

2010

# EQUITY WATCH

Assessing progress towards equity in health



## Mozambique



**Ministry of Health,  
Government of Mozambique**

with Training and Research Support Centre (TARSC)  
in the Regional Network for Equity in Health  
in East and Southern Africa





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Cover photo and photo on page 9 by Nelson Patria of the Ministry of Health, Mozambique  
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Support from SIDA Sweden and WHO Mozambique is gratefully acknowledged

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Cite as: Ministry of Health Mozambique, TARSC/EQUINET (2010) Equity Watch: Assessing Progress towards Equity in Health in Mozambique, Maputo and Harare

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ISBN : 978-0-7974-4314-3

# Foreword

It is with great satisfaction that the Ministry of Health presents the first Equity Watch report which maps our progress in advancing towards equity in health along various markers of equity in health, household access to the resources for health, redistributive health systems and a just return from the global economy. It uses a mix of quantitative, policy and qualitative information to provide an understanding of where progress has been made and where our challenges lie in improving equity in health.

Mozambique has a constitutional and policy commitment to ensure that all its people have universal access to health care and are not impoverished by ill health. With social differences in the population across regions, social groups, age, gender, different levels of wealth, and so on, achieving this calls for attention to equity, and a distribution of resources that responds to health need, and that raises the widest opportunities to be healthy for all. While the country has a high level of historical poverty and under-development, it has also had a decade of macro-economic progress, raising new opportunities for progressively realizing this goal.

It shows that what we do in the health system matters in closing social gaps in our society. Ensuring that Primary Health Care reaches and involves all groups is key. While we have made progress in closing wide differences between rural and urban areas, we need to ensure that being poor, less educated or living in particular regions does not create a barrier to the uptake of primary health care or reduce access to services. The report is a catalyst for discussion within our sector on the measures we need to take to widen universal coverage and to identify and encourage outreach to and uptake in vulnerable families and households in urban and rural areas, working with the community.

The report also shows that the health sector cannot achieve health equity alone. Many sectors of government play a role in dealing with gaps in safe water and sanitation, in education, in access to healthy food and other conditions that lead to differences in health. Equally, what we do nationally is affected by the global environment, and the international partnerships we have built. We hope that this report provides an entry point for wider discussions across sectors and with development partners on how we can work together on this.

Our constitution states in its Article 94 that 'all citizens...have the duty to promote and preserve health'. The report raises the need to strengthen our mechanisms for public and community participation and roles in health as a vital element in advancing equity in health. We see this as a priority that is a shared responsibility of government, civil society and all partners, implemented in a manner that includes all groups in our society, especially those who are more vulnerable, isolated and disadvantaged.

I wish to express my acknowledgement to the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and the World Health Organization (WHO) who contributed to the completion of the Equity Watch.

We look forward to our further partnership with Regional Network for Equity in Health in East and Southern Africa (EQUINET) and the World Health Organization and other entities to repeat this Equity Watch in 2012. We will review the progress we have made in building on the many opportunities raised in the report for advancing health equity, and also how far we have come in meeting the challenges raised.



*Prof. Dr. Paulo Ivo Garrido*  
Minister of Health of Mozambique  
Maputo, September 2010

# About the equity watch

An Equity Watch is a means of monitoring progress on health equity by gathering, organizing, analysing, reporting and reviewing evidence on equity in health. Equity Watch work is being implemented in countries in East and Southern Africa in line with national and regional policy commitments. In February 2010 the Regional Health Ministers Conference of the ECSA Health Community resolved that countries “Report on evidence on health equity and progress in addressing inequalities in health”. Using available secondary data, the Equity Watch is implemented by country personnel with support and input from EQUINET (TARSC). The aim is to assess the status and trends in a range of priority areas of health equity and to check progress on measures that promote health equity against commitments and goals. This first scoping report uses a framework developed by EQUINET in cooperation with the East, Central and Southern African Health Community and in consultation with WHO and UNICEF. The report introduces the context and the evidence within four major areas: equity in health, household access to the resources for health, equitable health systems and global justice. It shows past levels (1980–2005), current levels (most current data publicly available) and comments on the level of progress towards health equity with a coloured bar indicating whether the situation is:

- Improving
- Static, mixed or uncertain
- Worsening

The relationship to the average in the east and southern African region is also shown:

- + = better than regional average
- = worse than regional average



Relief map of Mozambique

# Key areas

- Advancing equity in health ..... 7
- Formal recognition and social expression of equity and universal rights to health
  - Achieving the MDG goal of reducing by half the number of people living on \$1 per day by 2015
  - Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in east and southern Africa)
  - Eliminating income and urban/rural differentials in maternal mortality, child mortality (neonatal, infant and under-five) and under-five undernutrition
  - Eliminating income and urban/rural differentials in access to immunization and antenatal care and in attendance by a skilled person at birth
  - Achieving UN goals of universal access to prevention of vertical transmission, condoms and antiretroviral treatment
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  - Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems
  - Abolishing user fees from health systems, backed by measures to resource services
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- Achieving the Abuja commitment of 15% government spending on health
  - Achieving US\$60 per capita public sector health expenditure
  - Increasing progressive tax funding to health and reducing out of pocket financing in health
  - Harmonizing the various health financing schemes into one framework for universal coverage
  - Establishing and ensuring a clear set of comprehensive health care entitlements for the population
  - Allocating at least 50 per cent of government spending on health to district health systems (including level I hospitals) and 25 per cent of government spending on primary health care
  - Implementing a mix of non-financial incentives agreed with health workers' organizations
  - Formally recognizing in law and policy and earmarking budgets for training, communication and functions or mechanisms for direct public participation in all levels of the health system
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- Reducing debt as a burden on health
  - Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers
  - No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws
  - Health officials included in trade negotiations and clauses included for protection of health in trade agreements
  - Bilateral and multilateral agreements to fund health worker training and retention

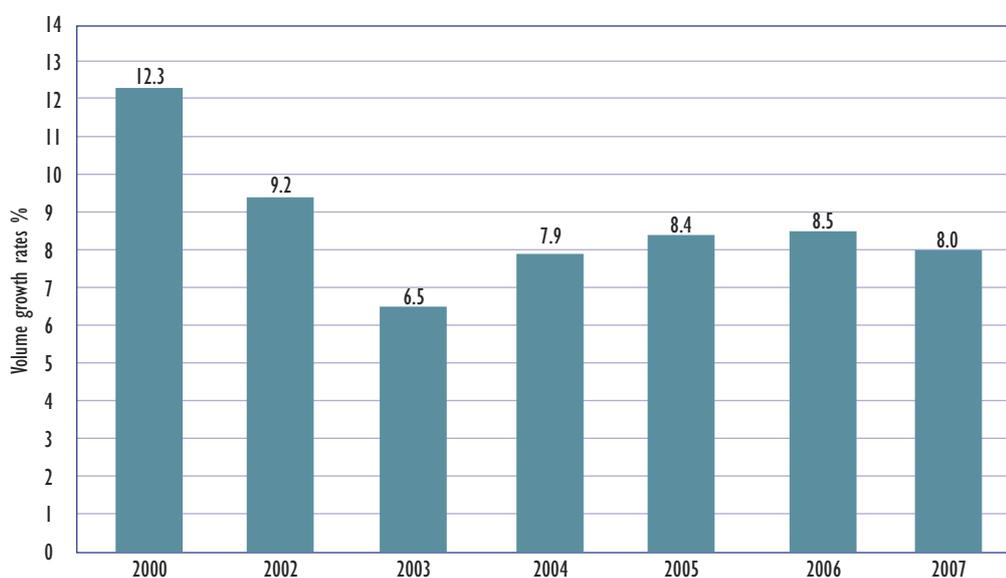
# EQUITY WATCH

In 2005 Mozambique had a population of 19,792,000 and the preliminary outcome from the third national census in 2007 put the population at 20,530,714, of which 52.3 per cent were female. The per capita Gross Domestic Product (GDP) was US\$335 in 2005 (WHO, 2006b; World Bank, 2006). It is one of the lowest income countries in east and southern Africa. However, after a difficult period of military conflict and economic hardship, the GDP grew significantly after 1995. Growth rates exceeded 10 per cent in 1997, 1998 and 2001. Over the same period, and particularly from 1997, other macro-economic indicators also improved as government controlled inflation and maintained currency stability (see Figure 1). According to the National Statistics Institute (INE), in 2006 alone the Mozambican economy grew by 8.5 per cent, an acceleration of 0.1 percentage points compared with 2005 (UNDP, 2008).



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Figure 1: GDP growth rates 2001–2007



Source: UNDP, 2008

Figure 2a: Contribution to gross domestic product (GDP) by province, 2007

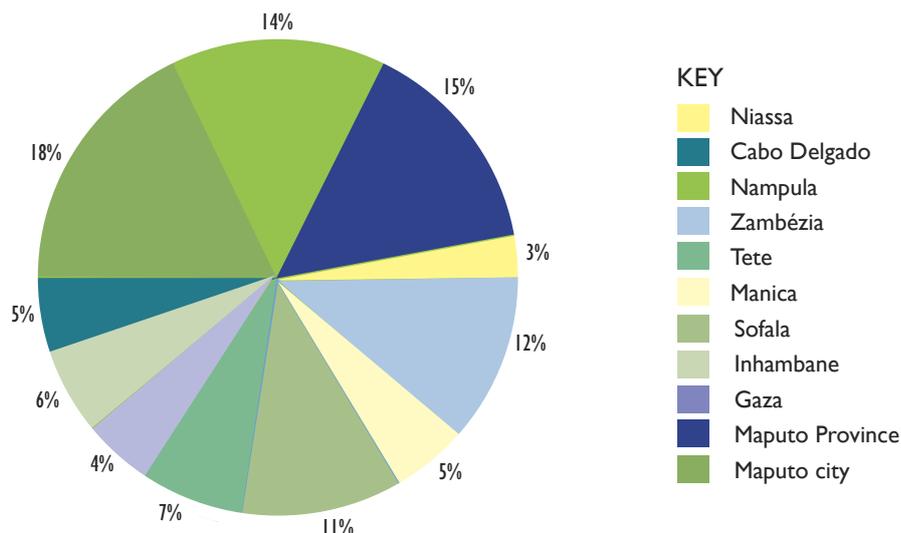


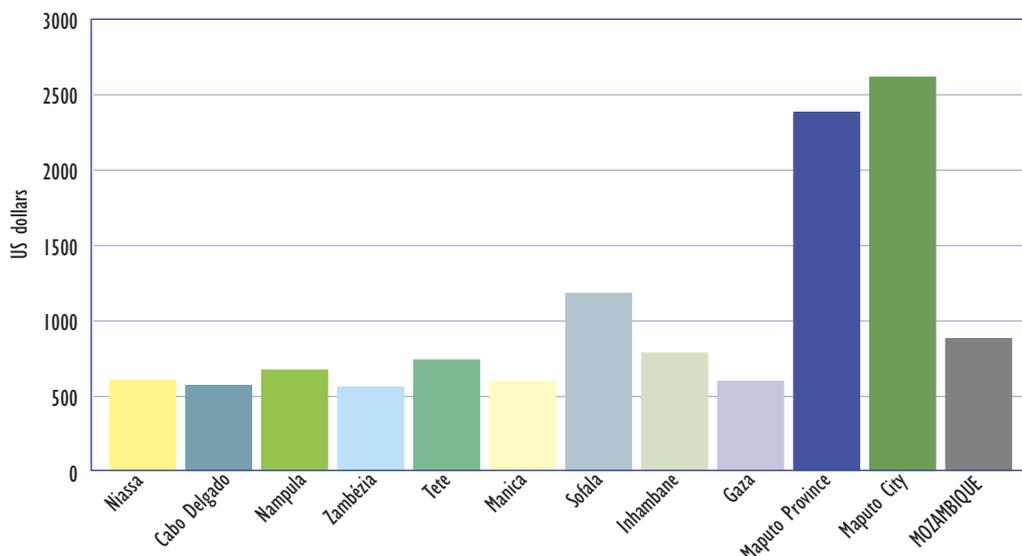
Figure 2b Map of Mozambique showing the provinces colour coded according to Figure 2a and key above



Within this context of progress, provinces have very different levels of GDP per capita (see Figures 2a and b) and of contribution to GDP (see Figure 3).

