate the achievement of the millennium goals. Though the MDGs aim at evaluating progress since 1990, in the case of Mozambique there is no comprehensive statistical (i.e., at national scale) and reliable information covering the initial years of the implementation of the MDGs. This is due to the armed conflict suffered by Mozambique until 1992. After the General Peace Agreement, Mozambique was able to start a more comprehensive and reliable statistical data collection process.

This report intends to serve as an instrument for the evaluation of the country 5 years before the end of the implementation of the MDG commitment and also intends to be an instrument of advocacy, awareness-raising, creation of alliances and renewal of the political commitment at national and international level.

The production of the MDG progress report is a collective effort involving all key ministries and institutions and national partners under the leadership of the Ministry of Planning and Development, with the collaboration of the Cooperation Partners and the United Nations Agencies. In addition, it received financial and technical support from the United Nations Development Programme in Mozambique (UNDP).

MOZAMBIQUE: DEVELOPMENT CONTEXT

In 2010, Mozambique completed 35 years of national independence from Portuguese colonial domination, characterised by little colonial investment in the training of local staff as well as in the construction of basic rural infrastructure in the country. In addition to the limited infrastructure left by the colonial machinery, Mozambique was target of successive waves of destruction as a consequence of the 10-year war for independence and the 16-year civil war, which the young country experienced. This history conditioned that at the end of the war Mozambique was considered the poorest country of the world, with an external debt of almost 200% of its Gross Domestic Product (according to World Bank data), with a level of poverty above 80% and a level of inflation of almost 50%. However, the Government of Mozambique, in partnership with the international community, engaged in an uninterrupted economic, social and political rehabilitation of the country. The fruits appeared soon, the economy reached a two-digit growth (one of the highest economic growth indexes of Southern Africa); the external debt was reduced to levels below 35% of GDP; poverty in the country was reduced by more than 15% and inflation was kept at one digit; All these advances were achieved in spite of the country having faced serious flood and drought crises, as well as the global economic crises. These successes reflect the political commitment of a country, which embraced the democratic multiparty system less than two decades ago and which is, however, one of the politically most stable countries of the region. Since the end of the armed conflict in 1992 the country has already held four general presidential and parliamentary elections, two municipal elections and one provincial assembly election. All these elections occurred in a climate of peace and tranquillity.

The reduction of poverty and the promotion of Mozambique's economic development have guided the intervention of the Government of Mozambique, which has demonstrated a serious commitment to the achievement of the millennium targets.

Notwithstanding the governmental commitment and the relative economic success, Mozambique still faces important challenges. Mozambique is still one of the poorest countries of the world (the 172nd country in the 2009 ranking of 182 countries in the Human Development Index of the United Nations); more than half of its population lives below the poverty line; Mozambicans are vulnerable to drought and floods (according to international disaster data, Mozambique suffers from 0.31 droughts and 0.62 floods per year); more than 40% of the State Budget still depends on external assistance; the AIDS epidemic continues a threat to development; the rural infrastructures still need rehabilitation, among others.

In the coming years, Mozambique will need to double its efforts to sustain and increase the successes achieved until now, as well as the challenges of the future.

BRIEF ANALYSIS OF THE SITUATION OF MOZAMBIQUE

In spite of the recent crises the world experienced, namely the financial, the fuel and the food crisis, and the threats resulting from the effects of climate change, Mozambique continued to have relatively strong economic growth and a robust macroeconomic structure. The growth of the Gross Domestic Product in each one of the last five years was above 6.5%, economic inflation reached its level lowest of the decade (3.75% in 2009) and the State reached an important milestone on the road to financial autonomy when for the first time in the recent history of Mozambique more than half of the State Budget is financed by the country's own funds.

Table 2: Macroeconomic Indicators

Indicator	1997	1998	1999	2003	2004	2005	2006	2007	2008	2009
Real GDP growth (%)	11.1	12.8	8.4	6.5	7.9	8.4	8.7	7.3	6.8	6.4
Inflation (%)	7.4	1.5	2.9	13.5	12.6	6.4	13.2	8.2	10,3	3,3
GDP *per capita* (USD)	235.8	253.0	260.4	256.9	301.6	334.5	352.8	398.7	476.9	453.8

Source: INE

The above mentioned successes happened despite the strong challenges imposed by the continuing poverty the Mozambican people live in; the relative weak financial capability by the Mozambican state; the effects of flooding and drought the country suffered in multiple occasions through the past decade and the effect of HIV/AIDS epidemic among others.

According to results from "Inquerito Demográfico de Saúde" (IDS) 2003 and the Multiple Indicator Cluster Survey (MICS) 2008 the prevalence of low weight in under-fives in Mozambique decreased from about 26% in 1997 to 18% in 2008; the enrolment rate in primary education increased from 44% in 1997 to 77.1% in 2008; the under-fives mortality rate decreased from 201 in 1000 live births in 1997 to 138 in 1000 live births in 2007. It should be pointed out that for this indicator, in the case of under-fives mortality, the improvement in the rural areas exceeded that of the urban areas: 7% against 1.5%. There was a decrease of 5% in the rates of malaria, respiratory diseases and diarrhoea.

In spite of these advances it should be recalled that that are several challenges still ahead. In spite of the child mortality rate having decreased, they are still very high. Additional efforts are necessary; The HIV/AIDS pandemic challenge is still threatening to undermine the gains until now achieved in the economic and socio-political field. The combination of the country's vulnerability to climate disasters, the

relative weakness of the national infrastructure and the effects of climate change remind us that Mozambique must work much harder to consolidate the gains achieved and to approach the Millennium Development Targets.

Table 3: Key Development Indicators

SELECTED INDICATORS	1997					2003					2007/8					2015
	Total	Urban	Rural	Men	Women	**Total**	Urban	Rural	Men	Women	Total	Urban	Rural	**M**	**W**	**Targ.**
Indicator of the MDG Targets																
1. Proportion of population living below the national poverty line (%)	**69.4**	62.0	71.3	69.9	66.8	**54.1**	51.5	55.3	51.9	62.5	**54.7**	49.6	56.9	53.9	57.8	**40.0**
2. Ratio of employed people to total population (%)											**74.6**	58.2	83.4	72.2	77.6	**100**
3. Underweight children under 5 years of age, %)	**26.1**	14.8	30.7	26.5	25.6	**23.7**	15.2	27.1	24.7	22.6	**17.5**	12.9	19.4	19.9	15.2	**17.0**
4. Primary schooling completion rate (%)	**22.0**	n/a	n/a	n/a	n/a	**38.7**	n/a	n/a	n/a	35.4	**77.1**	-	-	84.6	73	**100.0**
5. Ratio of girls to boys in EP1	**0.71**	n/a	n/a	-	-	**0.83**	n/a	n/a	-	-	**0.89**	n/a	n/a	n/a	n/a	**1.00**
6. Proportion of seats held by women in National Parliament										28					38.2	**50.0**
7. Under-five mortality rate (per 1,000 live births)	**245.3**	174.2	270.9	257.7	232.9	**153**	143	192	181	176	**147.2**	117.1	156.2	155.3	138.5	**108**
8. Proportion of 1 year-old children vaccinated against measles (%)	**55**	85.3	69.6	75.1	73.1	**63**	83.1	54.3	61.4	64.8	**58**	85.3	69.6	75.1	73.1	**95.0**
9. Maternal mortality rate (per 100,000 live births)	**692**	n/a	n/a	-	-		n/a	n/a	-	-	**500.1**					**250**
10. Deliveries attended by skilled health personnel (%)	**44.2**	81.4	33.9	-	-	**47.7**	80.7	34.2	-	-	**55.3**	78.9	46.3			**66.0**
11. Prevalence of HIV/AIDS among adults (15-49 years, %)	**8.6**	n/a	n/a	n/a	n/a	**9.3**	n/a	n/a	n/a	n/a	**11.5**					**n/a**
12. Land area covered by forests (%)	**21**	n/a	n/a	-	-	**n/a**	n/a	n/a	-	-	**51.0**	n/a	n/a	-	-	**n/a**
13. Population with access to improved water source (%)	**37.3**	30	40.3	-	-	**36.2**	36	36.3	-		**42.2**	40	43.2	-	-	**70.0**
14. Population with access to improved sanitation (%)	**29.0**	38	25.3	-	-	**44.8**	71.7	33.4	-	-	**42**	47.3	39.0			**50.0** (rural) **80.0** (urb.)-
15. Net development assistance received as percentage of GDP						**25.2**					**18.3**					
16. Debt service (% of exports of goods and services)	**21.7**					**3.9**					**1.87**					
Other Indicators																
17. Size of the population (million)	**16.1**	4.6	11.5	7.7	8.4	**18.5**	5.6	12.9	8.9	9.6	**21.2**	6.5	14.7	10.2	10.9	**-**
18. Annual population growth rate (%)	**2.3**	3.4	1.9	n/a	n/a	**2.4**	3.3	2.0	n/a	n/a	**2.4**	-	-	-	-	**-**
19. Gini Coefficient [income inequality]	**0.40**	n/a	n/a	-	-	**0.42**	n/a	n/a	-	-						**-**
20. Life expectancy at birth (average no. of years)	**42.3**	48.8	40.2	40.6	44.0	**46.3**	50.1	44.9	44.4	48.2	**51.3**	52.0	50.3	49.8	54.3	**-**
21. Adult illiteracy rate (15 years and above, %)	**39.5**	67.0	27.8	55.4	25.9	**46.4**	69.7	34.3	63.3	31.2	**49.7**	75	37.2	65.5	35.9	**-**
22. Net enrolment rate in EP1 (%)	**44.0**	n/a	n/a	49.0	39.0	**69.4**	n/a	n/a	72.4	66.4	**64.5**	72.5	61.2	67.2	62.1	**100.0**

Source: INE, MICS 2008

GOAL 1 – ERADICATE EXTREME POVERTY AND HUNGER

Rapid Assessment	Situation in Numbers				
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2009**	**2015**
Potentially	Proportion of population living below the national poverty line	69.4	54.1	54.7	40
Situation of the supportive environment:	Poverty gap ratio	29.3	20.5	21.3	N/A
Strong	Share of the poorest quintile in national consumption	4.0	4.0	3.6	N/A

1.1 REDUCE EXTREME POVERTY:

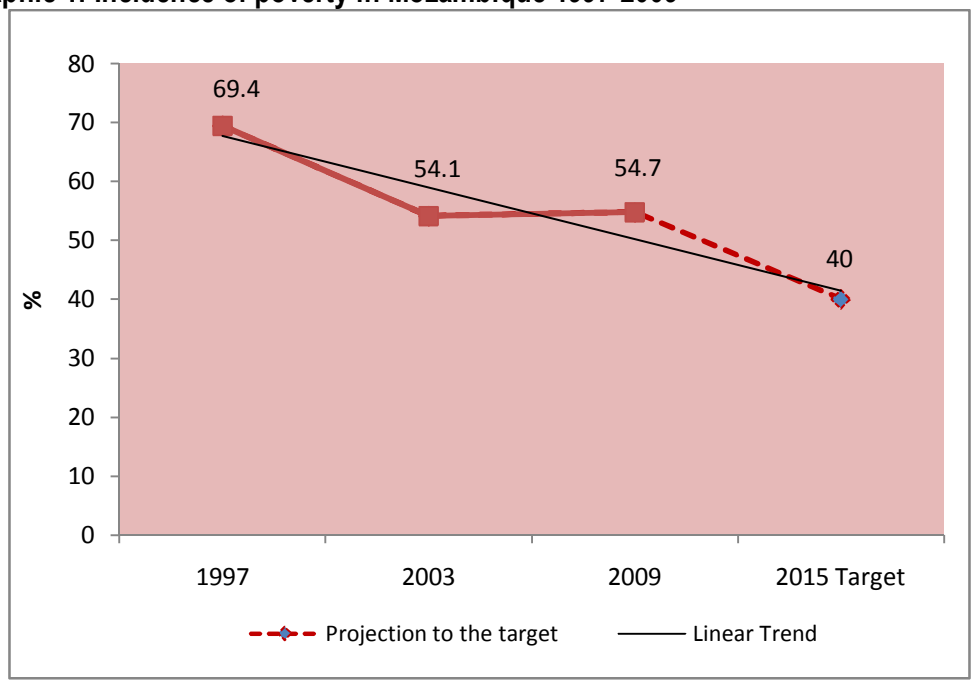
1.1.1 Situation and trends

In 2008/09 the National Statistics Institute carried out the Third National Family Budget Survey (IOF 08/09). The main objective of this inquiry is to update the poverty indexes in Mozambique and thus inform about the current situation of progress against the Millennium Development Goals, specifically about the target related to the percentage of the population living below the poverty line.

The first target of the MDGs aims at reducing to half, by 2015, the number of people living below the poverty line, starting from the 80% level in 1990. This indicator means that the country should reduce the incidence of poverty to 40% in 2015 to achieve the established target. It should be recalled that the objective of the reduction of poverty is expressed in the Action Plan for the Reduction of Absolute Poverty 2006-2009 (PARPAII), in which the country evolved from a strictly monetary vision (in PARPA I) to a more holistic one defining poverty as "*the impossibility due to incapacity or to the lack of opportunity of individuals, families and communities to have access to marginal conditions, according to the basic standards of society*". In this sense, PARPA II established targets for the reduction of monetary poverty with emphasis on consumption, and of non-monetary poverty with emphasis on the components of education, health/nutrition, and property.

Consumption-oriented poverty is estimated by focusing on the incidence of poverty rate, which refers to the percentage of the population living below the poverty line. The incidence of poverty in 2008/09 is estimated at 54.7% of the population at national level. This is a reduction of poverty by 12.1 percentage points (pp) compared to 1996/97, when the incidence was estimated at 69.4%. In 2002/03 the poverty incidence rate was 54.1%, which means that between 2002/03 and 2008/09 there were no statistically significant changes in the levels of poverty. The number of people below the poverty line increased from 9.9 million to 11.7 million people, due to the growth of the population, which was 3 million between 2002/03 and 2008/09.

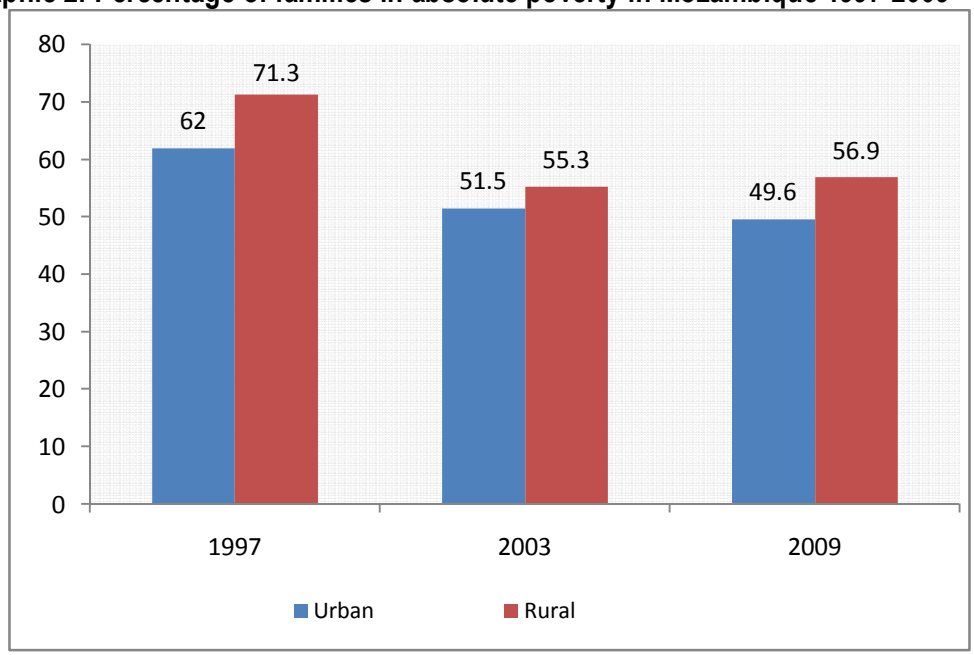
Graphic 1: Incidence of poverty in Mozambique 1997-2009



Source: INE

The structure of rural-urban poverty is quite constant. The rural areas have 56.9% of the population below the poverty line and the urban areas have 49.6% of the population below the poverty line while in 2002/03 rural poverty was 55.3% and urban poverty 51.5%. All regions had a reduction of poverty between 1996/97 and 2002/03, and this continued in 2008/09, except for the central region in which poverty increased by 14.2 percentage points. Currently, the northern region has a lower incidence of poverty, with 46.5% of the population below the poverty line, than the central region with an incidence of poverty of 59.7% and the southern region with 56.9%.

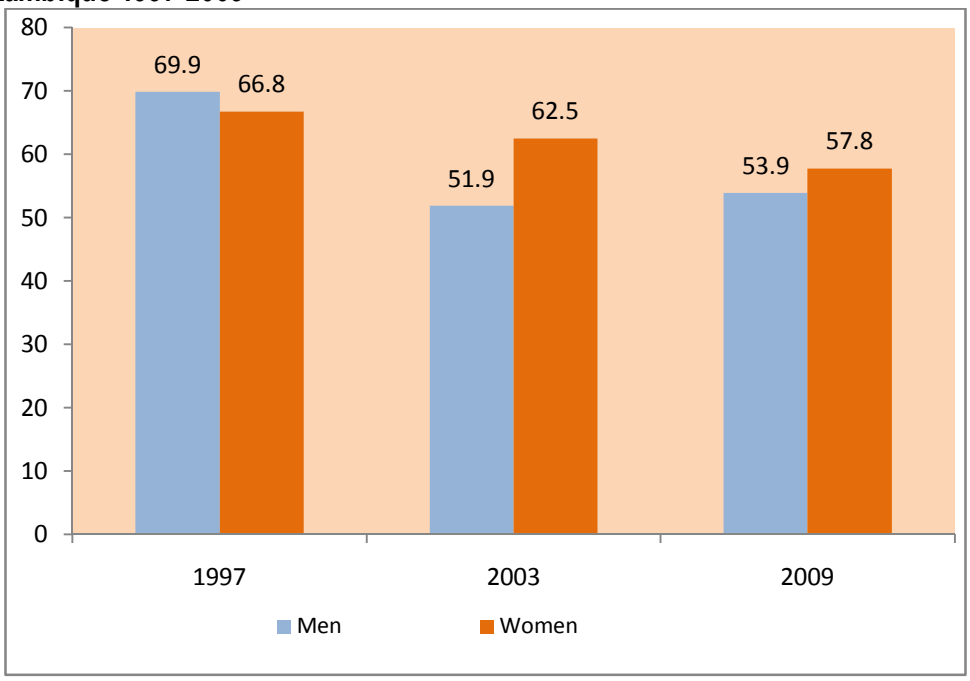
Graphic 2: Percentage of families in absolute poverty in Mozambique 1997-2009



Source: INE

Breaking up the poverty estimates by sex of the household head, variations are observed in the course of the period under analysis. In 1996/7, the families headed by women had a lower incidence of poverty than the families headed by men (69.9% for the families headed by men and 66.8% for the families headed by women). Between 1996/97 and 2002/3, both the families headed by men and those headed by women had a significant reduction of the poverty indexes, while the families headed by men surpassed those headed by women in the reduction of poverty, which resulted in a lower incidence of poverty in 2002/03 in the families headed by men than in those headed by women (52% for the families headed by men and 62.5% for the families headed by women). In the 2008/09 period there was an increase in the incidence of poverty in the families headed by men (from 52% in 2002/3 to 53.9% in 2008/9) and a reduction in the incidence of poverty in the families headed by women, from 62.5% to 57.8%. Even with this reduction of poverty, the families headed by women have higher levels of poverty than those headed by men.

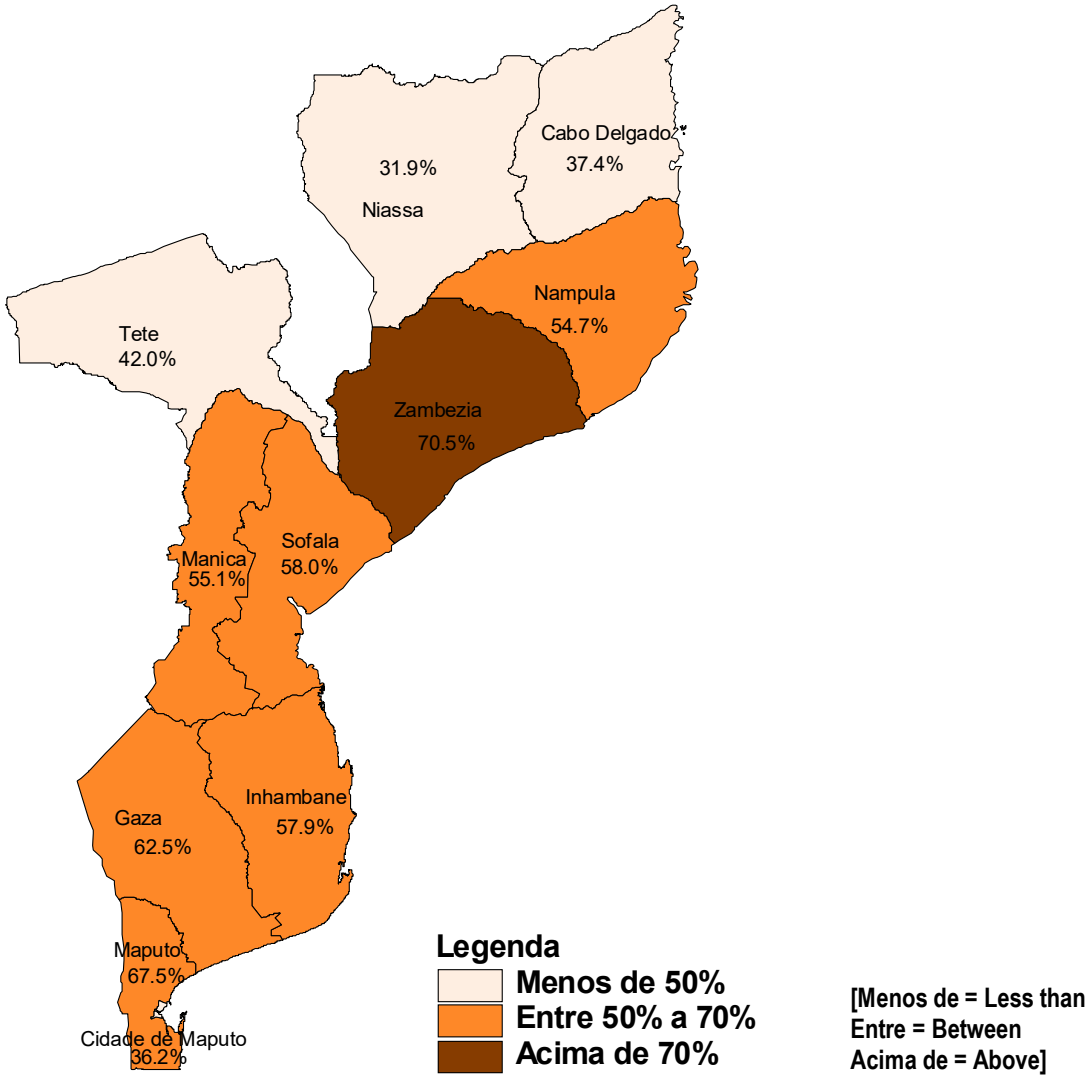
Graphic 3: Percentage of families in absolute poverty by gender of the head of the family in Mozambique 1997-2009



Source: INE

In provincial terms, Niassa, Maputo City, Cabo Delgado and Tete have the lowest rates of incidence of poverty (between 33% and 42%) and Maputo, Zambézia and Gaza Provinces have the highest rates (59% - 70.5%). Though the change in the rate of poverty at national level indicates no change, the rates at provincial level show substantial changes between the two periods.

Figure 1: Incidence of poverty by province in 2009 in Mozambique



National percentage of the population living in poverty: 54.7%
Source: MPD et al, 2010. IOF 2008/09 data

Constraints on the achievement of the targets for 2015

The not very positive results of the poverty analysis arise from a series of facts, including:

- Very low or zero growth rates for agricultural productivity, together with climate shocks (floods, cyclones and droughts). A series of TIA inquiries carried out since 2002 show hardly any sign of

agricultural transformation for the vast majority of producers. This is reflected in the poor growth of food crop production.

- Aggravated terms of trade due to big increases of international food and fuel prices. Fuel prices, particularly, increased substantially during the 2002/03 to 2008/09 period.

- Another possible factor explaining the maintenance of the levels of poverty at national level, and the increase of poverty in the central region, may be the cumulative effect of the HIV/AIDS epidemic. This epidemic is more mature in the central region of the country, and current estimates indicate the occurrence of approximately 300,000 deaths caused by AIDS in this region in the 2004 to 2009 period (INE et al., 2008). However, the economic effects of HIV/AIDS are not well-known, neither in Mozambique nor at international level. As such, more research will be necessary to determine the nature of the short and long-term relations between the epidemic, poverty and economic growth.

These facts contributed to the mitigation of the rates of poverty reduction in the north and south and to increase poverty in the centre. Succinctly, during most of the period of the IOF08 inquiry, the Mozambican population suddenly experienced the limited availability of locally produced food, very high cost of food imported from the international markets, and still higher fuel costs, which made the distribution of imports and the transport from areas with surplus production to areas with shortages substantially more expensive. Given that about three quarters of poor families' expenses for consumption is for food, these facts are definitely pertinent.

Challenges for the achievement of the targets for 2015

Notwithstanding the maintenance of the poverty indexes in the 2003-2009 period, the aim to meet the millennium target continues feasible. In the second half-year of the IOF08/09 inquiry, which was essentially based on the 2009 harvest, the measured rate of poverty was 52%. Even without the gains in agricultural productivity, the rate of poverty appears to decrease by about 1% per year. This puts the best estimate for the rate of poverty in the middle of 2010 at about 48%. In spite of the results obtained between 2003 and 2008, it is believed that Mozambique still has the possibility to achieve the millennium target. For the achievement of this target it is necessary to reduce the poverty indexes in the next 5 years by 14

percentage points. Looking at the 1997 to 2003 period, the country was able to reduce the poverty indexes by 16 percentage points, which encourages the achievement of the target in 2014.

Positive factors of progress in the Indicators

The Government is engaged in the improvement of the living conditions of the population. This commitment is demonstrated by the massive investment in the areas of education, health and the supply of safe drinking water. The decentralization of resources to the districts and the consequent creation of the District Fund represent the Government's effort in strengthening the districts as poles of development.

The financial support provided by the G-19 and other Government partners is also an important factor of progress in the indicators.

1.2 GUARANTEING EMPLOYMENT

Table 4: Rapid assessment and employment situation in Mozambique

Rapid Assessment	Situation in Numbers			
Will the target be met?	**Indicator / Year**	**1997**	**2005**	**2008**
No data	Employment to total population ratio	n/a	74.6	n/d
	Proportion of own-account people of the total of people employed in the country.	n/a	62.1	n/d
Situation of the supportive environment				
Poor but improving	Rate of unemployment	n/a	18.7	n/d

n/a = Not available

1.2.1 Situation and trend

According to the 1997 census data, in 1997 the economically active population in Mozambique was about 5.9 million people, the majority of whom self-employed workers (52%) and unpaid family workers (33.7%); 11.1% were employed, of whom 4.1% in the public sector and 7% in the private sector. However, in 2005 the rate of unemployment calculated through the Labour Force Survey (IFTRAB), carried out in 2004/2005, was 18.7%. Because IFTRAB 2004-2005 was the only official inquiry to employment carried out in Mozambique, it is not possible to make objective statements about the unemployment trend. However, employment data obtained annually from administrative sources indicate a continuous increase of jobs annually generated by the national economy. However, to what extent these jobs are respectable cannot

be determined insofar as this data results from the monitoring of job quality. A Survey on the quality of employment is urgent, as well as the creation and strengthening of employer and worker associations as partners of the State, which can guarantee permanent monitoring of the situation.

According to administrative data in the 2005 to 2009 period a total of 924,168 new jobs were created. The total number of new jobs created annually was 64,399 in 2005, 71,060 in 2006, 154,988 in 2007, 247,256 in 2008 and 385,732 in 2009. These data represent a successive growth of 10.34% in 2006, 118% in 2007, 59.5% in 2008 and 55% in 2009, compared to the previous year.

Table 5: Summary of the evolution of employment according to administrative data

INDICATOR	2005/2009		
	Men	Women	Total
Posts created	49,393	12,638	**62,031**
Direct admissions	121,047	35,083	**156,130**
Employment, Self-employment Promotion + Production Associations + F.P. - (INEFP)	155,704	65,957	**221,661**
Local Initiative Investment Budget (OIIL)	74,208	155,971	**230,179**
Recrut. for the mines in the RSA	220,947	**a)**	**220,947**
Recrut. for farms in the RSA	33,220	**b)**	**33,220**
TOTAL	**654,519**	**269,649**	**924,168**

Source: INEFP/DPTRAB

a) Women are not recruited for the mines in the RSA.
b) No data distribution by gender.

In comparison to the targets defined in PARPA II, the total number of jobs registered is 924,168, exceeding the planned target (900,000) by about 2.4%. Of the total number of jobs registered in the course of the five years (2005-2009), the main contribution came from the Local Initiative Investment Budget (OIIL), namely 230,179 jobs, representing 25%, followed by self-employment/production associations with 221,661 jobs, representing 24.1%.

The data presented show a progressive growth trend year after year of the number of jobs created insofar as, in spite of a slight decrease of the recruitment for the minas in the Republic of South Africa (RSA), growth in the other indicators presented was sufficient to compensate the decrease observed.

If the current dynamics of the performance of the economy in terms of job creation and actions taken for employment promotion and job creation in general, the target of the Employment and Professional Training Strategy, which is 1,000,000 Employment and Professional Training beneficiaries by 2015, may be exceeded by more than 100%.

Another factor that may contribute to the fact that the target is significantly exceeded is the progressive improvement of the capacity to collect information about the labour market, from district level, which somehow will increase the number of jobs registered by the employment services.

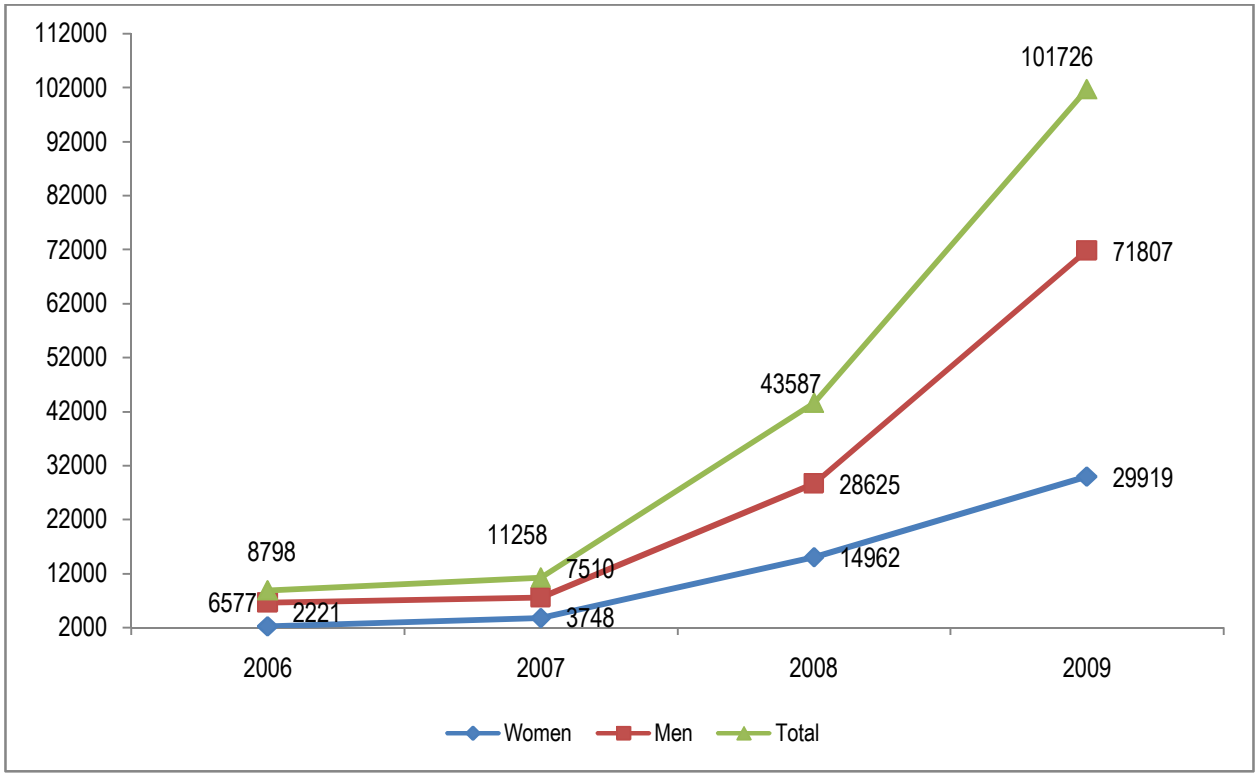
Though there is no information for 2010 about the percentage of women doing paid work in the non-agricultural sector, it should be mentioned that big differences between women and men regarding access to employment persist. For example, 10,971 jobs were created in 2009 in the scope of employment promotion in the provinces, 6,969 of which benefited men and only 3,948 benefited women (PES 2009 Review, p.122).

Concerning the private sector the situation is the same. Women represent only 21.4% of the 57,826 direct admissions by private companies (PES 2009 Review, p.122). The representativeness of women in Parliament is 39.2%. This percentage reflects an increase of about 1% compared to the 2004-2005 mandate.

1.2.2 Professional Training

Professional training for employment and self-employment has various stakeholders, both in the public sector and in the private sector. Thus, in the 2005 to 2009 period, 171,288 beneficiaries, of whom 119,350 men and 51,938 women, were trained at national level in various professional training courses.

Graphic 4: Evolution of Professional Training in Mozambique



Source: INEFP

From 2005 to 2006 there was a growth of 48.6% and from 2006 to 2007 it was 28%. This growth was due to the consolidation of professional training actions in the scope of the implementation of the Employment and Professional Training Strategy (EEFP). From 2007 to 2008 there was a growth of 287.2**%** and from 2008 to 2009 it was 133.4**%.**

Table 6: Percentage Evolution of Professional Training

Growth	
Year	**%**
2005-2006	48.6
2006-2007	28.0
2007-2008	287.2
2008-2009	133.4

Source: Ministry of Labour

The total number of 171,288 beneficiaries of professional training registered represents an achievement of about 66% of the target of 260,000 beneficiaries planned for the 1st phase of the implementation of the EEFP, which ends in 2010. Another 88,712 people should be trained to achieve the

target. Considering the level of growth of the performance registered and the achievement in 2009, everything indicates that the target will be met and exceeded.

Constraints on the achievement of the targets for 2015

In the scope of the implementation of the Employment and Professional Training Strategy 2006-2015, the target is to create one million jobs. More than the number of jobs created, the country's target is to create an institutional and participatory labour market management mechanism, which allows decision-making and starting actions that guarantee a balanced labour market and the mitigation of the phenomenon of unemployment and its effects. Starting from this presupposition the following constraints should be considered:

- Lack of resources for job creating investment;
- Weak trade unions in terms of technical capacity and coverage;
- Deficient information system for the labour market (collection, processing and dissemination of information about the labour market);
- Lack of resources for the development of professional training actions that promote the employability of the national human resources and improve their productivity;
- Incapacity to determine the quality of the created jobs, to allow the definition of actions for their improvement.

Challenges for the achievement of the targets for 2015

For the achievement of the targets for 2015 in the sphere of employment, the following challenges should be considered:

- Definition of strategies that allow giving priority to investment for labour-intensive industries;
- Strengthen the mechanisms for the promotion of and support to the development of small and medium enterprises;
- Create and finance the Employment Promotion Fund, which finances employment promotion programmes in the urban areas;

- Continue with the consolidation and operationalization of the District Development Funds, allowing the financing of economic activities in the rural areas, particularly in the districts;
- Continue with the creation of an information collection, processing, analysis and dissemination system for the labour market, including the employment observatory;
- Continue with the reform of professional education and guarantee the financing of technical and professional training programmes;
- Strengthen the partners' technical and negotiation capacity and their participation in the implementation of a national respectable employment promotion programme;
- Increase the capacity of the employers' and workers' organisations and of the public sector, to enable them to monitor fully the labour market to guarantee compliance with the employment quality and safety standards.

Positive factors of progress in the indicators

We consider, among many others, the following as being the main positive factors of progress in the indicators:

- The start of the creation of a labour market information system and the employment observatory;
- Creation of the Small and Medium Enterprise Institute;
- Start of the implementation of Professional Education reform;
- Creation of the District Development Fund, which will effectively proceed with the promotion of employment and economic development at district level, started with the implementation of the Local Initiative Investment Budget;
- Public-private partnership for local development through the Local Development Agencies (ADEL);
- Expansion of banking activities at district level;
- The acceptance by the private sector and by civil society of their role of socio-economic development engine favours the occurrence of the multiplier effect of investment and job creation.