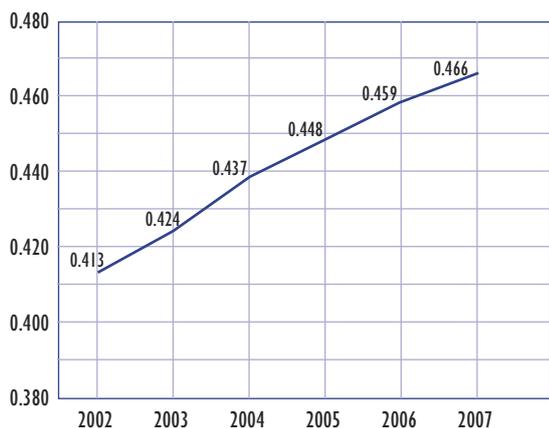
The growth was not equally distributed across all provinces, with GDP in provinces in the south growing more than in the north and centre (UNDP, 2008). Maputo City and the provinces of Sofala, Zambézia and Nampula had higher shares of contribution to GDP, although only the first three provinces had higher GDP per capita. Nampula and Zambézia are the most populated provinces with 4,1 and 3,8 million people respectively. Niassa, despite being one of the biggest provinces in the country, is the least populated. In contrast, Maputo City is smallest in area but has the highest population density, placing pressure on natural resources and services.

Figure 3: Gross domestic product per capita by province, 2007 (US\$ purchasing power parity)



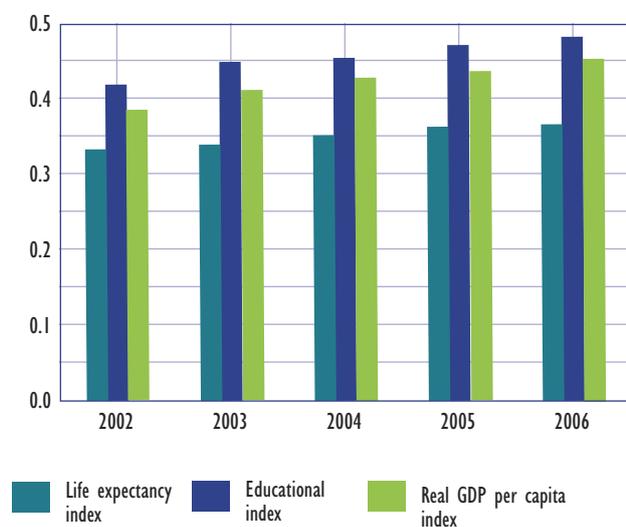
Source for Figures 2a, 2b and 3: UNDP 2008

Figure 4a: Human development index (HDI), 2002–2007



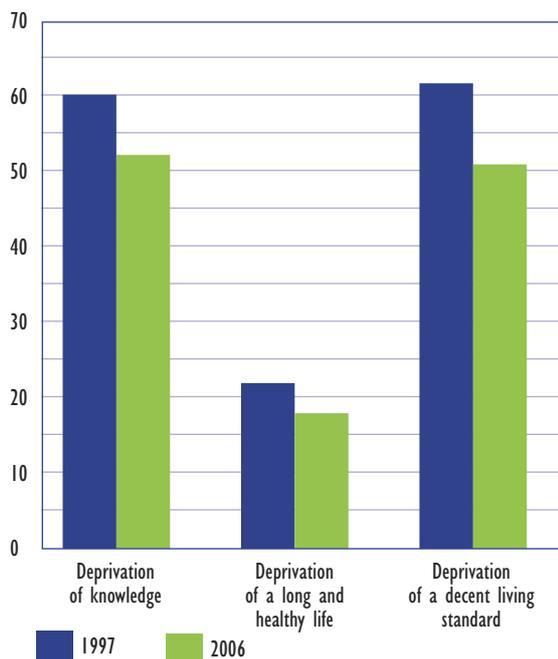
Source: UNDP 2008

Figure 4b: Changes in human development index elements



Source: UNDP 2008

Figure 5: Changes in dimensions of deprivation 1997–2006



Source: UNDP, 2008

The high rate of economic growth since the late 1990s has been associated with a steadily rising Human Development Index (HDI) in Mozambique since 1985 (see Figure 4a).

Despite this, the country still has the lowest HDI in southern Africa, reflecting the low baseline it started from, ranking as number 172 out of 175 countries with data. In addition, improvements in the HDI have been driven more by education and changes in the GDP per capita than by improvements in life expectancy (see Figure 4b).

The country’s poverty reduction strategy paper (2001–2005), PARPA I, recognizes that Mozambique has one of the highest poverty levels in the region. The human poverty index of 50.6 ranks Mozambique 101 out of 108 countries (UNDP, 2008). Poverty blocks access to the benefits of growth. The different dimensions of deprivation shown in Figure 5 have improved in the last decade, particularly in relation to knowledge and living standards. However, differences between social groups, based on residence, education and other social differentials, make the advantages of economic opportunities and public spending more accessible to certain groups. This is of concern where those with greatest need have less access so both poverty and inequality need to be addressed if the investment and growth that Mozambique is achieving is to translate into the wide improvements stipulated in the Millennium Development Goals (MDGs). Thus in PARPA I, the Government of Mozambique defines its main goals as the reduction of absolute poverty and the re-launching of economic and social development. Such immediate priorities are located within the long-term development vision for Mozambique in Agenda 2025.

This report explores the dimensions of inequality that need to be addressed for the improvements in economic performance to translate into the eradication of poverty and sustained and widest improvements in human development. It focuses on the social determinants of health and the features of the health system that have been shown to make a difference in reducing social inequalities, including in health, and asks the question: what progress are we making? The report examines the positive results achieved so far, the current levels and the prevailing constraints, in the context of the overall national response to equity. It presents recommendations based on an analysis of information available.

# EQUITY WATCH



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## Advancing equity in health

Progress markers

- Formal recognition and social expression of equity and universal rights to health
- Achieving the Millennium Development Goal of reducing by half the number of people living on \$1 per day by 2015
- Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in east and southern Africa)
- Eliminating income and urban/rural differentials in maternal mortality, child mortality (neonatal, infant and under-five) and under-five undernutrition
- Eliminating income, area differentials in immunisation, antenatal care and deliveries by skilled personnel
- Achieving UN goals of universal access to prevention of vertical transmission, condoms and antiretroviral treatment

# EQUITY WATCH



## Advancing equity in health

This section presents various markers of progress in health equity, in terms of the values that underpin it, and the progress in addressing socio-economic and health inequalities.



## Formal recognition and social expression of equity and universal rights to health

### PAST LEVELS (1980-2006)

Mozambique has had a consistent values framework for health equity over many decades, integrated in law and policy. The 1990 constitution guarantees universal access to health care as a right for all citizens in a comprehensive set of provisions. The relevant clauses are as follows:

- Article 94: *All citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and preserve health.*
- Article 54:
  - *Medical and health care for citizens shall be organized through a national health service which shall benefit all Mozambicans;*
  - *To achieve the goals of the national health system, the law shall regulate the delivery of medical and health care.*
  - *The State shall promote the participation of citizens and institutions in the raising of the level of public health care.*
- Article 89.2 provides the right to safe, secure and hygienic working conditions.
- Article 95 provides for the right to assistance in the case of disability or old age.
- Article 68 provides for rights of disabled citizens, excluding duties which their disability prevents them from undertaking.
- Article 57 provides for the emancipation of women and state incentives to increase the role of women in society.

Mozambique is a signatory to the following:

- African Charter on Human and People's Rights (1985),
- African Charter on the Rights and Welfare of the Child (1994),
- Protocol to the African Charter on the Rights of Women in Africa (2003),
- International Covenant on Civil and Political Rights (1993 – accession),
- Convention on the Rights of the Child (1986),
- Convention on the Elimination of all forms of Discrimination Against Women (CEDAW; 1979a) (EQUINET SC, 2007).

The establishment of a National Health System and the Beveridge model for health financing (through national public health financing) are major instruments for government to provide for its duty in the constitution.

The *health sector strategy plan 2007–2012* and the *health sector recovery programme 1994–1999* defined the health sector contribution to poverty reduction through providing universal access to health care, strengthening individuals and communities and promoting health advocacy. Government set a policy goal for all Mozambicans to have access to quality health care based on expanding access to primary health care (Chao and Kostermans, 2002). *PARPA I* (2001–2005) made a broad policy commitment to preventing catastrophic health costs from sinking poor households deeper into poverty. It set a target of reducing absolute poverty in Mozambique from 70 per cent to less than 50 per cent by 2010 through priority areas including health, agriculture, education, rural development, basic infrastructure, good governance and improved financial management (UN ECA, 2004).



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## CURRENT LEVEL (most recent data)

This values base has been sustained in more recent years. The 2004 Constitution of Mozambique continues to protect the right to health and health care, children's rights, gender equality, disabled citizens' rights (Articles 36 and 37) and the right to assistance in the case of disability or old age (Article 95). In Article 89 it provides that: 'All citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and protect public health.' Article 116 provides that:

1. *Medical and health care for citizens shall be organized through a national health system, which shall benefit all Mozambican people.*
2. *To achieve the goals of the national health system, the law shall establish the ways in which medical and health care are delivered.*
3. *The State shall encourage citizens and institutions to participate in raising the standard of health in the community.*
4. *The State shall promote the expansion of medical and health care and the equal access of all citizens to the enjoyment of this right.*
5. *The State shall be responsible for promoting, supervising and controlling the production, the sale and the use of chemical, biological and pharmaceutical products and other forms of treatment and diagnosis.*
6. *The medical and health care activities run by collective and private entities shall be carried out in accordance with the law and be subject to the supervision of the State.'*

The state's role is stated as being to promote the conditions to realize these rights.

Mozambique's health policy has also continued to articulate a commitment to universal coverage and primary health care in the health sector strategic plan (2007–2012) (PESS), which provides for stated cornerstones of 'primary health care, equity and better quality of care' (MISAU, 2008b), in the five year government plan (2005–2009), the poverty reduction strategy paper (2005–2009) (PARPA II), the social and economic plan (PESS) and in the medium term expenditure framework (CDFMP, or MTEF).

In 2010 the country is drafting its third poverty reduction strategy paper, *Plano de Acção para a Redução da Pobreza Absoluta 2009 +* (PARPA III), where it makes clear that the 'Government of Mozambique commits itself to gradually expand health services to the poorest in order to comply with the PARPA and the PESS' (MISAU, 2010). To achieve this, the health sector strategic plan identifies the following priority areas: development of human resources; development and strengthening of health infrastructures and equipment; and community participation, with emphasis on training elementary polyvalent agents (APEs) (MISAU, 2008b).

## Progress

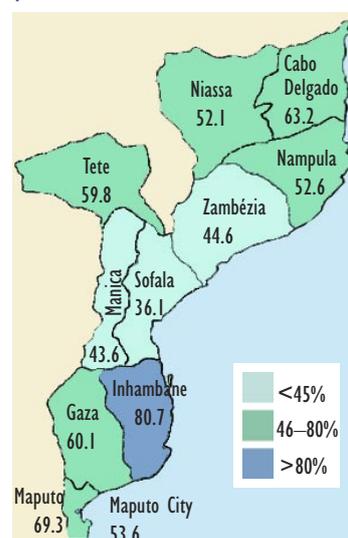
Mozambique has amongst the most comprehensive provisions for the right to health in the region. Paradoxically, it is yet to sign the International Covenant on Economic, Social and Cultural Rights. The state has put poverty reduction and health sector policies and strategies in place to fulfil its commitment to progressively realizing these rights, particularly through universal access to health care services and primary health care. In recent years, the government has recognized that an expansion of infrastructure and personnel is called for to achieve these outcomes. It has stated its policy intention to abolish user fees as a deliberate move to ensure the country adheres to its constitutional provisions for universal access to primary health care. Mozambique has thus consistently articulated a values base for equity in health and translated this through specific health sector policies. Civil society and parliamentary awareness are less evident as is the use of these rights and policies in promoting health.

## Achieving the Millennium Development Goal of reducing by half the number of people living on \$1 per day by 2015

INDICATOR	PAST LEVELS (1980–2005)	CURRENT LEVEL (most recent data)
% population living on less than US\$1 a day	36.2% 1990–2005	54% 2003 68.2% ppp US\$ 2005
% population living on less than US\$2 a day	74.1% 1990–2005	
Human poverty index	55.9% 1997	48.9% 2003
Rural poverty	71.3% 1997	55.3% 2005
Urban poverty	62.0% 1997	51.5% 2005

Sources: UNDP, 2008 – HDR; INE, 1997, 2003; HDNR Govt of Moz, 2005; WHO, 2009d; INE 2002/03

Figure 6: Incidence of poverty by province, 2003



Source: GoMoz, 2005

### PAST LEVELS (1980-2005)

In 1997 poverty was greater in rural than in urban areas. By 2003, the human poverty index had come down considerably in rural areas, while in urban areas it remained virtually constant. By 2003, when rural poverty had reduced by 16 percentage points and urban poverty by only 10.5 percentage points, the difference between rural and urban areas further narrowed from 9.3 to 3.3 percentage points. Whether the greater reduction in rural poverty may relate to returns from agriculture needs to be further explored.

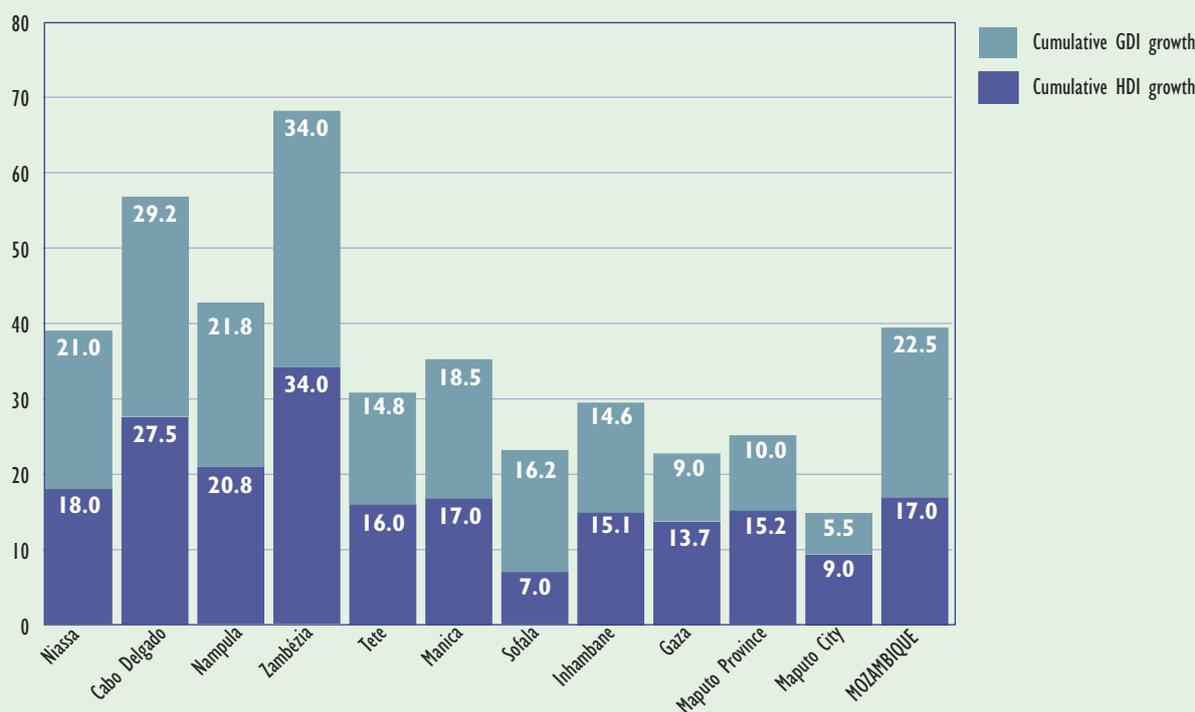
The reduction in rural poverty was associated with a rise in asset ownership, although not following a consistent trend. The proportion of households using radios rose from 27 per cent in 1997 to 49 per cent in 2001, fell to 28 per cent in 2003 and rose to 46.5 per cent in 2005. The proportion of households owning a bicycle rose from 12 per cent to 27 per cent over the period 1997–2005 (IAF, 1996/7). While growth was accompanied by a decline in the incidence of absolute poverty, increasing inequality in wealth was indicated during this period of growth, even while rural–urban inequalities were reportedly on the decline. The relative reduction in poverty shown in the table and described above indicates that high GDP growth in the 2000s was not shared equally by the population. Half of the growth went to the top 20 per cent and yet half the rural people who were above the poverty line in 2002 fell below the line in 2005 (Hanlon, 2007).

The shift from rural–urban differentials to a range of economic and social differentials was noted in government policy. In its first poverty reduction strategy paper (2001–2005) (*PARPA I*), the government acknowledged the economic and social inequalities between the Maputo-Matola conurbation area and the rest of the country as being the ‘most noticeable characteristic’ of the country, ascribing it to various factors, including the civil war. The government’s second poverty reduction strategy paper (2005–2009) (*PARPA II*) observed that both consumption-based poverty measures and non income-related measures varied considerably among the provinces. Dealing with regional disparities was a priority objective in both *PARPA I* and *PARPA II*.

## CURRENT LEVEL (most recent data)

Disparity has thus become a key concern in poverty reduction. Geographic disparities persist. The 1996/7 and 2002/3 household surveys both highlighted disparities in poverty between provinces. In the latter survey, for example, the index ranged from 81 per cent in Inhambane to 36 per cent in Sofala. From 1996 to 2003, poverty reduced most in the central provinces. Despite higher access to basic social services in the south of the country, however, poverty increased in the south in that period, particularly in Maputo Province and urban Maputo City (UNICEF, 2006). Mozambique thus has a mix of historical underdevelopment in the north and new urban poverty in the south. In 2007, provinces in the north generally had lower HDI and Gender Development Index (GDI) levels than those in the centre or south (Fox, 2008), even though the GDI had improved in all provinces in the 2001–2006 period, and particularly in Zambézia and Cabo Delgado (see Figure 7).

Figure 7: Distribution of human development index (HDI) and gender development index (GDI) by province, 2007



Source: SARDC, Instituto Superior de Relações Internacionais, INE and UNDP, 2007

By 2009, the evaluation of *PARPA II* found a generally modest reduction in disparities but an increase in disparities in agricultural production and a persistently high level of social disparity related to health and education (Ministry of Planning and Development, 2009).

## Progress

Two factors have been positive drivers for poverty reduction. Firstly, the positive macro-economic performance from 1996 to 2004 resulted in average annual growth rates of 8.5 per cent and higher rates in previously disadvantaged rural areas (INE, 2005). Secondly, public policies and laws aimed at reducing poverty, promoting development and respecting human rights in areas such as: nutrition; food production; food security; employment and professional training; and social protection and labour laws. Strategic development plans were adopted in districts in the context of local investment budgets (OILL) and backed by government subsidies for fuel and public transport in critical sectors (RNODM, 2008). There is evidence of reduced rural poverty but also of increased urban poverty and persistent disparities in health, agriculture and education. From 1997 to 2005, GDP per capita increased from US\$259 to US\$335 and between 1997 and 2003 poverty came down from 69.4 per cent to 54.1 per cent, corresponding to an elasticity of -0.8779. Maintaining this elasticity calls for an average annual per capita GDP growth rate of more than 3.1 per cent to achieve the MDG on poverty reduction, if national wealth distribution patterns remain constant (INE, IAF, 2002/2003). This suggests that reducing poverty and avoiding new risk populations, such as the urban poor, calls for disparities to be more actively addressed.

## Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in east and southern Africa)

### PAST LEVELS (1980–2005)

The Gini coefficient is a measure of statistical dispersion commonly used as a measure of inequality of income or wealth. The Gini coefficient can range from 0 to 1. A low Gini coefficient indicates a more equal distribution, with 0 corresponding to perfect equality, while higher Gini coefficients indicate a more unequal distribution, with 1 corresponding to perfect inequality.

The Gini coefficient has historically been low in Mozambique relative to other countries in the region. However, as described earlier, since the late 1990s there have been trends towards an increase in inequality. Based on the national surveys of household consumption (IAF) for 1996–97 and 2002–03, the Gini coefficient between those years rose from 0.40 to 0.42 (Arndt, 2006; National Statistics Institute, 1997).

### CURRENT LEVEL (most recent data)

The Gini coefficient rose moderately from 0.40 to 0.42 between 1997 and 2003, with higher levels in urban areas (James *et al.*, 2005). Table 1 shows the economic indicators between 2004 and 2007.

Table 1: Macro-economic indicators and development (2004–2007)

	2003	2004	2005	2006	2007
GDP per capita (U\$D)		281	286	284	294
Gross National Income per capita (103 Mt)		6.786	7.812	9.063	10.095
GDP growth (%)		7,9	8,4	8,7	7,3
Population below the poverty line	54 %				
Rate of inflation		12,6%	7%	13,6%	8,2%
Human development Index		0,454	0,463	0,471	0,479

Source: INE, 2002/2003, World Bank, 2004–2007

Recent evidence suggests that the inequalities in consumption that exist in Mozambique are often more pronounced within regions and provinces than between them (James, Arndt and Simler, 2005). Analysing the Gini coefficient or the generalized entropy ratio, both measures of income inequality, reveals marked differences between provinces. Income inequality is highest in Maputo City and the province of Cabo Delgado. Niassa, Nampula and Zambézia province have the lowest Gini coefficients and therefore the lowest income inequality (NHC MOZ, 2004–2006).



## Eliminating income and urban/rural differentials in maternal mortality, child mortality (neonatal, infant and under-five) and under-five undernutrition

The principal indicator used to measure child wellbeing levels and rates of change is the under-five mortality rate (U5MR). This results from a variety of factors: mothers' nutritional health and health knowledge; the availability, use and quality of maternal and child health services; income and food availability in the family; the availability of clean water and safe sanitation; and the overall safety of the child's environment. The U5MR can be taken as a proxy of the health status of Mozambican children and of the society as a whole.

INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
Child mortality rate 1–5 yrs / 1000 (CMR)	78 93 77 178 152	1982 1992 1997 2000 2004	145	2005
CMR for mothers with				
– no education	87	1997	68	2005
– secondary+ education	54	1997	24	2005
Rate ratio lowest to highest	1.6	1997	2.8	2005
Under-5 Mortality rate (0-5 years) / 1000	226 201	1993 2003	138 138	2006 2008
Under-5 Mortality rate / 1000				
– rural	270	1997	162	2008
– urban	166	1997	135	2008
Rate ratio rural: urban	1.6	1997	1.2	2008
Under-5 Mortality rate / 1000 by income quintile				
– lowest (1st)	277.5	1997		
– highest (5th)	144.6	1997		
– 1st	196.2	2003	171.9	2008
– 2nd	199.8	2003	169.2	2008
– 3rd	203.3	2003	169.1	2008
– 4th	154.6	2003	136.0	2008
– Highest (5th)	108.1	2003	109.9	2008
Rate ratio poorest: richest	1.9 1.8	1997 2003	1.6	2008
Infant mortality rate / 1000	145 109	1997 2003	93 520	2008 2005
Maternal mortality rate / 100 000	692 408	1997 2003	340	2008
Stunting in children under 5 years (height for age <2SD)				
– % total children	45.3 35.9	1990–1999 1997	47.0	2000–2006
– % rural children	38.9	1997	47.2	2008
– % urban children	27.3	1997	34.8	2008
Rate ratio rural: urban	1.4	1997	1.4	2008

Sources: Gaspar da Costa *et al.*, 1998; IDS, 1993; Chao and Kostermans, 2002; DHS, 1997; INE, 1996/97; INE, 2007; Gwatkin *et al.*, 2007; DHS, 2003; UNDP, 2008; WHO, 2005, 2006, 2006b, 2008, 2009; MISAU, 2008b; INE, 2005; GoMoz, UNICEF, 2010

## PAST LEVELS (1980–2005)

The summary table indicates that improvements occurred in the child mortality rate (CMR) between 1992 and 1997 and in the infant mortality rate (IMR) between 1997 and 2003. However, in the next period up to 2005, there were no improvements in child stunting and maternal mortality rose to 520/100,000. Thus there was no overall improvement in child and maternal mortality in this period.

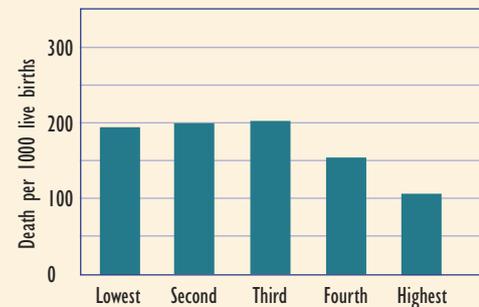
Maternal and child mortality also varied along a range of social and economic determinants, shown in the table:

- Large differentials were found between rural and urban residence: the rural CMR was 67 per cent higher than the rate in urban areas (Gaspar da Costa *et al.*, 1998). Infants in rural areas were 1.4 times more likely to die during the first year of life than those in urban areas (Macassa *et al.*, 2003; WHO, 2005).
- There were also wide social differentials, such as in the under five mortality rate (U5MR) by wealth quintile, as shown in Figure 8. Children in the lowest wealth quintile were 1.8 times more likely to die before their fifth birthday than those in the highest wealth quintile (Gwatkin *et al.*, 2007, using data from DHS, 2003). Between 1987 and 1997, the CMR was 61 per cent lower for mothers without education than for mothers with primary or secondary education (Gaspar, da Costa *et al.*, 1998). Children of mothers with no schooling had 1.2 times the rate of stunting as those with primary schooling (40.8 per cent vs 34.8 per cent) and 4.5 times the rate of stunting as those of mothers with secondary schooling (at 9.1 per cent) (Gaspar da Costa *et al.*, 1997; Gwatkin *et al.*, 2007).