1.3. REDUCING HUNGER:

Table 7: Rapid assessment and situation of hunger in Mozambique

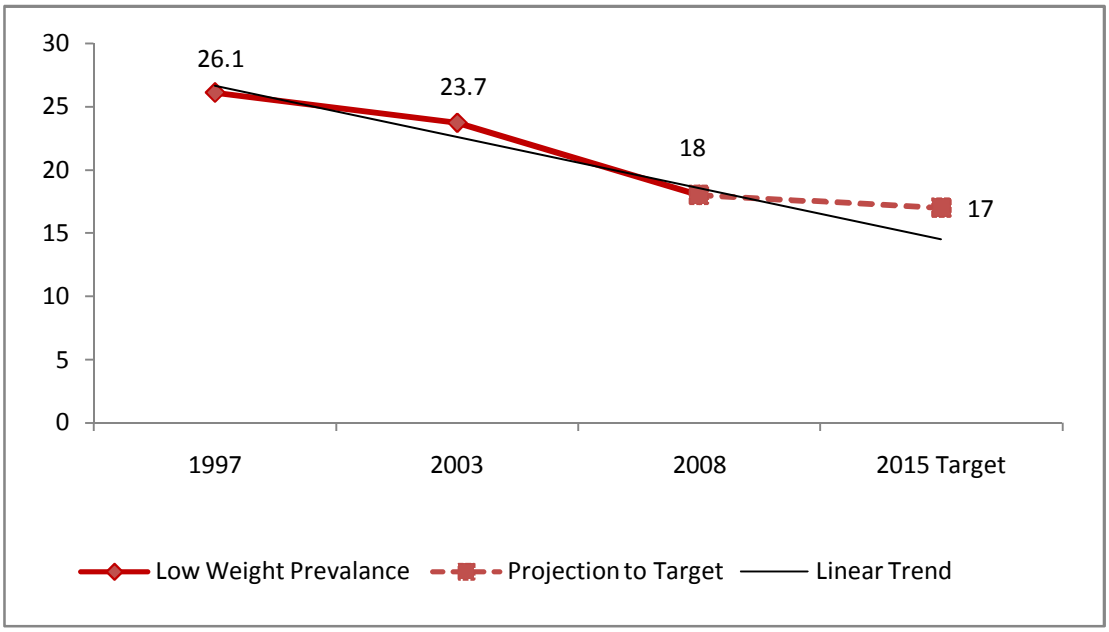
Rapid Assessment	Situation in Numbers				
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2008**	**2015**
Probably	Rate of prevalence of underweight children (under-fives)	26.1	23.7	17.5	17.0
	% moderate and severe acute malnutrition in children (under-fives)	7.9	5.0	4.0	n/d
Situation of the supportive environment					
Strong	% moderate and severe chronic malnutrition in children (under-fives)	35.9	47.7	44.0	n/d

1.3.1 Low Weight-for-Age: Situation and trends

The Percentage of Low Weight-for-Age, one of the indicators of nutrition surveillance, reflects the level of nutritional health in under-fives. The percentage values of moderate and severe low weight-for-age are still above the acceptable level (of 16%) and the target (17%) defined for 2015. The IDS results since 2003, recalculated on the basis of the WHO standard population for 2006 show a gradual downward trend of the percentage of under-fives, in spite of considerable differences between the IDS data for 2003[2] (20%) and those of SETSAN 2006[3] (25.5%). Between 2003 and 2008 this percentage decreased by about 5.7 %, reaching 18 % in 2008. Evidence from several countries shows that babies with low weight at birth (less than 2,500 gram) are more likely to die in their infancy than babies with more weight. The data of the Multiple Indicator Survey (MICS 2008) show that 58% of the newborn babies were weighed at birth and the weight of 50 % of them was below 2,500 grams. According to graphic 5, from 1997 to 2008 the rate of prevalence of low weight in under-fives has gradually decreased in the country. While the rate of prevalence of low weight in under-fives was 26.1% in 1997, it decreased to 23.7 % in 2003, which corresponds to a rate of decrease of 0.6% per year. From 2003 to 2008 the rate decreased to 18%, which corresponds to a rate of decrease of 1.14% per year. With these levels of decrease the country has accelerated the rate of reduction of the prevalence of low weight in under-fives and is on the road to meeting the target of the millennium goal (17%) before 2015.

[2] The IDS 2003 data were recalculated on the basis of the WHO standard population for 2006.
[3] Baseline Study of Food Security and Nutrition, September 2006 - SETSAN (use of CDC/WHO 1997 reference model)

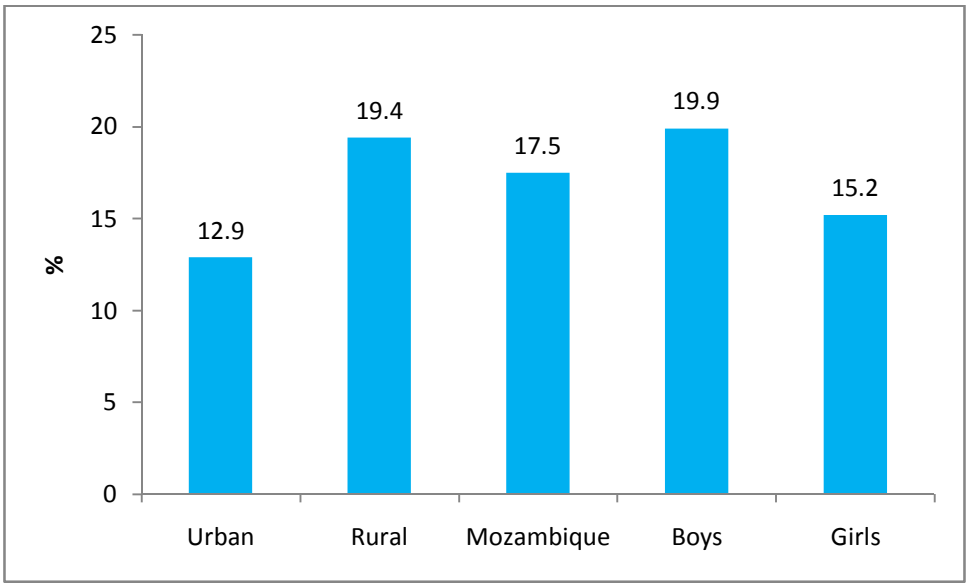
Graphic 5: Rate of prevalence of low weight in under-fives in Mozambique 1997-2008



Source: Ministry of Health

Graphic 6 shows the levels of prevalence of the occurrence of low weight in under-fives by sex and by area of residence (rural/urban) of the country's under-fives. The graph shows that the rates of prevalence of low weight in under-fives in Mozambique are in general doing well. The national average of the prevalence of low weight in under-fives is 17.5%, as target for 2015. However, looking at the children by sex and area of residence we observe that though the national average approaches the national target, there are still subgroups of under-fives with a prevalence of low weight above the national average. The under-fives living in rural environments and the male under-fives have rates of prevalence of low weight above the national average while the under-fives living in urban environments and the female under-fives in Mozambique have rates of prevalence of low weight below the national average. This suggests that for these two groups the millennium target has already been met.

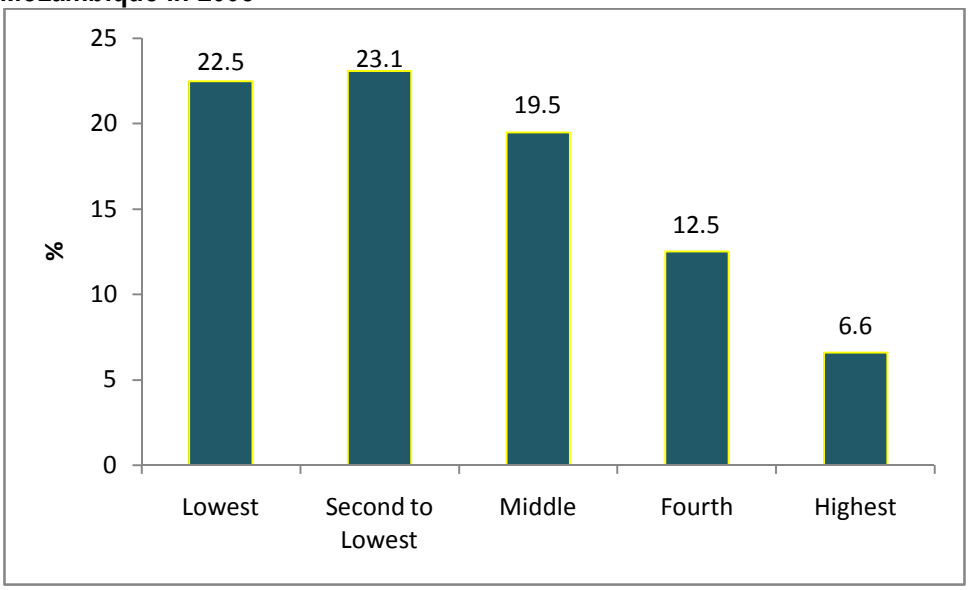
Graphic 6: Rate of Prevalence of low weight in under-fives by region and by sex in Mozambique in 2008



Source: MICS 2008

Looking at the occurrence of low weight in under-fives by their families' wealth quintile, we observe that the level of wealth of the families in which the children live seems to play an important role in their nutritional status. The occurrence of low weight in under-fives is inversely related to the wealth quintile to which their families belong. With the exception of the cases of the two lowest wealth quintiles, the richer the family is, the lower the rate of occurrence of cases of under-fives with low weight. It is also noted that the three lowest wealth quintiles in the country have a prevalence of low weight in under-fives above the national average.

Graphic 7: Rate of prevalence of low weight in under-fives by the wealth quintile of their families in Mozambique in 2008



Source: MICS 2008

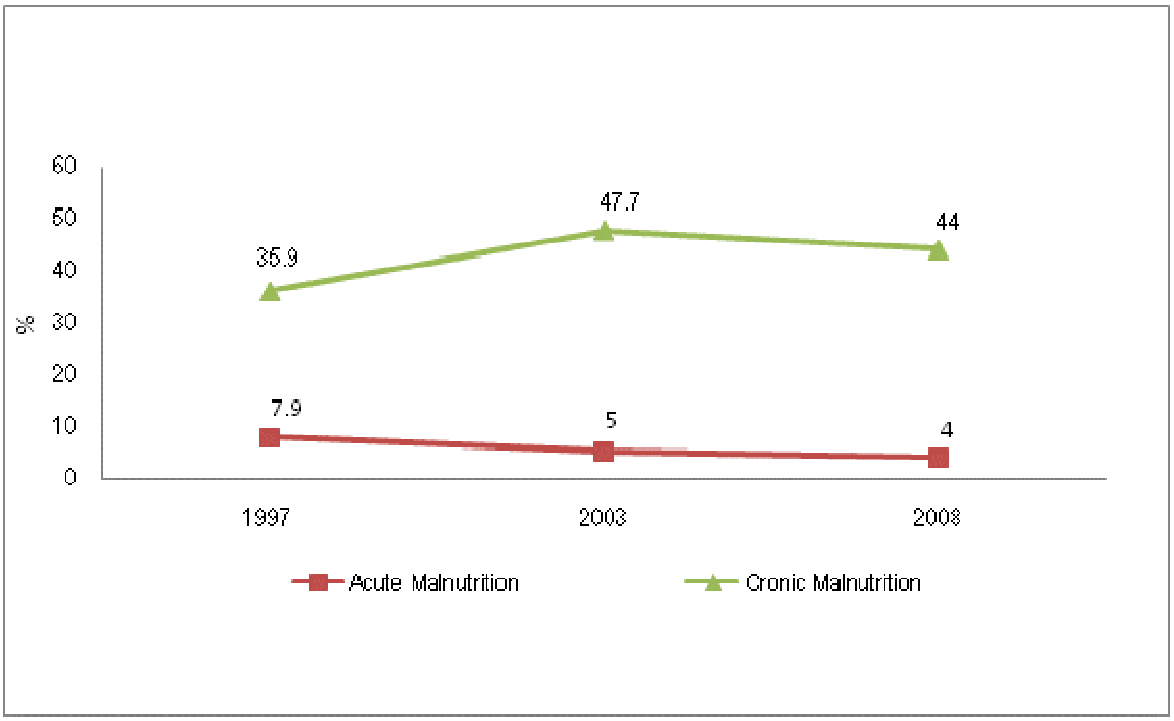
1.3.2. Chronic Malnutrition: Situation and trends

Chronic malnutrition or low height-for-age defines a situation of persistent deprivation of food and is caused by chronic or repeated infections or by inadequate nutritional consumption (SETSAN, 2008). A good nutritional status has a positive influence on the children's health status, immunological status and motor and cognitive development.

According to the Multiple Indicator Survey (MICS 2008) carried out by the National Statistics Institute (INE) there is some improvement in the nutritional status of the under-fives in Mozambique. However, according to the classification of the World Health Organisation (WHO) the levels of child malnutrition, especially chronic malnutrition (low height-for-age), continue very high.

The prevalence of chronic malnutrition in preschool children in Mozambique increased from 35.9% in 1997 to 47.7% in 2003, and started to decrease from 2003 to 2008 at a rate of 0.74% per year. This means that, if performance continues the same, by 2015 the rate of malnutrition in under-fives in Mozambique will be 42.5%.

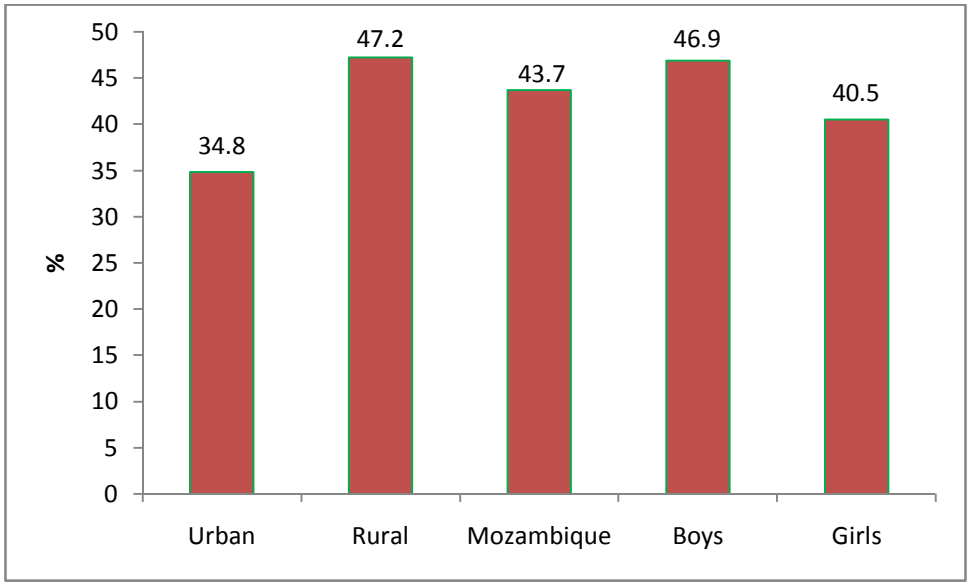
Graphic 8: Rate of prevalence of acute and chronic malnutrition in under-fives in Mozambique 1997 - 2008



Source: IDS 1997, 2003; MICS 2008

The incidence of chronic malnutrition in under-fives in 2008 in Mozambique was 44%, and was higher in rural environments (47.2%) than in urban environments (34.8%). It was also higher in boys (46.9%) than in girls (40.5).

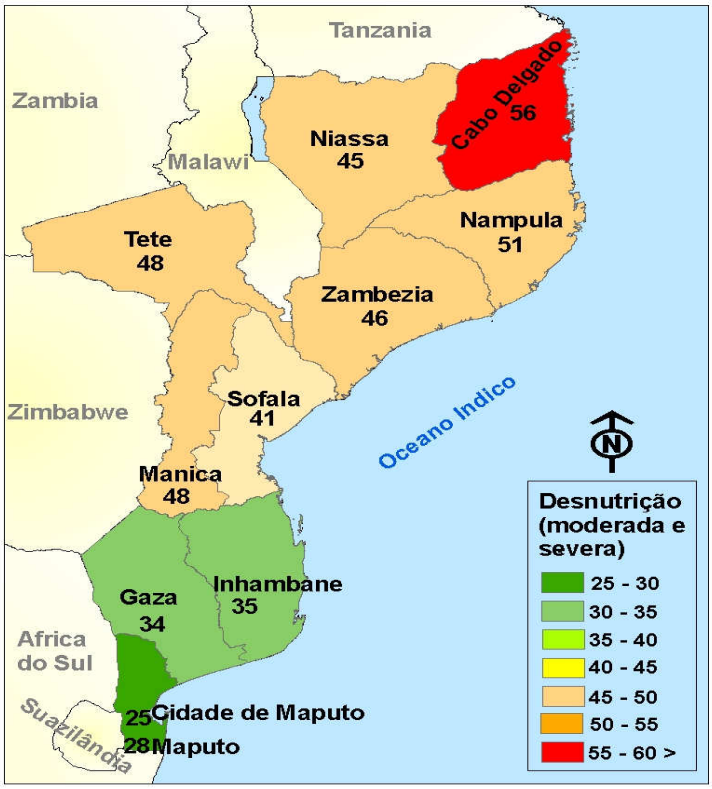
Graphic 9: Rate of prevalence of chronic malnutrition in under-fives in Mozambique by area of residence and by sex in 2008



Source: MICS 2008

Looking at the distribution of chronic malnutrition according to the administrative division of the country, the MICS 2008 data show that the distribution of under-fives suffering from chronic malnutrition in Mozambique follows a north-south geographical tendency. The southern provinces of the country tend to have a lower percentage of under-fives with chronic malnutrition than those of the centre, and the central provinces tend to have a lower percentage of under-fives with chronic malnutrition than the northern provinces of the country (with the exception of Niassa). The two provinces with a lower percentage of under-fives with chronic malnutrition are the country's capital (Maputo City), with 25%, and Maputo Province, with 28%. The provinces with the highest percentages of under-fives suffering from chronic malnutrition are Cabo Delgado, with 56%, followed by Nampula Province with 51%. It should be noted that Nampula Province, the most densely populated province of Mozambique, has the second worst percentage of under-fives with chronic malnutrition. This shows that, though the country in general has a good level of performance concerning the achievement of the MDG target for the reduction of the prevalence of malnutrition in under-fives, important challenges still persist in the distribution of these results over the country's provinces.

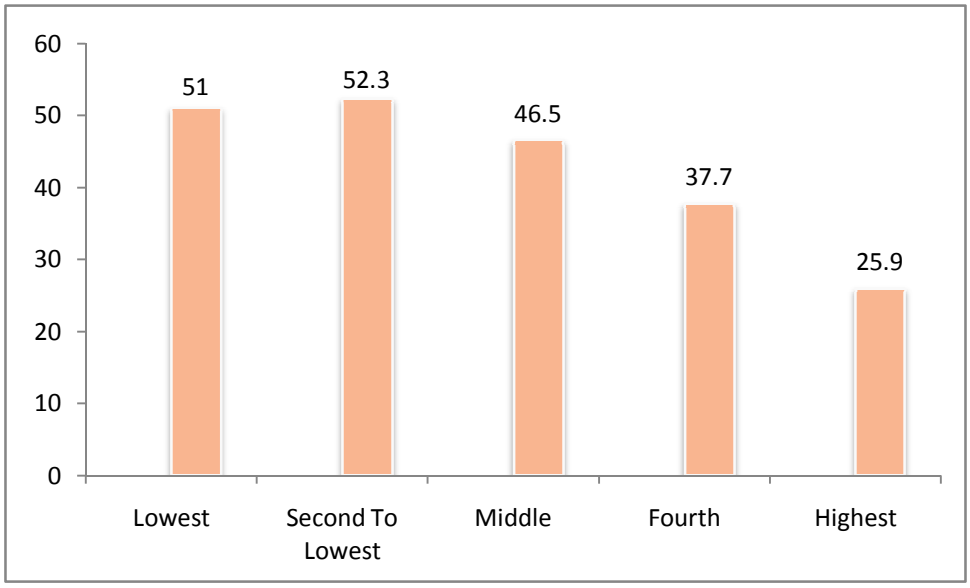
Figure 11: Percentage distribution by province of the prevalence of chronic malnutrition in under-fives in Mozambique, 2008



Source: MICS, 2008

When the wealth of the children's families is taken into consideration, we observe that chronic malnutrition of under-fives is worrisome in the poorer families, in which chronic malnutrition of under-fives is over 50%. Even in the higher wealth quintiles, the rate of low height-for-age in under-fives in 2008 was approximately 26%. These results occur even though the Mozambican economy has shown notable growth, which means that the Government has to adopt measures for reducing the high rates of chronic malnutrition, which go beyond the eradication of absolute poverty.

Graphic 10: Rate of prevalence of chronic malnutrition in under-fives by their families' wealth quintile in Mozambique in 2008



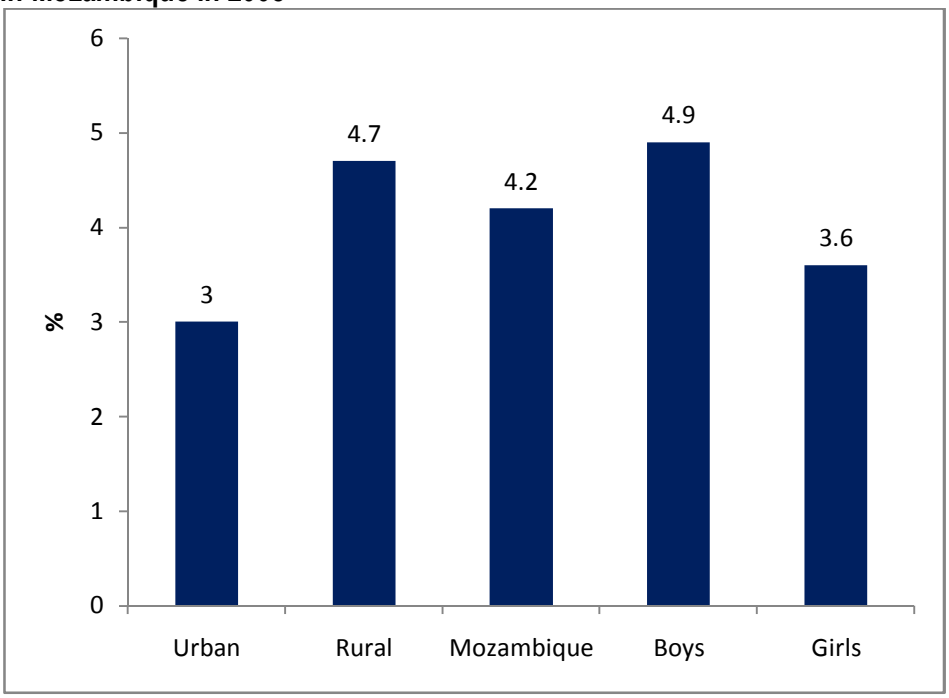
Source: MICS 2008

1.3.3. Acute Malnutrition: Situation and trends

Acute malnutrition, or low weight-for-height, indicates a deficit of muscle mass in relation to the expected amount in a child with the same height. This situation is caused, among other factors, by a low level of food consumption and can be moderate or severe (SETSAN, 2008). The results of the MICS 2008 Survey show that the levels of moderate and severe malnutrition in under-fives decreased from 7.9% in 1997 to 5% in 2003 and 4% in 2008, as referred to by the 2003 IDS (after adjustment to the same 1997 population base and the new World Health Organisation curves) and MICS 2008. Concerning the rate of acute malnutrition in under-fives in Mozambique, it is observed that it has been decreasing smoothly from 1997 to 2008. In this period Mozambique decreased 3.9%.

Acute malnutrition in under-fives in Mozambique seems to be a phenomenon affecting more the rural environment (4.7%) and boys (4.9%). These 2 groups have higher percentages of prevalence of acute malnutrition in under-fives than the national average (4.2% in 2008).

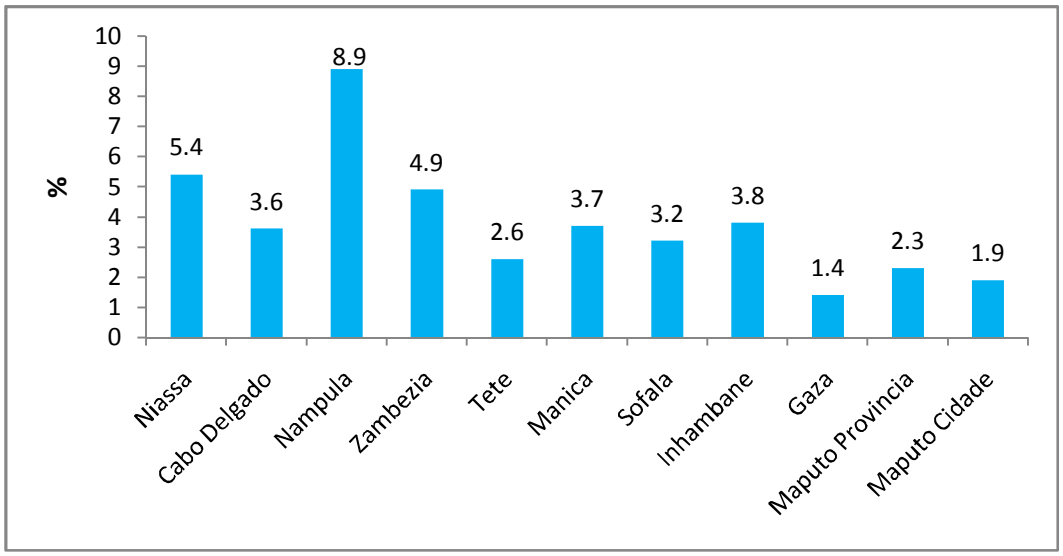
Graphic 11: Rate of Prevalence of acute malnutrition in under-fives by area of residence and by sex in Mozambique in 2008



Source: MICS 2008

Comparing the provinces of the country it is observed that Gaza Province and Maputo City have the lowest percentages of prevalence of acute malnutrition in under-fives, with rates of prevalence of 1.4% and 1.9% respectively while Nampula Province (the most densely populated of the country) has the highest rate of prevalence of acute malnutrition in under-fives, namely 8.9%. Niassa, Nampula, and Zambézia Provinces have higher percentages of chronic malnutrition in under-fives than the national average of 4%.

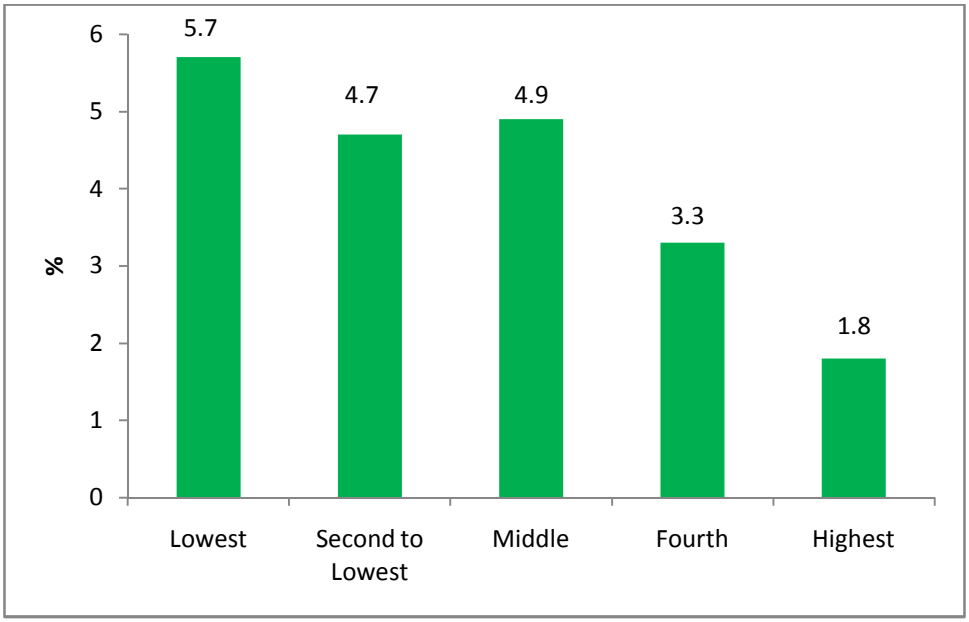
Graphic 12: Rate of Prevalence of acute malnutrition in under-fives in Mozambique by province in 2008



Source: MICS 2008

The occurrence of acute malnutrition in under-fives in Mozambique is positively correlated to the level of wealth of the children's household. The poorest families have higher levels of prevalence of acute malnutrition; the richer the child's family, the lower is the prevalence of malnutrition. It should be noted that only in the two highest wealth quintiles the rate of prevalence of acute malnutrition in under-fives is below the national average of 4%.

Graphic 13: Rate of Prevalence of acute malnutrition in under-fives by their family's wealth quintile in 2008



Source: MICS 2008

1.3.4 Food Consumption: Situation and trends

The Food Consumption Score[4], proxy indicator of the quality of the diet, shows that the situation tends to improve. It is noted that in the harvest period (March-April) the quality of the diet is better than in the period preceding the next agricultural campaign. In the harvest period 48-61% of the households (HHs) has had adequate food, 20-30% moderate food and 18-24% low-quality food. In the period preceding the next agricultural campaign (September-January), when food reserves are reduced or exhausted, the quality of the diet decreases, with 30-65% of the HHs having adequate food, 15-28% moderate food and 8-54% of the HHs having low-quality food, however with a large variation of food consumption (SETSAN/GAV, 2009; CHS/WFP, 2010)[5].

Recent data show that on average the families have had three meals per day, however in the period of food shortages (December to March) this frequency tends to go down to 2 or even 1 meal per day

4 "Food Consumption Score" (FCS) measures the "Quality of the Diet", proxy indicator of Food Security in PARPA II, by the type and frequency of consumption of the food groups, resulting in a low (<21), moderate (21- 35) or adequate (> 35) food consumption classification; adapted from FANTA (Classification of the Food and Nutrition Technical Assistance).

2. Vulnerability Analyses 2009 and Baseline Study SAN (Sep 2006) – SETSAN; Community and Household Surveillance System (CHS), World Food Programme (WFP) - Mozambique, March 2010.

(SETSAN/GAV, 2009). According to the same source, the quality of the HHs' diet is quite rich in cereals, vegetables and tubers. It is however necessary to double efforts to accelerate the improvement of the diversity of the Mozambican population's diet, which can to a large extent be done through the increase of agricultural production and productivity.

In general, the INE data show that food expenses consume on average 60-65% of the family budget. However, in 2009 food expenses were about 56% of the rural HHs' total expenses. The relative reduction in food expenses was to a large extent due to the high food prices and the reduction of food reserves, mainly for HHs with low food consumption and low income (SETSAN/GAV, 2009).

It is assumed that the Food Security and Nutrition (SAN) situation, particularly the quality of the diet, deteriorates due to the increase of the prices of basic products occurred in the last few years, with a tendency to aggravate, particularly in the period of food shortages, from October to February, due to the decrease of the availability of food in that period. The analysis shows that the populations in the urban areas and in the south of the country are the worst affected by the increase of basic food prices, as these groups depend more on the market for buying food.

After the peak prices in 2005 due to low production in the 2004/05 agricultural campaign, the 2006/07 and 2007/08 agricultural campaigns were characterized by normal variations of cereal prices, essentially due to good agricultural production boosted by the implementation of the Action Plan for Food Production (PAPA). In the 2008/09 agricultural campaign there was a marked increase in the prices of agricultural products, particularly of maize and beans due to the effects of the drought that was felt in the central and southern regions of the country. As a consequence, it was observed in several markets that the average price in June 2008 was almost double the average in June 2007[6].

Constraints on the achievement of the targets for 2015

- Apparent weak coordination of the interventions to combat chronic malnutrition.
- Apparent ineffectiveness of the interventions to combat chronic malnutrition and to reach the most vulnerable rights holders.
- Low agricultural, animal and fish production and productivity, which contributes to food insecurity.
- High prices of foodstuffs, which contributes to food insecurity.
- Deficient transport of basic foods from the production areas to the consumption areas in the country.

6. Information System for the Agricultural Markets (SIMA) - Ministry of Agriculture (MINAG), July 2010.

Challenges for the achievement of the targets for 2015

- Prepare and implement the Multisectoral Strategy for the Reduction of Chronic Malnutrition.
- Prepare the Bill of Human Right to Adequate Food (DHAA) foreseen in PARPA II and in the Food Security and Nutrition Strategy (ESAN II).
- Accelerate the national response of the fight against chronic malnutrition in under-fives and in women of child-bearing age.
- Promote nutrition education talks and adequate food for the populations.
- Strengthen the lifestyle of the populations and stimulate the sustainable vulnerability reduction measures, taking into account climate change.
- Strengthen the multisectoral coordination mandate in the scope of the Food Security and Nutrition Strategy (ESAN II).

Positive factors of progress in the indicators

- SAN heads the development agenda of the Government, since it is a cross-cutting issue in the Government Five-Year Plan (2009-2010).
- Existence of prevention and timely response mechanisms for natural disasters, such as droughts, floods, cyclones etc.

GOAL 2 – ACHIEVE UNIVERSAL PRIMARY EDUCATION

Rapid assessment	Situation in Numbers					
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2008**	**2009**	**2015**
Potentially	Net enrolment rate in primary education (EP1)	44.0 a)	69.4 b)	64.5 c)		100.0
Situation of the supportive environment	Primary education completion rate (EP1)	22.0 a)	38.7 b)	77.1 c)		100.0
Reasonable	Literacy rate of 15–24 year-olds	52.1 a)	58.2 b)			n/d
	Adult literacy rate (15 years or above)	39.5 d)	46.4	46.9 c)		n/a

a) IDS 1997; b) IDS 2003; c) MICS 2008

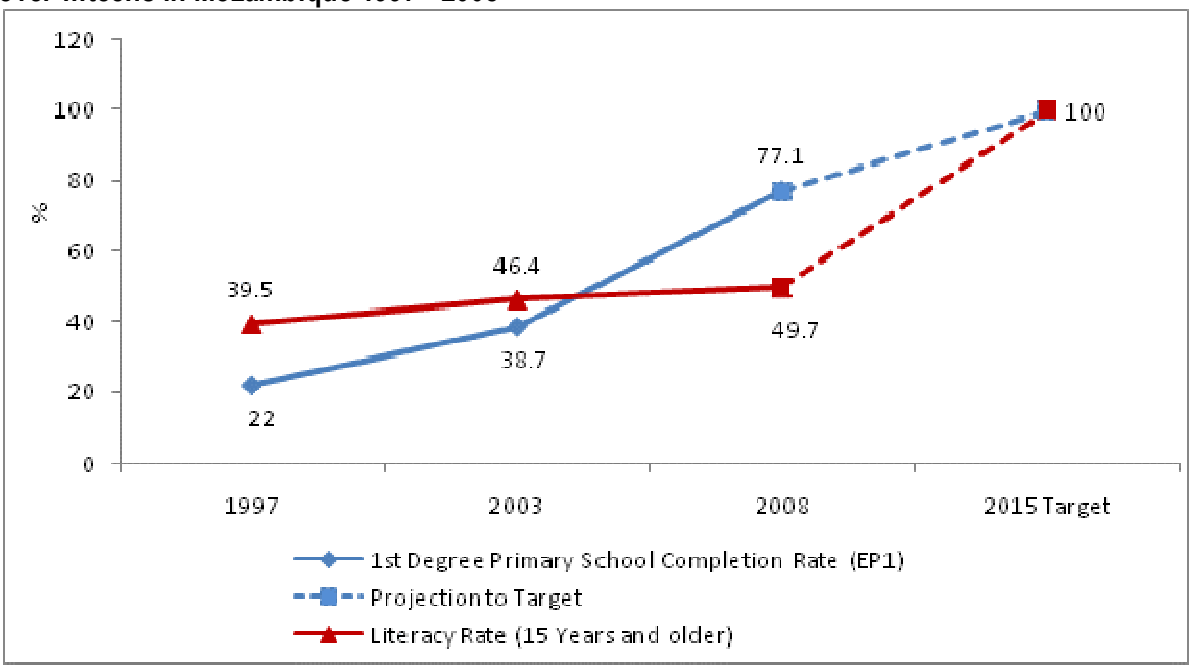
2.1 UNIVERSAL PRIMARY EDUCATION

2.1.1 Situation and trend

Primary Education (EP) in Mozambique comprises two levels, the 1st level (grade 1 to 5) and the 2nd level (grade 6 and 7). According to the millennium goals, Mozambique should achieve universal primary education by 2015, i.e., 100% of the school going-age children should be enrolled in primary education.

According to the following graphic the net conclusion rate in the first level primary school increased from 22% in 1997 to 77.1 % in 2008 (55% in 11 years) and the rate of adult education increased from 39.5% in 1997 to 49.7 in 2008. MICS data indicates that 81% of children in the age for attending primary school (6-12 Years old) are actually enrolled in school (net school enrolment rate).

Graphic 14: Net first-level primary education enrolment and completion rate, and literacy rate for over-fifteens in Mozambique 1997 - 2008

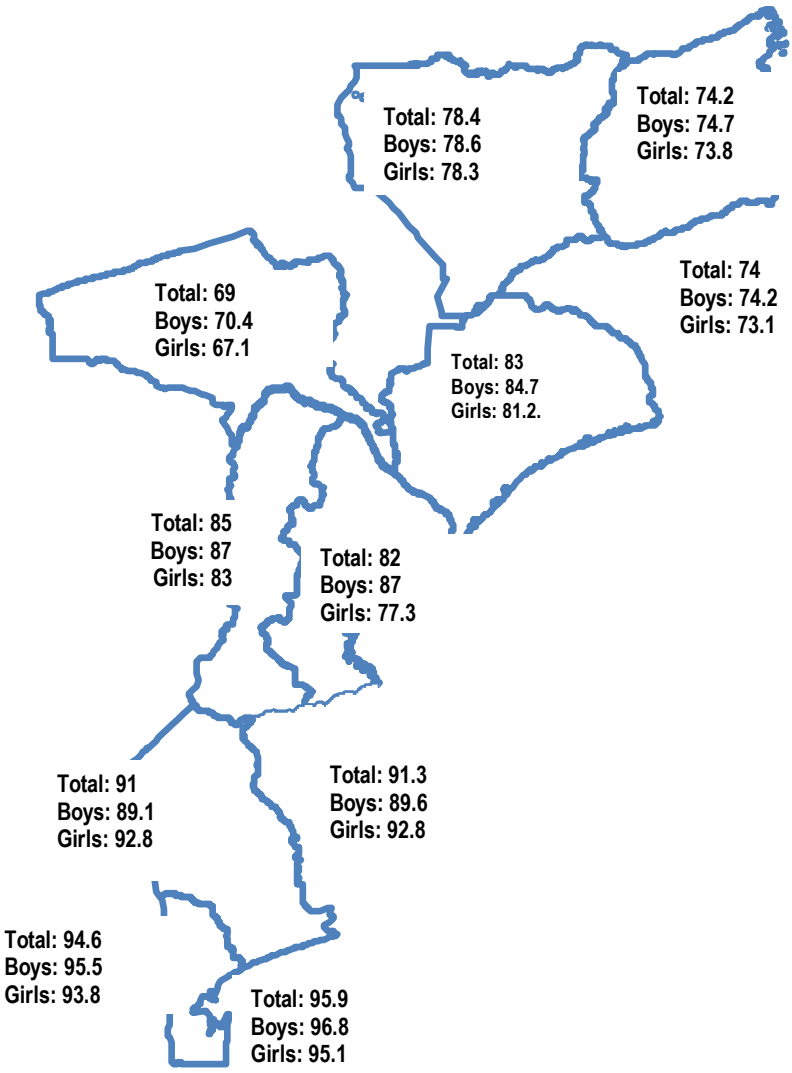


Source: IDS 1997, IDS 2004, MICS 2008

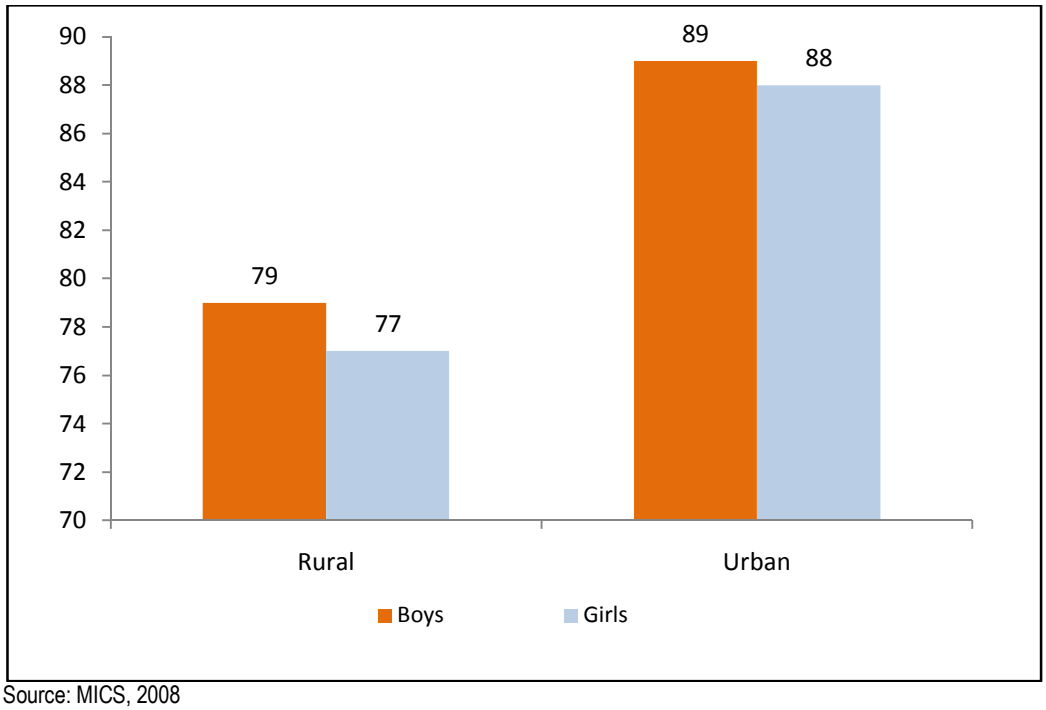
The MICS data show that 81% of primary schoolgoing-age children (6-12 years) attend school (net school enrolment rate). The national average of the schoolgoing-age children of EP enrolment rate is 81.3%, which means that about 19% of the schoogoing-age children continue without attending EP.

In regional terms (Figura17) the EP enrolment rates tend to be higher in the southern region, in Maputo City (96%), Maputo Province (95%), Gaza (91%), and Inhambane (91%), compared to the centre and north of the country. Tete Province has the lowest school enrolment rate at national level, with 69%.

Figure 2: Net EP enrolment rate for 6-12 year old children, by province in 2008



Graphic 15: Net primary school enrolment rate for schoolgoing-age children by area of residence and by sex in Mozambique, 2008

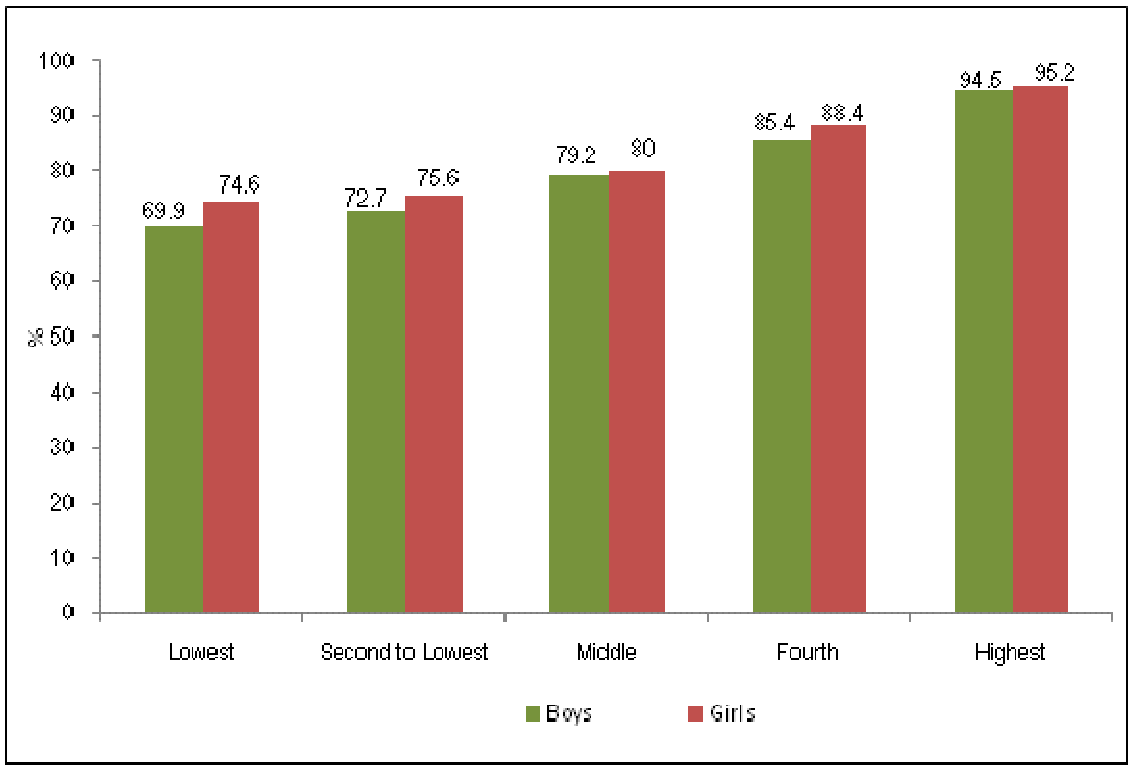


Source: MICS, 2008

According to graphic 16, the primary education enrolment rate for schoolgoing-age children (6-12 years) tends to be related to the level of wealth of their households. Boys and girls from higher wealth quintiles tend to have higher enrolment rates (95.2% boys and 94.5% girls), than girls and boys from lower quintiles (74.6% boys and 69.9% girls).

In general, the primary education enrolment rate of boys is greater than the enrolment rate of girls in all wealth quintiles. The difference between the enrolment rates of boys and of girls is the highest in the lowest wealth quintiles. The difference between the enrolment rate of boys and of girls in the highest wealth quintile is 0.7% while in the lowest wealth quintile it is 4.7%. This shows partly that the poor participation of girls in primary school in comparison with boys is greater in the poorer families.

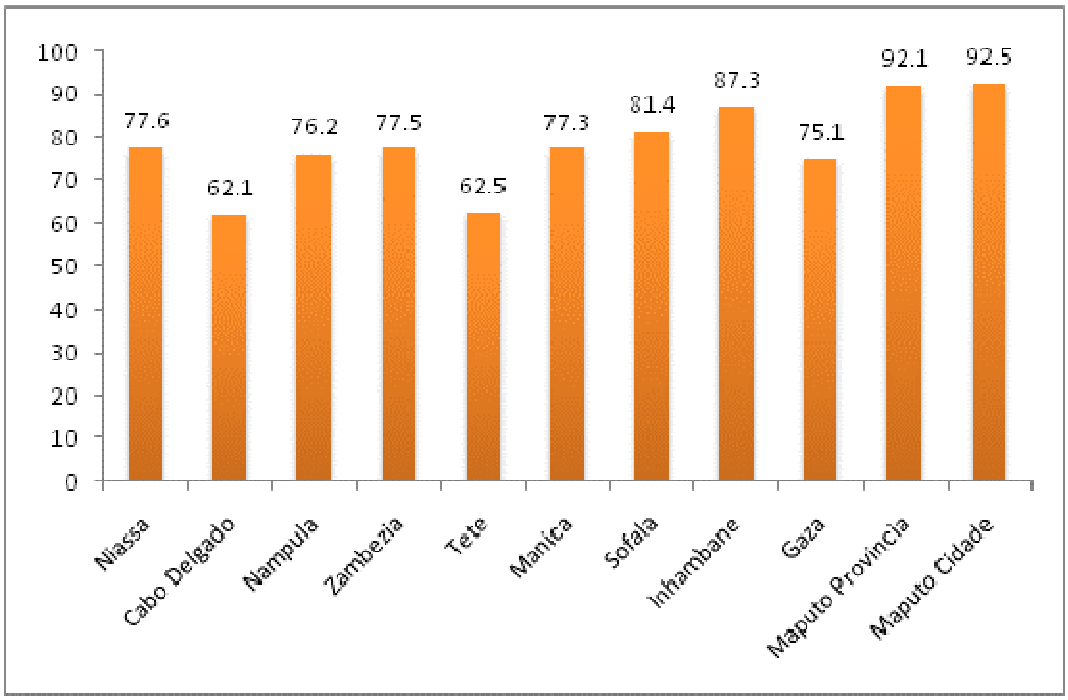
Graphic 16: Net primary education enrolment rate for 6-12 year-old children by wealth quintile of their families in Mozambique, 2008



Source: MICS 2008

Significant geographical inequalities also exist, both between provinces and between districts in the provinces. In 2008, the provinces of the southern region had higher completion rates, with the highest being for Maputo City (92.5%). Tete in the central region and Cabo Delgado in the north have the lowest EP1 completion rates, 62.5% and 62.1 respectively.

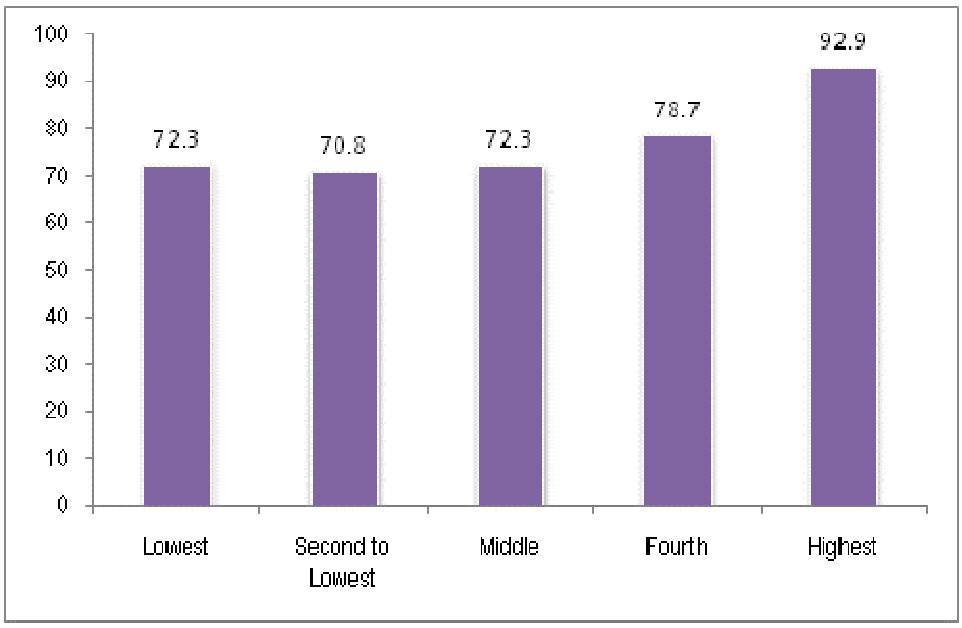
Graphic 17: Net primary education (EP1) completion rate by province in Mozambique, 2008



Source: MICS 2008

The net EP1 completion rates are also related to the wealth quintiles as the MICS data for 2008 in graphic 18 show. In the higher wealth quintiles the completion rates are higher (92.9%) than in the lower wealth quintiles (72.3%). This relation shows that the fact that EP1 is free does in itself not guarantee the stay of poorer households' children at school until completion.

Graphic 18: First level primary education (EP1) completion rates by the families' wealth quintile in Mozambique 2008



Source: MICS 2008

Constraints on the achievement of the targets for 2015

- The increase of the school population in primary education is not always accompanied by the improvement of the quality of education;
- The lack of classrooms is still being felt and a significant part of the 6 year-old children has no access to school;
- The combined fail and dropout rates produce considerable school waste;
- The student/teacher ratio continues high;
- The results that have been achieved in primary education create new challenges for the subsequent levels of education, namely general secondary and technical-professional education;
- The lack of a law making primary education compulsory in Mozambique;
- The existence of cultural habits which give little importance to schooling in the rural areas of Mozambique.

Recommendations for the achievement of the targets for 2015

- Improve the student/teacher ratio and improvement, support and supervision of the teaching-learning process.

- Strengthening of the institutional capacity of the Ministry of Education, particularly at provincial, district and school level, through training actions for education managers and administrators at all levels.
- It is necessary to continue the expansion of the next levels of education (ESG) to give schooling and training continuity to the youth and according to the country's socio-economic development needs.
- Continuing with teacher's training, both initial and in-service training and pedagogical supervision and support in the scope of the new socio-economic development dynamics and the creation of technical abilities and capacity on the part of the youths.
- The continuing eradication of illiteracy, is still a priority given its importance for the reduction of poverty.

Positive factors of progress in the indicators

- The Government's priority area is the quality of education, the sustainable expansion of the post-primary systems and the programme management capacity, mainly at decentralised level.
- The Ministry of Education has um strategic plan aimed at increasing access, improving the quality and strengthening the institutional capacity, at all levels, as well as to deal with the above-mentioned challenges in a systematic way. This plan, which had the consensus of civil society and the cooperation partners, has created a favourable environment for the increase of access to school and the improvement of the quality of education. It is also an important instrument for the mobilisation of resources and political dialogue about education for all by 2015.
- Investment in the area of education has increased annually, and the sector budget's proportion of the General State Budget is currently about 21%.
- The allocation of financial resources to schools and the free distribution of school books have contributed to the improvement of the teaching-learning environment.
- The Government has recruited more teachers for primary education, about 10,000 new teachers per year, to increase access.
- The Government of Mozambique decided to make primary education free in Mozambique.

GOAL 3 – PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

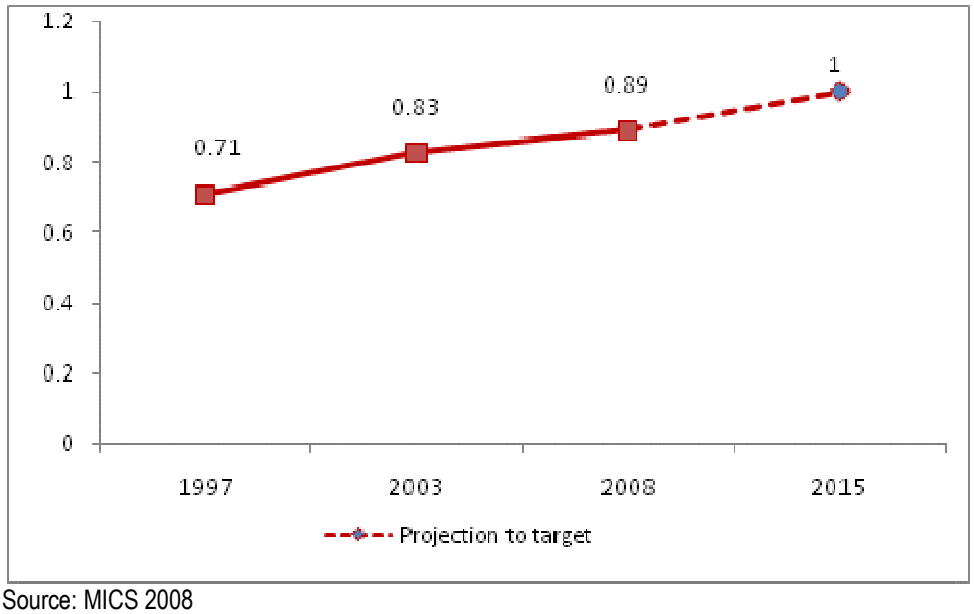
3.1 SCHOOLING OF GIRLS

Rapid assessment	Situation in Numbers					
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2008**	**2009**	**2015**
Probably	Ratio of girls to boys in EP1	0.71	0.83	0.9	n/a	1.0
Situation of the supportive environment	Ratio of literate women to men (15-24 years of age)	0.62	0.83	n/a	n/a	1.0
	Women illiteracy rate (%)	71.4	68.8	64.1	56%	n/a
Strong	The proportion of seats held by women in the national parliament	28.0	35.6	37.2	37.2	50

3.1.1 Girl-Boy ratio in 1st Level Primary Education (EP1)

Graphic 19 shows that the girl-boy ratio in 1st level primary education in Mozambique has increased since 1997. In 11 years the ratio increased from 0.71 to 0.89, which corresponds to an increase of 0.016 points per year. At this speed, in 2015 Mozambique will achieve a ratio of 0.97, which means that in 1st level primary education there will be almost one girl for each boy.

Graphic 19: Girl-boy ratio in 1st level primary education in Mozambique 1997-2008

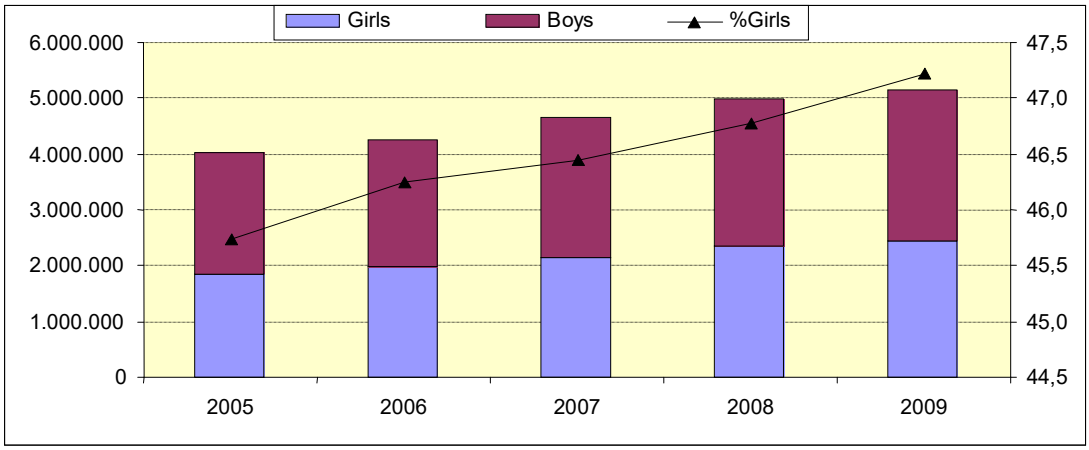


Source: MICS 2008

According to the education statistics, primary education has been increasing school enrolment opportunities, as the number of enrolled students increased from 4,019,356 in 2005 to 5,146,175 in 2009, as the following graph shows.

The reduction of the gender disparities, as shown in Graph 23, is a challenge that has been responded to in the course of the years, with the adoption of specific programmes, aimed at the promotion of girls' school enrolment and retention. Indeed, the proportion of girls increased from 45.7% in 2005 to 47.2% in 2009. Similarly, in the scope of gender the education statistics show an important reduction of the disparities between the provinces, when compared with the results of the previous school years.

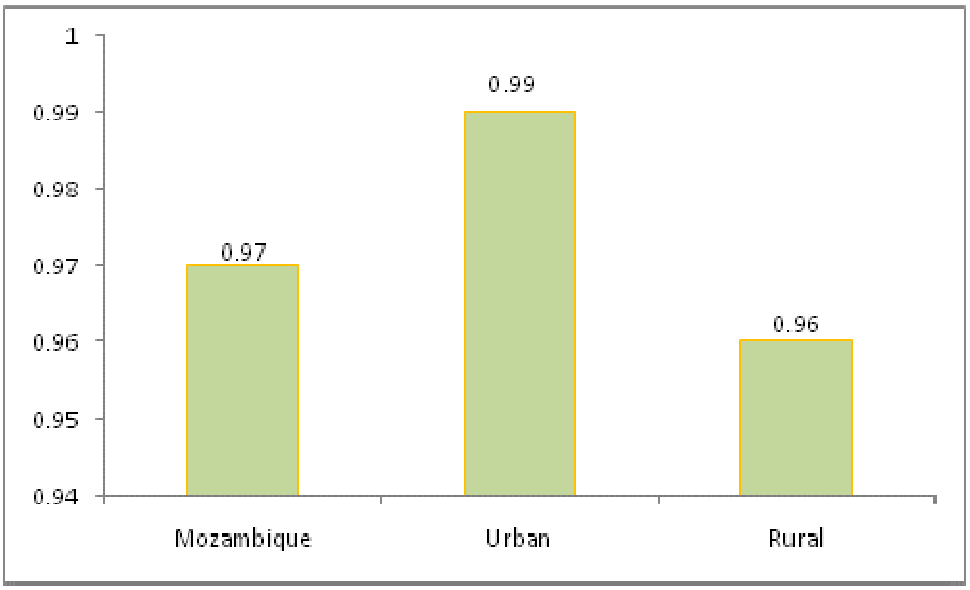
Graphic 20: Evolution of the number of students in primary education, by sex



Source: MINED

The girl-boy ratio in primary education until the end of 2008 in Mozambique was very near 1, which means that the number of boys and girls in primary education is similar. This is a true fact, both in rural and in urban areas. The difference of the ratio between urban and rural areas is only 0.03.

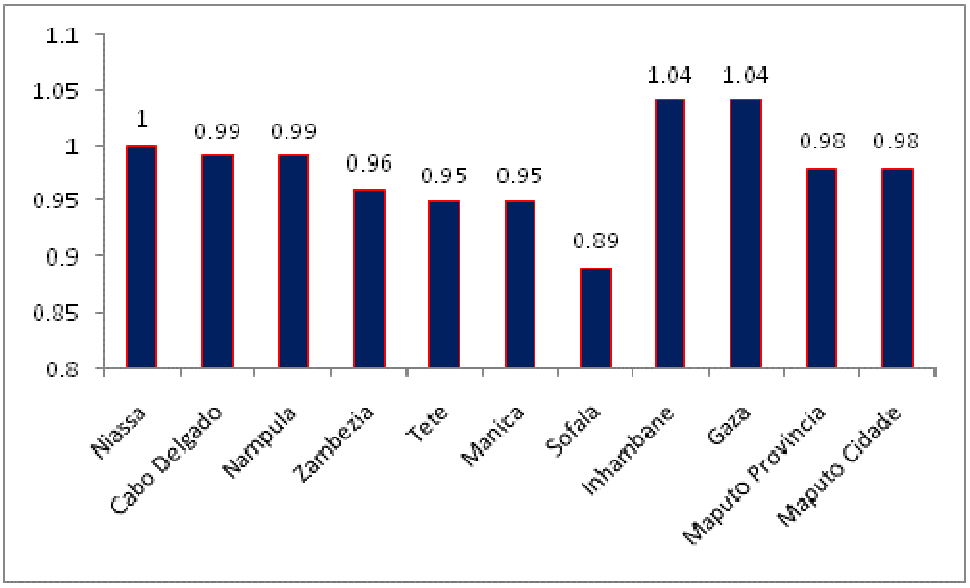
Graphic 21: Girl-boy ratio in primary education by area of residence in Mozambique, 2008



Source: MICS 2008

Looking at the girl-boy ratio in primary education by province it is observed that in Inhambane and Gaza provinces the girl-boy ratio exceed the target for 2015, which is 1. This means that in Inhambane and Gaza there are more girls than boys in primary education. With the exception of Sofala Province, where the girl-boy ratio in primary education is 0.89, the ratio in all other provinces is 0.95 to 1.04.

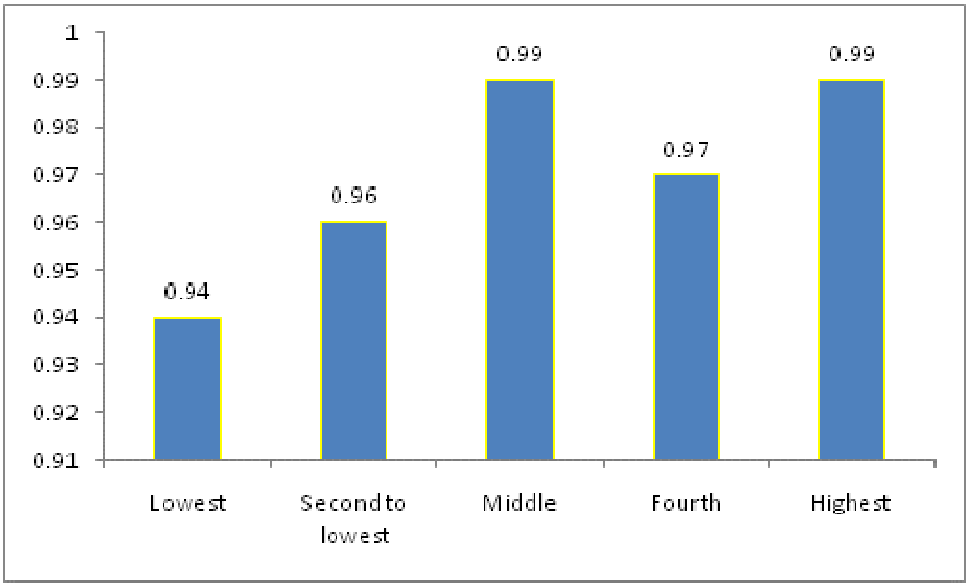
Graphic 22: Girl-boy ratio in primary education by province in Mozambique 2008



Source: MICS 2008

Looking at the distribution of the girl-boy ratio in school according to their families' wealth quintile, it is observed that the ratios are high in all wealth quintiles. The ratio is slightly lower in the lowest wealth quintile (0.94) and the ratio is higher in the highest and middle wealth quintile (0.99).

Graphic 23: Girl-boy ratio in primary education by their families' wealth quintile in Mozambique 2008



Source: MICS 2008

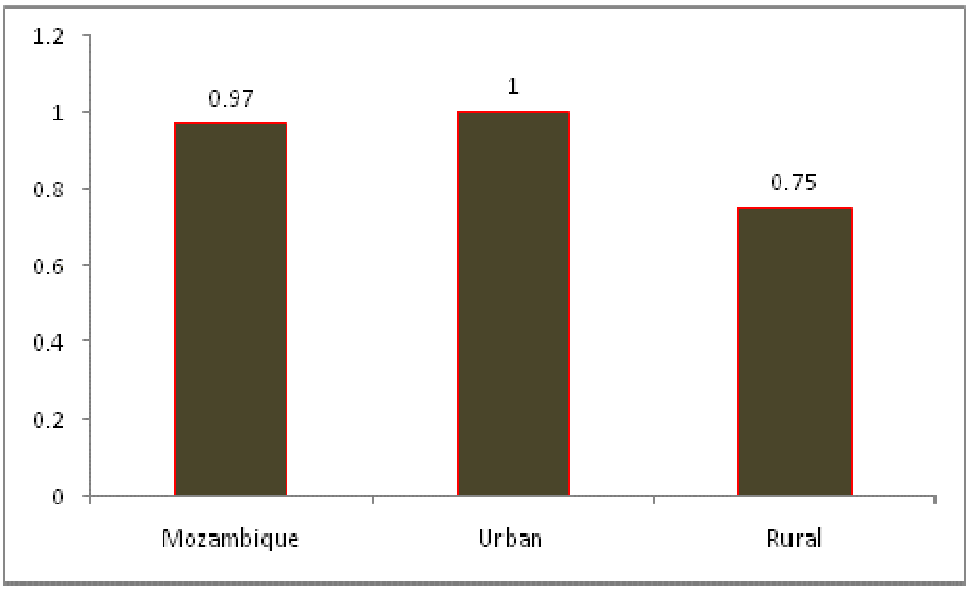
However, the primary education completion rate by sex in 2008 in Mozambique showed that boys perform better than girls. While 74.4% of the girls concluded primary education, this rate for boys is 79.7%.

Graphic 24: Net primary education completion rate by sex in Mozambique 2008

Source: MICS 2008

The secondary education girl-boy ratio in Mozambique until the end of 2008 was 1 for the urban areas, 0.75 for the rural areas and 0.97 for the country. These results show that there is still a need to work on increasing the number of girls in rural secondary schools.

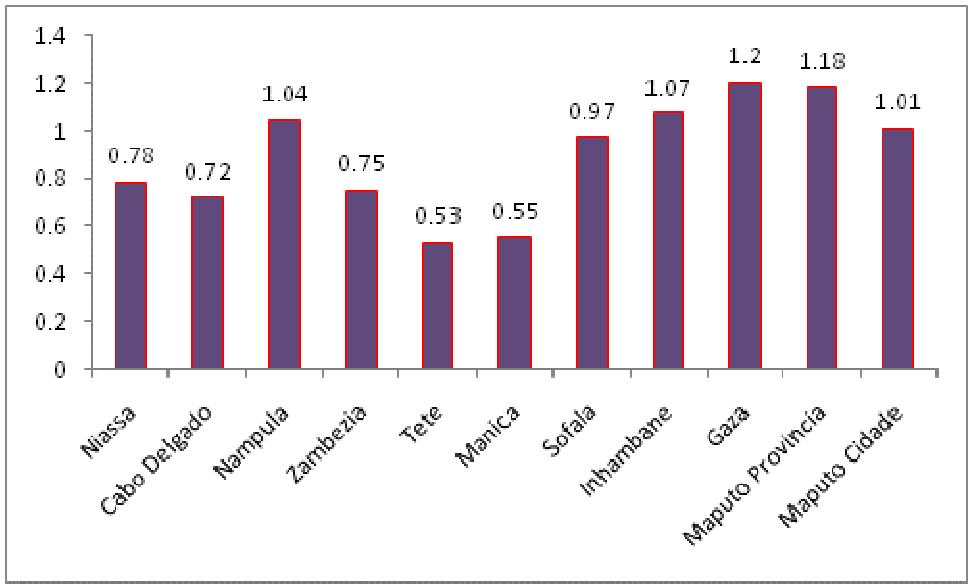
Graphic 25: Girl-boy ratio in secondary education in Mozambique 2008



Source: MICS 2008

Comparing the girl-boy ratio in secondary education by province, the results are more heterogeneous than those of primary education. They vary from 0.55 in Manica (the lowest) to 1.18 in Maputo Province (the highest). It can also be observed that in all southern provinces of Mozambique and also in Nampula Province the girl-boy ratio is larger than 1, which means that the gender parity target had already been exceeded. There are however still provinces with relatively lower ratios (Manica and Tete) and which will need to double their efforts.

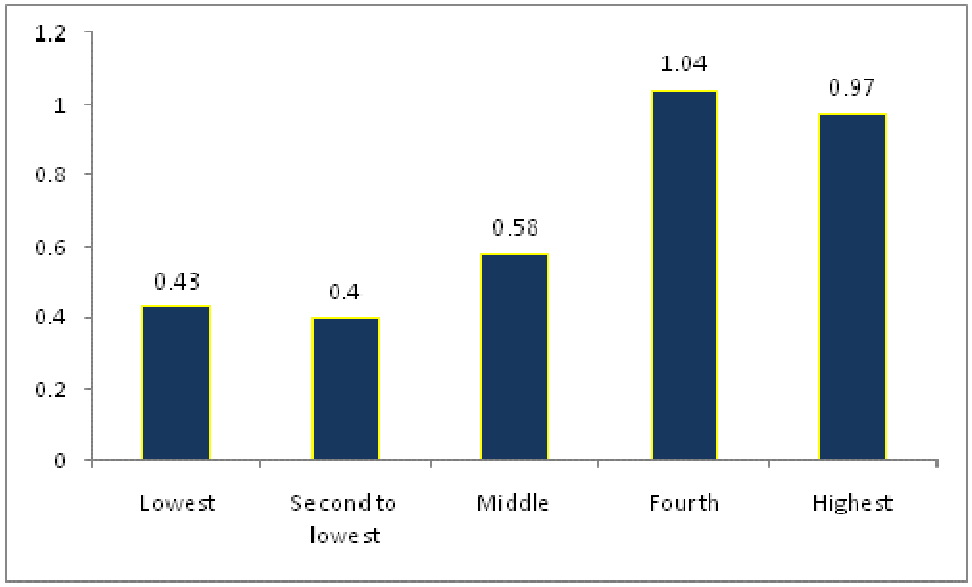
Graphic 26: Girl-boy ratio in secondary education by province in Mozambique 2008



Source: MICS 2008

The girl-boy ratio in secondary education in Mozambique in 2008 shows that it is related to the families' level of wealth. In the two highest wealth quintiles, the ratio varies from 0.97 to 1.04 while in the three lower wealth quintiles it varies from 0.43 to 0.58.

Graphic 27: Girl-boy ratio in secondary education by the families' wealth quintile in Mozambique 2008



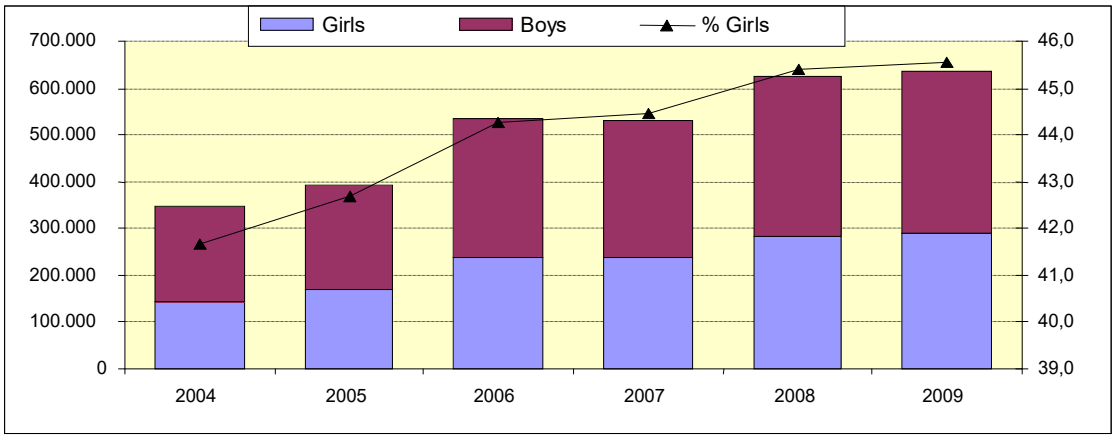
Source: MICS 2008

In the evolution of the number of students enrolled in grade 5, special emphasis should be given to the increase of the proportion of girls, as these represented 41.7% in 2004 and achieved in 2009 a proportion of 45.6%. This level of participation, compared to the previous school years, is positive. However, the efforts to achieve gender parity should be increased.

The stay of girls in school is an opportunity for the girls to be able to abandon poverty and protect their rights. One of the still prevailing big problems is the high rate of repeaters, which occurs at almost all levels and types of schooling. This problem affects all provinces and assumes similar characteristics in rural and in urban environments. It has a gender dimension, as it is more accentuated in female than in male students.

According to MICS 2008, 59.3% of the female students stated to have repeated a class once, while the number of boys who stated to have repeated a class is 57.4%.

Graphic 28: Evolution of the number of students by sex in grade 5



Source: MINED

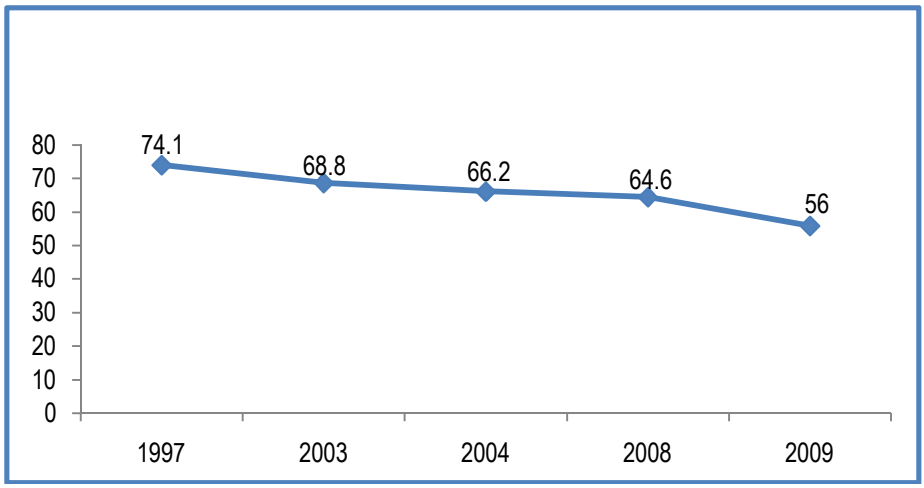
3.2. FEMALE ILLITERACY RATE

3.2.1: Situation and trend

The literacy indicators show significant changes year after year. Between 2007 and 2009 there was an increase of 60% of the rate of women's participation in adult literacy classes. Literacy programmes by radio were offered in all provinces covering 245,771 participants, of which 78% are women (192,758 women).

The female illiteracy rate, though still high, has decreased in the course of time. In 2004 it was 66.2% and it dropped to 56% in 2009. Women are in general the major beneficiaries of literacy programmes in all provinces and have the highest presence in the Adult Literacy Centres.

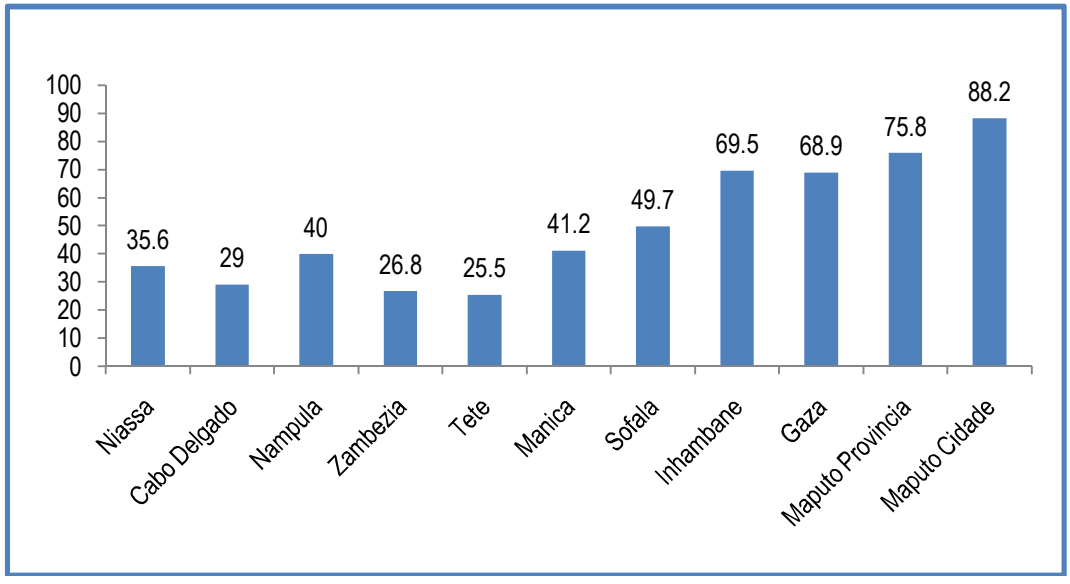
Graphic 29: Female illiteracy rate in Mozambique 1997-2009



Source: MINED

MICS 2008 data show that the literacy rate of 15-24 year-old women is higher in the southern region of the country, with the highest rates occurring in Maputo City (88.2%), Maputo Province (75.8%), Gaza (68.9%) and Inhambane (69.5%). Zambézia and Tete Provinces in the central region have the worst situation in terms of female literacy, as shown in graphic 30.