In 1997, the CMR was unevenly distributed by province, with Inhambane (49/1000), Maputo city (51/1000) and Cabo Delgado (47/1000) having 2–3 times lower rates than Nampula (132/1000) and Tete (146/1000) (Gaspar da Costa *et al.*, 1998). The highest levels of child stunting were found in Nampula and Cabo Delgado. Over the period there were changes in these differentials. In urban areas, the CMR declined between 1973–1977 and 1988–1992 but increased in 1993–1997. Rural areas experienced a similar reduction in CMR between 1973 and 1982 and an increase in 1988–1992 but then an improvement up to 1997. As noted earlier, urban areas began to experience a rise in poverty which may also have related to mothers whose children had high levels of mortality immigrating to urban areas (Macassa *et al.*, 2003).

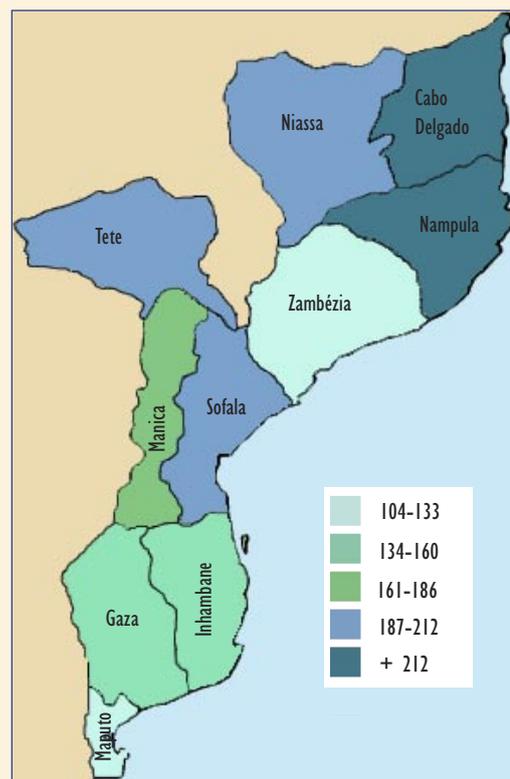
Changes in maternal mortality were found to relate to conditions in both communities and health services. In 1999, the health ministry carried out a study to identify the main determinants of maternal morbidity and mortality as part of the safe motherhood programme. This study identified three levels of delay in care which can lead to the woman's death. They were of a social and/or family nature or related to lack of resources in the community, such as infrastructure (for example, roads), transport and poor health services conditions.

Figure 8 Under five mortality rate by wealth quintile, 2003



Note: Rate for ten-year period preceding the survey  
Source: DHS, 2003

Figure 9 Under five mortality rate (per 1000 births) by province, 2003



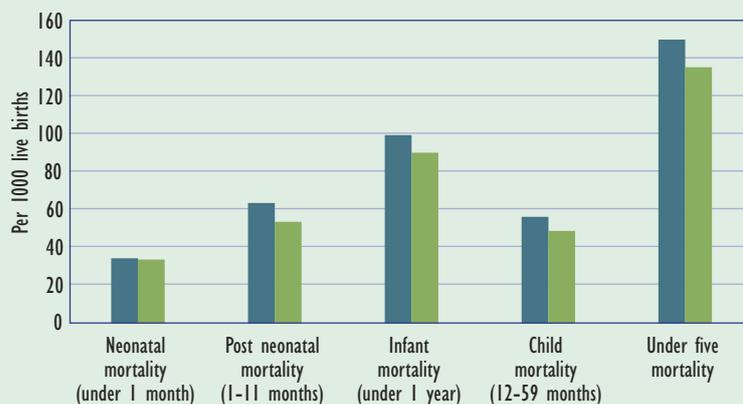
Source: WHO Country fact sheet, 2006

## CURRENT LEVEL (most recent data)

Progress has been made in recent years in improving child and maternal health and survival in Mozambique, although improvement in the under-five mortality rate has slowed. Positive gains were recorded in the IMR and U5MR up to 2008, with reductions to 93/1000 and 138/1000 respectively (GoMoz, UNICEF, 2010). While the latter is still far from the MDG goal of 53/1000 by 2015 (WHO 2006b) and the HIV epidemic is taking a significant toll on children's lives, the trend is encouraging. Furthermore the differentials between the richest and poorest groups in U5MR have fallen from 1.9 in 1997 to 1.8 in 2003 and to 1.6 in 2006 (GoMoz, UNICEF, 2010).

The reduction in mortality has been more pronounced in rural areas, with the rural U5MR down by 32 per cent from an average in 1987–1997 of 237/1000 to 162/1000 in 1998–2008, while the urban U5MR was down by 10 per cent from 150/1000 to 135/1000 in the same period (see Figure 11). The improvement in rural areas is probably due to better access to health facilities and services. A similar trend was observed with respect to the IMR (see Figure 12).

Figure 10: Changes in child mortality 2003–2008



Source: GoMoz, UNICEF, 2010

Geographical disparities persist, with a child in Cabo Delgado province almost three times more likely to die before five than a child in Maputo City (GoMoz, UNICEF, 2010).

There are differentials in U5MR between the central and northern provinces, with the highest rates recorded in Zambézia (205/1000) and Cabo Delgado (180/1000). Tete province has the third highest U5MR at 174/1000 while Maputo Province and Maputo City report the lowest U5MR (103 and 108 respectively) (GoMoz, UNICEF, 2010).

There are challenges to address. Large disparities in the CMR also still exist by social determinants: in relation to mothers' education, with children born to women with no education having 2.8 times the CMR (68/1000) than those born to women with high school education or above (24/1000) (INE, 2005). 2003 data for severe stunting in under five year olds (2003) showed 1.9 fold differentials between lowest and highest income groups:

- 1st – 25.2 per cent;
- 2nd – 26.0 per cent;
- 3rd – 25.2 per cent;
- 4th – 21.2 per cent;
- 5th – 13.4 per cent (DHS, 2003).

By 2008 the differential between lowest and highest income group in severe stunting widened to 3.1, with 21.8 per cent in the lowest group and 7.1 per cent in the highest (GoMoz, UNICEF, 2010).

Figure 11: Under 5 mortality rate by residence, 1997–2008

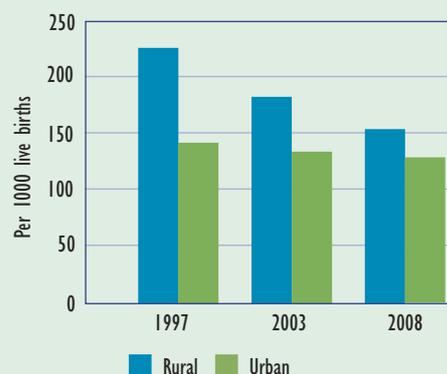
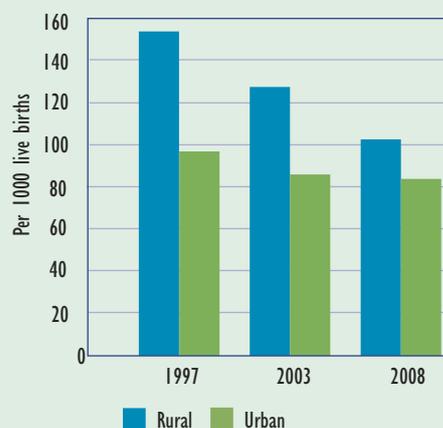


Figure 12: Infant mortality rate by residence, 1997–2008

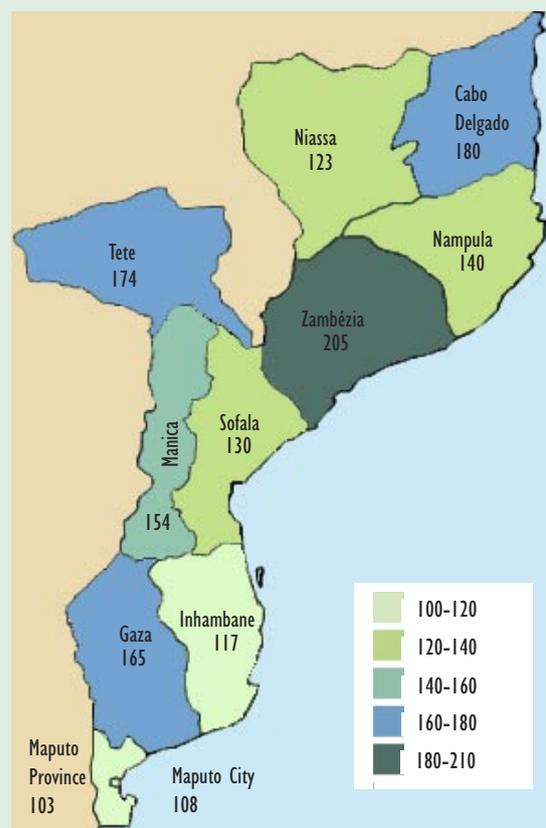


Sources: Figures 11 and 12: GoMoz, UNICEF, 2010; DHS INE, 1997, 2003



The maternal mortality rate (MMR) decreased from 692 in 1997 to 340 in 2008 (GoMoz, 2008b). This is attributed to the national plan and strategy for the reduction of maternal and newborn mortality from the year 2000, with better diagnosis and treatment of obstetric complications and greater access to quality health services, including in antenatal consultations and family planning (GoMoz, 2008b). The health sector has launched a national logbook and expanded the integrated care strategy for child diseases (AIDI) for the newborn within the first week of life. A presidential initiative to support infant, newborn and maternal health was launched and a strategic plan on infant and newborn health has been developed (PESNI, 2008–2012). Health staff in general, and particularly mother-and-child health nurses, medical and surgical technical staff, and doctors, have had updated training in assisting in childbirth and emergency obstetric care. As a result the proportion of births taking place in health units with qualified staff rose from 44 per cent in 1997 to 48 per cent in 2003 and 55 per cent by 2009 (INE, 1997, 2003, 2009). There are gaps to address between social groups – deliveries at a health facility were 2.3 times more likely in mothers from the highest wealth quintiles than those from the lowest and 2.1 times more likely in mothers with secondary or higher education than those no education (Govt of Moz, UNICEF 2010).

Figure 13 Under five mortality rate (per 1000 births) by province, 2010



Source: GoMoz, UNICEF, 2010

## Progress

The U5MR and MMR improved significantly between 1987 and 2008, leading to optimism that the 2015 child mortality MDG could be achieved if improvements accelerate, reducing the MMR by 4.3 per cent annually and the IMR by 3.7 per cent annually. Recent U5MR improvements were most marked in rural areas, reducing urban–rural differentials. Provincial differences in U5MR were reduced but persisted, while there continued to be wide differentials by wealth in stunting. Of concern are the relative increase in the urban CMR and continuing differences in CMR by wealth and mothers’ education. Overcoming differentials in access to key services to reduce MMR and CMR is one issue for improvement. Various programmes have been put in place to support maternal and child health, and the MMR has been reduced by addressing the demand and supply side factors affecting maternal mortality. There is need to assess and address as relevant the social distribution of this reduction and access to such services, particularly in the provinces with highest mortality burdens and in mothers with lowest income and education. This is further discussed later.



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## Eliminating income and urban/rural differentials in access to immunization and antenatal care and in attendance by a skilled person at birth

INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
Measles immunization % coverage in <1yrs			74.1	2008
– Rural	70.8	2003	69.6	2008
– Urban	90.8	2003	85.8	2008
– Lowest income	60.8	2003	62.0	2008
– Highest income	96.4	2008	89.8	2008
– Rich: poor ratio	1.6	2003	1.5	2008
Full immunization % coverage	47	1997	60.1	2008
	63	2003		
– Rural	56	2003	54.8	2008
– Urban	81	2003	74.1	2008
– Lowest income	45	2003	47.0	2008
– Highest income	91	2003	78.8	2008
– Rich: poor ratio	2.0	2003	1.7	2008
% pregnant women with access to ANC			92.4	2008
– Rural	66.1	1997	89.7	2008
– Urban	96.1	1997	99.0	2008
– No education	61.7	1997	88.0	2008
– High school education+	98.7	1997	99.3	2008
% pregnant women with 4 ANC visits	36	1990-1999	53	2000-2006
% births attended by skilled personnel			48	2000-2006
			55.2	2008
– Rural	34.1	2003	46.0	2008
– Urban	80.7	2003	78.7	2008
– No education	61.7	1997	41.0	2008
– High school education+	98.7	1997	89.1	2008
Births attended by skilled personnel by wealth quintile				
– lowest (1st)	25	2003	36.1	2008
– 2nd	33	2003	45.0	2008
– 3rd	68	2003	52.9	2008
– 4th	89	2003	66.2	2008
– Highest (5th)	89	2003	88.3	2008
– Rich: poor ratio	3.6	2003	2.5	2008

Sources: Gaspar da Costa et al., 1998; INE, 1996/97), 2003; INE, 2007; Gwatkin et al., 2007; INE and OCR Macro, 1997, 2003; WHO, 2008, 2009d; MISAU, 2007. GoMoz, UNICEF 2010





## PAST LEVELS (1980–2005)

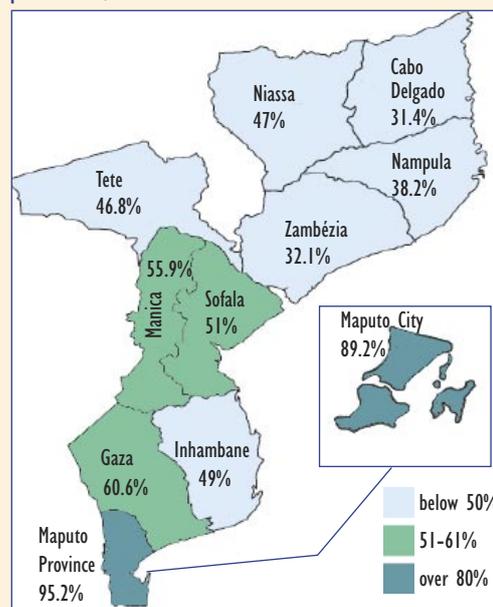
The summary table indicates that immunization rates were low in rural areas and in low-income groups. Routine immunization is in policy administered to all children under five in all health service delivery points. Children under one receive BCG, OPV, diphtheria tetanus pertussis (DPT) /hepatitis B and measles immunization, and tetanus toxoid is administered to women of childbearing age, with coverage rates of 57.5 per cent in 1990 (UNDP, 2005). Immunization among one year olds in 2003 varied by residence and income, with urban–rural ratios of 1.3 and highest–lowest income ratios of 1.6 (WHO, 2008).