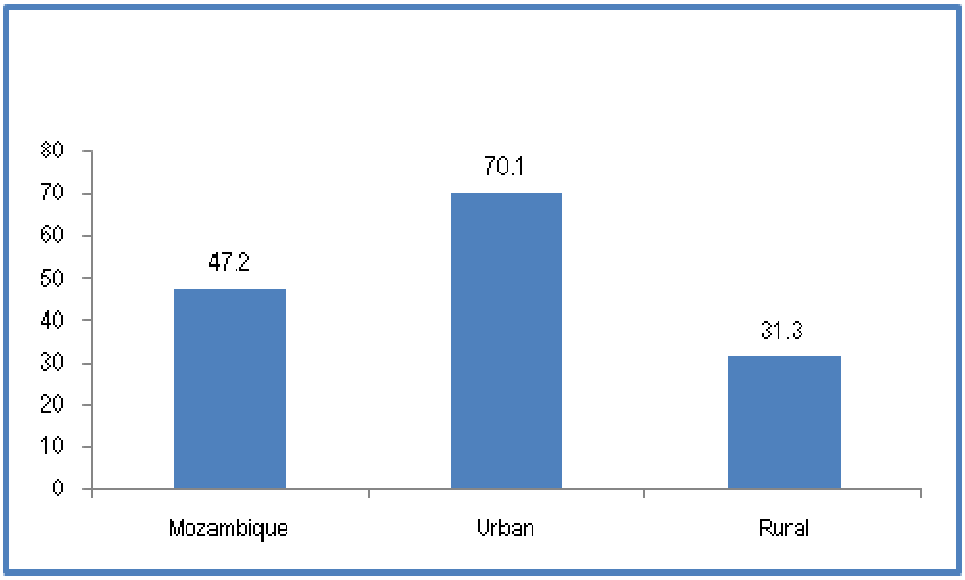
Graphic 30: Literacy rate of 15-24 year-old women by province in Mozambique in 2008



Source: MICS 2008

The literacy rates of 15-24 year-old women are higher in the urban areas than in the rural areas, where literacy is less than half that of the urban areas. In the rural areas female literacy is 31.3% while in the urban areas it is 70.1%. The national average is 47.2%.

Graphic 31: Literacy rate of 15-24 year-old women by area of residence in Mozambique 2008



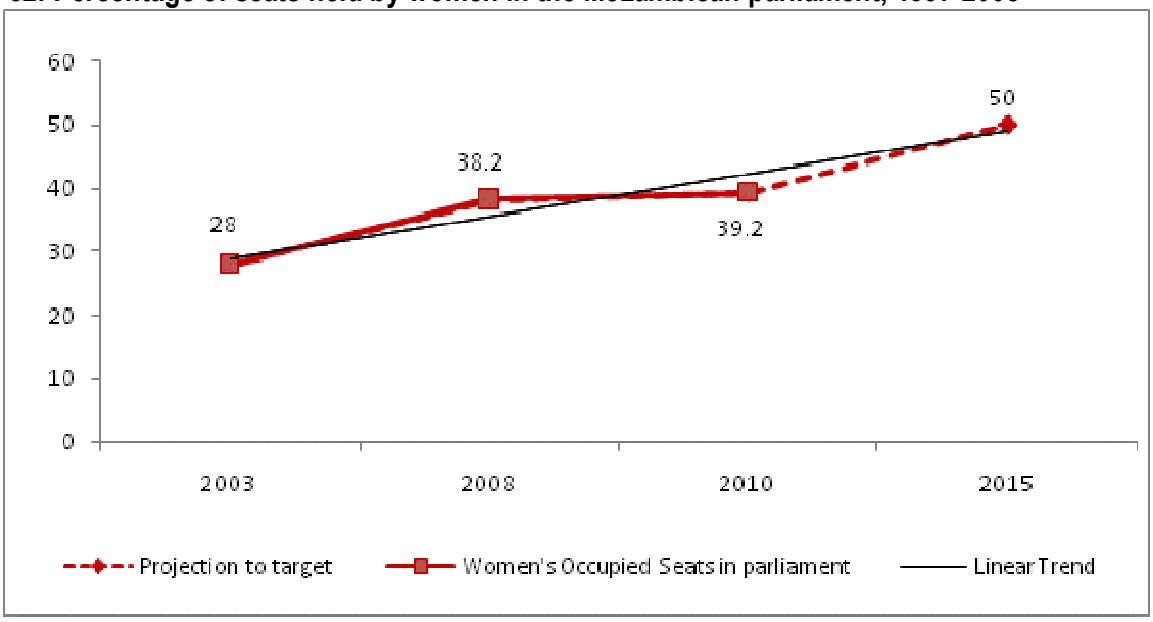
Source: MICS 2008

3.3 WOMEN'S PARTICIPATION IN GOVERNANCE

3.3.1 Percentage of seats held by women in parliament

The percentage of seats held by women in the Mozambican parliament has increased since 1997. It was 28% in 2003, 38.2% in 2008 and is 39.2% in 2010.

Graphic 32: Percentage of seats held by women in the Mozambican parliament, 1997-2008



Source: MMAs

Table 8 details the distribution of female presence in the executive and legislative bodies of Mozambique. It should be noted that the President of the Assembly of the Republic is a woman, that two parliamentary groups are headed by women and that six women are member of the Permanent Commission of the Assembly of the Republic, which corresponds to 40% of the 15 members of this body.

It should be emphasized that at executive level there is a growing percentage of female ministers in the Government (from 25.9% in 2008 to 28.5% in 2010). On the other hand, in this legislature three female Provincial Governors were appointed, representing a growth from 18.1% to 27.2% in 2010.

Table 8: Percentage of men and women in State authority and decision-making bodies (2003-2010)

Description	2003/4		2008		2010	
	%W	%M	%W	%M	%W	%M
Executive-Government Body						
Ministers	15.3	84.7	25.9	74.1	28,5	71.5
Deputy Ministers	16.3	83.7	31.5	68.5	19,0	81.0
Governors	0.0	100.0	18.1	81.9	27,2	72.8
Ministerial Permanent Secretaries	11.7	88.3	31.5	68.5	24	76
Provincial Permanent Secretaries			45.4	54.6	45,5	54.5
District Administrators			20.3	80.7	-	
Heads of Administrative Posts			11.0	89.0	-	
Provincial Directors	8.4	91.6	20.7	79.3	-	
Legislative Body						
Members of Parliament	**28.0**	**72.0**	**38.2**	**61.8**	39.2	60.8

Source: MMAS

Constraints on the achievement of the targets for 2015

- Gender equality issues can have more impact in the rural areas, as it is known that some parents are afraid to send their daughters to school where male teachers dominate, due to the fear of sexual harassment. The absence of female teachers means that the female students are in a predominantly male environment which leads to an increased sense of insecurity.
- As education and training are one of the fundamental components for greater integration of women in the political, economic and social domains, the multiplication of initiatives focussed on the professionalization of women are encouraged, mainly in areas with high employability as it is from there that women will acquire the capacity for better meeting the challenges they are facing in these areas.
- The existence of cultural habits which lead to the non-enrolment or dropout of girls from schools, such as premature marriages and the absence of recognition on the part of the parents of the importance of schooling for girls.

Challenges for the achievement of the targets for 2015

- In spite of the advances registered challenges still persist of the integration of women in technical-professional education, the dissemination of information and contents that reduce the stereotypes that discriminate women.

- Reducing of repetition and dropouts rates, dealing with issues of regional and gender inequality, improving the students' school performance in general, and dealing with concerns regarding management and supervision.
- Strengthening the support to girls through the Direct Support to Schools (ADE) Programme, especially for secondary and technical-professional schools, will boost the actions for the advancement of women in the Education sector.
- All Government sectors should be made aware of the need to organise and adopt a gender profile in their area of intervention. They should start with the splitting up of data by sex for all activities carried out.
- Implement coordinated actions at provincial and district level in all priority areas defined in the National Plan for the Advancement of Women and other economic management instruments.
- Increase the financing of other initiatives for the promotion of gender equality and women empowerment through the adoption of gender-responsive budgeting and planning in all sectors and at all levels.
- Continue the training and awareness-raising efforts regarding gender issues in State institutions, civil society and private institutions.
- Introduction and/or expansion of radio programmes for awareness-raising and teaching women and girls.

However, for meeting the MDG3 targets in 2015 special attention should be given to the continuity of awareness-raising actions for girls and to the reduction of gender imbalances at the various levels, especially the targets regarding second level primary education (EP2), especially for the districts with less than 45% of girls in basic education, and secondary education (ESG).

Positive factors for the achievement of the target for 2015

- In the Constitution of the Republic the principles of equality of rights and gender were introduced (Articles 35 and 36). At Policy and Strategy level there are several instruments such as the Government Five-Year Programme for 2010-2014, PARPA 2010-2011, the Gender Policy and Implementation Strategy, the National Plan for the Advancement of Women, sector gender strategies of Education, Health, Public Administration, Energy and Environmental Affairs. Specifically the Education sector has a Strategic Plan (2006-2010/11) that gives priority to gender issues. Other important initiatives are the creation of Gender Units in all Provincial Directorates of Education and

District Services of Education, Youth and Technology, the creation of 11 Provincial Councils for the Advancement of Women (CPAMs) and of 30 District Councils for the Advancement of Women (CDAM) in 4 provinces (Nampula, Zambézia, Tete and Niassa).

- The political will and commitment regarding gender issues is expressed in the legislation as well as in the Government programmes, policies and plans in force. Since the proclamation of the Beijing Declaration and Platform for Action, the country has made efforts for the promotion of gender equality through legal reforms and the adoption of policies, strategies and plans that are aligned with the objectives of gender equality.

- In addition to this there is a variety of bodies working in an interrelated way for the coordination of the promotion of gender equality, such as MMAS, CNAM (Government), Office of Women Members of Parliament and the Social, Gender and Environmental Affairs Commission (Parliament) and Civil Society Organisations.

  Thus, it can be concluded that there exists a favourable legal, political and institutional framework in the country for the promotion of gender issues and women empowerment.

GOAL 4 – REDUCE CHILD MORTALITY

Rapid assessment	Situation in Numbers					
Will the target be met?	**Indicator / Year**	**1997 (a)**	2003 (b)	**2007 (c)**	**2008 (d)**	**2015 (e)**
Probably	Under-five mortality rate (per 1,000 live births)	245.3	154	147.2	138	108
Situation of the supportive environment	Rate of infant mortality (0-1 year, per 1,000 live births)	143.7	101	95.5	93	67
Strong	Proportion of 1 year old children immunized against measles	55	63	58	58	95
	Rate of coverage with DPT3 and HB in 0-12 month old children	58	67	71	71	n/d

a) Censo 1997. b) IDS 2003. c) Censo 2007 d) MICS 2008 e) Metas do Plano Nacional Integrado para o Alcance dos ODM 4&5: 95% para 2012.

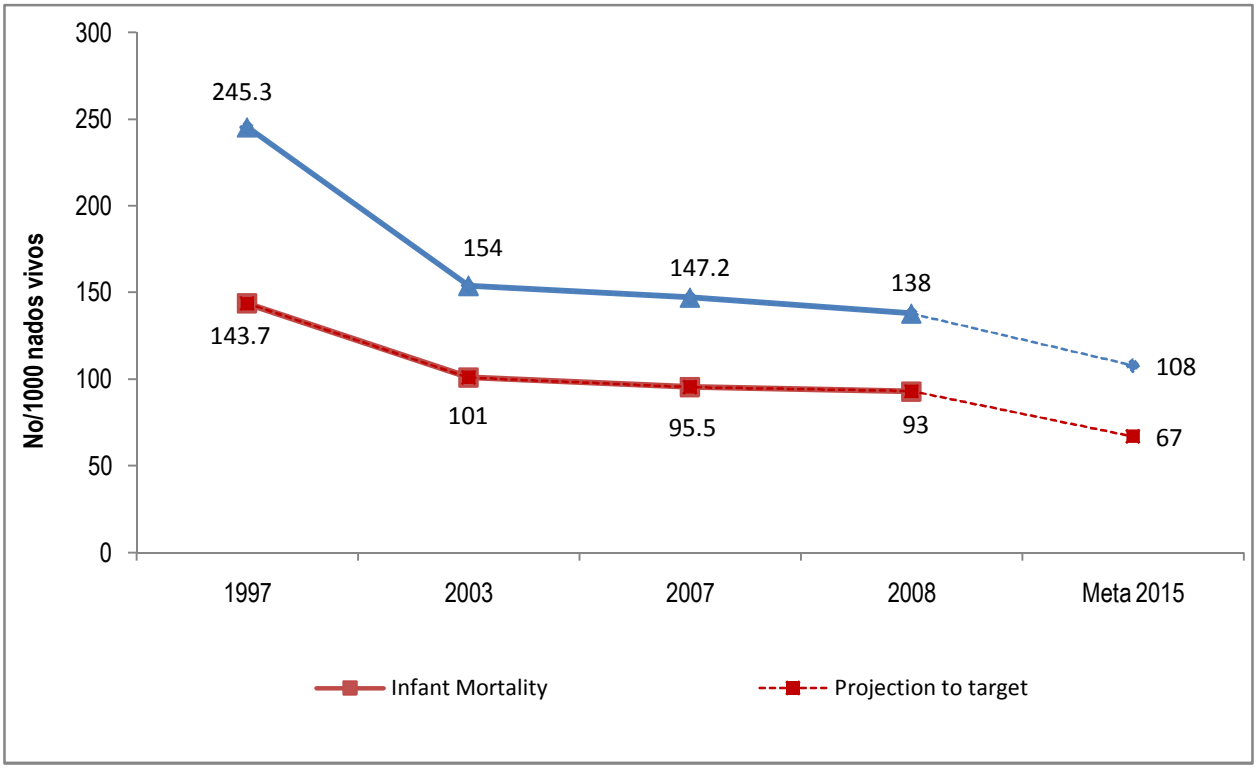
4.1 Infant and child mortality rate

4.1.1 Situation and trend

In the last few decades, the country has seen a continuous reduction of the neonatal, infant and child mortality rates. However, the speed of its decrease has been less than in previous periods. The Neonatal Mortality Rate (NMR) decreased from 57 obits in 1,000 live births (LB) in 1997 (IDS) to 48/1,000 LB in 2003 (IDS) and to 42 obits/1,000 LB in 2008 (MICS).

The Infant Mortality Rate (IMR) decreased from 143.7/1,000 LB in 1997 (Censo 1997) to 101/1,000 LB in 2003 (IDS) and to 95.5/1,000 LB in 2007 (Censo 2007), while the Child Mortality Rate (CMR) or Under-Five Mortality Rate (<5MR) decreased between 1997 and 2003 from 245.3 to 154/1,000 LB, and to 147.2/1,000 LB in 2007 (Censo 2007). The reduction observed in the IMR and CMR has been the result of a more significant reduction in the rural areas and a smaller reduction in the urban areas. The country has the potential to achieve its 2015 targets for child mortality (67/1,000 LB) and under-five mortality (108/1,000 LB).

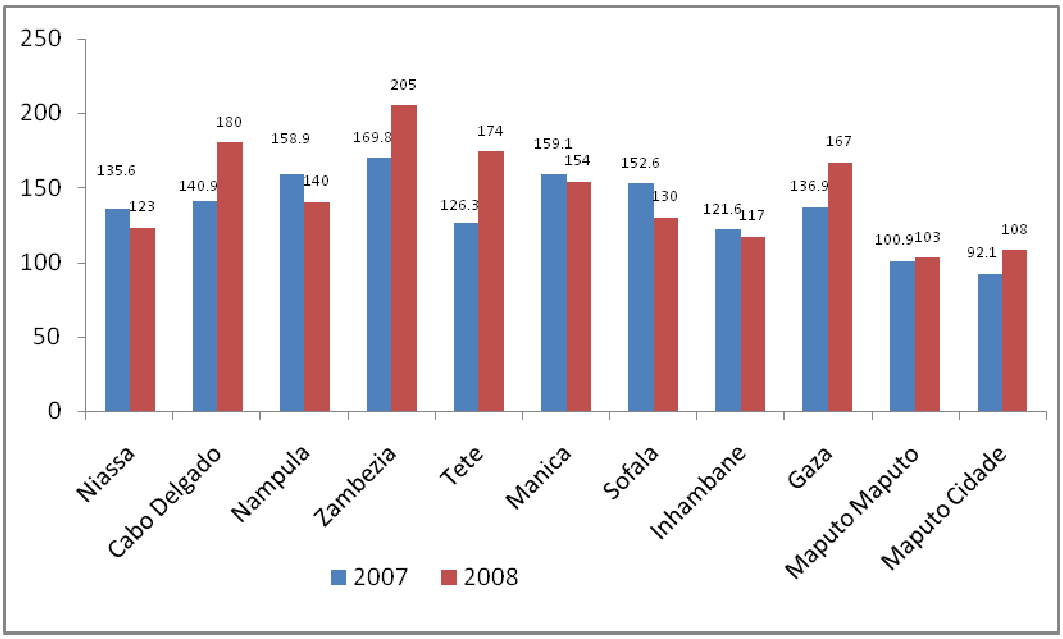
Graphic 33: Rate of infant and child mortality 1997-2008



Source: Censo 1997, IDS 2003, Censo 2007, MICS 2008

The disparities between the provinces persist, with Cabo Delgado and Zambézia having on average the highest mortality rates, 180/1,000 LB and 205/1,000 LB respectively. The lowest child mortality rates occur in Maputo City (108/1,000 LB) and Maputo Province (103/1,000 LB).

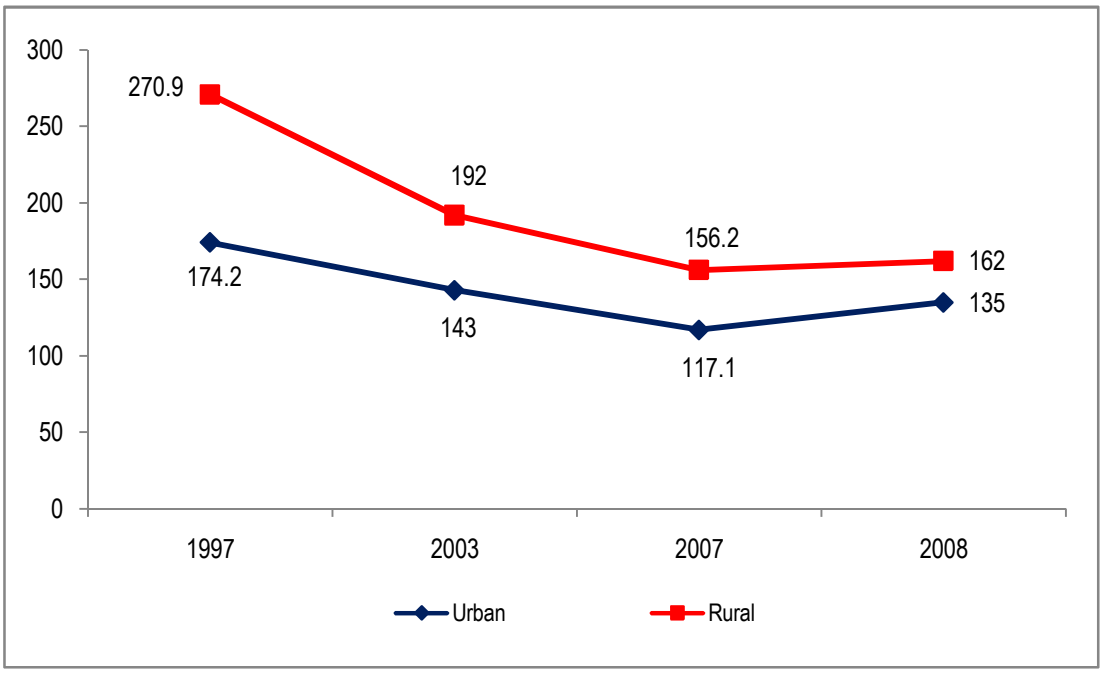
Graphic 34: Child mortality rate by province in Mozambique 2008



(Source: Censo1997, MICS 2008)

Concerning the Child Mortality Rate by area of residence, the data show a larger number of obits in the rural areas than in the urban areas. As the graph below shows, between 1997 and 2008 the child mortality rate decreased in an accelerated way in the rural areas and more slowly in the urban areas.

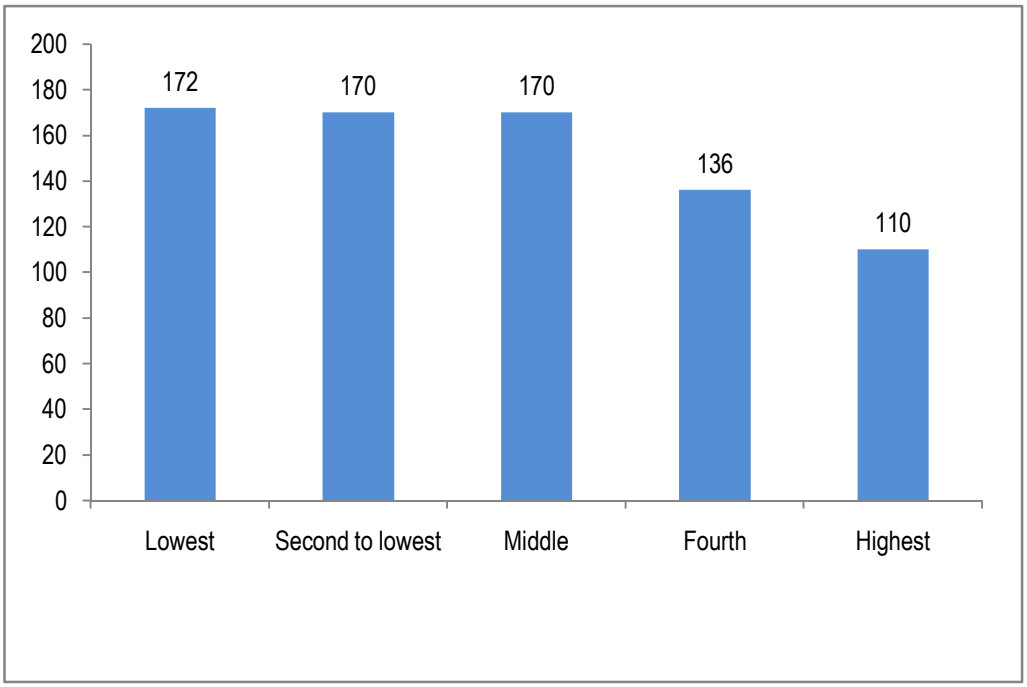
Graphic 35: Child mortality rate by area of residence in Mozambique 1997-2008



Source: Censo 1997, IDS 2003; Censo 2007, MISC 2008

When presented by wealth quintiles, and as shown in graphic 36, the child mortality rates relate inversely, in that the highest wealth quintiles have the lowest child mortality rates and the lowest quintiles have the highest child mortality rates.

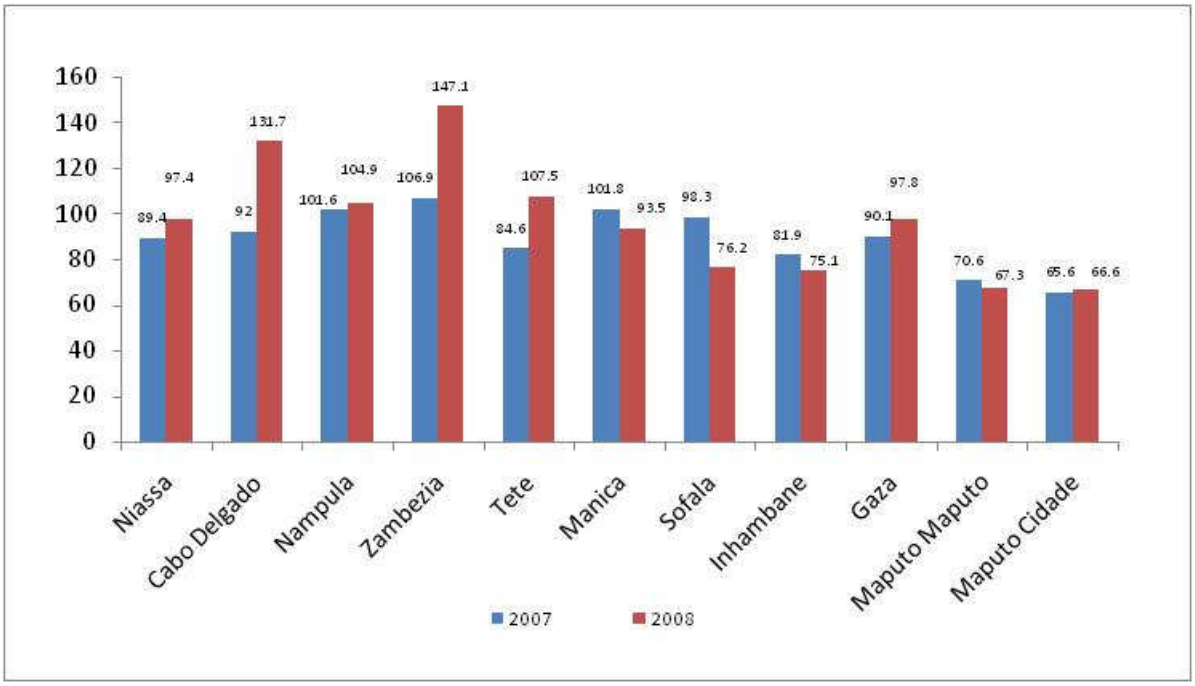
Graphic 36: Child mortality rate by wealth quintile in Mozambique 2008



Source: MICS 2008

The infant mortality rate by province shows a dynamics similar to the other indicators in that the southern region continues having less obits than the central and the northern region of the country. Zambézia (147.1) and Cabo Delgado (131.7) have the highest infant mortality rates at national level and are in need of an increasingly focused intervention to reduce the number of obits per year.

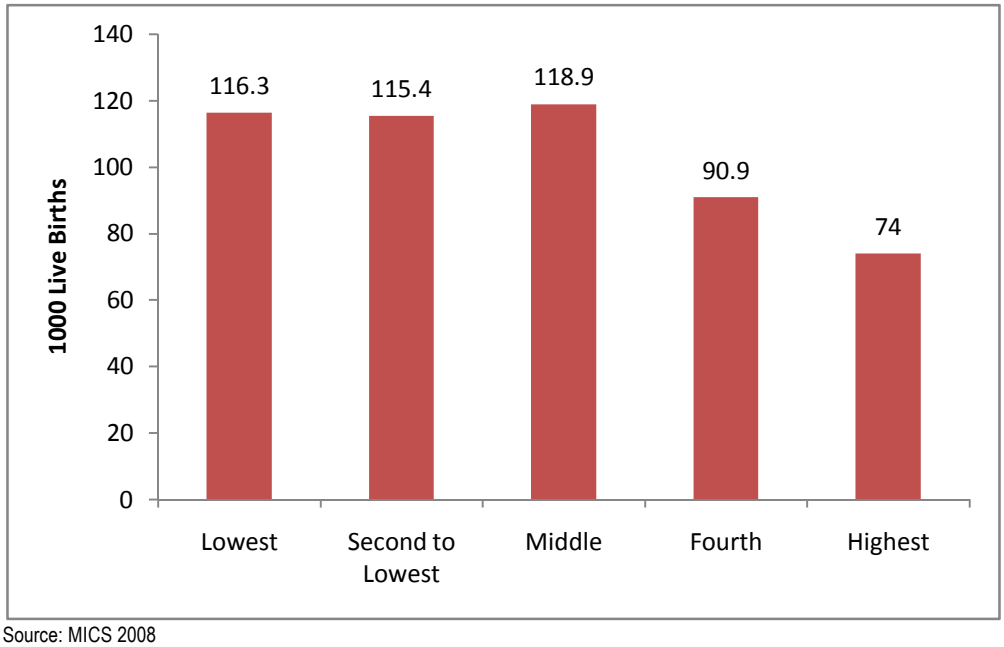
Graphic 37: Rate of infant mortality by province in Mozambique 2008



Source: Censo 2007, MICS 2008

The behaviour of the infant mortality rate according to wealth quintiles has an interesting characteristic between the lowest and the middle quintile: the first one has less infant obits (116.3/1,000 LB) than the middle one (118.9/1,000 LB). The highest wealth quintile has the lowest infant mortality rate (74/1,000 LB).

Graphic 38: Infant mortality rate by wealth quintile in Mozambique 2008



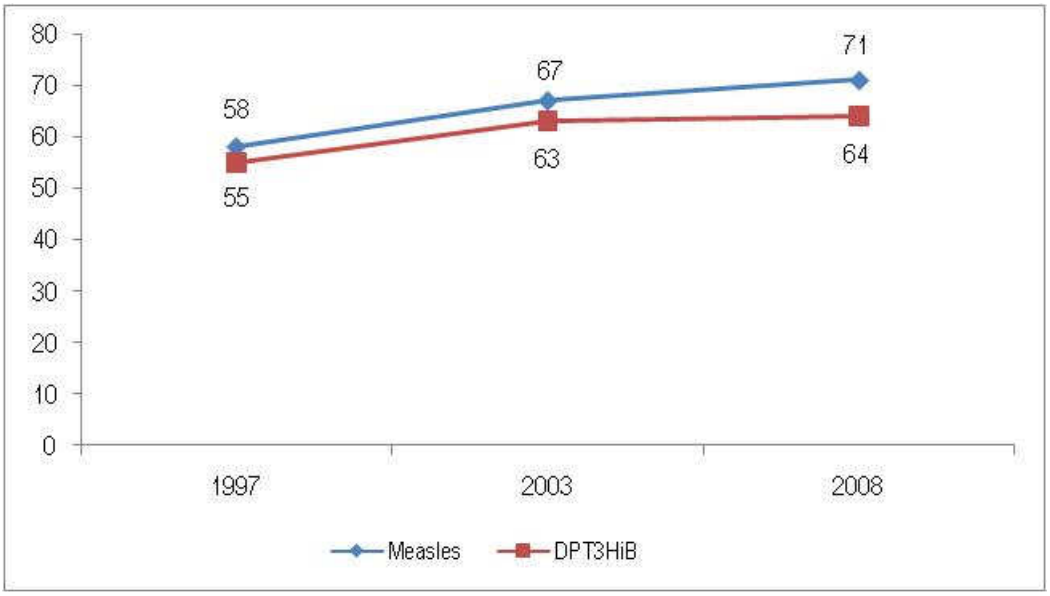
Source: MICS 2008

4.2 IMMUNIZATIONS

4.2.1 Situation and trend

One of the interventions that contribute more to the reduction of child mortality is vaccination. Vaccination leads to the decrease of the incidence of preventable diseases. The MICS data for 2008 show some progress in the coverage of vaccination of children of less than one year of age against the main preventable diseases: BCG 87%, DPT-3 dose 71%, Polio-3 dose 70% and Measles 64%. However, the increase of the coverage of vaccinations in the 2003-2008 period was smaller than in the 1997-2003 period.

Graphic 39: Rate of immunization against Measles and DPT3HiB of children of under 1 year of age in Mozambique 1997-2008



Source: IDS 1997, IDS 2003 & MICS 2008

The disparities between rural and urban areas are evident (Table 9): only 54.8% of the 12-23 month-old children in the rural areas received all vaccines against about 74% of the children living in urban areas. Concerning gender, the coverage of 12-23 month-old boys for all vaccines (61%) is slightly higher than that of girls (59.3%). This difference may however not be significant for the sampling done in the study. Comparing the 5 vaccines presented above (Measles, DPT3, Polio and BCG), BCG had the best coverage in all areas of residence and gender, achieving a coverage of 93% in the urban areas. The

vaccine with the lowest coverage among 12-23 month-old children is Polio, the lowest coverage of which was in the rural areas with 68.8%.

Table 9: Rate of vaccination of 12-23 month-old children by gender and residence in 2008

Residence & Gender	Measles	DPT3	Polio3	BCG	All
Urban	85.3	85.9	85.1	93	74.1
Rural	69.6	69.6	68.8	85.4	54.8
Boys	75.1	74.4	74.5	87.7	61
Girls	73.1	73.8	72.2	87.2	59.3

Source: MICS 2008

Concerning the differences of the coverage of the vaccination of 12-23 month-old children by province, the MICS data for 2008 show that Maputo City and Maputo Province had the highest coverage for all vaccines while Tete Province had the lowest coverage of the country for the total package of vaccinations, with a coverage of 34.2%.

Table 10: Rate of vaccination of 12-23 month-old children by province in 2008

Province	Measles	DPT3	Polio3	BCG	All
Niassa	74.9	74.9	75.4	91.3	56.2
Cabo Delgado	83.3	88.2	86.9	93.2	70.5
Nampula	67.1	63.5	63	82.2	51
Zambézia	61.7	61.7	60.2	75.1	46.8
Tete	60	55.5	54	83	34.2
Manica	69.2	75.4	72.8	87.8	58.3
Sofala	82.9	81.2	81.3	93.7	72.4
Inhambane	86.9	90.5	91.3	98.3	79.8
Gaza	83.3	89.4	89.9	97.3	73.9
Maputo Province	87.4	87.4	87.2	90.1	81.9
Maputo City	93	89.5	86.2	97.7	81.8

Source: MICS 2008

The families' wealth quintile appears to have a positive correlation with the coverage of the vaccination of 12-23 month-old children in Mozambique. The 12-23 month-old children of the lowest wealth quintile have the lowest coverage of the package of all 4 vaccines presented (Measles, DPT3, Polio and BCG), namely 47%, while the 12-23 month-old children of the highest wealth quintile have a higher coverage of the total package of the above-mentioned 4 vaccines (78.8%). Between the 2 extremes defined by the coverage of

the vaccination of the 12-23 month-old children of the highest and the lowest quintiles, the rates of coverage are also positively correlated with the level of wealth quintile to which the children belong. The coverage of the total package of the above-mentioned 4 vaccines in 12-23 month-old children of the second lowest quintile, the middle quintile and the fourth quintile are respectively 50.2%, 61.8%, and 70.5%.

Table 11: Rate of vaccination of 12-23 month-old children by wealth quintile in 2008

Wealth quintiles	Measles	DPT3	Polio3	BCG	All
Lowest	62	59.4	58.5	80.1	47
Second	66.2	67.1	66.7	83.6	50.2
Middle	78.1	79.1	78.3	88.6	61.8
Fourth	81.3	83.3	82.6	95	70.5
Highest	89.8	88.9	87.7	93	78.8

Source: MICS 2008

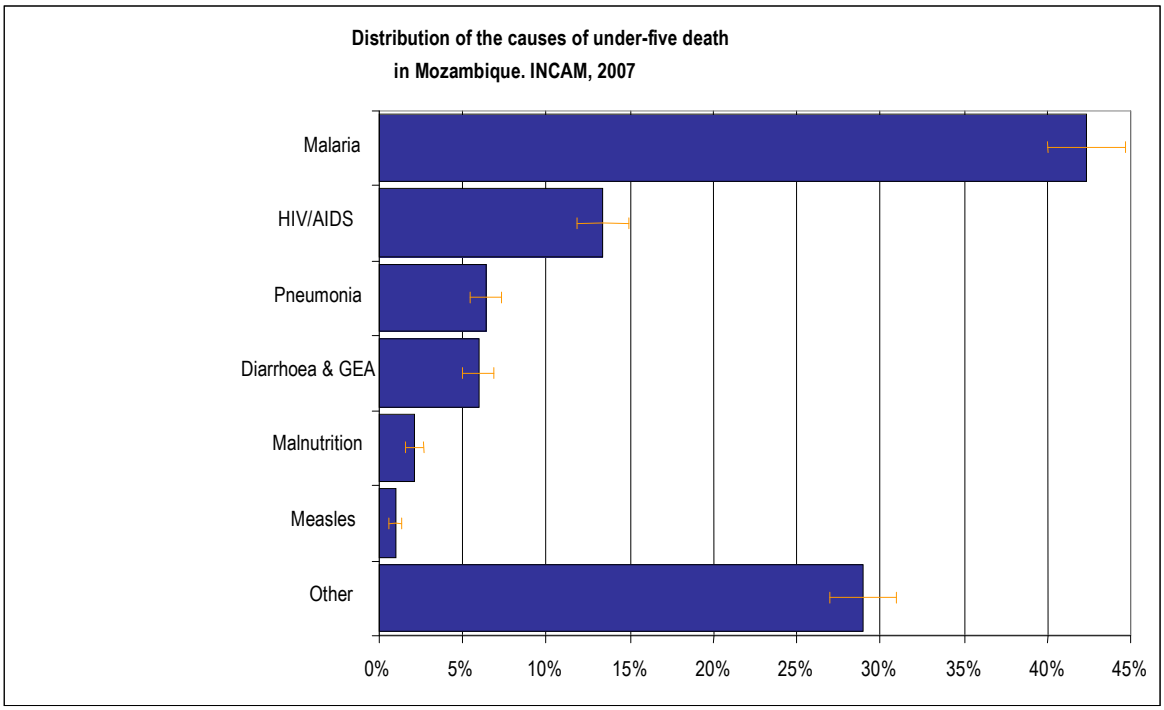
4.3 CAUSES OF MORTALITY

4.4.1 Situation and trend

According to the National Assessment of Maternal and Neonatal Health Needs in Mozambique (ANN, 2007/2008), the main causes of institutional neonatal deaths are premature birth (50%), serious suffocation (32%) and neonatal sepsis (29%). In the first 24 hours after delivery about 32% of the neonatal deaths occur and 49% after the first 24 hours after delivery until the seventh day. These data show the consequences of inadequate maternal health, inadequate care during pregnancy, delivery and the first few days after delivery and the urgent need to increase the coverage of institutional deliveries, essential newborn care and the coverage of visits until the seventh day.

The 2007/8 National Survey about the Causes of Mortality in Mozambique shows that malaria is the first cause of death in under-fives (42.3%), followed by AIDS (13.4%), pneumonia (6.4%) and diarrhoeas (5.9%).

Graphic 40: Distribution of the causes of child death in Mozambique in 2008



(Source: INCAM 2007/8)

The use of mosquito nets is among the most effective methods to prevent malaria and the percentage of under-fives sleeping the previous night under a mosquito net increased from 10% in 2003 to 42% in 2008 (MICS), with a higher increase in the rural areas. The MICS data show that 65% of the children with symptoms of an Acute Respiratory Infection were taken to a health service provider against 51% in 2003 (IDS) and that 47% of the children who had diarrhoea received oral rehydration therapy against 71% in 2003.

The prevalence of chronic malnutrition among under-fives decreased from 48% in 2003 (IDS) to 44% in 2008 (MICS), which is however still high. Little spaced pregnancies have a higher probability to result in babies with low weight-at-birth and interfere with breastfeeding, which has a fundamental role in infant nutrition. In spite of the increase of the coverage of new users of family planning in 2009, it is essential to guarantee the provision of quality family planning care as one of the strategies for the prevention of unwanted and high-risk pregnancies and for the increase of the interval between deliveries, thus reducing the risk of a related mother and child morbidity and mortality. The MICS data also show that the nutritional status of the children varies substantially according to the mother's level of schooling: almost

one in each two under-fives, whose mother has not been to school, is affected by chronic malnutrition, against one in each four children whose mother has a secondary level of schooling or above.

With a view to reduce child mortality, the sector has been implementing the Integrated Management of Childhood Illness (IMCI) strategy. However, in 2009 the IMCI coverage was 80% of the health network, representing a regression compared to the 90% achieved in 2008, according to the Health Sector's routine data. The implementation of the Reaching Every District (RED) strategy has represented an additional effort of the sector to reduce the prevalence of preventable diseases through vaccination. Its expansion has however been slow due to lack of sufficient funds.

ANN 2007/2008 shows serious deficiencies in the availability of goods and products for neonatal health: 35.1% of the delivery rooms did not have an operational ambulance for reanimating newborn babies, 79% of the delivery rooms did not have ampicillin on the day of the visit, 54% did not have nevirapine syrup and about 73% did not have vitamin K.