The constraints were on both supply and uptake. Only 75 per cent of facilities offering child immunizations had all vaccines in stock in a 2003 survey (Lindelöw *et al.*, 2004). Non-governmental and other community-based organizations, such as Fundação para O Desenvolvimento da Família (FDC) and Village Reach, play a valuable role in ensuring social mobilization for immunization and encourage community participation.

The summary table shows that maternal health services varied: by rural–urban area, with 2.4 times higher rates in urban areas; by education of mothers, with 1.6 fold differences in ante-natal care (ANC) attendance; and by income group, with rich to poor ratios of 3.6 (WHO, 2008; Gwatkin *et al.*, 2007).

This indicates that in the period there were barriers to accessing care that followed similar social and economic differentials as those affecting maternal and child health outcomes, making care more accessible for those with less need, despite the strong values framework for and policy commitment to equity.

Figure 14 Institutional deliveries (%) by province, 2003



Source: GoMoz, 2005

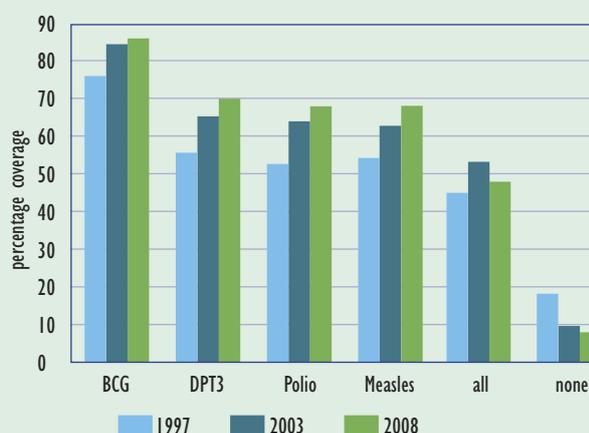
## CURRENT LEVEL (most recent data)

Policy commitments have been made through ratifying the Convention on the Rights of the Child (1989), developing the mother and child health and family planning programme and passing a law against domestic violence (Law number 29/2009). Programmes have been expanded to improve maternal and child health, including the Expanded Immunization Programme (PAV), nutrition, essential drugs, safe motherhood, exclusive breastfeeding, vitamin A supplements, insecticide-treated mosquito nets, integrated care for childhood, diseases (AIDI), prevention of vertical transmission of HIV and AIDS, child nutrition, roll back malaria, and treatment of AIDS (MISAU, 2005).

Immunization coverage increased after 2005. In 2008, 87 per cent of children under one were vaccinated against tuberculosis, 71 per cent for DPT3, 70 per cent for Polio3 and 64 per cent against measles (Figure 15). Children of 12–23 months in urban areas are still more likely to be vaccinated than those in rural areas, with 55 per cent of rural children having all vaccines compared to 74 per cent of urban children. Children in the highest wealth quintiles had 1.7 times the coverage of full immunisation than those in the lowest in 2008, although this is a decline from the 2003 levels (GoMoz, UNICEF, 2010).

The summary table indicates that access to ANC and skilled health worker assistance on delivery rose after 2005, particularly in rural areas. In 2003, 47 per cent of births were reported to be at a health facility

Figure 15: Immunization coverage children 12–23 mths 1997–2008



Source: INE and OCR Macro 1997, 2003; GoMoz, UNICEF, 2010



and 53 per cent at home (INE, 2003). By 2007, the Ministry of Health estimated 53.8 per cent of women delivered at a health facility, with 28.6 per cent rural and 71.4 per cent urban (MISAU, 2007). There is some variation on this estimate and the figures are affected by changes in recording practices at health facilities in the period. *PARPA II* estimated that only 48 per cent of women deliver at health facilities (MISAU, 2008:4). Health information system data reported Maputo City, Niassa, Inhambane and Sofala as having above national average coverage (Ministry of Health, MISAU, 2007; GoMoz, 2008b). Household surveys indicate that differentials in access and coverage persisted for immunization coverage but fell for ANC and skilled assistance at delivery, :

- 1.4 in 2008, and 1.7 in 2005 in urban–rural immunization coverage (1.4 in 2003)
- 1.1 in 2008 and 1.2 in 2003 in urban–rural ANC coverage (1.5 in 1997)
- 1.7 in 2008 and 2.4 in 2007 in urban–rural assistance at birth by skilled attendants (2.4 in 2003).

As with other health outcomes, ANC coverage rates varied by wealth quintile, with 1.5 differentials in highest to lowest quintile:

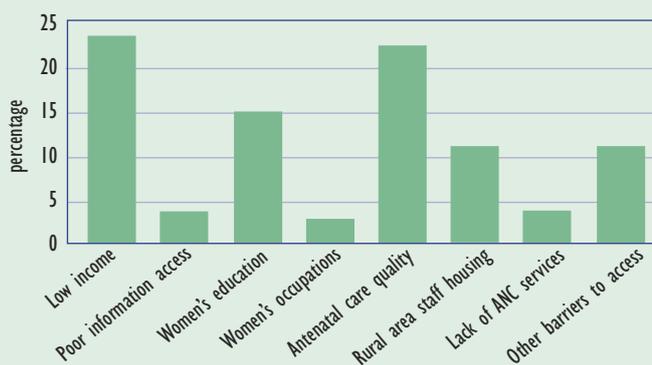
1st (lowest) quintile	67 per cent
2nd quintile	83 per cent
3rd quintile	86 per cent
4th quintile	97 per cent
5th (highest) quintile	98 per cent

(Gwatkin *et al.*, 2007).

By 2008, wealth differentials of 2.5 in skilled assistance on delivery were wider than urban–rural differentials, indicating that socio-economic variables affect access more.

ANC coverage rates were lower for multiple visits to a medically trained person (2003), from 53 per cent in the lowest quintile to 90 per cent in the highest, and 65 per cent in rural areas to 86 per cent in urban (Gwatkin *et al.*, 2007). It is reported that 45.2 per cent of rural expectant mothers and 70.7 per cent of urban expectant mothers visited ANC four times or more during their pregnancy (INE, 2005). Figure 16 shows the factors Ministry of Health surveys identified as leading to differentials in skilled deliveries, suggesting that barriers exist in the community (due to low income) and the services (due to quality of ANC).

Figure 16: Factors contributing to differentials in skilled deliveries



Source: GoMoz, 2008d

## Progress

Immunization coverage has increased since 1997, new vaccines – hepatitis B and haemophilus influenza – were introduced and rota virus and pneumococcus vaccines are planned. ANC and skilled assistance at delivery coverage, while better, are still below target. Urban to rural area differentials have improved for ANC and skilled assistance at delivery but not for immunization. Vaccination coverage is still higher in urban areas and varies by level of wealth, indicating the need for more effort and investment to close such gaps. Wealth differentials are now wider than urban–rural differentials suggesting that while supply side factors (availability) need to be addressed, demand side barriers are more important for MDG targets and overcoming differentials. This shifts focus to maternal and child health programmes reaching those least served, through measures promoting universal coverage complemented by programmes to ensure uptake in families with lower incomes and education and other disadvantages.

Government is planning to build more health units in areas that are currently least served to reduce geographical inequity in public health care provision (MISAU/ DNS, 2005a, 2004b). The presidential initiative aims to support infant, newborn and maternal health with a strategic plan for infant and newborn health (PESNI, 2008–2012). The health sector has expanded the integrated care for child diseases (AIDI) strategy for newborns within the first week of life to raise coverage in all districts through the Reaching All Districts (RED) strategy. This includes re-adopting mobile team services, supervision, liaison with the community, monitoring and record-keeping and resource planning and management. This approach focuses on building the capacity of districts, health workers and communities to address major obstacles to improving immunization and other maternal and child survival services. Once consolidated, the RED approach will serve as an entry point for all maternal and child survival interventions at district level. These important plans for geographical coverage need to integrate measures to identify and ensure uptake in low-income, socially disadvantaged families in all areas (even in areas of high coverage) and to include disaggregated monitoring of uptake and coverage.



## Achieving UN goals of universal access to prevention of vertical transmission, condoms and antiretroviral treatment

INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
Adult HIV prevalence	10.2%	1996	16%	2007
	13.0%	2004		
	16.1%	2005		
% attended VCT and taken an HIV test	2.5	2003		
– Rural women	1.1	2003		
– Urban women	8.9	2003		
– Lowest income women	0.4	2003		
– Highest income women	12.1	2003		
% pregnant women (15–49) having VCT as part of ANC				
– lowest (Zambézia)	27%	2003	28%	2006
– highest (Maputo city)	81%	2003	94%	2006
People accessing treatment				
% in need on ART	6%	2005	30.0%	2007
	12%	2006		
Pregnant women on ART	0.2%	2002	8.3%	2006
	6.5%	2005	29.7%	2007
Pregnant women on PMTCT	0.7%	2003		
	8.3%	2006		
% knowing about PMTCT				
– Rural women	53	2003		
– Urban women	74	2003		
– Lowest income women	45	2003		
– Highest income women	81	2003		
Contraceptive prevalence	16.5%	2000–2006		

Sources: NAC, 2008; Gwatkin et al., 2007; WHO, 2008, 2009; Kaiser Foundation, 2005; MISAU PMTCT programme, 2007.

### PAST LEVELS (1980–2005)

The adult HIV prevalence in the country rose from 10.2 per cent in 1996 to 16.1 per cent in 2005, with higher prevalence among women and in the central region. According to UNAIDS: ‘After appearing to stabilize in the early 2000s, Mozambique’s epidemic has again grown, with HIV prevalence rising in all parts of the country’ (UNAIDS, 2008). Rising infection levels have been noted in people of 15–24 years (NAC, 2006).

The country began a concerted response in 1986, setting up a National AIDS Commission and then a national programme for the prevention and control of AIDS (PNPCS) in 1988 and a National AIDS Council (NAC) to coordinate, monitor and evaluate the multisectoral response. Parliament passed a law prohibiting any discrimination against people living with HIV/AIDS (PLWHA) in the workplace (UN ECA, 2004; NAC, 2008). The government endorsed the 2001 UN Declaration of Commitment on HIV/AIDS and the UN Millennium Development Goal to halt and reverse the spread of HIV by 2015. A national prevention of mother to child transmission (PMTCT) programme was established in 2002 with international partners (GoMoz, 2007; RNDH, 2007).

By 2005, 204,000 people were estimated to need antiretroviral treatment (ART), while 146,245 pregnant women were estimated to be HIV positive and in need of PMTCT treatment. While ART coverage rose from 5 per cent of people in need in 2005 to 12 per cent in 2006, it was still below the regional average of 21 per cent (WHO, 2008).



Voluntary testing and counselling (VCT) coverage was fairly low and, as shown in the summary table, varied 30 fold between highest and lowest income quintile, and 8 fold by rural–urban residence. Knowledge of PMTCT similarly varied 1.4 fold by 1st and 5th income quintile and 1.8 fold by residence, with rural and lowest income women most disadvantaged.

### CURRENT LEVEL (most recent data)

Surveillance data in 2007 showed that although HIV prevalence in the north and centre of the country had stabilized, with prevalence rates of 9 per cent and 18 per cent respectively, in the southern region prevalence had a dramatic upward trend, reaching 21 per cent (NAC, 2008).

Figure 17: HIV prevalence by province, 2004,2007

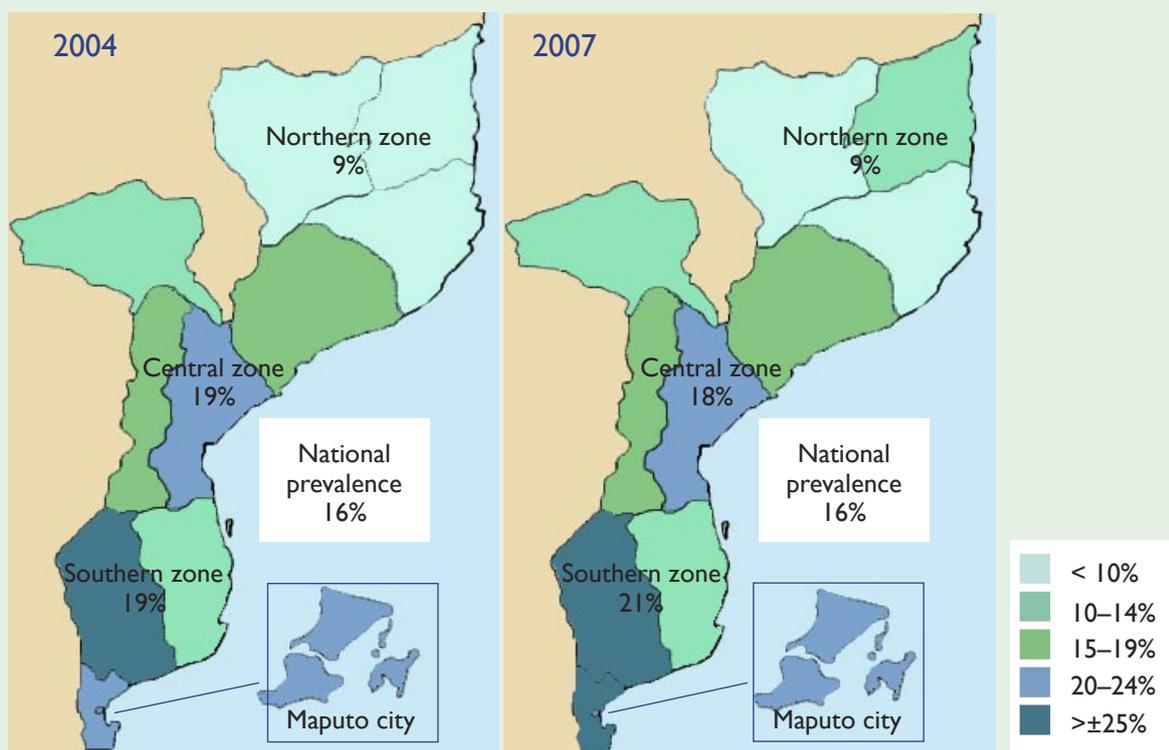
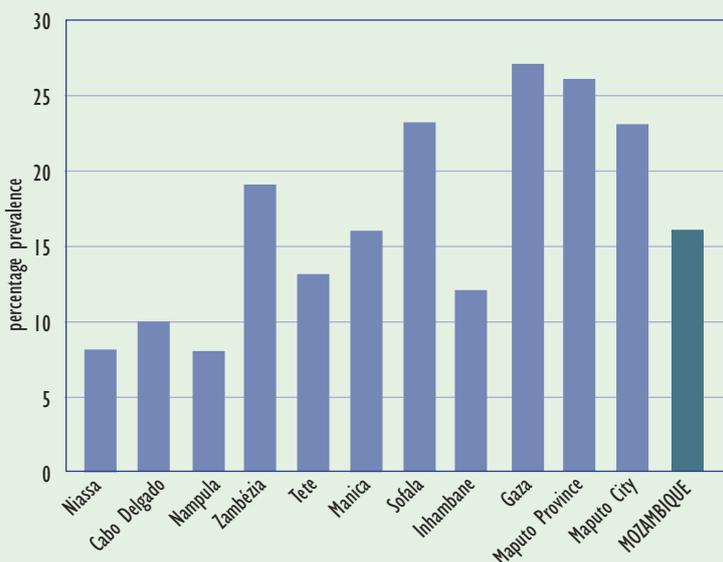


Figure 18: HIV prevalence by province, 2007

The distribution of adult HIV prevalence by province is shown in Figures 17 and 18. It was lowest in the north (9 per cent in 2004) but increases by 2007, with lower prevalence possibly due to male circumcision being more common. Higher and increasing prevalence is evident in the southern zones (20 per cent), including in the capital, Maputo (UNAIDS, 2008, citing NAC, 2006).



Source of Figures 17 and 18: MISAU/INE 2007; Mozambique National AIDS Council, 2008



The epidemic has increased in young people indicating that we need to complement efforts towards universal coverage with specific measures for particular groups with higher risk. For young adults in the northern zone, HIV prevalence doubled to 10 per cent between 2000 and 2004 and rose from 12 to 18 per cent in the south, suggesting that this group needs particular attention in prevention (MISAU, 2005). There are also significant gender differentials with 22 per cent of 20–24 year old women infected, compared to 7 per cent of men (NAC, 2008).

By 2006 there were 356 VCT sites, including 281 in health facilities and 78 that offered PMTCT. VCT coverage increased by 81 per cent between 2005 and 2007 (NAC, 2008). There were however significant geographic disparities in the proportion of women who received HIV counselling as part of their antenatal consultation. This varied from only 28 per cent in Zambézia province (27 per cent in 2003) to 94 per cent in Maputo City (81 per cent in 2003), with the most rapid increase in coverage in Maputo. This data does not disaggregate who is and is not accessing testing, nor the extent to which testing leads to treatment. Significant fallout is evident considering that only 43 per cent of women received their test results (NAC, 2008).

Roll out of ART treatment and care expanded rapidly in 2006/07. In 2007, antiretroviral coverage in general rose to 30 per cent and to 29.7 per cent for pregnant women, changing from below to above the regional average of 24 per cent (WHO, 2009). In 2008, of 738,793 women attending ANC, 63 per cent were tested for HIV and 54,749 received ART at 504 PMTCT sites across the country (QAD, 2008). The national strategic plan to combat STI, HIV and AIDS 2004-2008 (Ministry of Health, 2004a) integrates all the components of care, making counselling, voluntary testing, laboratory examinations, ART and treatment for opportunist infection fully subsidized by the state for the network of people living with HIV and AIDS (MISAU, 2006). The number of health centre units integrating PMTCT services rose significantly from 286 in 2007 to 504 in 2008 and 800 in 2009.

Antiretroviral treatment for children is being brought progressively closer to the people by expanding across the country, although with inequitable geographic distribution.

In 2006, 68 per cent of all children receiving treatment were living in the four southern provinces of the country and 55 per cent were living in Maputo City. By 2008, the southern provinces accounted for 56 per cent of all children receiving antiretrovirals and Maputo City accounted for 33 per cent. In spite of the expansion to other provinces, the geographic distribution of children accessing treatment remains highly inequitable with approximately half the children in need of ART able to access it in the south and less than 20 per cent in the central and northern regions (see Figure 20 on page 26).

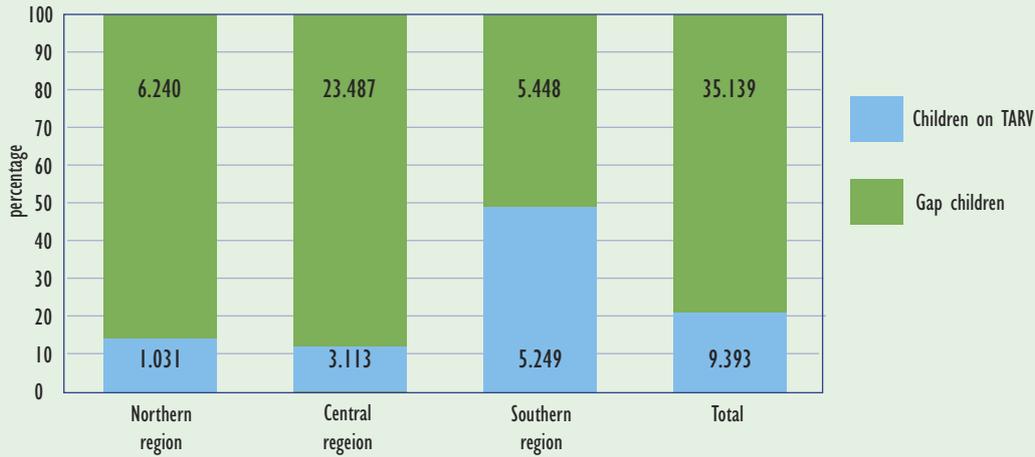
Figure 19: HIV positive pregnant women receiving antiretrovirals 2002–2007



Source: MISAU/PMTCT programme, 2007



Figure 20: Unmet need for antiretroviral therapy (ART) in children below 15 years, December 2008



Source: Ministry of Health, Directorate of Medical Assistance data, 2008.

Distribution of condoms has expanded, with 69 million condoms distributed in 2007, 58 per cent more than in 2006. UNFPA provided 1,25 million female condoms for distribution (IRIN, 2009) and guidelines for using the female condom are being elaborated.

## Progress

The government of Mozambique has prioritised HIV and AIDS in its national agenda, mainstreamed it in the national development and poverty reduction frameworks and is promoting integrated services for people living with HIV and AIDS, from VCT to integrating counselling and health screening into chronic disease management. As a result, access to treatment has expanded impressively in a relatively short timeframe, reaching above regional averages, although still below universal coverage. There are a number of challenges:

- HIV prevalence is increasing in southern regions and in youth and with significant gender inequalities. The determinants of this risk need to be addressed and prevention services intensified in specific risk groups, even while treatment is expanding.
- The unmet need and inequitable geographical distribution of ART for children calls for resource allocation to address low access in northern and central regions.

The ministry has identified a number of supply side barriers to its goal of universal coverage. For example, the lack of skilled health workers is being addressed in a human resources development plan for 2008–2015. Where services are more available, barriers to uptake need to be identified and addressed. The rapid scale of expansion, particularly in Maputo, suggests that higher income, more educated groups may have had more rapid uptake.

Further, dropout from treatment is now a concern, pointing to the need to address determinants of uptake: 'The number of people "lost to follow up" on ART is beginning to become an issue and indicates the need for greater understanding of people's access to and use of health service facilities' (NAC, 2008). A proposal to implement a communications strategy to reclaim Mozambican socio-cultural values and fight stigma could be informed by a geographically disaggregated assessment of the barriers to service access and coverage.



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# EQUITY WATCH



## Household access to resources for health

Progress markers

- Achieving and closing gender differentials in attainment of universal primary and secondary education
- Achieving the MDG goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
- Increasing the ratio of wages to GDP
- Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems
- Abolishing user fees from health systems, backed by measures to resource services
- Overcoming the barriers that disadvantaged communities face in accessing and using health and essential services

# EQUITY WATCH



## Household access to the resources for health

The health inequalities and their determinants described in the previous section are addressed by households accessing resources for health through redistributive health systems and through wider national and global policies. This section explores progress in selected parameters of how far households are accessing the educational, environmental, income, health care and social protection resources they need to improve their health, and to close differentials in the social determinants of health. The parameters indicate the wider spectrum of such resources.



## Achieving and closing gender differentials in attainment of universal primary and secondary education

INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)		
% net enrolment in primary school of primary school age children	– Females	37	1990-1994	73	2000–2006
		46	1995-1999	80	2008
	– Males	47	1990-1994	80	2000–2006
		58	1995-1999	82	2008
– Overall	69	2003	81	2008	
% adult literacy (overall)	45.4	2002	48.3	2007	

Source: WHO, 2008; UNDP, 2008; GoMoz, UNICEF, 2010

### PAST LEVELS (1980–2005)

Levels of adult literacy in Mozambique are relatively low. Although Mozambique was aiming for universal primary school attendance from 1981, a 16-year internal conflict led to a significant regression in education by 1990. In 1995, the government approved the national education policy (PNE), prioritising basic education (for children and adults). Recovery in the education system was based on expanding and improving the quality of education, particularly basic education.

Gender was a significant determinant of education outcomes. There was a considerable but narrowing gap between male and female children in primary school enrolment, as shown in the summary table (WHO, 2008). In 2002 the net enrolment ratio for the first phase of primary education (EPI) of girls to boys in rural areas was 48:57 per cent or a ratio of 1.2, while the girl to boy ratio in urban areas was 76:76 per cent or equal (WHO, 2009d). Gender differentials were thus wider in rural areas and worse in the northern and central provinces (MINED, 1998). Pass rates at primary school improved from 56–60 per cent in 1997 to 77 per cent in 2004, with the gender difference closing (UNDP, 2005). School attendance rates in 2003 differed significantly by wealth quintile, with lowest to highest wealth quintile ratios for girls of 32:85 per cent or 2.7 and for boys of 45:84 per cent or 1.9, thus wider for girls than for boys (Gwatkin *et al.*, 2007).