Constraints on the achievement of the targets for 2015

- The insufficient availability of human resources, in terms of quantity as well as quality, and their capacity to rotate, is also a challenge the health sector is facing and may be one of the causes of the retrocession of the expansion of the IMCI and may put at risk the expansion of the Essential Newborn Baby Care.
- Poor management capacity of the Neonatal and Infant Health Programme.
- Deficiencies in the availability and restocking of goods and products for neonatal and infant health.
- Deficient referral system at the various levels for the timely referral of children with a serious illness.
- Deficient information, monitoring and evaluation system, as well as deficient inter and intra-sector coordination.
- Ineffective intersectoral collaboration for the effort to intensify multi-sector actions for the reduction of neonatal and infant morbidity and mortality.
- AIDS and malaria continue a threat for the achievement of MDG4. In spite of the enormous progress regarding paediatric ART, the expansion of the quality services continues an enormous challenge for the sector.

- Though Mozambique is making significant progress in the children's well-being, this continues not being shared in the same way by all households.

Recommendations for the achievement of the targets for 2015

- Fair allocation of qualified human resources for neonatal and infant health at all levels;
- There is a need to increase efforts for the expansion of preventive measures against malaria, such as intra-domiciliary spraying and the distribution of mosquito nets, as well as to increase the percentage of cases treated with anti-malaria drugs within 24 hours after the start of the symptoms;
- Strengthening of preventive activities and reduction of mortality due to serious acute malnutrition and chronic malnutrition;
- Promotion of actions aimed at the improvement of the nutritional status of pregnant women and children;
- Strengthen the logistical system of the health sector for medicines and equipment as a fundamental strategy for the provision of quality newborn baby and child care;
- Revitalization of the Elementary General Agent Programme and other initiatives at community level to strengthen the involvement of the community in neonatal and infant health activities, especially for the more vulnerable children and communities;
- Strengthen advocacy to guarantee the integration of the rights of the child in the policies and legislation and raise the awareness of the communities/families regarding good child care practices.

Positive factors of progress in the indicators

- The Government and its development partners have assumed strong commitment at the highest political level to support neonatal and infant health, with the launching of the Presidential Initiative for Maternal, Neonatal and Infant Health and the Partnership in 2008 and more recently with the launching of the National Partnership for the Promotion of Maternal, Neonatal and Infant Health (2010).
- There is a trend to mobilise global initiatives, through financial support and in terms of strengthening institutional capacity, with a view to the achievement of this MDG.

GOAL 5 –IMPROVE MATERNAL HEALTH

Rapid assessment	Situation in Numbers				
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2007 /8**	**2015**
Potentially	Maternal mortality rate (per 100,000 live births)	692.0 (a)	(b)	500*. 1	250
Situation of the supportive environment	Proportion of births attended by skilled health personnel (15-49 years, %)	44.2	47.7	55.3 (c)	66
Reasonable	Contraceptive prevalence rate	6.0 (a)	18.2 (b)	16.2 (c)	34
	Antenatal care coverage with at least 1 visit (%)	71.4 (a)	84.5 (b)	92.4 % (c)	95
	Prenatal care coverage with 4 or + visits (%)	37.3 (a)	53.1 (b)	n/d	n/d
	Unmet need for family planning (%)	n/d	18.4 (b)	n/d	n/d

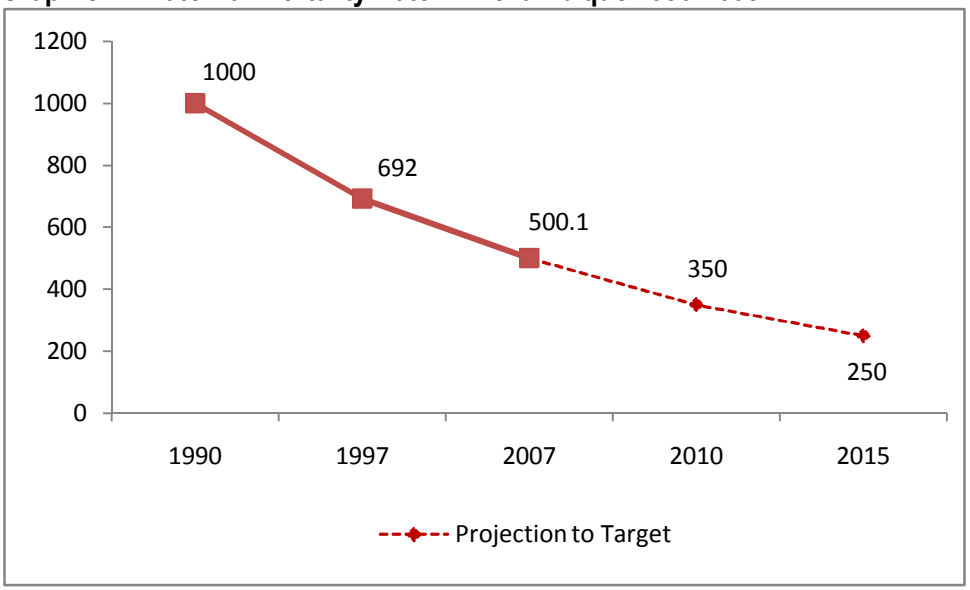
a) IDS 1997. b) IDS 2003. c) MICS 2008. * Censo 2007.

5.1 Maternal mortality in Mozambique

5.1.1 -Situation and trends

The maternal mortality rate has reduced gradually from 1000 deaths per 100,000 live births in the beginning of the 90s to 500.1 deaths per 100,000 LB in 2007 (Censo 2007)

Graphic 41 Maternal Mortality Rate in Mozambique 1990-2003

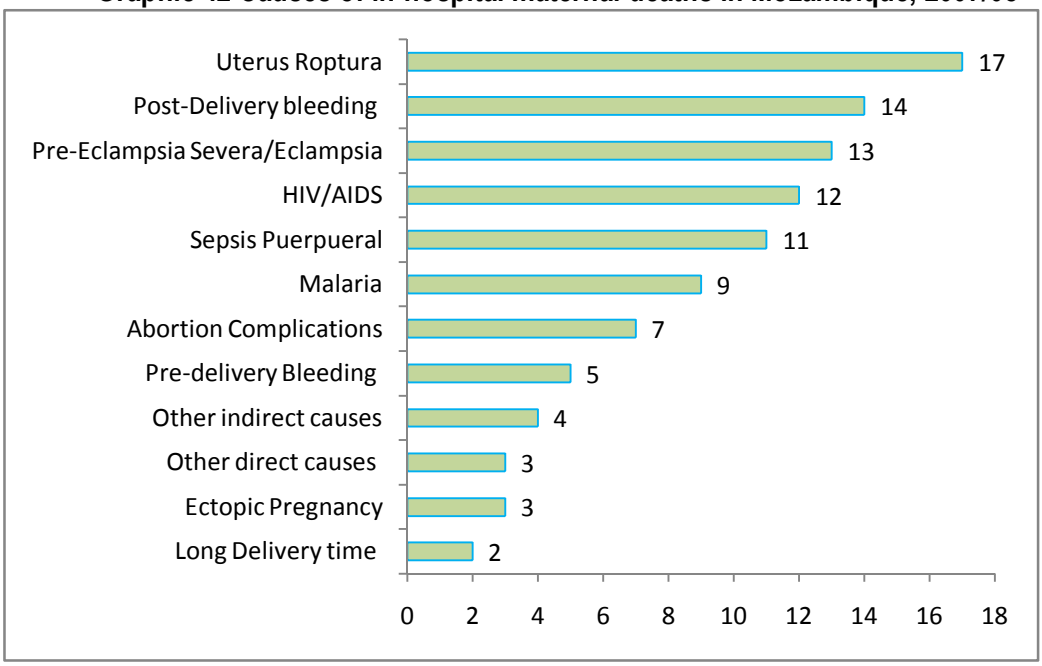


Source: INE, IDS 1997, Censo 2007

In-hospital maternal mortality represents an indicator of the quality of pregnancy and delivery care. Routine data show that the in-hospital Maternal Mortality Rate per 100,000 live births (LB) decreased substantially between 2008 and 2009 from 196/100,000 LB to 149/100,000 LB. However, the data of the National Assessment of the Maternal and Neonatal Health Needs in Mozambique (ANN 2007/2008) show a rate of 473/100,000 LB. The difference between these two data reflects the fact that under notification of maternal obits in the Health Information System (SIS) still persists. According to the ANN data, in the 15-30 year age group about 66.5% of the maternal deaths occur, which reflects the need to double efforts for the collection of information and sexual and reproductive health education of adolescents and youths.

About 43% of the maternal obits occur during delivery and before 24 hours after delivery, while in the primary level health units death occurs with greater frequency in the first two hours of the woman's admission, showing the precarious conditions and the late arrival of the women at the health unit. Regarding the causes of maternal death, 76% of the obits were due to direct causes and 24% to indirect causes. The main causes are uterine rupture (17%), post-delivery haemorrhage (14%), pre-eclampsia/eclampsia (13%), AIDS (12%) and puerperal sepsis (11%). AIDS appears as the first indirect cause of maternal death and the fourth of all causes.

Graphic 42 Causes of in-hospital maternal deaths in Mozambique, 2007/08



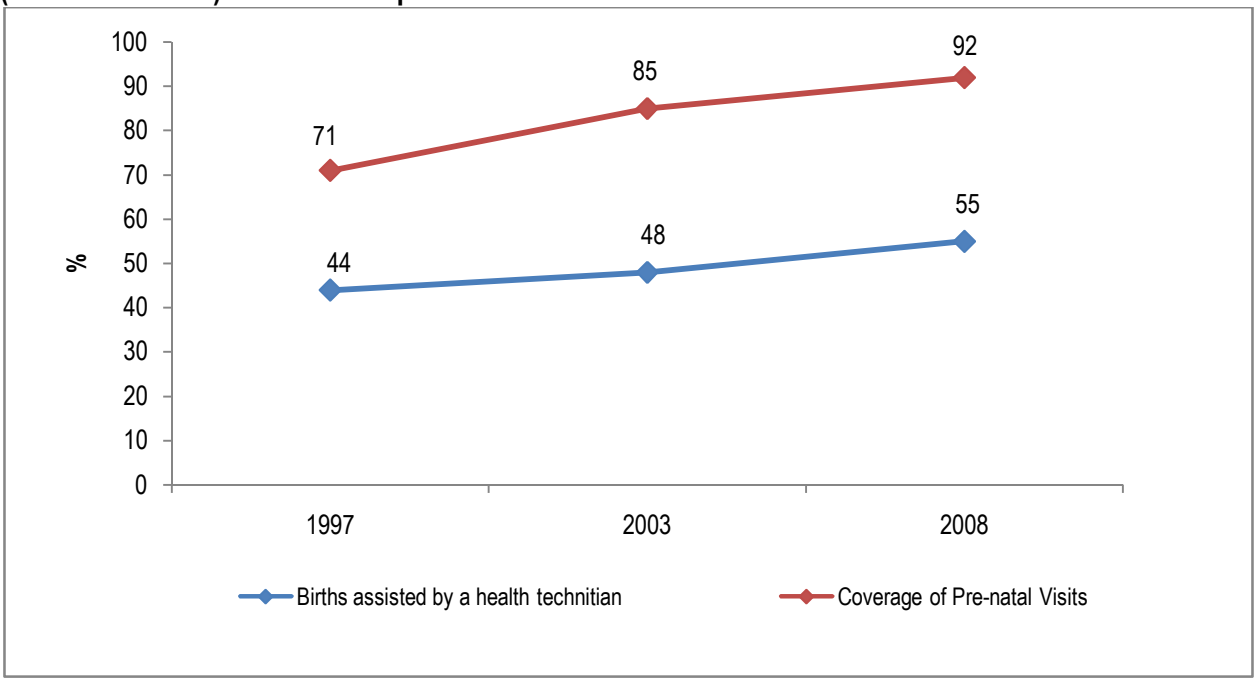
Source: MISAU

5.2 Coverage of prenatal visits

5.2.1 Situation and trend

According to the two IDSs, 1997 and 2003 and MICS 2008 the coverage of prenatal visits with at least a year increased from 71.4% to 84.5% and to 92% respectively. The rate of deliveries attended by health technicians has increased from 44.2% in 1997 (IDS 1997) to 47.7% in 2003 (IDS 2003) and to 55% in 2008 (MICS).

Graphic 43: Percentage of deliveries attended by health technicians and coverage of prenatal visits (at least one visit) - in Mozambique 1997-2008

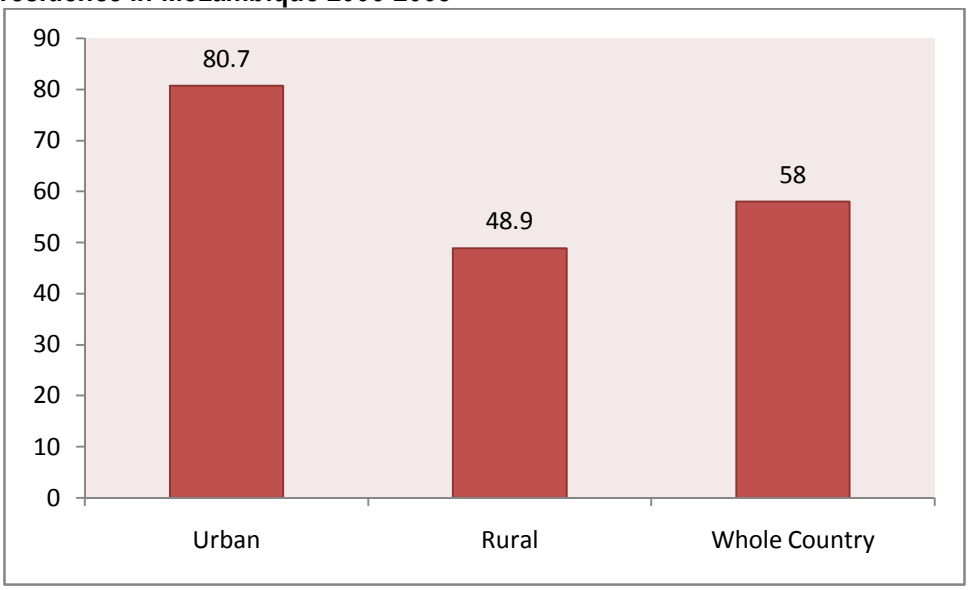


Source: MISAU

The coverage of prenatal visits with 4 or more control visits increased from 37.3% (1997) to 53.1% (2003). The routine data of the Health Information System (Ministry of Health, MISAU 2009) show a stagnation trend of the coverage of institutional deliveries from 53.8% in 2007 to 55.6% in 2008 and 55.0% in 2009.

According to 2008 MICS data, the coverage of institutional deliveries was 58%. In the rural areas it was 49%, representing an increase in relation to the 2003 data (34%) and it remained stable in the urban areas (81%).

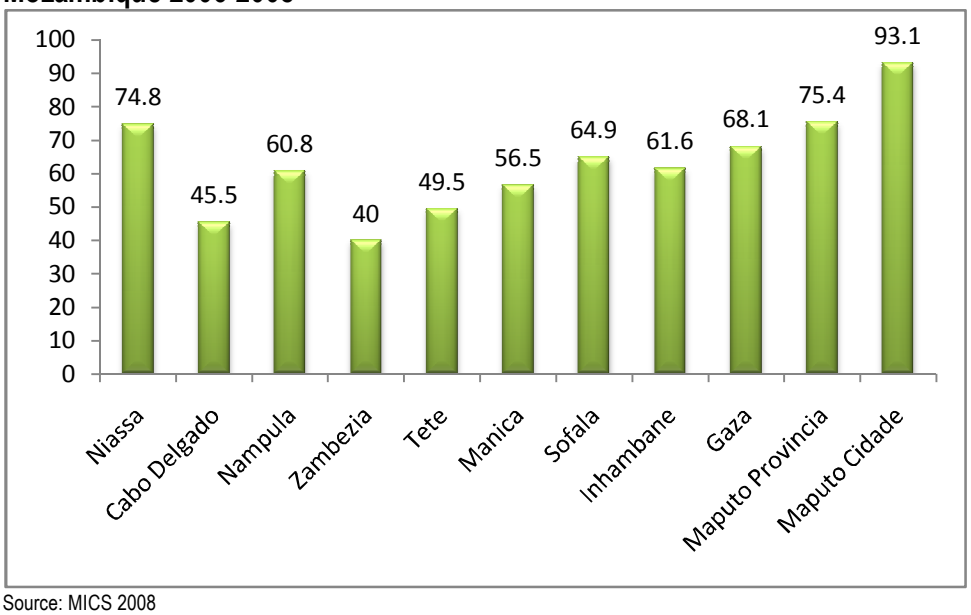
Graphic 44: Percentage of 15-49 year-old women who had institutional deliveries by area of residence in Mozambique 2006-2008



Source: MICS 2008

In terms of distribution by province of the institutional deliveries of 15 to 49 year-old women, it is observed that the northern and central provinces of the country (except Niassa) have the lowest percentages of institutional deliveries of the country. It should be observed that the second more populous province of the country (Zambézia) has the lowest rate of institutional deliveries.

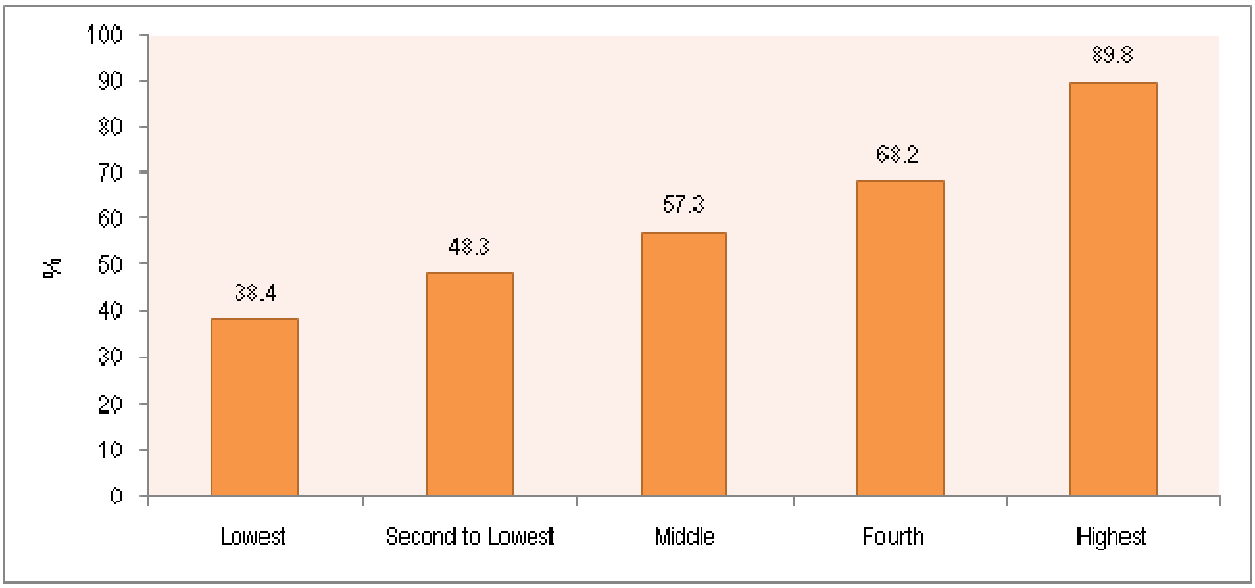
Graphic 45: Percentage of 15-49 year-old women who had institutional deliveries by province in Mozambique 2006-2008



Source: MICS 2008

The MICS data show once again that the probability of occurrence of deliveries in the health units is positively correlated to the households' level of wealth: 38% of the deliveries of the lowest wealth quintile occurred in health units, against 90% of the highest wealth quintile and the tendency in the intermediate quintiles continues the same.

Graphic 46: Percentage of 15-49 year-old women who had institutional deliveries by wealth quintiles in Mozambique 2006-2008



Source: MICS 2008

5.3 Family Planning

5.3.1 Situation and trend

One of the main interventions for the reduction of maternal mortality is the expansion of Basic and Complete Emergency Obstetric Care. According to the WHO/UNFPA criteria for the coverage of Emergency Obstetric Care (COEm) the assessment indicates that the need to expand COEm substantially still exists as well as to double efforts for the improvement of the quality of delivery attendance and the management of obstetric complications.

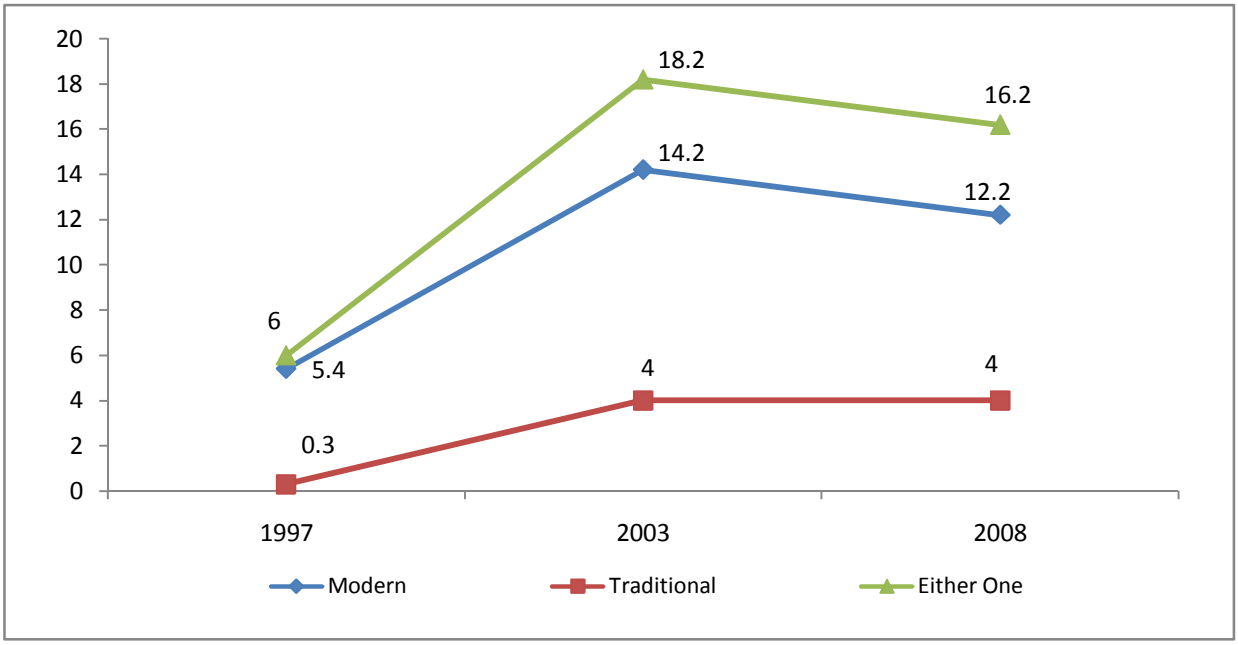
Table 12: Basic indicators of the national needs assessment 2007-2008

NU Indicators	National Needs Assessment 2007-2008
Number of Health Units offering Basic Emergency Obstetric Care (COEmB)[7]	45 (38% of the minimum coverage)
Number of Health Units offering Complete Emergency Obstetric Care (COEmC)	33 (80% of the minimum coverage)
Proportion of deliveries attended in Health Units with COEm	17%
COEm needs satisfied	11%
Proportion of Caesarean deliveries	2% (below the minimum of 5% recommended by the WHO)
Fatality rate due to direct obstetric Complications	5.9% in Health Units with COEm and 5.2% in all Health Units
Rate of Foetal Intra-delivery and Precocious Neonatal Mortality	2.4% in Health Units with COEm and 1.0% in all Health Units

Source: MISAU

Regarding family planning, the rate of the use of contraceptives by married women (or women living in a marital union) increased from 6% in 1997 to 18.2% in 2003 and decreased slightly to 16.2% in 2008. This decrease corresponds to the decrease of the use of modern contraceptives, which decreased from 14.2% in 2003 to 12.2% in 2008. The percentage of the use of traditional contraceptives increased from 0.3% in 1997 to 4% in 2003 and stayed at this level until 2008.

Graphic 47: Prevalence of the use of contraceptive methods and types by married women and women living in a marital union 15-49 year-old women in Mozambique 1997-2008



Source: MISAU

[7] The COEmB and COEmC indicator per 500,000 inhabitants was not calculated.

The prevalence of the use of contraceptives varies, but is higher in the southern and central provinces. The women prefer modern methods except in Sofala Province where the women prefer traditional methods (26%). Modern methods are more used in Maputo City (32.9%) and Maputo Province (32.4%). Cabo Delgado Province has the lowest rates in all methods.

Table 13: Prevalence of the use of contraceptives by province in 2008

Provinces	Modern	Traditional	Any
Niassa	12.8	0.9	13.6
Cabo Delgado	3	0.2	3.2
Nampula	3.8	3.5	7.3
Zambézia	8.4	0.4	8.8
Tete	17.2	0.7	17.9
Manica	9.9	0.7	10.6
Sofala	11.1	26	37.2
Inhambane	17.1	1	18.1
Gaza	17.1	0.4	17.5
Maputo Province	32.4	1.7	34.1
Maputo City	32.9	1.3	34.2

Source: MICS 2008

In general, the use of contraceptives is higher in the urban areas (24.8%) than in the rural areas (12.4%), and modern methods are more preferred in the urban areas (21.6% against 3.2% of traditional methods). In the rural areas modern methods are more preferred (8% against 4.4% of traditional methods). When the level of wealth is taken into consideration the poorest families tend to prefer the use of traditional methods while the richer families tend to prefer modern methods. The data appear to indicate the existence of an inverse relation between the number of users of traditional methods and the level of wealth of the families, i.e. the greater the family's level of wealth the smaller the use of traditional methods. For the case of modern methods there is a direct relation between the household's level of wealth and their use.

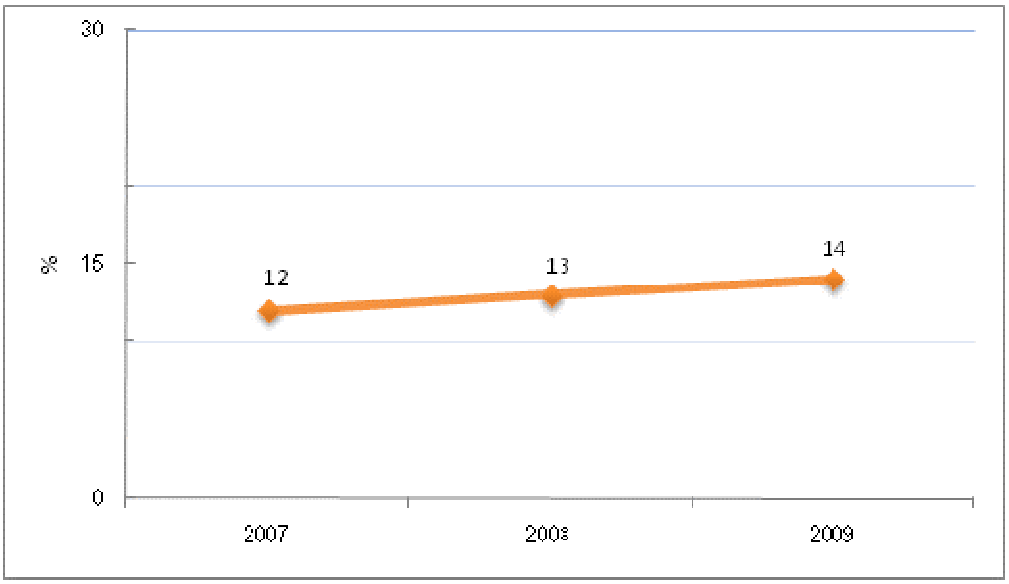
Table 14: Prevalence of the use of contraceptives by area of residence and wealth quintiles Mozambique 2008

Area of Residence and Wealth Group	Modern	Traditional	Any
Urban	21.6	3.2	24.8
Rural	8	4.4	12.4
Wealth quintiles			
Lowest	4.9	5.7	10.7
Second	4.8	5.3	10.1
Middle	8.3	3	11.6
Fourth	14.8	3.3	18.1
Highest	29.9	2.9	32.8

Source: MICS 2008

MISAU routine data (SIS) indicate an important growth of the Family Planning Programme in 2009, as the coverage of new users of family planning methods increased from 12.5% in 2008 to 13.9% in 2009. However, facts such as inadequate management of the family planning programme, insufficient information and education of the population and deficient integration of men in the sexual and reproductive health policies/strategies and programmes, among others, may limit the expansion of the programme and slow down Mozambique's progress to the achievement of the target for the Contraceptive Prevalence Rate in 2015 (34%).

Graphic 48: Coverage of new users of family planning 2007-2009



Source: SIS 2007, 2008 and 2009.

The use of Family Planning Services is not met by 18.4% (18% in the rural areas and 20% in the urban areas). The rate of prevalence of contraception for sexually active unmarried/not united women was 43.7% for all methods and 40.6% for modern methods, which may reflect the fact that unmarried/not united women have greater decision power at the moment to decide about the use of family planning methods. Regarding the overall fertility rate, i.e., the average number of children per woman, when comparing the 1997 and the 2007 data there was no progress: from 5.9 to 5.8 respectively. There are no data about the adolescent birth rate.

INAIDS 2009 data show that the proportion of youths who had sexual relations before the age of 15 decreased slightly in the last few years, especially among women: 25% of the women between 15-24 years had sexual relations before the age of 15 against 28% in 2003 (IDS). For men the proportion decreased by 1%, i.e., from 26% in 2003 (IDS) to 25% in 2009 (INAIDS). The delay in the start of sexual life took mainly place in the rural areas.

It should be emphasized that, according to INAIDS 2009, the proportion of women who had sexual relations before the age of 15 decreases drastically with the level of schooling, from 38% for women without schooling to 11% for women with secondary education. In the case of men this difference does not occur. The study about Iniquity in Maternal and Infant Health in Mozambique (WHO, 2007) identified the education of women as one of the key socio-economic facts that contribute to the iniquities for a delivery by qualified staff. All these data once again show the need to strengthen intersectoral interventions to increase the access of girls to education.

The existence of qualified professionals for the attendance of deliveries and obstetric complications is a key factor for the reduction of maternal mortality. In the ANN it was evident how the absence of professionals qualified to provide emergency care, such as doctors with surgical abilities, surgical technicians, anaesthetists and instrumentalists was decisive for the occurrence of maternal deaths. Another important aspect is that only 4.2% of the inquired Health Units mentioned the existence of trained staff for the repair of obstetric fistulas, one of the most incapacitating and serious consequences of pregnancy. This study shows once again the persistence of iniquities in the distribution of human resources in the country: about half of the paediatricians and gynaeco-obstetricians are working in Maputo City.

On the other hand, the study shows serious deficiencies in the availability of goods and products for reproductive and neonatal health to perform the fundamental functions that can save lives: only 37.7%

of the delivery rooms has at least one complete delivery kit, 31.4% of the maternities did not have diazepam and 38.2% did not have magnesium sulphate on the day before the inquiry.

Constraints on the achievement of the targets for 2015

- Insufficient number and quality of human resources to respond to the need of improvement of the management of the programmes and services at all levels; a more equitable distribution of the existing qualified human resources and the provision of quality service. This insufficiency hampers the expansion of COEmB and COEmC, post-delivery visits, post-abortion care, the prevention of vertical transmission and the preventive intermittent treatment of malaria, among others.
- Poor management capacity of the Sexual and Reproductive Health Programme, including Family Planning.
- Deficiencies in the availability and restocking of goods and products for reproductive health.
- A deficient referral system at the various levels for the timely referral of obstetric complications and other emergency situations.
- Poor community involvement, particularly of the men, in problems related to reproductive health, and especially family planning.
- A deficient information, monitoring and evaluation system, as well as inter and intra-sector coordination.
- Poor effective intersectoral cooperation in an effort to increase multi-sector interventions for the reduction of maternal and neonatal morbidity and mortality and the promotion of a healthy sexual life.

Recommendations for the achievement of the targets for 2015

- Invest strongly in the initial training of specialised maternal health professionals, and their availability at district level (maternal and infant health nurses, surgery technicians and doctors);
- Continuous training and expansion of emergency obstetric care and essential obstetric care;
- Implement the Family Planning Strategy;
- Strengthening of the logistical system to guarantee that the goods and products for sexual and reproductive health are at the right place and the right time as fundamental pillar for the provision of quality care;
- The need to give priority to guaranteeing service quality through formative supervision at all levels;

- Ensure the implementation of interventions for strengthening community involvement, especially focussed on the youth and on the involvement of men in the reproductive health services;
- Strengthening of the information, monitoring and evaluation system and inter and intra-sector coordination.

Positive factors of progress in the indicators

- Since 1977 Maternal Health is at the top of the Government priorities and has benefited from an increase of investment and significant progress in the main reproductive health indicators.
- Since 2008 until today, the Presidential Campaign for Maternal, Neonatal and Infant Health was launched (2008) as well as the National Guide to Accelerate the Reduction of Maternal and Neonatal Mortality (2008), the Integrated National Plan for the Achievement of MDG 4&5 (2009), the Campaign to Accelerate the Reduction of Maternal Mortality in Africa (CARMMA, 2009). And recently the National Partnership for the Promotion of Maternal, Neonatal and Infant Health was launched (2010). All these events express the strong commitment at the highest political level between the Government and the Development Partners to Maternal, Neonatal and Infant Health. The Family Planning Strategy has recently been approved with the objective to increase considerably the use of the Family Planning and Contraception Services by the Mozambican population.
- The effort of the programmes for the achievement of MDG5 is measured annually through indicators that are part of the Joint Health Sector Performance Assessment Framework (Government and Partners) and occupy an important place in the political dialogue.

GOAL 6 – COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Rapid assessment	Situation in Numbers					
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2008**	**2009**	**2015**
Potentially	Rate of prevalence of HIV/AIDS among adults (15-49 years of age) (a)	8.6%	9.3%	11.5%	11.5%	n/a
Situation of the supportive environment **Reasonable**	Prevalence of HIV in pregnant women aged 15-24 years	11.0	12.9	n/a		n/a
	Rate of condom use of the rate of prevalence of contraceptives	1.1 c)		b)		n/a
	Ratio of the current school attendance of orphans to school attendance of non-orphans aged 10-14 years		0.9	0.89		

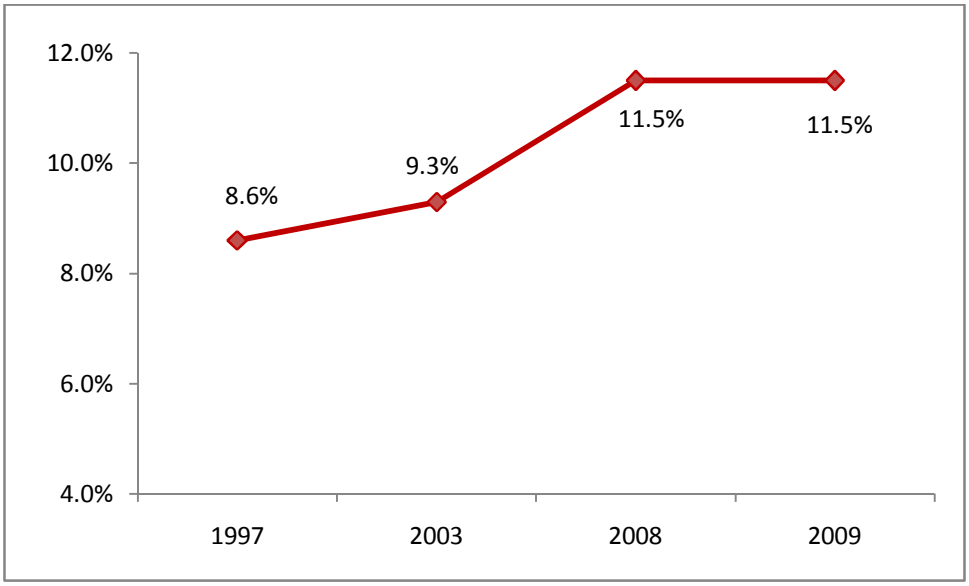
Source: INSIDA 2009, MICS 2008; a) The HIV/AIDS prevalence rates through the years were calibrated using the 2009 INSIDA survey results

6.1 Fighting HIV AND AIDS

6.1.1: Situation and trend

HIV/AIDS is one of the big threats to development in Mozambique. The prevalence of HIV/AIDS among youths and adults (15 to 49 years of age), estimated on the basis of blood samples obtained during the national survey on prevalence, behaviour risks, and knowledge about HIV/AIDS in Mozambique – INSIDA 2009, as well as from the calibration of previous HIV/AIDS rates results using the INSIDA2009 survey data, stayed constant with a rate of 11.5% between 2008 and 2009, after having shown an increasing tendency from 8.6% to 11.5% between 1997 to 2008 .

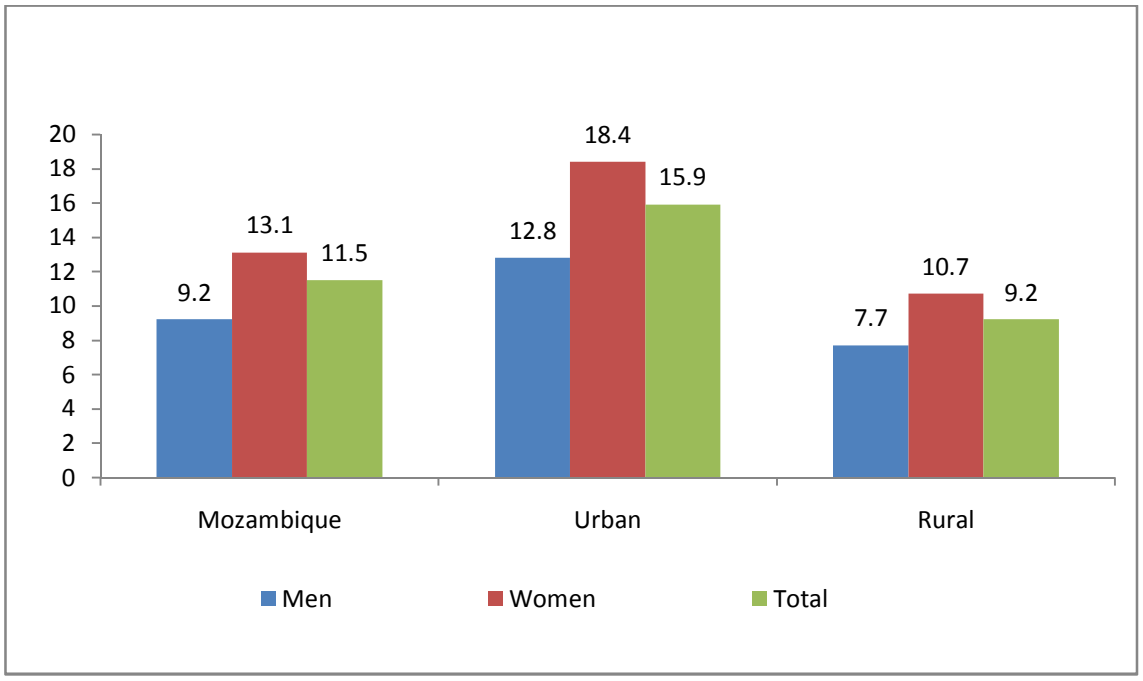
Graphic 49: Rate of prevalence of HIV/AIDS among adults aged 15-49 years in Mozambique 1997-2009



Source: INSIDA 2009

Looking at the distribution of the prevalence of HIV/AIDS by sex in Mozambique in 2009, it is observed that the prevalence of HIV/AIDS was higher in women (18.4%) than in men (12.8%). This confirms the vulnerability of women to HIV/AIDS contamination in Mozambique. Looking at the distribution of HIV/AIDS over residential areas in Mozambique in 2009, it becomes clear that the prevalence of HIV/AIDS in Mozambique was higher in the urban areas (15.9%) than in the rural areas (9.2%). This result is surprising when taking into consideration that in the urban areas the conditions for the dissemination of information about HIV/AIDS are more favourable and where people with a higher level of education and with greater purchasing power live.