At the same time income was an even greater determinant of education outcomes. School completion rates in 2003 between lowest and highest wealth quintiles were 3.5:52.3 per cent in girls or a ratio of 14.9 and 17.6:63.9 per cent in boys or a ratio of 3.6 (Gwatkin *et al.*, 2007).

### CURRENT LEVEL (most recent data)

Adult literacy improved slightly between 2002 and 2007, as shown in the summary table, but with a persistent gap in literacy rates between men (69 per cent) and women (36 per cent) in 2007 (UNDP, 2008).

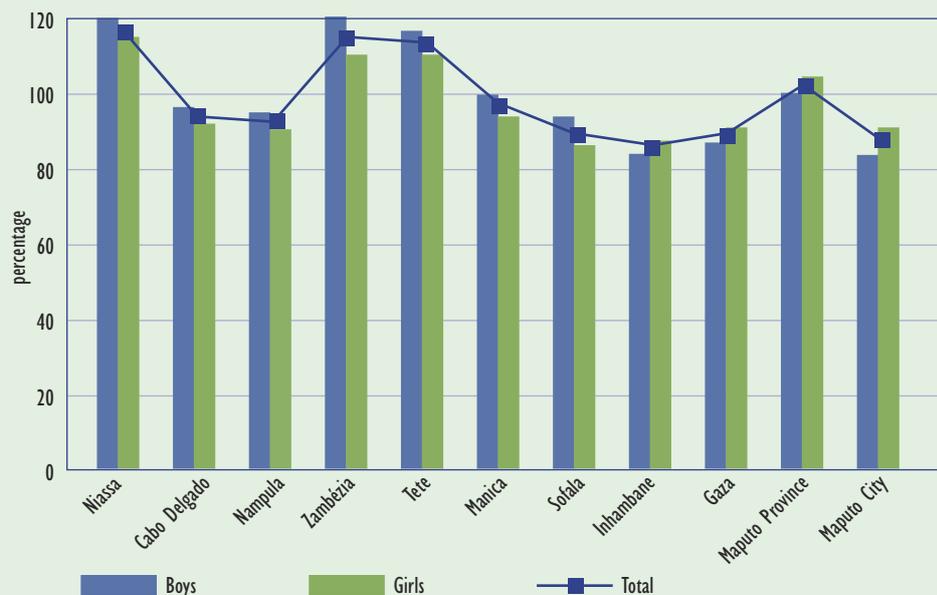
At policy and strategy level, the five year government programme, *PARPA II*, the gender policy and implementation strategy, the national progress plan for women and the strategic plan for education (2006–2010/11) focused on integrating gender equity in education. The Ministry of Social and Women Affairs, the National Council for the Progress of Women (CNAM), the female Members of Parliament, Cabinet and the Social Welfare Commission for Gender and Environment (Parliament) and selected civil society organizations are supporting the implementation of these policies. In 2005–2007, 20.8 per cent of the government budget was allocated to education, with the highest expenditure on general education. With these policies, the construction of schools and investments in better quality education, the average net primary school enrolment index rose and the gender gap closed, as shown in the summary table. The Ministry of Education recorded a significant increase in children completing EPI, from 38.7

per cent in 2003 to 72.6 per cent in 2007. The MDG target for reducing gender gaps in the EPI (grades 1–5) are likely to be achieved by 2015, although 100 per cent completion of primary education for boys and girls by 2015 is unlikely.

At EP2 (grade 6–7) and secondary levels the gap persists. The girls' completion index for EP2 was 28.8 per cent in 2006 and the gap between boys (80 per cent) and girls (65.1 per cent) remained high (GoMoz, 2008b; UNDP, 2008).

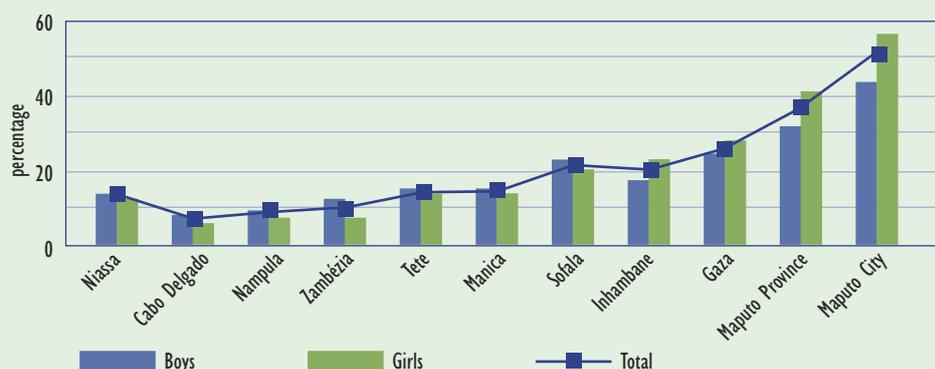
Further, there are wide geographical disparities. Although the net enrolment ratio for EPI is over 80 per cent in every province, the gross enrolment ratio (GER) for the second phase (EP2) reveals marked geographical disparities. Girls' public school completion rates in Inhambane, Gaza and Maputo Province and City were higher than boys', although in other areas they were lower. Maputo City and Maputo Province, which recorded the highest levels of enrolment, had a higher gross enrolment ratio for girls in EP2 than for boys, while in other provinces it was lower. Regionally, the provinces with the lowest gross enrolment ratio in EP2 and the greatest gender gaps are those in the central and northern parts of the country. Cabo Delgado, Nampula, Niassa and Zambézia are among the worst performing provinces, each with a net enrolment ratio of less than 15 per cent (GoMoz, 2008b) (see Figures 21–24). School attendance follows a pattern similar to school enrolment. The 2008 multiple indicator cluster survey revealed that pupils in southern provinces attend school frequently, with primary school attendance rates of 91–96 per cent. Attendance is much lower in the northern and central provinces, ranging from 85 per cent in Manica to 69 per cent in Tete.

Figure 21: Net enrolment rate for Grades 1–5 (EPI) by province, 2008



Source: INE, 2009

Figure 22: Net enrolment rate for Grades 6–7 (EP2) by province, 2008

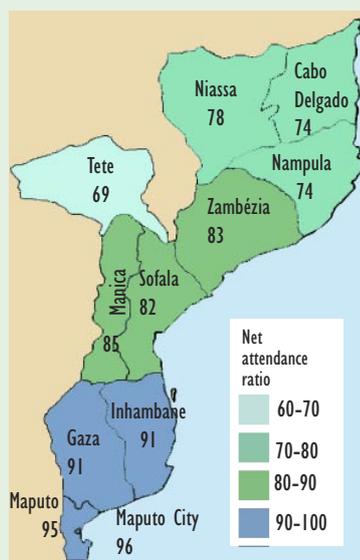
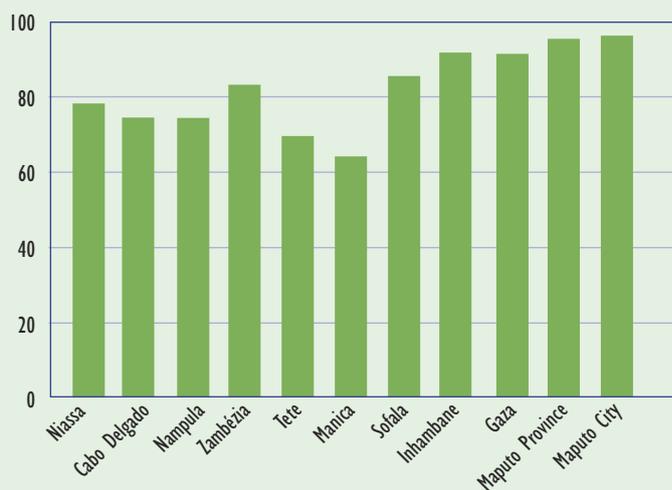


Source: INE, 2009

Figure 23: Gross completion ratio for Grades 6–7 (EP2) by province



Figure 24: Net primary attendance ratio among children aged 6-12 years, by province, 2008



Source of Figures 23 and 24: INE, 2009; Source of map: GoMoz, 2008





Table 2: Ratio of qualified teacher by province, 2008

Province	EPI % with training – total	EP2 % with training – total
C. de Maputo	97.2	96.6
Maputo	87.4	91.5
Sofala	81.3	91.3
Niassa	71.0	87.5
Nampula	63.7	78.2
Cabo Delgado	63.6	68.7
Tete	62.4	76.4
Inhambane	59.2	55.4
Gaza	58.4	71.7
Zambézia	54.0	72.3
Manica	39.5	71.2

Table 3: Pupil–teacher ratio, 2008

Province	EPI Pupil: teacher ratio	EP2 Pupil: teacher ratio
C. de Maputo	62	59
Cabo Delgado	71	37
Gaza	55	44
Inhambane	56	48
Manica	63	45
Maputo	56	48
Nampula	83	45
Niassa	68	41
Sofala	75	58
Tete	75	45
Zambézia	91	44

For each indicator, provinces were categorized into three groups (four best provinces, three middle level provinces and four worst provinces), after which they were scored Blue: best four, Yellow: middle, Green: worst four

Source: Ministry of Education data, 2008, 2008a

## Progress

Primary education enrolment has improved significantly but Mozambique still has to eliminate gender disparity in primary and secondary education, improve adult literacy rates and deal with geographical disparities as achievement is better in the southern region than in the northern and central regions. These differentials interact. The five provinces where EP2 completion rates are below the national average have very low female EP2 completion rates, while in Maputo City and Maputo Province, where overall completion rates are higher, over 90 per cent of girls complete EP2. As shown in the data, income differentials are also important and up to seven times higher than gender differentials. Promoting education access, uptake and completion, generally, for girls and in the poorest families now needs specific attention.

Government has promoted availability, supporting schools, distributing free schoolbooks and increasing the annual education budget to 20.8 per cent in 2007 (GoMoz, 2008). A further area to address is the geographical variation in teacher qualification, with the highest share of EPI and EP2 teachers in Maputo City, Maputo Province, Sofala and Niassa and lowest in Inhambane, Gaza and Manica (see Table 2). Further, higher enrolment raises the demand for teachers so that at EP2, the worst pupil–teacher ratios are located in the southern part of the country (see Table 3). Better student–pupil ratios are needed as well as retraining and more support and supervision of learning and teaching processes.

Uptake and successful completion rates need to be promoted, especially for girls and poorest families. Measures taken to date include: reshaping the basic education curriculum; setting norms to protect girls against sexual harassment; reducing distances to schools by enabling some EPI schools to offer first to seventh grades; piloting school lunches, particularly for girls; and recruiting female primary school teachers, with equitable access to initial and in-service training.



## Achieving the MDG goal of halving the proportion of people with no sustainable access to safe drinking water by 2015

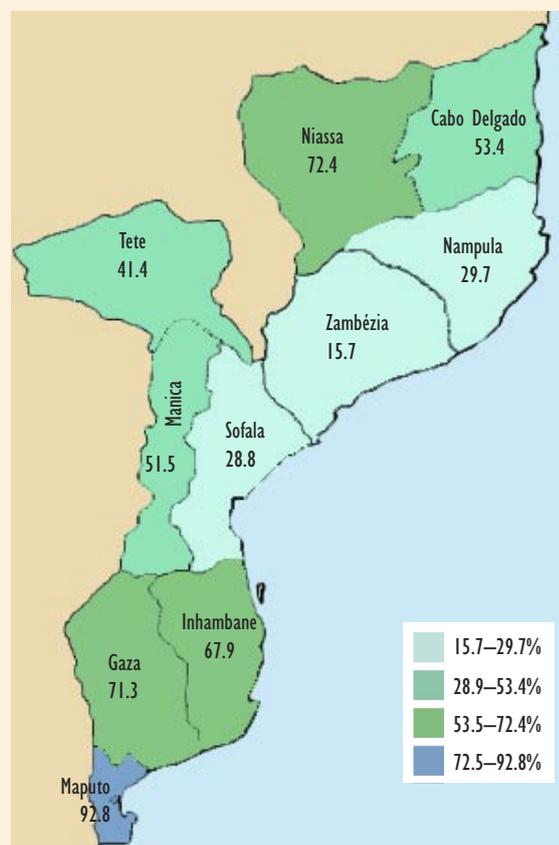
INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
% households with safe water	25	2000	30	2008
– rural	77	2000	70	2008
– urban	36	1990	43	2008
– overall	41	2000		
% households with safe sanitation	27	2000	6	2008
– rural	51	2000	47	2008
– urban	27	2000	19	2008

Source: WHO, 2008; UNDP, 2008; GoMoz, UNICEF, 2010.