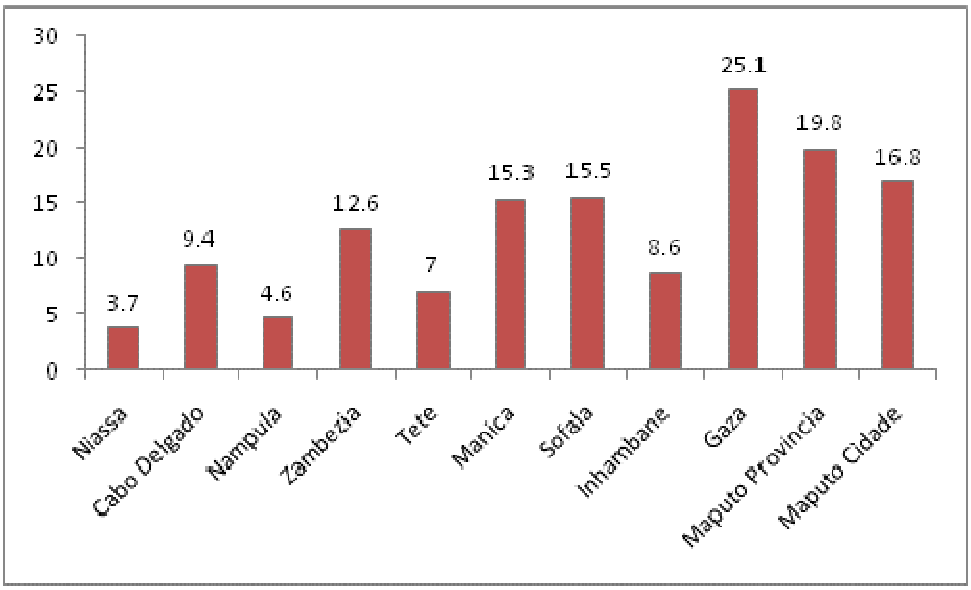
Graphic 50: Prevalence of HIV among adults aged 15-49 years, by area of residence and sex in Mozambique, 2009



Source: INSIDA, 2009

Looking at the distribution of the prevalence of HIV/AIDS by province, we observe that Gaza Province has the highest prevalence (25.1%) and Niassa Province has the lowest prevalence of HIV/AIDS (3.7%). The high rate of HIV/AIDS prevalence observed in Gaza may be related to the fact that Gaza is the province of the country sending a larger number of workers to the mines of South Africa and has therefore a higher level of exchange with South Africa. As Niassa Province in the north of the country is very isolated from the rest of the country it has the lowest rate of prevalence.

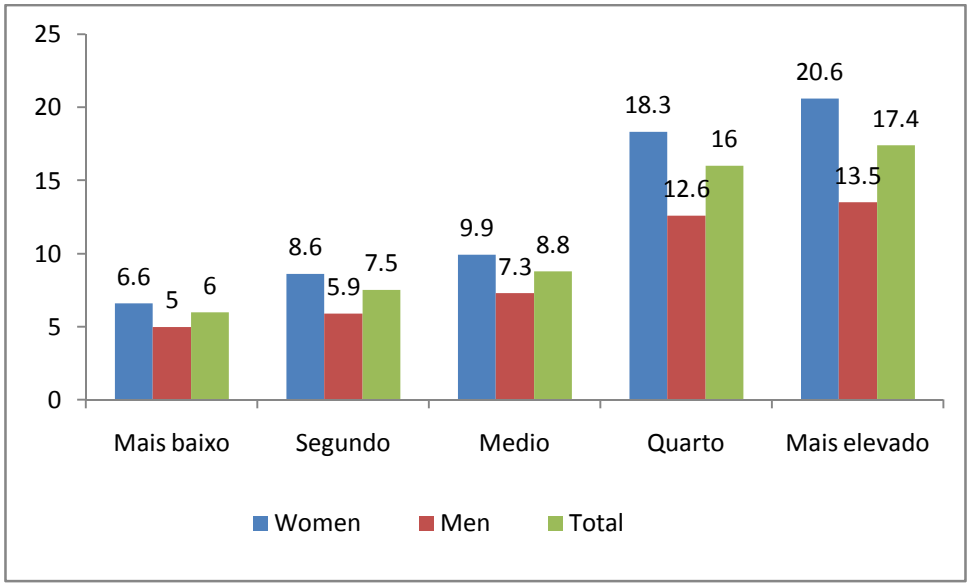
Graphic 51: Prevalence of HIV among adults aged 15-49 years, by province, Mozambique, 2009



[Source: INAIDS, 2009]

Looking at the prevalence of HIV/AIDS infections by sex and also by the different wealth quintiles in Mozambique in 2009, it is observed that the rate of prevalence was higher in women than in men in all wealth quintiles. The most surprising fact is that the difference between women and men in the wealth quintiles is increasingly bigger with the increase of the people's level of wealth. Another important aspect to be observed is that the level of prevalence of HIV/AIDS infection increases according to the increase of the level of wealth.

Graphic 52: Prevalence of HIV among adults aged 15-49 years, by province, Mozambique, 2009



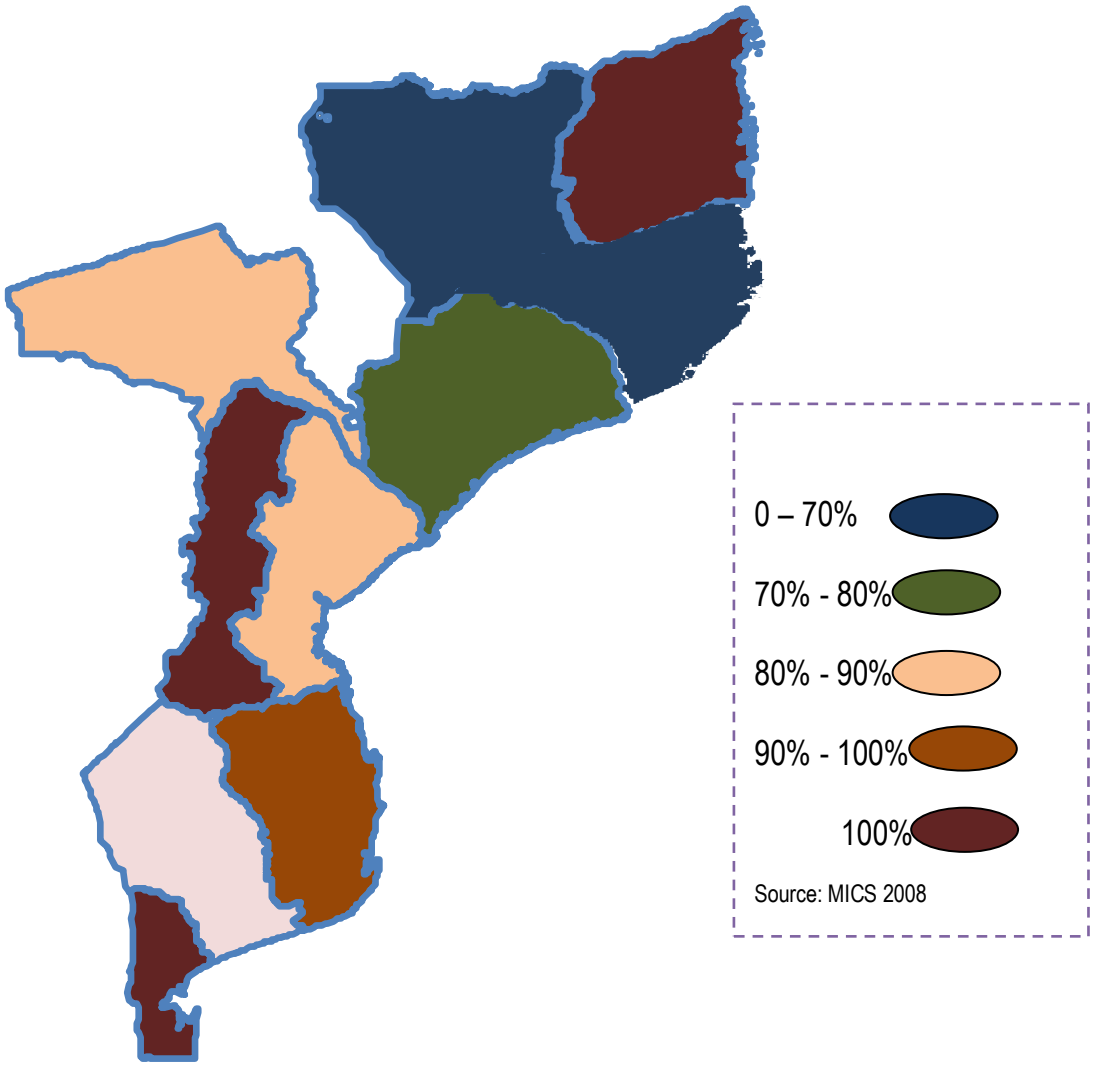
Source: INAIDS, 2009

In the course of the last few years there was progress in the field of prevention, care and treatment. Several actions are taken in the area of prevention, with emphasis on the preparation and implementation of the Prevention Acceleration Strategy (EAP), approved by the Council of Ministers, and on HIV counselling and testing, which reaches an increasingly larger number of people. The expansion of health counselling and testing, both in the clinical context and at community level, led to an increase in the number of people tested during 2009.

Thus, about 602,171 people were attended in the Health Counselling and Testing Units (UATS) and 528,347 were tested, of whom 128,403 were positive in the 359 units providing these services. In Community Health Counselling and Testing (ATSC) about 260 users were attended and 232,143 were tested, 17,934 of whom were positive.

Regarding the Vertical Transmission Prevention programme (PTV), the number of health units offering PTV service increased to 832 units in 2009, against 744 units in 2008. Thus, in 2009 a total of 888,861 pregnant women were attended for the first time in the CPN with PTV services (712,768 were attended in 2008). The number of pregnant women counselled and tested in these health units also increased to 649,820 (73.1%) in 2009, against 511,972 (71.8%) in 2008. Meanwhile, until December 2009, 66,615 pregnant women had received anti-retroviral treatment for the prevention of vertical transmission, corresponding to 45.8% of the total number of HIV-positive pregnant women estimated in the country. In 2008 a total of 46,848 pregnant women received anti-retroviral treatment (32.1% of the total).

Figure 3: Percentage of Health Units with Prenatal and Vertical Transmission Prevention Services, September 2009.



6.1.2 Anti Retroviral treatment

Anti-retroviral Treatment (ART) has been growing, both in the number of health units and the number of patients in treatment, including children under 15 years of age. Until 30 December 2009 there were 156,688 adults and 13,510 children under 15 years of age receiving ART, giving a total of 170,198 ART patients.

There was a rapid increase in the number of places providing antiretroviral treatment. By December of 2009 there were 222 health units providing antiretroviral treatments of which 221 (99.5%) provided antiretroviral treatment to HIV positive children, compared to 188 of 213 (88%) in 2008 and 148 of 211 (70%) in 2007.

Table 15 Number of health units offering anti-retroviral treatment (ART)

	2004	2005	2006	2007	2008	2009
No. of health units offering ART	24	38	156	211	213	222
Quaternary	24	24	11	10	10	10
Secondary	0	14	36	39	40	39
Primary	0	0	109	162	163	177

Source: MISAU

Of the 242,854 registered patients who entered for ART as new (230,181) or resuming (12,673) patients since the beginning of the treatment provision at the end of 2003, to the end of 2009 3% had been suspended (6,269), 17% had abandoned (39,098), and 8% had died (18,794).

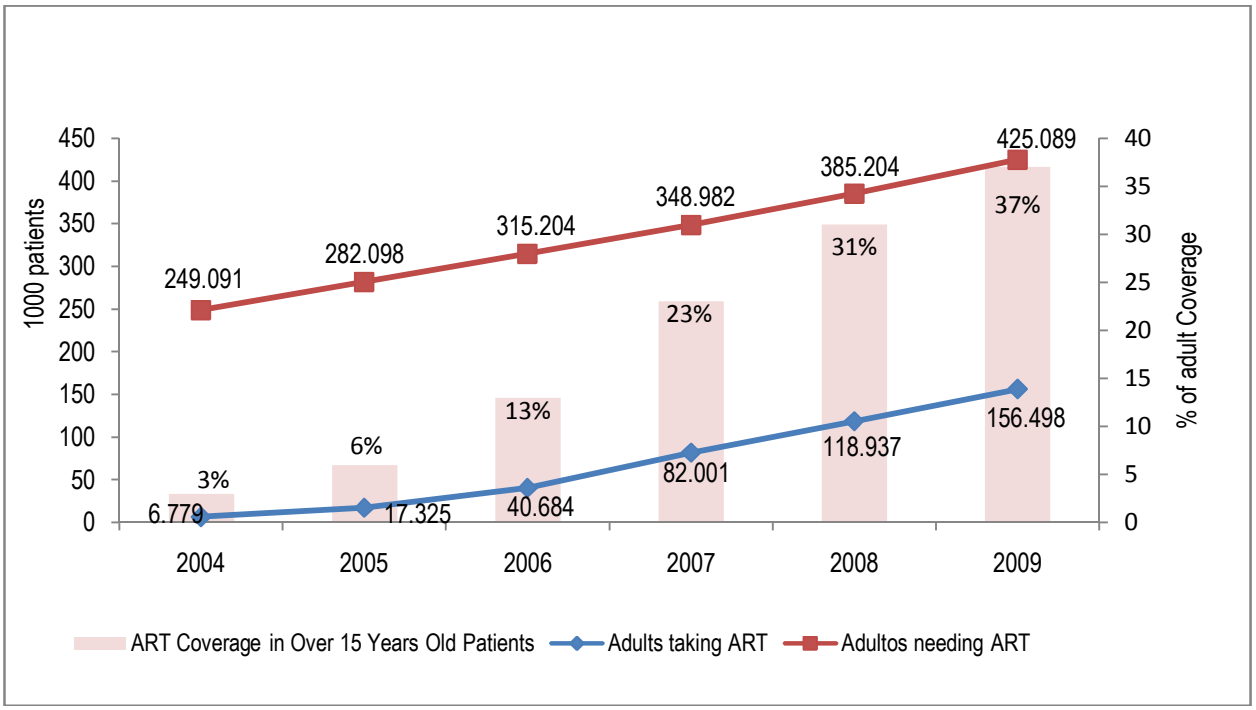
The percentage of HIV-infected blood units decreased from 8.3% (2003) to 5.6 % (2009). This was lower than the estimated national prevalence of HIV in adults.

The percentage of syphilis and hepatitis B-infected blood units decreased in the last few years and has been below the prevalence of HIV in blood donors, with the exception of last year in which the prevalence of hepatitis B was higher than that of HIV.

6.1.3 Antiretroviral treatment for adults

Regarding ART for adults, graphic 53 shows the expansion of the services and coverage between 2004 and 2009. At the end of 2009, the sector (MISAU) target of 148,500 adult patients receiving ART was exceeded by approximately 8188 patients, with 156,688 adult patients in fact receiving ART. Based on estimates of treatment needs calculated with the use of the Spectrum projections package, about 37% of adults in need of treatment were receiving ART.

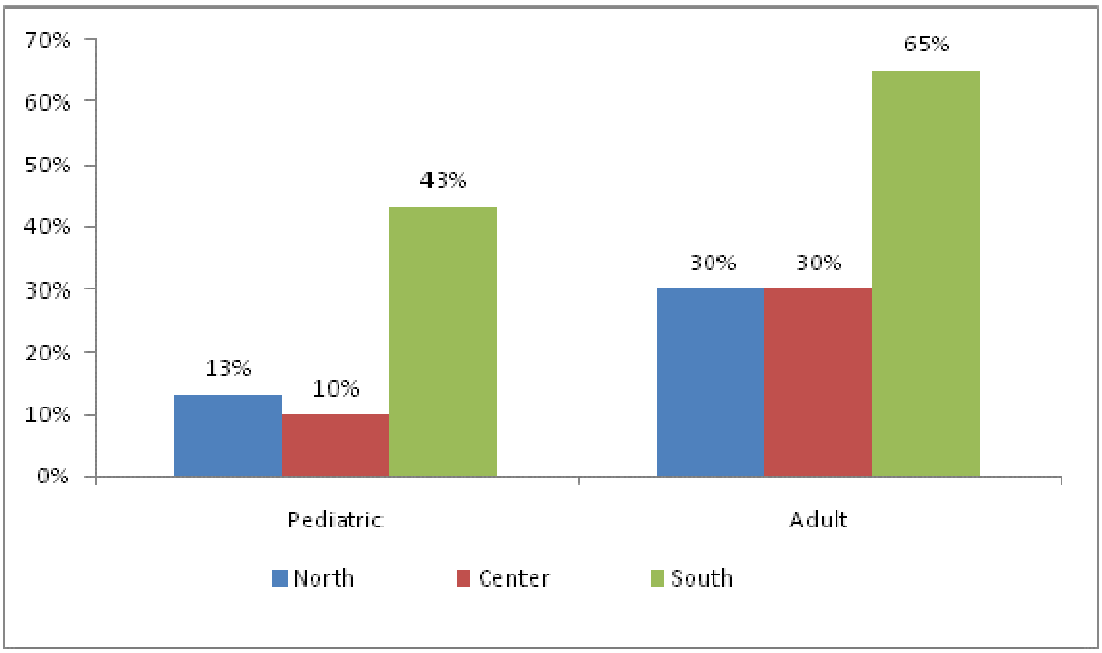
Graphic 53 – Access, need and coverage of anti-retroviral treatment of patients over 15 years of age in Mozambique, 2004-2009



Source: MISAU

Though this is an impressive success for a national programme that has been providing treatment and care for only six years, fairness in the distribution of ART coverage over the different regions of Mozambique is an issue of concern. As graphic 54 shows, the central and northern provinces have less than half of the coverage of ART than the southern region, where the capital is situated.

Graphic 54 – Coverage of Anti-Retroviral Treatment of adults and children by region, in 2009

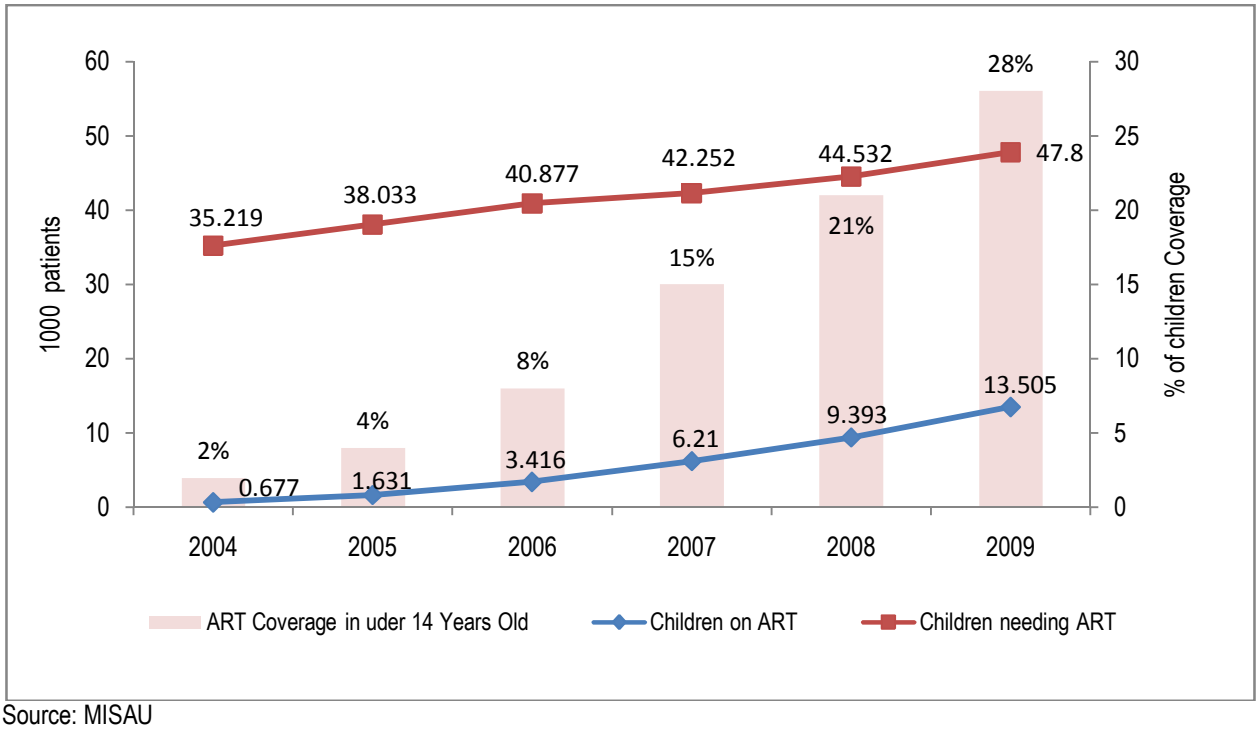


Source: MISAU

6.1.4 Paediatric Anti-Retroviral Treatment

Mozambique has come a long way on the expansion of paediatric anti-retroviral treatment services, since the beginning of the programme in 2004. In this period, the number of children under 15 years of age in treatment in the country increased from less than 677 in 2004 to 13,505 at the end of 2009. This represents a coverage of 28% of eligible children by the Ministry of Health, based on the application of the Spectrum model.

Graphic 55: Access, need and coverage of anti-retroviral treatment of minors under 14 years in Mozambique, 2004-2009



Source: MISAU

The official projections of the Ministry of Health (MISAU) were updated for the UNGASS report in the light of the changes introduced by MISAU regarding the eligibility criteria for adults and children. In particular, these last estimates show a reduction of the coverage of children between 2008 (21%) and 2009 (19%), as a result of MISAU's new instructions for paediatric treatment. However, the absolute number increased from 9,393 in 2008 to 13,510 in 2009. Though this figure represents a significant improvement of the 0.2% coverage in 2004, the coverage of treatment for children is still very far from being satisfactory.

Anti-retroviral treatment for children is being brought progressively to the populations and is expanding all over the country. In 2006, 68% of all children receiving treatment were living in the four southern provinces of the country and 55% were living in Maputo City. In 2008, the southern provinces had 56% of all children in anti-retroviral treatment and Maputo City had 33%. Also, in 2009 the southern provinces represented 57% of all children in ART, with Maputo representing 30%. In spite of the expansion to other provinces, the geographical distribution of the children with access to treatment is still not fair. in the southern region of the country, approximately half of the children in need of anti-retroviral treatment has the possibility to receive treatment, while the percentage of unattended needs is much higher in the central and northern regions.

An adjustment was made of the targets of paediatric treatment between 2008 and 2009. In PARPA II an initial target of 50% coverage by 2009 was agreed, accompanied by an increase of the number of paediatric treatment centres from 34 in 2005 to 150 in 2009, particularly the expansion of the services in the central and northern provinces of the country.

In 2008 the Ministry of Health decided to reduce the paediatric targets drastically in response to the increase of the deficit between the expected results and progress achieved in 2007 and 2008. Giving follow-up to the evaluation of the progress achieved and an analysis of the number of new children who started ART in the previous year, the Ministry of Health reduced the target for 2009 from the target previously established in PARPA II of a coverage of 50% to 24% or 11,500.

In 2009, following the adoption by Mozambique of the anti-retroviral treatment directives and the expansion of Early Infant Diagnosis through the installation of two PCR machines in the central and northern regions of the country, the Ministry of Health, in cooperation with implementation partners, decided to raise the ART targets for 2010-2014 (Table below).

Table 16: Revised Paediatric HIV targets for 2009, Ministry of Health, Mozambique

	2010	2011	2012	2013	2014
Children in anti-retroviral treatment	19,426	23,818	29,058	34,258	39,743
Children in ART as proportion of the total	9.9%	10.7%	11.4%	11.9%	12.3%

Source:MISAU

Even representing an improvement, these revised targets continue much below the original PARPA II targets (50% coverage in 2009) and further away from the commitment to universal access.

While in the past some “Day Hospitals” had a dedicated space for paediatric patients, while others offered visits to children in certain periods, since 2008 MISAU’s policy is to integrate the treatment of seropositive children into the general ART services.

Until today, in the majority of the health units paediatric ART is started by doctors. The medical technicians, who initially were trained in 2006 to start the first “standard” adult protocol line and monitor the patients in treatment directly, and from there be allowed in 2007 to start a first alternative treatment line and the treatment of pregnant women and patients with tuberculosis (TB). At this moment their training / retraining in paediatric ART is being planned. Paediatric ART training packages were developed for these technicians and the training of trainers is planned for the first quarter of 2010.

Paediatric ART in Mozambique was initially based on the use of individual syrups. Mozambique changed its approach in 2009 and opted for combinations of paediatric fixed doses that are cheaper, easier to administer, keep longer and have an equivalent effectiveness.

The identification, referral and retention services for HIV-infected children in hospital care and in treatment are poor. The links between the various entry points for HIV-infected children are still weak and inconsistent and at all levels of the health units the referral systems between the existing paediatric care services require significant improvement. In the treatment frontline there is currently no system to identify an exposure or infection or the stage of the infection of the children who come to receive a vaccination or who come for ambulatory treatment.

In terms of integration of services, the protocols for the integrated management of neonatal and infant diseases (AIDNI) were updated to include HIV/AIDS and its dissemination occurred in 2008.

There was an accelerated increase of the number of centres providing anti-retroviral treatment: until December 2009 there were 226 health units with anti-retroviral treatment services and 221 of these units (98%) offered anti-retroviral treatment to seropositive children, against 188 of 213 units (88%) in 2008 and 148 of 211 units (70%) in 2007.

6.1.5 Availability of contraceptives

The availability of contraceptives increased considerably in 2009 in comparison to the previous year. This was due to the improvement of the logistical and management capacity of the distribution of contraceptives at all levels, mainly in the rural areas, with the support of the United Nations Population Fund (UNFPA), Population Services International (PSI) and the Department for International Development (DFID). Other aspects contributed to the increase of the availability of contraceptives, such as the creation of multisectoral contraceptive groups at central and provincial level, headed and/or coordinated by the Provincial HIV/AIDS Combat Nuclei (NPCS's), the Provincial Directorates of Health (DPSs), and with the participation of Non-Governmental Organisations (NGOs) and the public and private sectors. The training given to the provincial trainers about female contraceptives also contributed to the increase of their availability.

Of the 93,600,034 male contraceptives planned for 2009, 88,257,368 male and 922,950 female contraceptives were distributed. There was thus an increase of 54.4% in the distribution of contraceptives in 2009, which in absolute numbers means 89,180,318 contraceptives in 2009 against 48,527,329 contraceptives distributed in the previous year.

Challenges for the achievement of the targets for 2015

For the achievement of the targets for 2015, the country should:

- Focus actions on the high risk groups and on people in stable relations (a single partner);
- Promote and consolidate the consistent use of female and male contraceptives;
- Prepare specific communication strategies for social and behavioural change;
- Continue the expansion of quality paediatric and adult ART;
- Decrease of the regional inequalities of access to HIV care and treatment;
- Promote Institutional capacity-building and training of health professionals in nutritional assessment and referral systems, as well as setting up community distribution systems and the "basic food basket" monitoring system.
- It is necessary to strengthen counselling and advising, nutritional/food support and monitoring of the impact of the activities carried out by the grassroots community organisations;
- Reduce the time between HIV diagnostics and the beginning of ART and strengthen the links between the services to reduce the number of cases of abandonment and lost opportunities.
- Continue to ensure the implementation of a comprehensive paediatric package, which includes strong psychosocial support to the child, support to the parents and support staff and above all mobilise them to enter ART and care. In cases in which this is not possible, follow the minimum paediatric package model as a basis for their expansion in health centres;
- Strengthen the capacity of the health unit and community health staff regarding nutrition and HIV, particularly the selection of patients on the basis of anthropometrical measurements, monitoring, follow-up and evaluation;

Positive factors of progress in the indicators

- As a result of the strong commitment of the Government to the fight against HIV/AIDS, Mozambique approved two important instruments that are used as a guide to design actions to fight this disease at national level, namely the Prevention Acceleration Strategy (at the end of 2008) and the National Strategic Plan III for the fight against the pandemic (in 2010). The implementation of the Nutritional Support Strategy for People Living with HIV/ AIDS and other chronic diseases (approved by the

Government in 2007) started already during 2009. Sector plans were also approved by several governmental institutions to fight the epidemic with emphasis on the approval of the Strategy to Combat HIV/AIDS in Public Administration 2009-2013.

- There were approvals of sector's plan for fighting HIV/AIDS in several government sectors; especially the approval of the Strategy for Fighting HIV/AIDs in the public sector 2009-2013.

- There are significant improvements in the collection, analysis and splitting up of data at sector level and particularly in the ART area. All 220 treatment centres supply data split up by sex and by age (adults of 25 years or above, adolescents aged 15-24 years, and children of 15 years or below) in the number of patients who entered for new, transferred, or resumed treatment. Besides, data are also collected about the number of patients who interrupt treatment due to death, abandonment, suspension and transfers.

- The health information system (SIS), which allows the collection, consolidation, analysis, and dissemination of relevant data about care and treatment, was centralized in the Ministry of Health until the end of 2007, but this task became increasingly difficult given the rapid expansion of the number of units and of the number of treatment beneficiaries between 2006 and 2007. Given these growing demands on the SIS in the Ministry of Health at central level, the SIS was decentralised in 2008 from the central level to the provincial and district levels through the training of relevant teams of technicians of all provinces in data inputs and in standard operational monitoring and evaluation procedures.

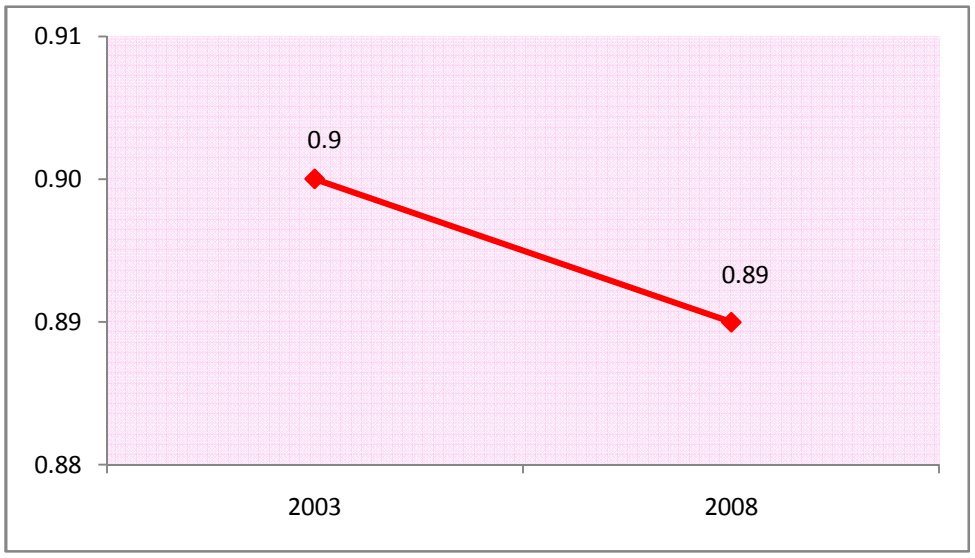
6.2. EFFECTS OF HIV/AIDS

6.2.1 Situation and trend

One of the ways to measure the effect of HIV/AIDS is to evaluate the ratio between double orphans due to HIV/AIDS and non-orphans in schools. graphic 56 shows the dynamics of this factor between 2003 and 2008 in Mozambique. The same figure shows that the ratio between double orphans due to HIV/AIDS and non-orphans in the Mozambican schools was 0.9 in 2003 and 0.89 in 2008 (a decrease of 0.01). An important fact of these statistics is that this ratio is relatively high. The statistics tell-us that there was

approximately one double orphan due to HIV/AIDS for each non-orphan in the Mozambican schools between 2003 and 2008, which is quite alarming.

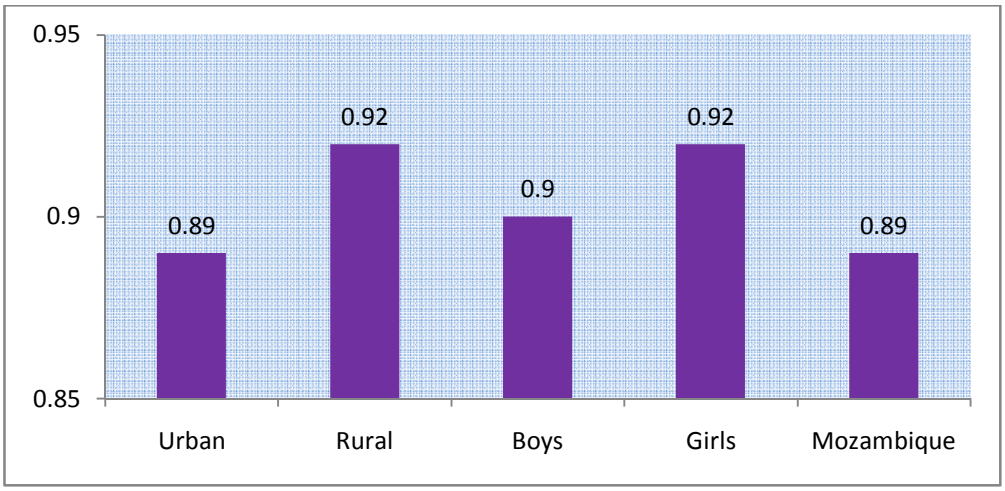
Graphic 56: Ratio between double orphans and non-orphans aged 10-14 years attending school in Mozambique 2003-2008



Source: MICS 2008

The graphic shows the ratio of orphans of father and mother (double orphans) and non-orphans in the Mozambican schools between 2003 and 2008 as a function of its distribution across genders and area of residency. There was a slight decrease of this ratio (0.01) in 5 years. It should also be emphasized that the value of the ratio continues relatively high, i.e., there are 0.89 double orphans for each non-orphan in the Mozambican schools.

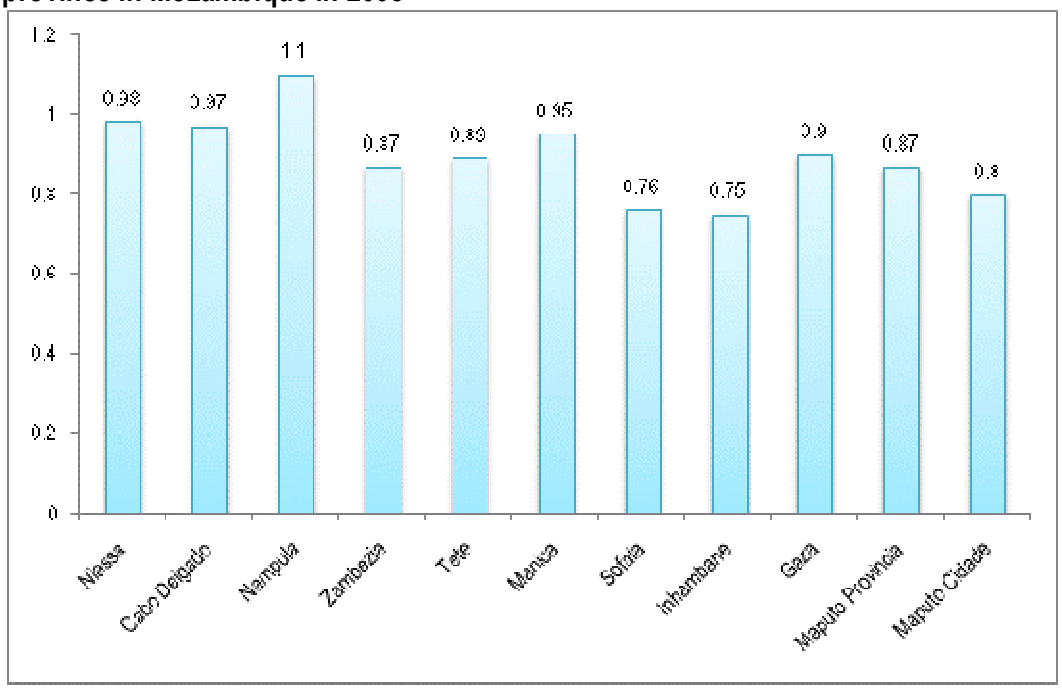
Graphic 57: Ratio between double orphans and non orphans aged 10-14 years attending school by area of residence and gender in Mozambique in 2008



Source: MICS 2008

Looking closely at the ratio between double orphans and non-orphans in 2008 by area of residence and gender in Mozambique, it is observed that it is higher in rural areas and between girls for which values are relatively high (0.92) in comparison with the national average (0.89).

Graphic 58: Ratio between double orphans and non-orphans aged 10-14 years attending school by province in Mozambique in 2008

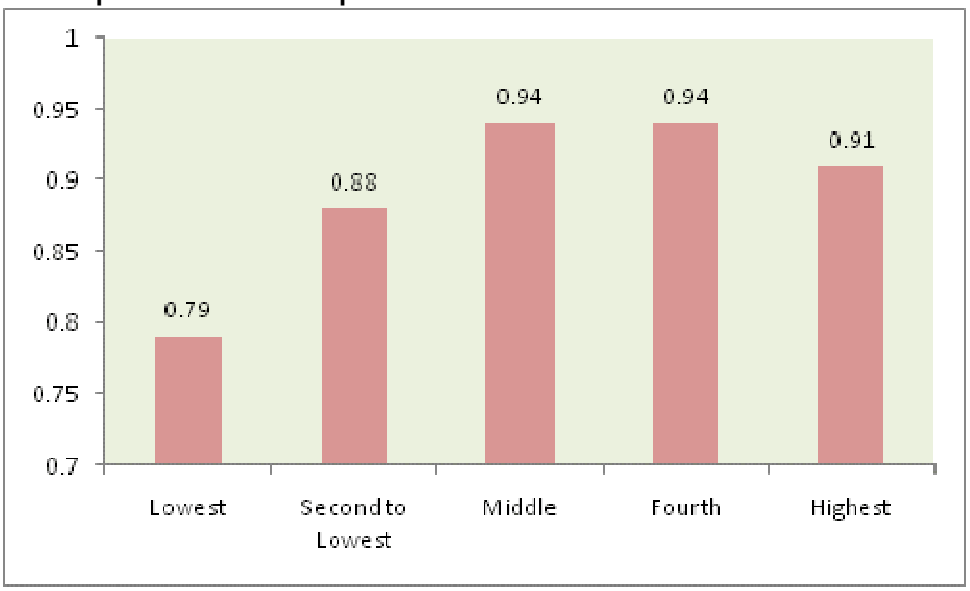


Source: MICS 2008

Looking at the distribution of the ratio between double orphans and non-orphans by province in 2008, one observes that it varies between 0.75 and 1.1. The highest ratio is in Nampula Province (the most populous province of Mozambique) with 1.1 and the lowest is in Inhambane Province with 0.75. It should be emphasized that the ratio between double orphans and non-orphans shown for Nampula Province is higher than 1, meaning that there are more double orphans than non-orphans in the schools of Nampula Province. This is an alarming situation considering that Nampula Province is the most populous province of the country, therefore having a relative influence on the future of Mozambique.

With regard to the distribution of the scores of ratio of double orphans to non-orphans aged 10-14 years attending school by wealth quintile of their parents in Mozambique in 2008, results indicate the ratio is higher in the in the higher wealth quintiles (the middle wealth quintile,. the fourth wealth quintile and the highest health quintile) with scores of 0.94, 094, 0.91 respectively when compared to the scores from the lower wealth quintiles (the lowest wealth quintile and the second to lowest wealth quintile), with scores of 0.79 and 0.88 respectively.

Graphic 59: Ratio between double orphans and non-orphans aged 10-14 years attending school by wealth quintile in Mozambique in 2008



Source: MICS 2008

6.3 MALARIA:

Rapid Assessment	Situation in Numbers					
Will the target be met?	**Indicator / Year**	**1997**	**2003**	**2008**	**2009**	**2015**
Potentially	Prevalence and death rates associated with malaria		58%	52%	47%	35%
	Rate of incidence of malaria among under-fives (per 10,000)		134/	108	94	80
Situation of the environment	Proportion of the population using effective prevention measures a) Intradomicilary spraying (PIDOM)		15	35	42	60
	b) Mosquito nets		8.7	15	25	80
Poor but improving	Prevalence and death rates associated with tuberculosis	na	11.0	na	na	6
	Prevalence and death rates associated with tuberculosis (in number) per 100,000 inhabitants	na	636	624	504	144
	Proportion of cured cases	82	81	82	82	85
	Proportion of tuberculosis cases detected and cured in the scope of DOTS	50	47	50	53	80

6.3.1 Situation and trend

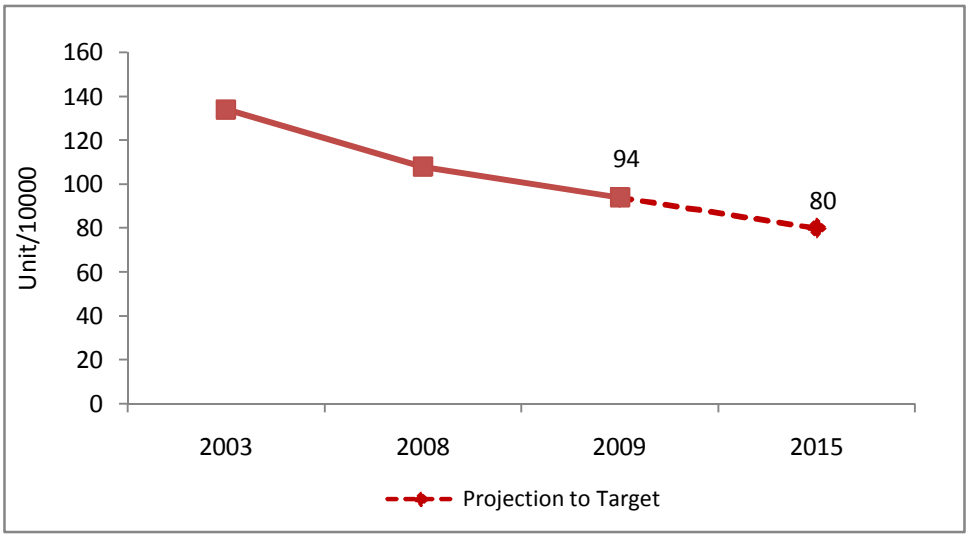
Malaria is still a big public health problem in Mozambique. Though we have observed a decrease of the death rate associated with malaria in the last few years, this disease is still one of the main causes of morbidity and mortality. The rate of prevalence in under-fives varies between 35% and 60% and more than 80% of these children suffer from anaemia, one of the main complications of malaria. During pregnancy malaria is also a big risk factor. It is one of the main causes of premature births and/or low weight at birth, about 35% of the pregnant women carry the parasite and more than 60% suffer from associated anaemia. The weight of the disease is enormous: about 45% of all cases observed in the outpatient visits and approximately 56% of the admissions to the paediatric wards are due to malaria. Though there is a decreasing tendency, the mortality rate associated with malaria is still very high. Malaria contributes with about 26% to intra-hospital deaths and in 2009 the situation did not change, with 27% of the deaths.

The main interventions that contributed to the reduction of the weight of the disease in the country were: intra-domiciliary spraying which in 2009 achieved a coverage of 42%, with a coverage of 85% of the planned houses and a coverage of 83% of the protected population; individual protection through the distribution of long-lasting insecticidal mosquito nets, having 838,130 nets been distributed to pregnant women in the whole country, resulting in a coverage of 76.6%; rapid diagnostic and adequate treatment of the cases, Preventive Intermittent Treatment (PIT) of pregnant women which in 2009 achieved a coverage of 51.1%; and awareness-raising of the communities regarding prevention strategies and behaviour change regarding seeking medical assistance.

According to graphic 60 the occurrence of cases of malaria per 10,000 children in Mozambique shows a decreasing tendency between 2003 and 2009. The rate decreased from 134 in 2003 to 94 per 10,000 children in 2009. The decrease was of 5 cases per year, which means that at this speed by 2015 the country will have exceeded the MDG target (80 cases per 10,000 children).

The decrease of malaria cases in the country is related to several efforts of the Government, civil society and Mozambique's development partners to combat malaria. One of these efforts is the distribution of insecticide-treated mosquito nets.

Graphic 60: Occurrence of malaria cases in Mozambique 2003-2009 in percentage

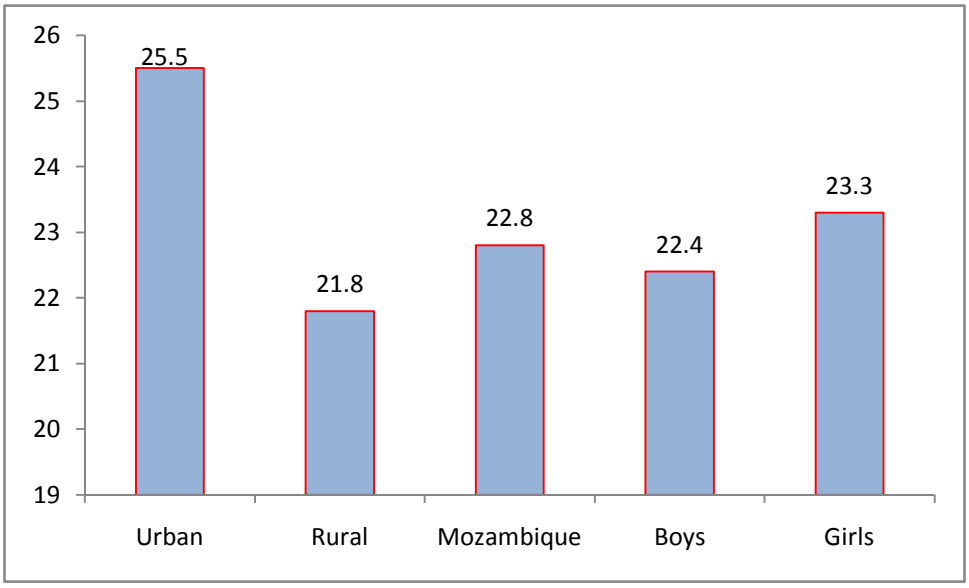


Source: MICS 2008

6.3.2 Coverage of insecticide-treated mosquito nets

Graphic 61 shows the percentage of under-fives sleeping under a mosquito net in Mozambique, by area of residence and gender. The data show that the percentage of children using mosquito nets is higher in urban environments (25.5%) than in rural environments (21.8%), and is higher in girls (23.3%) than in boys (22.4%).

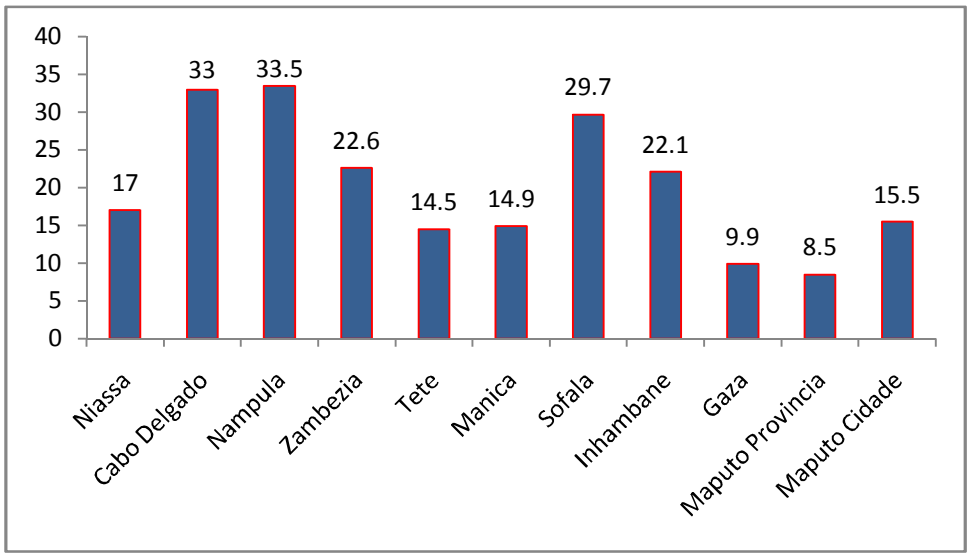
Graphic 61: Percentage of under-fives sleeping under insecticide-treated mosquito nets by area of residence and gender in Mozambique, 2008



Source: MICS 2008

Comparing the percentage of under-fives sleeping under an insecticide-treated mosquito net in Mozambique, we observe that the percentage is higher in Nampula Province (33.5%) and is lower in Maputo Province (8.5%). It should be noted that the level of variation of the percentage of under-fives sleeping under a mosquito net between provinces is relatively large. It is a one-digit figure in Gaza and Maputo Provinces and is over 30% in Nampula and Cabo Delgado. It should also be noted that none of the provinces of the country has a percentage of under-fives sleeping under a mosquito net above 50%.

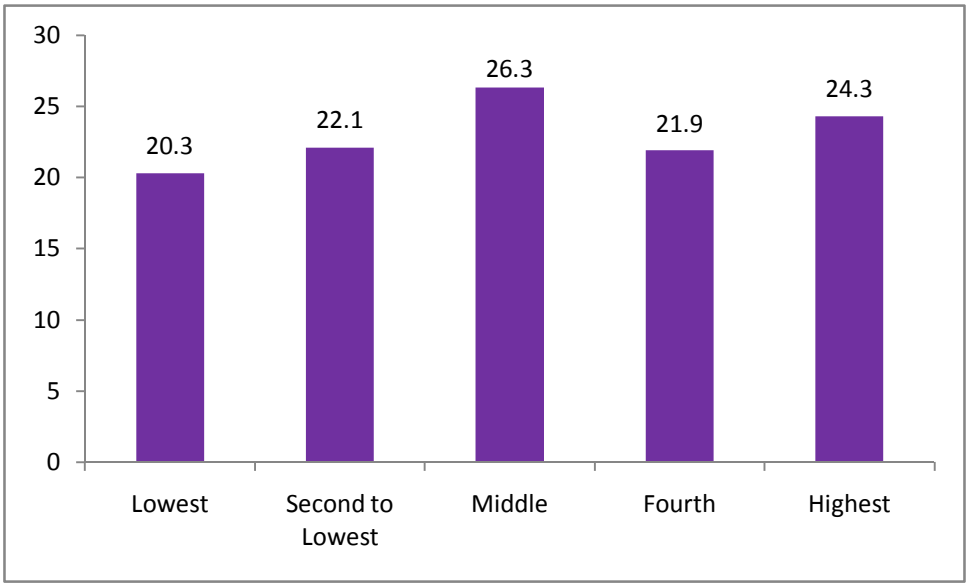
Graphic 62: Percentage of under-fives sleeping under insecticide-treated mosquito nets by province in Mozambique, 2008



Source: MICS 2008

Comparing the percentage of under-fives sleeping under insecticide-treated mosquito nets between the wealth quintiles in Mozambique, we observe that the distribution is the largest in the middle wealth quintile (26.3%) and the lowest in the lowest wealth quintile (20.3%). The graph shows that the difference between the percentages of under-fives sleeping under a mosquito net between the wealth quintiles is only 6.1%. Omitting the fact that the lowest percentage of under-fives sleeping under insecticide-treated mosquito nets is in the lowest wealth quintile, the families' level of wealth does not seem to influence the level of the percentage of children sleeping under insecticide-treated mosquito nets.

Graphic 63: Percentage of under-fives sleeping under insecticide-treated mosquito nets by their families' wealth quintile in Mozambique, 2008



Source: MICS 2008

Constraints on the achievement of the targets for 2015

The main constraint on the achievement of the targets for 2015 are:

- Poor adherence of the communities to the spraying campaigns, t
- Poor level of attendance of pregnant women at pre-natal visits and the poor coverage of mosquito nets.

Positive factors of progress in the indicators

- There was a clear reduction of the number of cases and obits associated with malaria in the whole country, as a result of united actions, namely the strengthening of the diagnosis and treatment capacity through the introduction of rapid malaria tests and the training of clinical staff in diagnostics and the treatment of cases;
- The introduction of intermittent malaria treatment of pregnant women;
- The expansion of intra-domiciliary spraying and the consolidation of the distribution of mosquito nets;
- The national malaria control programme prepared a new Strategic Plan and the respective monitoring and evaluation plan for 2010-2014;
- The antimalaria movement provides an opportunity to intensify the fight against the disease.

Recommendations for the achievement of the targets for 2015

The big challenges for the malaria programme are the reintroduction of other vector control methods such as the application of larvicides and the laboratory confirmation of all suspected cases of malaria.

6.4 Tuberculosis

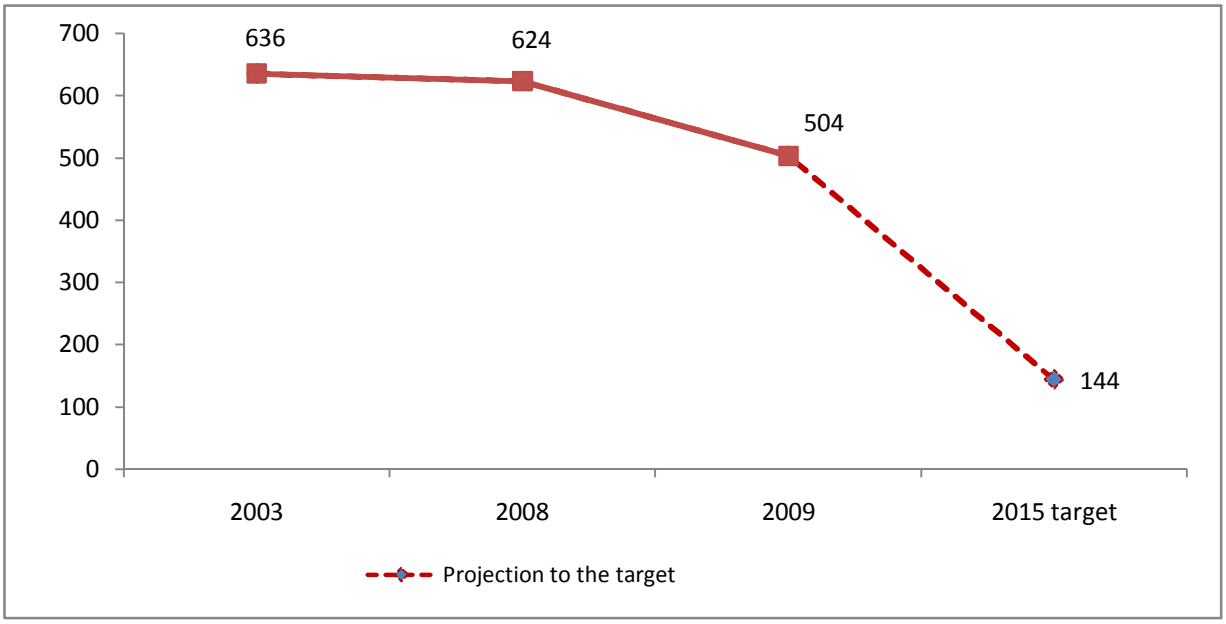
6.4.1 Situation and trend

Another serious public health problem in Mozambique is tuberculosis. The target for this disease by 2015 is to lower its prevalence from 298 to 149 cases per 100,000 inhabitants and to reduce mortality from36 to 18 deaths per 100,000 inhabitants.

The indicators of the programme show that in 2009, 53% of the expected cases in Mozambique were diagnosed and 82% of these cases were cured. While the cure rate is very near the established target, the detection of cases is still a problem. However, some progress has been achieved in the last few years, with the expansion of the Direct Observation Treatment Strategy (DOTS), which is currently being implemented in all health units. On the other hand, this strategy is being expanded to the community to cover the population living in the more remote rural areas.

The impact of the various actions was reflected in the reduction of the prevalence of 636 cases per 100,000 inhabitants in 2006 to 624 cases per 100,000 inhabitants in 2008. The mortality rate also decreased, from 129 deaths per 100,000 inhabitants in 2006 to 117 deaths per 100,000 inhabitants in 2008. In spite of this progress, tuberculosis (TB) continues to represent a serious public health problem in our country and its worsening in the last few years results from its association with the HIV/AIDS pandemic, which is one of the biggest obstacles, since more than half (66%) of the patients with TB are HIV positive. However, in 2006 counselling and testing of all TB patients was introduced and 84% of the TB patients are currently counselled and tested for HIV. However, the tracking of TB in HIV-positive patients is an area requiring special attention.

Graphic 64: Number of deaths associated with tuberculosis per 100 000 people in Mozambique 2003-2009



Source: MISAU

Constraints on the achievement of the targets for 2015

- The main constraint is the low case detection rate, due to poor access to the health services and the poor laboratory network.
- On the other hand, the high rate of HIV seroprevalence and the low coverage of anti-retroviral treatment of TB/HIV co-infected patients contribute a lot to the high death rate.

Recommendations for the achievement of the targets for 2015

- Continuous expansion of the Direct Observation Treatment Strategy (DOTS) to the community, the improvement of the diagnostic capacity through the increase and strengthening of the laboratory network and also the improvement of the implementation of interventions to deal with TB/HIV co-infection at all levels.

Positive factors of progress in the indicators

- In June 2007, the national TB control programme concluded the new National Strategic Tuberculosis Control Plan, designed for the period 2008-2012, which takes into account the size of the TB problem and of TB associated with HIV/AIDS at national level. The Plan defines as main objectives the improvement of equitable access to tuberculosis care and services, in the scope of the DOTS Strategy, and the expansion of TB/HIV activities and TB-MR control activities, with special emphasis on the underprivileged groups, as well as to increase and strengthen the laboratory network.
- Progress was achieved in the last few years, with the expansion of the DOTS strategy, the current coverage of which at health unit level is 100%. On the other hand, this strategy is being expanded to the community to cover the population living in the more remote rural areas.

- The impact of the various actions was reflected in the reduction of the prevalence of 636 cases per 100,000 inhabitants in 2006 to 624 cases per 100,000 inhabitants in 2008. The mortality rate also suffered a decrease from 129 deaths per 100,000 inhabitants in 2006 to 117 deaths per 100,000 inhabitants in 2008.

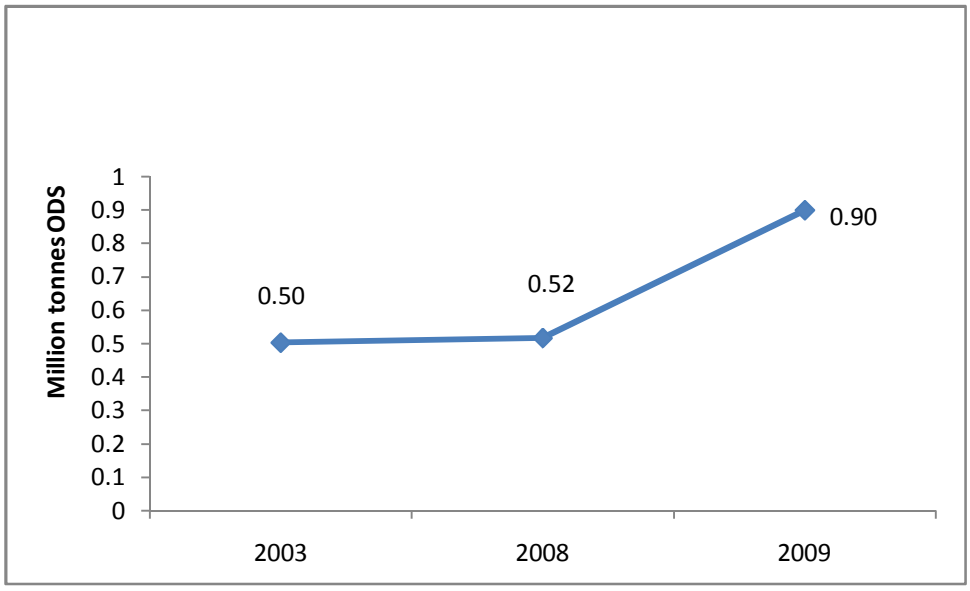
GOAL 7 – ENSURE ENVIRONMENTAL SUSTAINABILITY

Rapid assessment	Situation in Numbers					
Will the target be met?	**Indicator / Year**	**2001**	**2003**	**2008**	**2009**	**2015**
Potentially	Proportion of land area covered by forest	21.0	n/a	51		
Situation of the supportive environment	Proportion of land declared protected area		12.6			
Poor but improving	Use of energy (equivalent kg of fuel) USD per capita	2.8				
	Consumption of ozone depleting substances (tons of ODS)		503148	516751	898835	
	Hydroclorofluorocarbon (HCFs)				46.5	
	Proportion of the population with access to an improved water source, of which: Total	37.1	35.7	51%	57%	70%
	Rural (%)			43.2%	54%	
	Urban (%)			40%	60%	
	Proportion of the population with access to improved sanitation, of which: Total	41.1	40.0		45%	50%
	Rural (%)			39%	39%	
	Urban (%)			40%	50%	

7.1 THE ENVIRONMENT

7.1.1 Situation and trends

Graphic 65: Consumption of ozone layer depleting substances in Mozambique 2003-2009



Source: MICOA

The consumption of ozone layer depleting substances has increased in Mozambique. Between 2003 and 2008 this consumption increased by 0.01 million tons of ODS, i.e. from 0.5 million tons of ODS in 2003 to 0.52 million tons of ODS in 2008. From 2008 to 2009 the relative consumption of ozone layer

depleting substances in Mozambique suffered a relative increase of 0.5 million tons of ODS in 2008 to 0.9 million tons of ODS in 2009. This behaviour of the consumption of ozone layer depleting substances is in agreement with the economic growth occurred in the country, with the increase of the use of air conditioners in the country, caused by the increase of late of average temperatures, and with the increase of the number of vehicles circulating in the country, among others.

In response to the threat to the ozone layer, the Government of Mozambique has banned the import of chlorofluorocarbons (CFCs), through Resolution 78/2009 of 22 December. However, there are large amounts of CFCs in stock at national level, requiring their collection and subsequent destruction in centres with the appropriate technologies.

For the conservation of biodiversity the establishment of several protection measures for the sensitive habitats was decided, which resulted in an increase of the percentage of protected areas from 11% to 16% with the creation of new national parks and reserves, including marine and coastal environments, namely:

- Quirimbas National Park, Limpopo National Park and Chimanimani National Park;
- Ponta de Ouro marine Reserve
- Proclamation of new Trans-Frontier Conservation Areas (TFCAs) (Libombos, Grande Limpopo, Chimanimani);
- Rehabilitation of the Gorongosa National Park;
- Proclamation of the Marromeu complex (comprising the Marromeu Reserve and 4 hunting blocks) as a Ramsar site;
- Proposal for the creation of new conservation areas in Lake Niassa and in the Primeiras and Segundas Islands;
- Proposal for the creation of the new Rovuma TFCA (Mozambique and Tanzania) and the Zimoza TFCA (Mozambique, Zimbabwe and Zambia).

Concerning the forest coverage indicator, the 2008 forest survey concluded that forest coverage in Mozambique is estimated at 51%. The rate of deforestation was calculated at 0.58%.

In the last few years, there has been a substantial increase of investment in the country by the forest sector for the reforestation area. In 2009 a total of 13,889 hectares were reforested, 13,313 of which by the private sector for industrial purposes and for carbon sequestration. According to the investment portfolio of the

reforestation sector several companies have requested Land Use and Benefit Rights (DUAT) for forest plantations for industrial purposes.

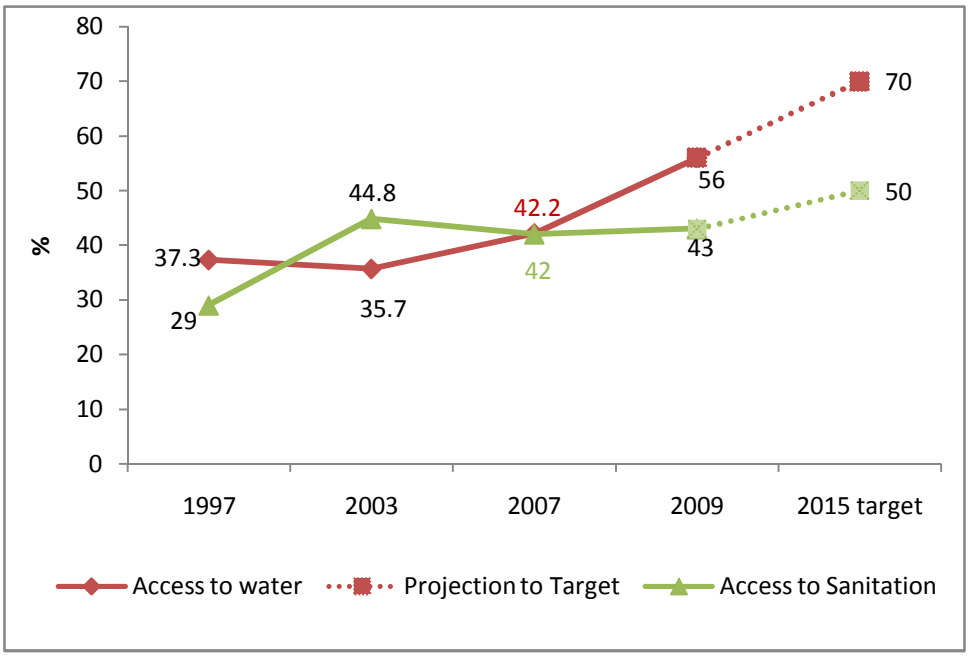
7.2 Coverage of improved drinking water and sanitation

7.2.1 Situation and trend

According to the National Directorate of Water (DNA) national reports the objective of the water and sanitation area is to contribute to the satisfaction of basic human needs, to increase people's well-being and reduce rural poverty, through the increase of the use of and access to water supply and sanitation services. The intermediate objective is to increase sustainable access to water supply and sanitation until 2015 to at least 70% and 50% respectively of the rural population.

In the scope of the expansion of sustainable access to safe drinking water, the country has a growth trend as illustrated in table below. In this context, national coverage of safe drinking water supply increased from 37.3% in 1997 to 56.0% in 2009. Regarding rural sanitation, the national coverage went from 29% in 1997 to 43% in 2009. At this rate of improvement Mozambique will likely meet the 2015 targets for access to water as well as sanitation.

Graphic 66: Rate of access to safe drinking water and improved sanitation in Mozambique, 2003-2009



Source: DNA

When it comes to access of clean water in the rural areas the coverage went from 40.3% in 1997 to 54% in 2009. In urban areas the coverage of clean water doubled from 30% in 1997 to 60% in 2009. For case of access to improved sanitation in the rural areas the coverage went from 25.3% in 1997 to 40% in 2009. In the urban areas the coverage of improved sanitation reached 50% of beneficiaries.

Table 17: National access to Clean water and improved sanitation in Mozambique, 1997-2009.

Year	Access to Clean Water (%)			Access to improved Sanitation (%)		
	Rural	Urban	**Total**	Rural	Urban	**Total**
1997	40.3	30	**37.3**	25.3	38	**29**
2003	36.3	36	**36.2**	36.2	48.8	**40**
2007	43.2	40	**42.2**	39	47.3	**42**
2009	54	60	**56**	40	50	**43**
2015 Target			**70**			**50**

Source: DNA Reports.

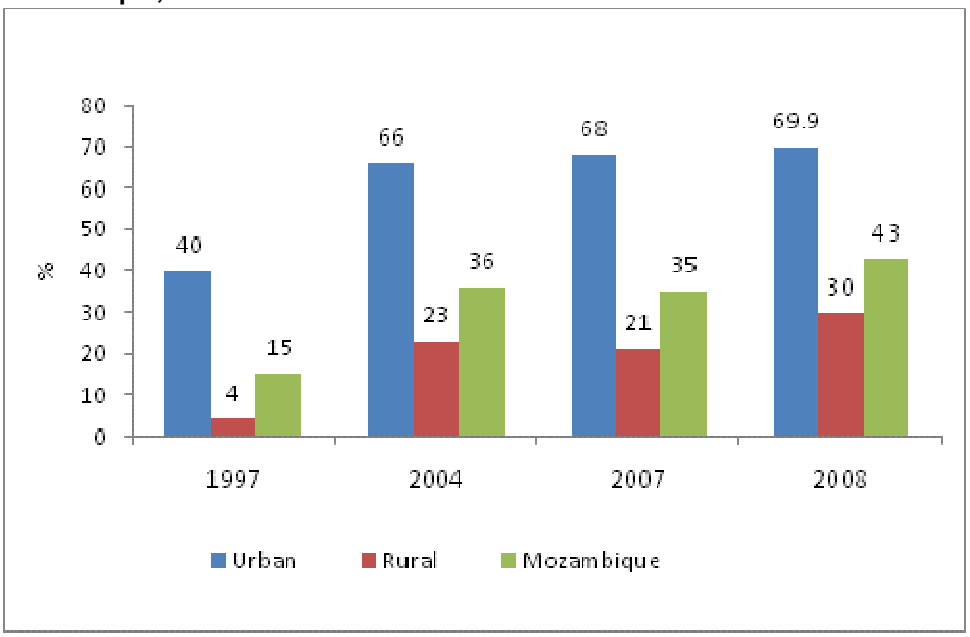
7.3 Rate of safe drinking water consumption

7.3.1 Situation and trend

Regarding the aspect of the use of water and sanitation services, the Multiple Indicator Survey report (MICS, 2008) provides data showing that in spite of progress in this area, the rates in this area are significantly different from the service access rates.

According to information of the 2008 Multiple Indicator Survey, the water consumption rate in the urban areas was approximately 70%, representing a growth of about 4% in relation to 2004. In the rural areas, the safe drinking water consumption rate in Mozambique was about 23% in 2004 and 30% in 2008, representing an increase of 7% of the water consumption rate in rural areas. In overall terms the rate of consumption of safe drinking water in Mozambique was 36% in 2004 and 43% in 2008, representing a growth of 1.75% per year of the consumption of safe drinking water in Mozambique.

Graphic 67: Percentage of the consumption of safe drinking water by area of residence in Mozambique, 1997-2008

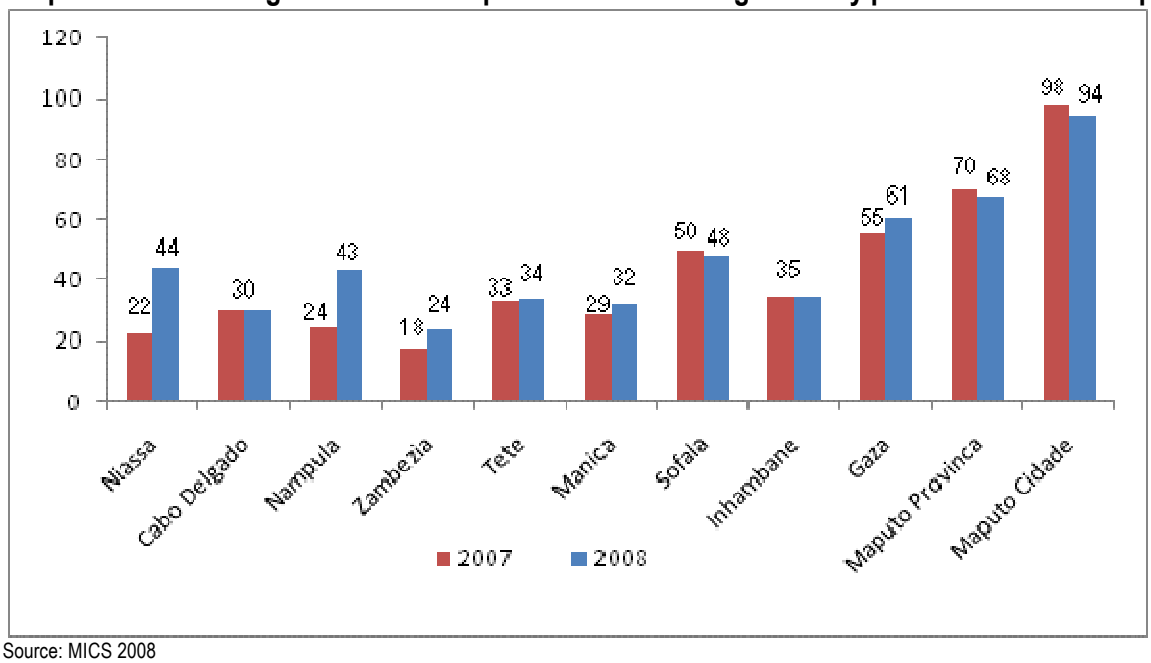


Source: MICS 2008

Regarding the rate of consumption of safe drinking water at national level in 2008 it should be noted that only the 3 southern provinces of the country, namely Maputo Provinces, Maputo City and Gaza Province, have rates of consumption of safe drinking water above 50%. Maputo City has the highest rate of

consumption of safe drinking water, with 94.3%, while Zambézia Province (the second most populous of the country) has the lowest rate of consumption of safe drinking water of the country (24%).

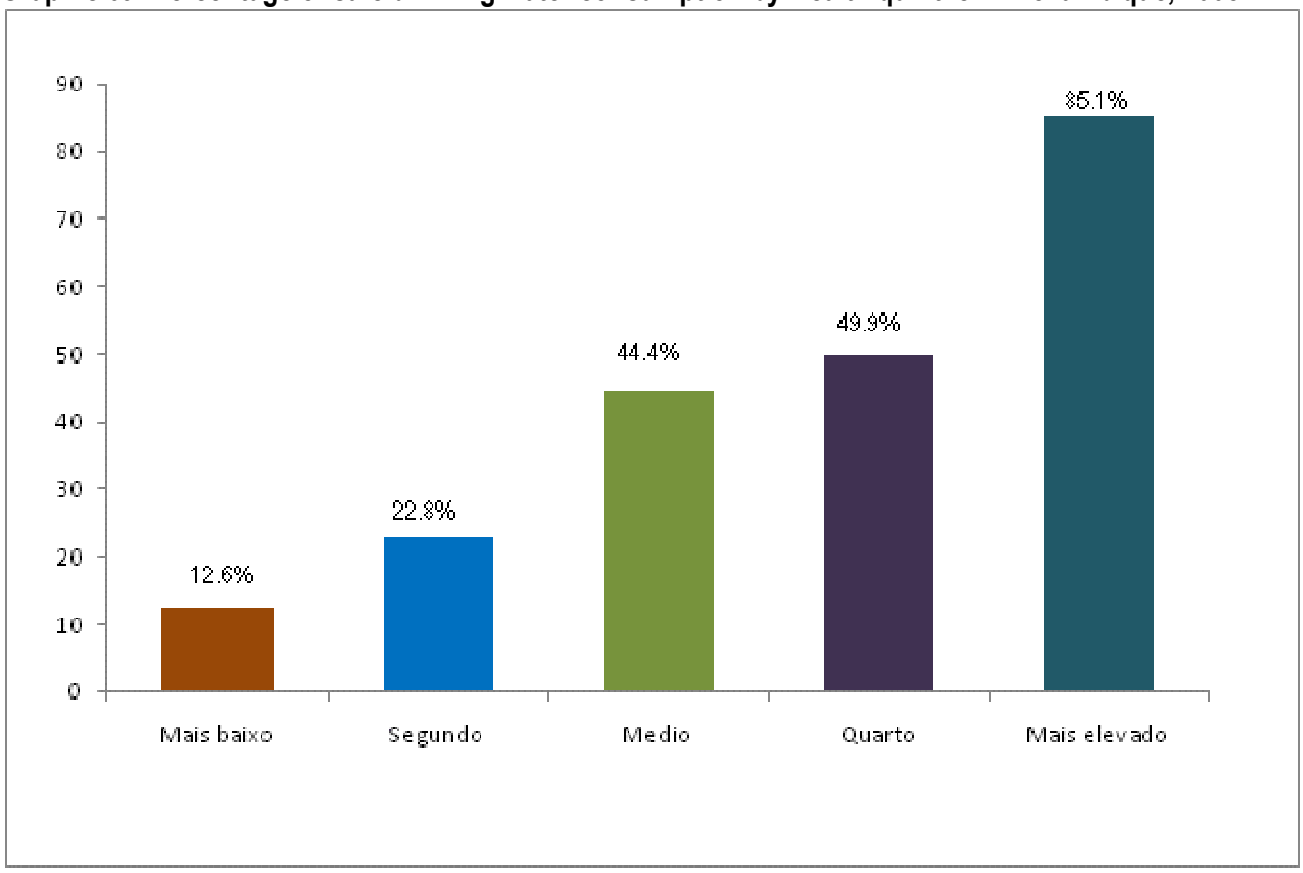
Graphic 68: Percentage of the consumption of safe drinking water by province in Mozambique, 2008



Source: MICS 2008

Taking into consideration the level of wealth of the beneficiaries of safe drinking water supply, the 2008 MICS data show that the safe drinking water consumption rates are positively correlated to the level of wealth of the target group. The group with the highest rate of safe drinking water consumption is that of the highest wealth quintile, with a rate of 85.1%, and the group with the lowest rate of safe drinking water consumption is that of the lowest wealth quintile, with a rate of 12.6%. In the remaining wealth groups, such as the second poorest wealth quintile, the middle wealth quintile and the fourth richer wealth quintile, the rates of safe drinking water consumption are 22.8%, 44.4% and 49.9% respectively.

Graphic 69: Percentage of safe drinking water consumption by wealth quintile in Mozambique, 2008



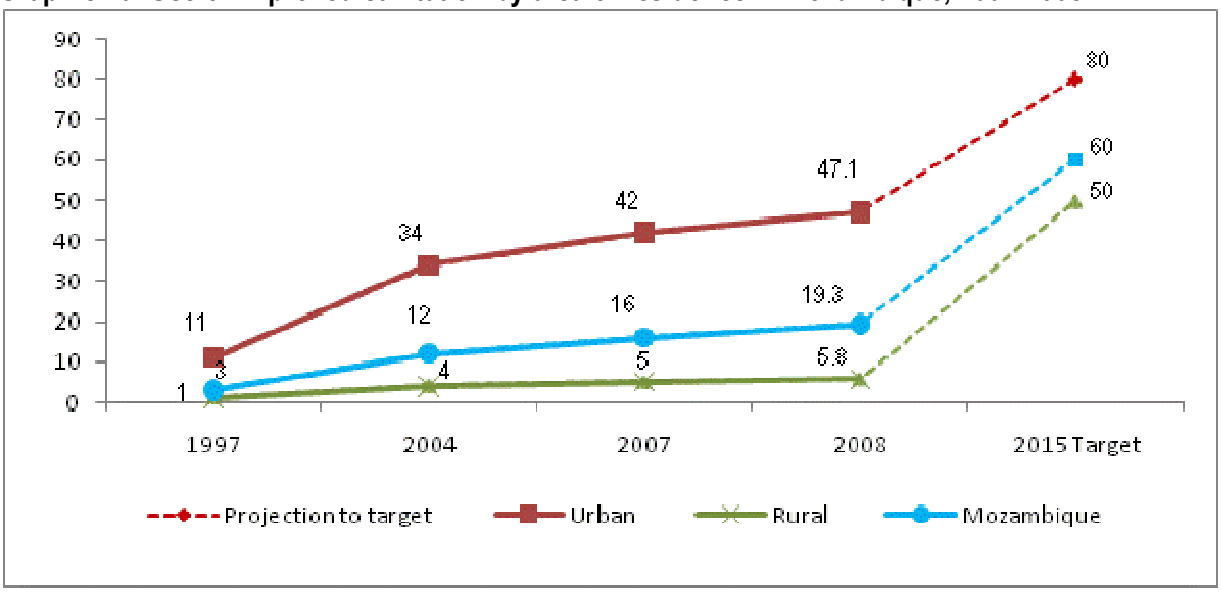
Source: MICS 2008

7.4 Rate of use of improved sanitation

7.4.1 Situation and trend

According to the 2008 MICS data the percentage of the use of improved sanitation in Mozambique was 12% in 2004 and 19.3% in 2008. This implies that the rate of growth of the use of improved sanitation in the country is 1.83% per year, which implies that if everything continues as it has been until now, by 2015 the rate of use of improved sanitation will be 32.11%. The rate of use of improved sanitation in the rural areas in Mozambique increased from 4% in 2004 to 6% in 2008, i.e., a growth of 0.5% of the rate of use per year. At this speed, if conditions remain the same, by 2015 the country will achieve a rate of use of improved rural sanitation of about 9.5%. The rate of use of improved urban sanitation was 43% in 2004 and increased to 47% in 2008. This represents a growth of 3.25% per year in this period, implying that at this speed, by 2015 the rate of use of improved urban sanitation will be about 70%.

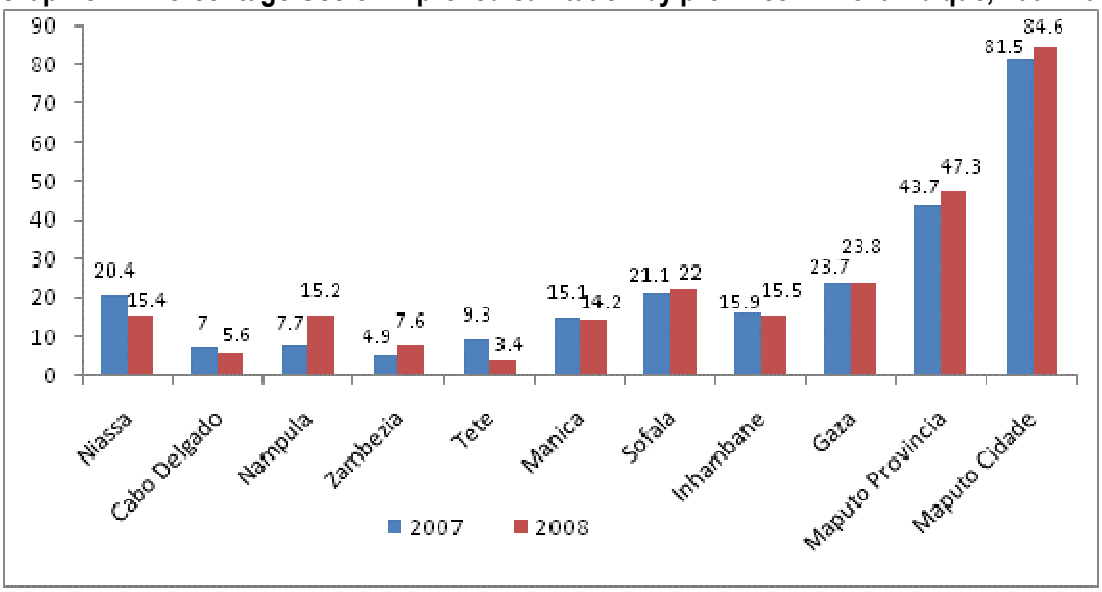
Graphic 70: Use of improved sanitation by area of residence in Mozambique, 2004-2008



Source: MICS 2008 [Meta = Target]

According to Censo 2007 and of 2008 MICS data, the distribution of the rate of use of improved sanitation in Mozambique is larger in the 3 southern provinces of the country, namely, in Maputo Province, Maputo City and Gaza Province. With the exception of Maputo City, which has a rate of use of improved sanitation of 82% for 2007 and 84.6% for 2008, none of the country's provinces has a rate of use of improved sanitation of more than 50%. With the exception of the provinces of Niassa, Cabo Delgado, Manica and Tete, all the other provinces showed an improvement in the rate of usage of improved sanitation from 2007 to 2008. The province with the lowest rate of use of improved sanitation was the province of Zambezia with 4.9% usage while in 2008 it was Tete Province, with a rate of 3.4%.

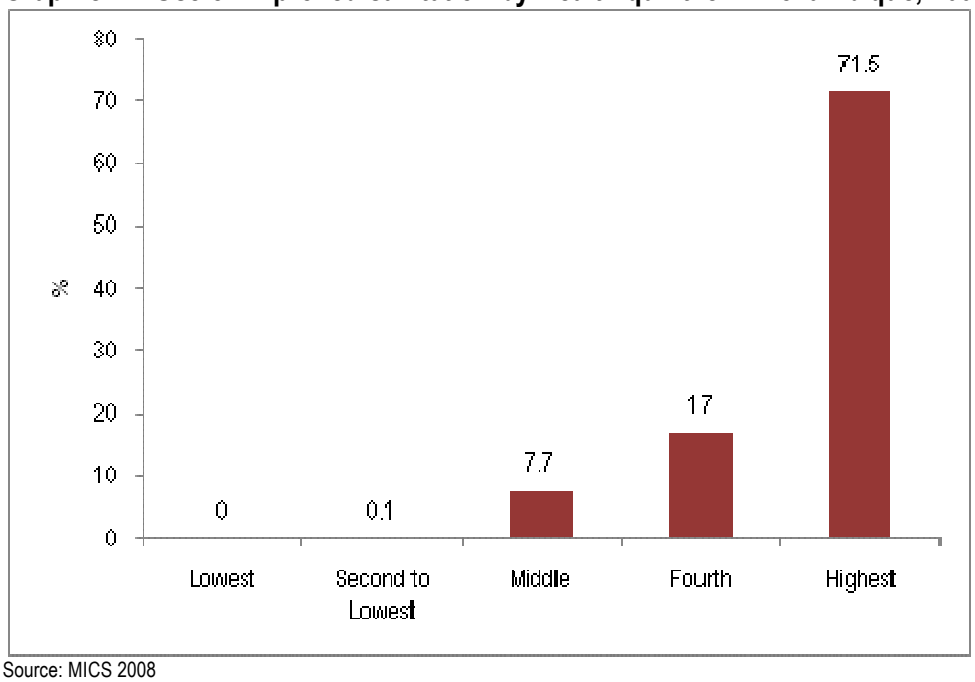
Graphic 71: Percentage Use of improved sanitation by province in Mozambique, 2007-2008



Source: MICS 2008

Comparing the rates of use of improved sanitation by wealth quintile in 2008, we observe a strong association between the rate of use of improved sanitation and the families' level of wealth. While the highest wealth quintile has a rate of use of improved sanitation of 71.5%, the rate of use of improved sanitation in the lowest wealth quintile is zero; the second poorest quintile has a rate of use of improved sanitation of 0.1%. With the exception of the highest wealth quintile, none of the wealth groups has a rate of use of improved sanitation over 18%.

Graphic 72: Use of improved sanitation by wealth quintile in Mozambique, 2008



Source: MICS 2008

Constraints on the achievement of the targets for 2015

The difficulties faced in the achievement of some targets were:

- Lack of training for the importers about banned chemicals as well as chemicals that are in the process of being banned at international level.
- Lack of training for refrigeration and air conditioning technicians about banned substances and substances being banned as well as about good environmental practices, with a view to the prevention of atmospheric emissions of ozone layer depleting substances.
- Due to the impact of climate change the country is losing natural resources and biodiversity due to cyclical floods, cyclones and droughts. The increase of the average sea water level is causing salt intrusion, provoking the salting of soils that previously were suitable for agriculture, and is also increasing coastal erosion and affecting the coastal and marine ecosystems, which are an important source of income for the Mozambican population, since about 60% of the Mozambican population lives in the coastal areas.

Recommendations for the achievement of the targets for 2015

To improve sector performance with a view to the rapid achievement of the MDG targets it is necessary to:

- Assure a sustainability supply of water and sanitation services
- Reinforce the coordination and dialogue among ministries, institutions, civil society, private sector, and partners involved in the environment activitie
- Promote measure conducing to adaptation to climate change particularly in the coastal areas
- Fortify education, communication, environment promotion actions especially in the local communities
- Promotion of instruments such as the Strategic Environmental Evaluation (AAE), so that the environmental sustainability of the sector's programs can be assured;
- Set Systematic and uniform procedures for the environmental data collection.
- Fortify the training activities for the police, custom officers, border guards in the monitoring and preservation of natural resources.
- Promote capacity building for the refrigeration and climatization technicians on substance that destroy the ozone layer as well as on alternatives susbstances.
- Equip regional centers for recycling and recovering of ozone destroying substances;
- Collection of all equipment functioning with chlorofluorocarbons (CFCs), carbon tetrachloride (CCl4) and halogenated substances for destruction
- Promote awareness campaign on methyl bromide importers to guarantee these substances banning until 2015.
- Run an inventory in the sectors working with refrigeration and air conditioning equipment for the destruction of ozone destroying material in the centres with appropriate technologies
- Make available the equipments capable of detecting environment-friendly substances such as, for example, R-410a, R-407C, R-507, R- 600a and R-290, among others.
-

- Provide better training for border police and customs officials for the inspection and preservation of natural resources;
- Train the refrigeration and air conditioning technicians in topics related to ozone layer depleting substances as well as the use of alternative sources;
- Promote public debate and talks with the citizens about environmental issues;
- Improve the inspection of the import and use of environmentally harmful and banned substances;
- Collect and destroy the environmentally harmful and banned substances in the national stock.

Positive factors of progress in the indicators

- The Strategic Environmental Evaluation of the coastal area (AAE) is on the top of government agenda
- Bigger action of the Ministry for Environmental Coordination in the coordination of the across sectors, at the central level (environmental unities, environmental focal points) and local governances to deepen the process of integration of environmental agenda in the secoral plans and programs
- Beginning of the National Program for water and rural and establishment of common fund for rural investment
- Fortification of process of decentralization especially for the water supply and sanitation in the urban areas by the creation of the infrastructure's administration for water which will make the investment in the urban area sustainable.
- A positive factor to be emphasized in the implementation of the MDG is the strengthening of intersectoral coordination, given that the implementation and monitoring of Objective 7 (Ensure environmental sustainability) requires the cooperation of many sectors, due to the cross-cutting nature of environmental issues.
- At this moment the forestry sector benefits from support for the implementation of the National Forest Programme, with emphasis on the sustainable management of natural resources.

- With the banning of the CFCs an increase is observed of imports of refrigeration and air conditioning equipment functioning on the basis of environment-friendly substances.
- The existence of presidential initiatives promoting the cause of the environment:
    - The “One student one plant” movement;
    - The “community forests” movement.
- The existence of private initiatives such as the “A tree as a friend” movement of the SOICO group, promoting the cause of the environment.

GOAL 8 – DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Rapid assessment	Situation in Numbers					
Will the target be met?	Indicator / Year	1997	2003	2008	2009	2015
Potentially	Net development aid received as percentage of GDP		25.2	18.3		
Situation of the supportive environment	Debt relief committed under the HIPC Initiative (USD million)					
Reasonable	Debt service (% of exports of goods and services)	21.7	3.9	1.87	2.54	

a) 2005 data. b) 2007 data.

8.1. PUBLIC FINANCE

8.1.1 Situation and trend

Mozambique continues being a country beneficiary of external assistance for the financing of public expenditure including that of a priority character as defined by PARPA for the achievement of the MDG. To this end the State has resorted to resources from internal income, grants and concessionary external credit.

With the progress registered in the collection of internal income, the use of external sources for the execution of the budget decreased from an average of 50% in the last few years to 49.7%, 45.7%, 43.9% and 45.4% for 2006, 2007, 2008 and 2009, respectively. However, more than 50% of investment expenditure continues being guaranteed by external assistance, which represented 66.9%, 65.6%, 62.6%, 54.3% and 62.3% for 2005, 2006, 2007, 2008 and 2009 respectively.

Table 18: - Budget Equilibrium from 2004 to 2010 (in thousand million MT)

State Budget	2005	2006	2007	2008	2009	% of GDP				
	CGE	CGE	CGE	CGE	REO	2005	2006	2007	2008	2009
1 State Income	20.9	27.8	34.5	39.2	47.4	13.8	15.4	16.0	16.0	17,8
2 Grants	11.9	18.2	20.3	23.0	25.4	7.8	10.1	9.4	9.4	9,5
3 External Credit	8.1	9.2	8.7	7.9	14.4	5.3	5.1	4.1	3.2	5,4
4 Internal Credit	3.6	0.1	0.0	0.4	0.3	2.4	0.0	0.0	0.1	0,1
TOTAL RESOURCES	**44,5**	**55.3**	**63.5**	**70.5**	**87.5**	**29.3**	**30.6**	**29.5**	**33.2**	**32.9**

Source: CGE, PES and REOE

The discontinuity of the growth of State Income as % of GDP in 2008 is due to the alteration of the deflator that was being used until 2007, um new deflator having been adopted in 2008.

The above-mentioned framework shows that in the 2005-2009 five-year period the mobilisation of resources to ensure the execution of public current and investment expenditure had an upward tendency. Indeed, the total mobilized resources increased between 2005 and 2009 from 44.5 to 87.5 thousand million MT, and internal income from 20.9 to 47.4 thousand million MT in the same period, representing an

average annual variation of 22.5%. Notwithstanding the adverse impact of the international financial crisis, income was collected to the value of 47.4 thousand million MT against a target of 46.2 thousand million MT planned for 2009, i.e. corresponding to 102.5% of the respective annual target.

The progress achieved in the collection of internal income resulted in a commitment to apply greater dynamism, efficiency and effectiveness in the collection of income, particularly guaranteeing an annual growth of internal income of approximately 0.5% of GDP during the 2005-2014 period, with a view to safeguard greater availability of internal resources for financing the priority activities in the context of the MDG.

8.1.2 Programme Aid to the State budget

Programme aid aimed at strengthening the State Budget and the Balance of Payments is one of the mechanisms for the mobilisation of financial resources, in the form of grants and credits, to which the Mozambican State has resorted, given the better harmonization, alignment, predictability, accountability and subsequently greater effectiveness of external assistance. This assistance is currently provided by a group of 19 donors called the Programme Aid Partners (PAPs), against 7 in 2001, when this financing mechanism started in Mozambique.

Table 19: - Programme Aid to the State Budget (in USD million)

	2005	2006	2007	2008	2009
GRANTS					
Netherlands	18.1	22.9	24.1	26.2	25.2
Norway	16.0	18.6	22.7	29.7	24.3
Canada	2.0	2.1	4.3	7.5	9.9
France	3.9	3.8	2.7	3	3.0
Ireland	7.8	7.2	12.5	15.1	14.8
Sweden	17.3	18	44.7	54.3	40.0
Denmark	0.0	2.6	19.4	10.5	8.9
United Kingdom	56.5	62.2	70.2	81.3	61.7
Finland	5.1	6.2	6.8	10	8.9
Spain	3.6	3.8	4.2	7.1	9.9
Belgium	2.6	3.8	4.1	4.6	
Portugal	1.5	1.5	1.5	1.5	1.5
Italy	4.2	3.9	5.6	5.9	5.3
European Commission	56.3	49.2	58.9	66.3	85.5
Germany	4.4	12.7	13.7	17.8	19.5
Austria	0.0	0.0	0.0	2.5	4.4
World Bank				10.0	10.0
Switzerland	7.7	6.7	7.5	6.8	6.6
Sub-total Grants	**207.0**	**225.2**	**302.9**	**360.1**	**339.4**
CREDITS					
ADB	2.4	61.8	30.4	30	30.3
World Bank	60.0	60.0	69.7	71.8	65.0
Sub-total Credits	**62.4**	**121.8**	**100.1**	**102**	**95.3**
Overall Total	**269.4**	**347**	**403**	**461.9**	**434.7**

Source: PAPs Disbursement Flexibility Table

From 2005 to 2009 PAPs' financial aid to the country increased substantially from USD 269.4 million in 2005 to USD 434.7 million in 2009, which represents an average increase of 19% of the total financial aid.

Regarding grants, the largest contributions came from the United Kingdom and the European Commission, representing an average weight of 24% and 22% of total resources. Regarding credits the largest contribution came from the World Bank, representing 74% of total resources channelled in this way.

The programme aid commitments to the sectors of the Mozambican economy also increased from 223 million American dollars in 2007 to about 263 million American dollars in 2011.

Table 20: Evolution of the programme aid commitments for the sectors of the Mozambican economy, 2007-2011

	2007	2008	2009	2010	2011
EDUCATION	55.68	71.56	143	111	85
HEALTH	88.98	70.00	95	86	75
AGRICULTURE	37.68	38.46	43	43	26
ROADS	35.80	24.02	31	36	10
HIV/AIDS		21.62	19	4	4
WATER	5.22	6.25	10	11	1
UTRAFE		9.17	7	10	9
TAX AUTHORITY		0.00	6	4	2
UTRESP		0.00	4	12	4
ADMINISTRATIVE TRIBUNAL		0.00	4	5	3
PSA (Food Subsidy)				7	5
INE				7	6
Fisheries					8
Decentralization (PNPFD)					12
Water and Sanitation (PRONASAR)					13
Total	**223**	**241**	**361**	**328**	**263**

8.1.3. Budget execution in the PARPA and MDG priority sectors

PARPA defines that at least 65% of the State Budget's annual resources should be allocated to the financing of the sectors of agriculture, rural development, infrastructures (roads, water and sanitation), good governance and other priority sectors for the reduction of absolute poverty. In this context, the budgeted resources for ensuring current as well as investment expenditure in PARPA's priority sectors and in the scope of the MDG, in 2005, 2006, 2007, 2008 and 2009, amounted to a total of 27,431, 30,353 and 41,011, 53,897 and 57,832 million Meticais, respectively, corresponding to 68%, 65%, 62%, 67% and 64% of the total of budgeted resources in each respective year, excluding debt service, i.e. an average of 65%.

Thus, both the budget allocation and the effective application of resources in the PARPA priority sectors, in the context of the achievement of the MDG targets, benefited from an upward trend, on average amounting to about 65% of overall budgeted expenditure in the course of this period. In terms of annual amounts, the total actually executed expenditure was 24,081, 28,078, 34,188, 41,492 and 47,787 million Meticais in 2005, 2006, 2007, 2008 and 2009, respectively, corresponding to a level of execution of 67.6%, 64.6%, 61.7%, 64.5% and 61.6% of annual expenditure realized, excluding debt service, i.e. an average of 64%.

In the period under analysis, the largest slices of public expenditure de facto executed in PARPA's priority sectors went to the Education (21.8%), Health (12.0%) and Infra-structure (15.1%) sectors, which

shows greater Government efforts in these three vital areas for the reduction of poverty and the achievement of the MDG.

Table 21: Distribution of expenditure executed in the PARPA priority sectors

(em milhões de Mt)	CGE 2006	CGE 2007	CGE 2008	CGE 2009
TOTAL DA DESPESA NOS SECTORES PRIORITÁRIOS	**28.076,9**	**34.187,0**	**41.494,0**	**47.582,8**
(em percentagem da despesa total excluindo juros e ops. Fin.)	**64,6%**	**61,7%**	**64,5%**	**61,2%**
EDUCAÇÃO	**8.797**	**11.949**	**15.116**	**16.673**
ENSINO GERAL	7.690	10.568	13.170	14.194
ENSINO SUPERIOR	1.106	1.381	1.946	2.479
SAÚDE	**6.048**	**7.404**	**7.149**	**8.052**
INFRAESTRUTURAS	**7.298**	**7.827**	**9.561**	**10.482**
ESTRADAS	5.073	5.189	5.000	5.450
ÁGUAS E OBRAS PÚBLICAS	1.974	1.971	3.094	3.893
RECURSOS MINERAIS E ENERGIA	251	667	1.368	1.139
AGRICULTURA E DESENVOLVIMENTO RURAL	**1.989**	**2.067**	**2.471**	**3.648**
GOVERNAÇÃO, SEGURANÇA E SISTEMA JUDICIAL	**3.534**	**4.433**	**6.256**	**7.645**
SEGURANÇA E ORDEM PÚBLICA	1.912	2.145	2.551	2.823
GOVERNAÇÃO	694	1.161	1.891	1.748
SISTEMA JUDICIAL	928	1.127	1.814	3.074
OUTROS SECTORES PRIORITÁRIOS	**412**	**507**	**941**	**1.083**
ACÇÃO SOCIAL	269	349	724	836
TRABALHO E EMPREGO	142	158	217	247
(Como percentagem da despesa total excluindo juros da dívida e ops. Fin.)				
EDUCAÇÃO	**20,3%**	**21,6%**	**23,5%**	**21,4%**
ENSINO GERAL	17,7%	19,1%	20,5%	18,3%
ENSINO SUPERIOR	2,5%	2,5%	3,0%	3,2%
SAÚDE	**13,9%**	**13,4%**	**11,1%**	**10,4%**
INFRAESTRUTURAS	**16,8%**	**14,1%**	**14,9%**	**13,5%**
ESTRADAS	11,7%	9,4%	7,8%	7,0%
ÁGUAS E OBRAS PÚBLICAS	4,5%	3,6%	4,8%	5,0%
RECURSOS MINERAIS E ENERGIA	0,6%	1,2%	2,1%	1,5%
AGRICULTURA E DESENVOLVIMENTO RURAL	**4,6%**	**3,7%**	**3,8%**	**4,7%**
GOVERNAÇÃO, SEGURANÇA E SISTEMA JUDICIAL	**8,1%**	**8,0%**	**9,7%**	**9,8%**
SEGURANÇA E ORDEM PÚBLICA	4,4%	3,9%	4,0%	3,6%
GOVERNAÇÃO	1,6%	2,1%	2,9%	2,2%
SISTEMA JUDICIAL	2,1%	2,0%	2,8%	4,0%
OUTROS SECTORES PRIORITÁRIOS	**0,9%**	**0,9%**	**1,5%**	**1,4%**
ACÇÃO SOCIAL	0,6%	0,6%	1,1%	1,1%
TRABALHO E EMPREGO	0,3%	0,3%	0,3%	0,3%

8.1.4 Public debt situation in Mozambique

For financing the budget deficit the Government has resorted to concessionary external loans as well as internal loans to meet the investment needs in crucial socio-economic infrastructures for the development of the country.

The internal debt of Mozambique is made up of public debt certificates that have played an important role, not only for financing the State Budget deficit, but also for the promotion of public savings,

the macroeconomic equilibrium and to stimulate the functioning of the Financial Market in general and the Capital Market in particular.

The main internal public debt instruments used are:

Treasury Bonds**:** long-term instruments, with the objective to finance budget deficits;

Treasury Bills: short-term instruments with the objective to finance temporary State Treasury deficits, resulting from the seasonal nature of tax income and for the coverage of possible delays in the disbursements promised by our cooperation partners in the course of the economic exercise;

Each year's Budget Law serves as a legal basis for the Decree that delegates competencies for contracting this debt. The internal debt service is foreseen in each year's State Budget and is executed accordingly;

According to the table below, on 31 December 2009 the internal debt stock amounted to 14,429 million MT, 4,050 million of which represent Treasury Bonds, and the remainder correspond to other categories of internal debt. It should be noted that in 2009 the State subsidised the petrol station holders to a total of 2,514.62 million MT (entered in the "Others" budget line).

Table 22: Evolution of the Internal Debt Stock by type of Instrument 2005-2009
In million Meticais

Description	2005	2006	2007	2008	2009
Treasury Bonds	5.433	5.196	4.850	4.268	4.050
Treasury Bills	2.300	0	0	0	4.700
Others	250	1.736	3.192	3.178	5.679
Total	7.983	6.932	8.042	7.446	14.429

8.1.5 Debt relief commitment under the Heavily Indebted Poor Countries (HIPC) and the Multilateral Debt Relief Initiative (MDRI) initiatives

Due to its good economic performance, Mozambique has had several benefits, among which successive debt cancellations and a growing increase of financing for the country. In this context, the Government's responsibilities are increasingly heavier and it should get organised to face the resulting challenges, such as: (i) improve its vision of indebtedness, taking measures to keep the debt within sustainable levels with a view to economic growth, and (ii) prepare a coherent debt strategy in agreement with at medium and long-term balanced and sustainable economic growth.

In this context, a public debt strategy is being prepared, which among other aspects will include a risk analysis as well as debt sustainability limits and indicators. The creditors from which Mozambique has not yet received relief of its debt are the following: Poland, Bulgaria, India, ex-Yugoslavia, Angola, Algeria and Libya.

Table 23: Creditors that participated in debt relief under the HIPC initiative:

1.. Multilateral	World Bank (IDA), International Monetary Fund (FMI), African Development Bank Group (ADB), Arab Bank for Economic Development in Africa (BADEA), International Fund for Agricultural Development (IFAD), Nordic Development Fund (NDF), OPEC Fund and European Investment Bank (EIB)
2. Bilateral 2.1 Members of the Paris Club	United States of America, United Kingdom, Austria, Germany, Italy, France, Russia, Spain, Sweden, Brazil and Portugal. Japan has already announced its intention to cancel 100% of the debt of Mozambique, the signing of the agreement is awaited.
2.2 Non-Members of the Paris Club	Kuwait, China, Romania and Hungary.
2.3 Commercial	China, Operation Buy Back (Brazil, India, Ex-Yugoslavia and the Czech Republic).

Under the MDRI, Mozambique has benefited from additional debt relief, since it had reached its completion point. Indeed, the FMI cancelled an amount of USD 154.0 million (100%) of the debt incurred and disbursed until 31 December 2004. The World Bank granted a relief of about USD 1.3 thousand million of the debt incurred and disbursed until 31 December 2003, including the HIPC.

Regarding the African Development Fund, an amount of about USD 500.0 million was cancelled, referring to the debt incurred and disbursed until 31 December 2004. Thus, the debt stock decreased from USD 4.6 thousand million in 2005 to 3.9 thousand million in 2009 and the annual debt service from about USD 52 million in 2005 to USD 46 million in 2009. The increase of the external debt stock results from new loans.

Table 24: External Debt Stock by type of creditors and in USD million

Description	2005	2006	2007	2008	2009
Multilateral	2,535.00	1,191.60	1,543.41	1,835.90	2,108.30
Bilateral	2,113.90	2,090.40	1,773.50	1,801.19	1,801.67
Total	4,648.90	3,282.00	3,316.91	3,637.09	3,909.97

8.1.6 Debt service as percentage of exports of goods and services

According to the table below, the debt of Mozambique has remained sustainable in the last few years. In the whole period under analysis, the sustainability of the debt, measured by the Debt Service (SD) / Exports of Goods and Services (X) Ratio, has stayed much below the limit of the sustainability ratio, which is 20%. In 2009 this ratio was 2.54%.

Table 25: Debt service, exports and their ratio in Mozambique 2005-2009

Description	2005	2006	2007	2008	2009
Debt service	51.60	61.80	47.60	49.65	46.22
Exports of goods and services	1,745.30	2,381.10	2,412.20	2,653.30	1,821.50
SD/X (%)	2.96%	2.60%	1.97%	1.87%	2.54%

Constraints on the achievement of the targets for 2015

a. In spite of still being high, the external assistance flows are subject to a high level of uncertainty and at medium-term may decrease in real terms. To deal with this uncertainty, it is fundamental that the State continues in the next few years its effort to increase the collection of internal income so as to be able to face a possible fall of the external assistance and continue to invest in the priority sectors in the fight against poverty.

b. There is an enormous potential for the increase of exports. The main challenges are in the creation of an investment-favourable business environment, which includes, among other aspects, the efficiency of the judicial system. The creation of adequate infrastructures is another challenge (for example, roads and the reliable supply of utility goods, such as water and electricity). Other challenges include compliance with the standards of the external market and the trade policy.

c. In the scope of debt management: (i) the Government should continue to improve its vision taking measures to maintain debt sustainability with a view to economic growth, and (ii) prepare a debt strategy that includes a risk analysis and debt sustainability limits and indicators.

Recommendations for the achievement of the targets for 2015

- Improve the effectiveness, transparency and predictability of disbursements of external assistance, harmonizing the Cooperation Partners' assistance with Government priorities and the harmonization and improvement of the planning, budgeting, PES review (BdPES) and mutual accounts rendering cycles in the spirit of the Paris Declaration.
- Increase support to the productive sectors of the economy to alleviate the constraints on the supply side (for example, poor production capacity, poor quality of infrastructures, high cost of transport, unreliable supply of utility goods, etc.) that impede trade competitiveness.
- Ensure the strengthening of technical analysis and negotiation capacity regarding regional and international trade issues.

- Ensure that total debt cancellation is obtained in the bilateral and multilateral conversations and negotiations.
- There is a need for the development of a scientific and technological knowledge acquisition, dissemination and communication system that absorbs the new information and communication technologies in the framework of the promotion and coordination of the development of services and the creation of infrastructures to guarantee the successful implementation of Government reforms and the introduction of new stakeholder services.
- Consolidation of the diversified industrial use of the energetic potential created by the extraction of natural gas.
- Assess the costs and benefits and the economic and social viability of the promotion of the development of large projects.
- Effective use of the industrial property system.

Positive factors of progress in the indicators

- The existence of a positive dialogue between the Government and the development partners is added value;
- The good reputation of Mozambique in the international arena favours the country's performance;
- The preservation of a climate of peace and political stability has contributed to better performance;
- The entry of foreign investment in the country has contributed positively;
- The commitment of the Government to improve the performance of the production of own income is a decisive factor for the improvement of performance.

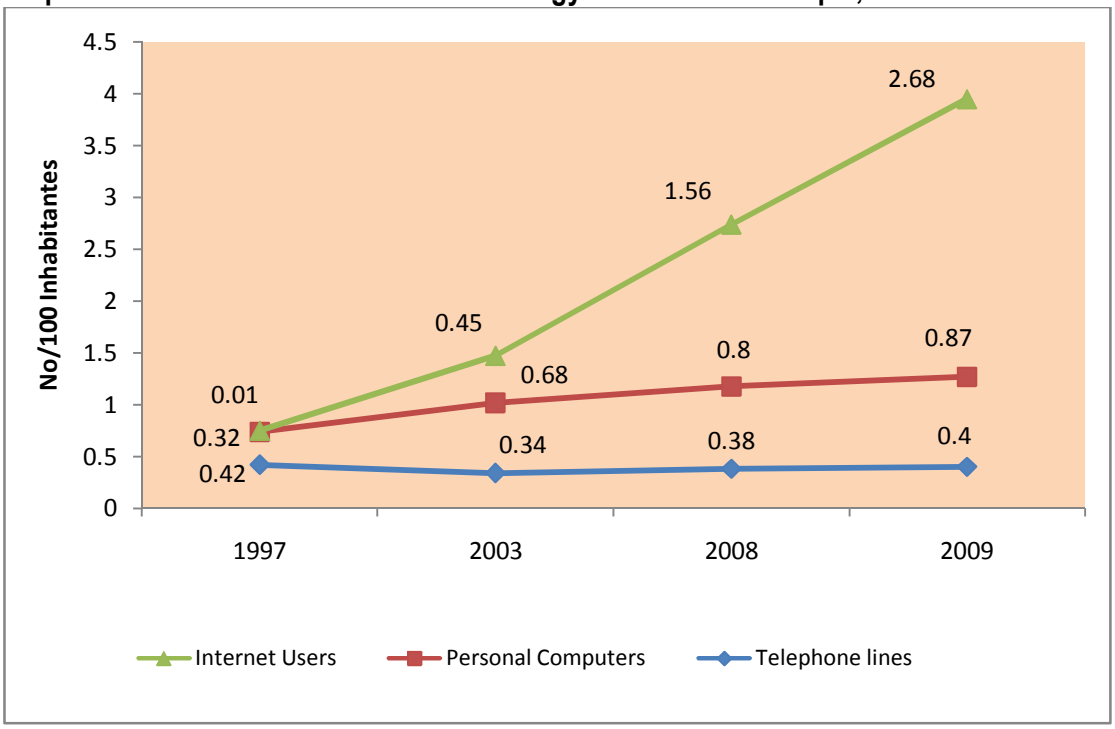
8.2 INFORMATION AND COMMUNICATION TECHNOLOGIES (ICT's)

Rapid assessment	Situation in Numbers	1997	2003	2008	2009	2015
Will the target be met? **No information**	Telephone lines per 100 people / population	0.42	0.34	0.38	0.40	n/d
	Cellular subscribers per 100 people / population	0.013	2.6	21.45	29.08	n/d
Situation of the supportive environment **Reasonable**	PCs in use per 100 people / population	0.32	0.68	0.8	0.87	n/d
	Internet users per 100 people / population	0.01	0.45	1.56	2.68	n/d

8.2.1 Situation and trend

Graphic 79 shows that in general the use of information technologies has increased in Mozambique. From 1997 to 2009 the number of internet users has increased from 0.01 to 2.68 users per 100 inhabitants. The number of personal computers (PC) users increased from 0.82 to 0.87 users per 100 inhabitants and the number of telephone line users suffered a slight decrease from 0.42 to 0.4 users per 100 inhabitants. It should be noted that the number of internet users was always higher than the number of PC users. This shows the role that schools, companies, internet cafés and computer centres play in the dissemination of the Internet in Mozambique.

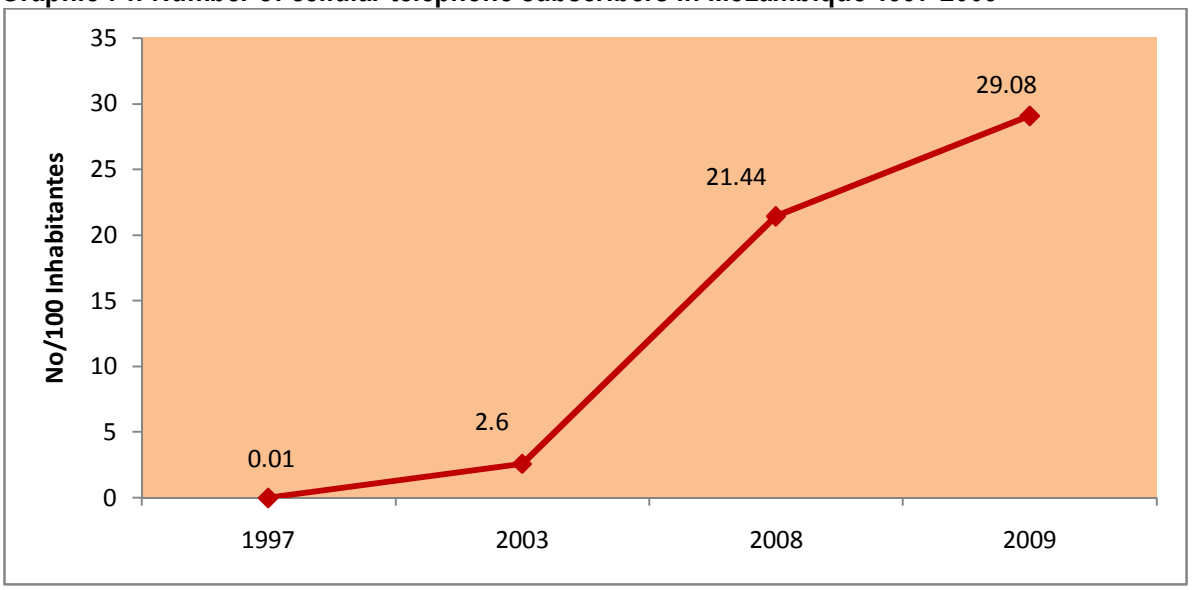
Graphic 73: Number of information technology users in Mozambique, 1997-2009



Source: MTC

An important technology adopted in Mozambique was the use of cellular telephones. The number of cellular telephone users has increased from 0.01 per 100 inhabitants in 1997 to 29.08 per 100 inhabitants in 2009. The cellular technology is a more rapidly adopted technology by Mozambicans than other information technologies and this may explain the slight decrease of the number of fixed telephone users in Mozambique.

Graphic 74: Number of cellular telephone subscribers in Mozambique 1997-2009



Source: MTC

Additional information from the communication sector shows that 79% of the population using telephones uses mobile telephony services while 21% uses fixed telephones. The coverage of telephony in the rural areas is 1% of the telephone users. The remaining 99% is in the rural areas.

Constraints on the achievement of the targets for 2015

- Absence or restriction of the supply of electricity in some areas of the country.
- Poor purchasing power of a large part of the Mozambican population to be able to acquire information technologies for private use.
- Relative high cost of internet installations for private use.

Challenges for achieving the 2015 Targets

- With regard to the communication and information technologies the challenges are stem from the need to assure horizontal integration of organizations and its key services, given that the communication and information technologies supply a powerful information and service channel to sustain economic growth and human capacity making it possible for the government to witness an increase in the need of cross ministries, inter province and districts communication as well as the development of processes and service provision.

Recommendations for the achievement of the targets for 2015

- Continuing with the price reduction in the price of cellular telephone services
- Continue Government and donor support to expand the use of information technologies in the country.

Positive factors of progress in the indicators

- Good receptiveness of the information technologies on the part of the Mozambican people, particularly mobile telephony.
- There is commitment on the part of the Government and development partners of Mozambique to take the information technologies to the rural areas.
- Adoption on the part of the public sector of information technologies for their daily work.