### PAST LEVELS (1980-2005)

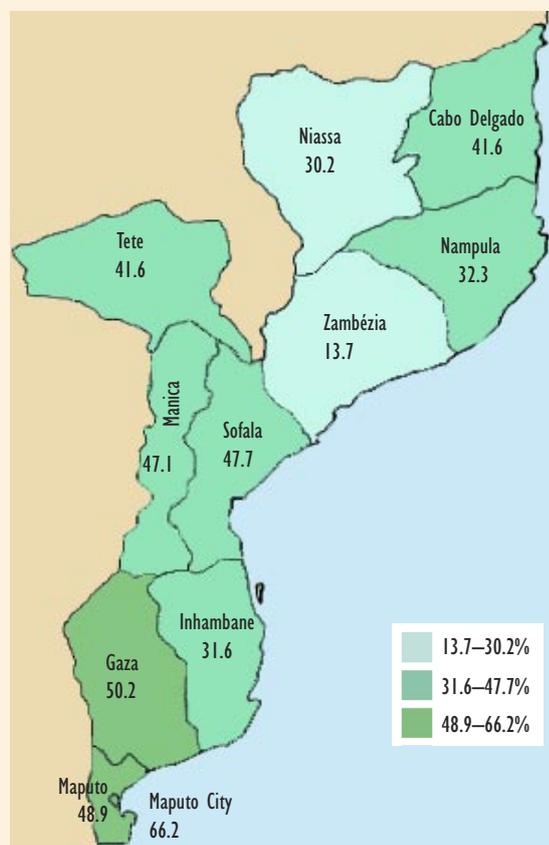
Safe water and sanitation coverage rates have been low, as shown in the table, with threefold gaps between rural and urban areas. In the 1990s, overall and rural water supply coverage increased slightly but with significant differences between provinces and some decline in urban water supply coverage (WHO, 2008). There is variation across provinces. In 2005 the lowest rate was in Nampula, where only 22 per cent of people had access to clean drinking water, a small improvement on the 2003 figure of 19.6 per cent. The highest rates of safe drinking water coverage were found in Inhambane and Sofala, with 67.1 per cent and 65.9 per cent, respectively. Sofala, Zambézia and Nampula had the lowest rates of safe sanitation.

Figure 25: Improved sanitation coverage by district, 2005



Source: GoMoz, 2005

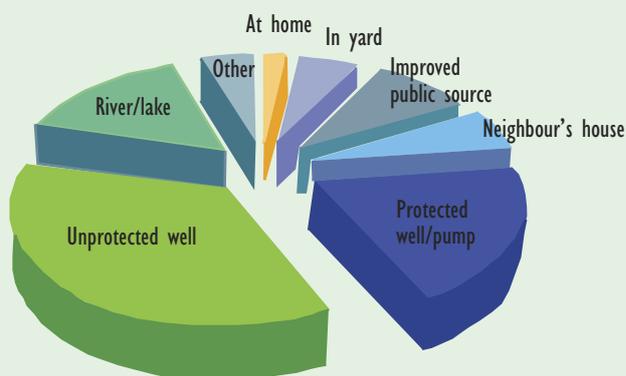
Figure 26: Safe water coverage by district, 2003



## CURRENT LEVEL (most recent data)

Overall rates of improved water source usage did not increase much up to 2007, although rural rates rose in five of Mozambique's provinces: Nampula, Inhambane, Niassa, Zambézia and Maputo (WHO, 2008). Use of improved water supplies increased from 41 per cent of households in 2003 to 43 per cent in 2008. The most common water source is an unprotected well and the majority of households (89 per cent) do not treat drinking water (for example, by boiling it), increasing the risk of waterborne diseases (see Figure 27). Significant disparities in use of improved water sources persist between urban and rural areas and among provinces, with 30 per cent of rural households using improved water sources, compared with 70 per cent of urban households. Almost all households in Maputo City (94 per cent) have access to improved water sources, whereas only 24 per cent of households in Zambézia province and 30 per cent in Cabo Delgado province access improved water sources. Use of improved water sources also varies sevenfold across household wealth quintiles, ranging from 13 per cent of households in the poorest quintile compared to 85 per cent of households in the wealthiest quintile (GoMoz, UNICEF, 2010).

Figure 27: Main source of drinking water, 2008

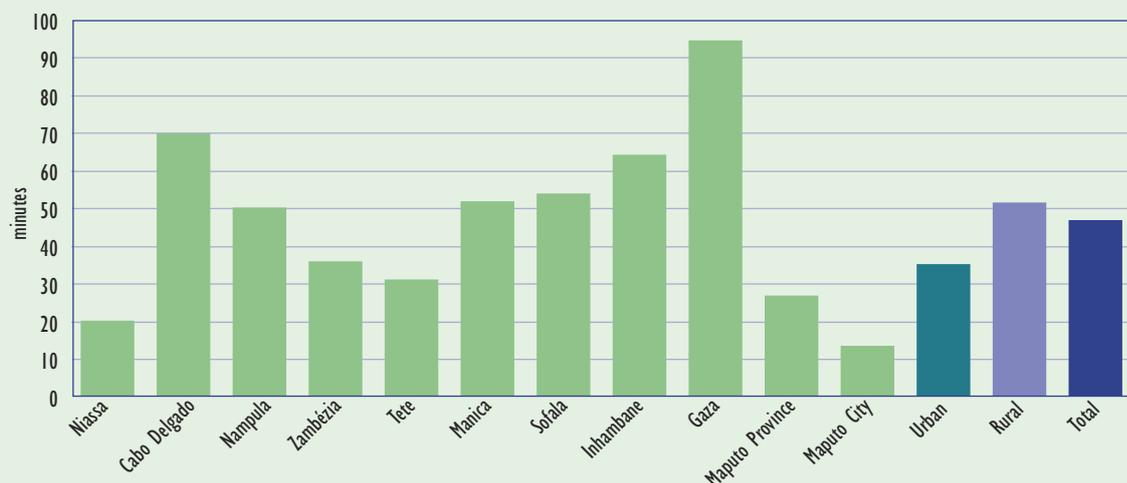


Source: GoMoz, UNICEF, 2010



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Figure 28: Mean time to water source, 2008

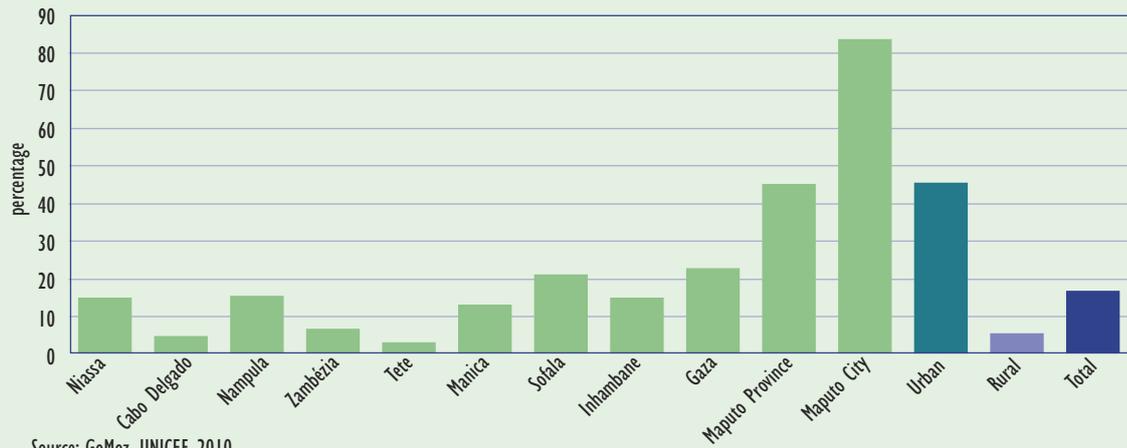


Source: GoMoz, UNICEF, 2010

These rates are far from the goal of reducing by half the proportion of people without sustainable access to safe drinking water by 2015, and the coverage gap in safe water and sanitation increases the risk of waterborne disease (MISAU/DNS, 2005a, 2004b). Between January and May 2009, a total of 17,888 cholera cases and 140 deaths (0.8 per cent fatality rate) were reported (WHO, 2009b). Further, these shortfalls are likely to exacerbate other social differentials, such as domestic burdens on women and female children. In 86 per cent of households in all provinces, an adult woman normally collects water and where children collect water, it is much more likely to be a female than male child. This takes up to 96 minutes per trip, with the longest time in Gaza province (see Figure 28).



Figure 29: Access to improved sanitation, 2008



Source: GoMoz, UNICEF, 2010

Access to improved sanitation facilities remains low at under 20 per cent in total but particularly in rural areas (at 5 per cent of households) and in northern and central provinces (see summary table and Figure 29). Wealth differentials in access to improved sanitation are high, with 20 per cent access in the highest wealth quintile compared to 0 per cent in the lowest (GoMoz, UNICEF, 2010).



Due to discrepancies in the definitions of improved sanitation (with specific reference to latrines), comparisons between the Multiple Indicator Cluster Survey (MICS), 2008 and the 2003 Demographic and Health Survey are not valid. To resolve this, the government and its partners are currently revising the definitions used for sanitation. Improving access to water and sanitation is a key government priority within the human capital pillar of *PARPA II*, which recognizes its importance in reducing poverty.

*PARPA II* is supported by the national water policy, approved in 1995. A revised version that incorporates updated targets and emphasizes water as a resource for socio-economic development was approved in 2007. It focuses on decentralization, sustainability, effective user participation, a shift in government roles and responsibilities from implementer to facilitator and increased involvement of the private sector and non-governmental and community-based organizations. The 2009 national rural water supply and sanitation programme (Ministry of Public Works, March 2009) is the framework for implementing the rural water supply strategic plan (PESA-ASR) 2006–2015. With the private sector and civil society participating more in constructing water points and household sanitation, the government focus is shifting to sustainability and quality of infrastructures. Recent studies by the Water and Sanitation Foundation (Fairwater) found that there are 50,000 non-functioning water supply systems across Africa, which reportedly represent losses of US\$215–360 million. In recent sustainability checks, external auditors of rural water and sanitation facilities in Tete, Manica, Sofala and Zambézia provinces concluded that up to 30 per cent of all rural water supplies are non-operational. They attributed this to lack of community ownership of facilities, a weak spare parts chain and lack of trained mechanics (Ernst and Young, 2008).

## Progress

In policy Mozambique is committed to safe water and sanitation. 'The Government of Mozambique recognizes the importance of sanitation for public welfare. One of the objectives of the 'Access to water, sanitation and housing' component in the five-year development plan (*Programa Quinquenal do Governo — PQG, 2005–2009*) is to ensure the sustainability of water supply and sanitation systems, as well as to increase sanitation coverage, in both urban and rural areas' (UNDP, 2008). Government has drawn up, on the basis of wide-ranging intersectoral consultation, a draft water resource management strategy, backed by a revised water law (1991), a national water policy (1995) and a rural water supply strategic plan (PESA-ASR) 2006–2015. Mozambique is the only country in southern Africa with a contingency plan for climatic disasters which is drawn up annually, under the 'eye' of the Prime Minister, using technologies and measures to predict and manage climatic disasters and monitor the hydrological situation in almost real time (UNDP, 2005).

Yet, on the ground, improvement in safe water has been extremely slow, with some decline recorded in urban areas. Widening access to safe water and sanitation is a public health priority to avoid epidemics of waterborne and other communicable diseases affecting adults and children and their costs to poor households. It is also essential to reduce women's work time in water collection. Based on the available data, this area merits higher profile intersectoral action, motivated by the health sector, and monitored for improvements in coverage of facilities and rates of waterborne and environmental disease.

To sustain rural water supplies attention must be paid to equity and quality throughout the rural water supply project cycle, including when preparing bidding documents and technical specifications; constructing water points; procuring all materials and equipment; and building capacity within communities.

## Increasing the ratio of wages to GDP

### PAST LEVELS (1980–2005)

Evidence on this indicator was not available

### CURRENT LEVEL (most recent data)

With a GDP per capita of US\$349 in 2006, Mozambique has one of the lowest per capita incomes in the world (UNDP, 2008). Information on the relative distribution of wages to profits and to GDP and on the changes and distribution of real incomes was not available. However the earlier discussion on poverty and inequality suggests greater polarization in the growth in incomes between social groups, with strong growth not translating adequately into poverty reduction. This needs to be assessed.

Progress

Ensuring employment security and improving real wages are important means of translating macroeconomic growth into household income. In the absence of adequate evidence this area needs further investigation.



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The role of health systems in promoting health equity is further discussed in the next section. We use three parameters to assess how far households access the resources in the health system for their health needs, through indicators of:

- availability coverage (provision of health workers and drugs to district and primary care level)
- accessibility coverage (removal of fee barriers to use of services), and
- acceptability and contact coverage (removal of other barriers households face to use of services).

Further discussion on the organization of the health system for health equity is included in the section on redistributive health systems.

## Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems

This is an indicator of the availability coverage of resources in the health system for households.

HEALTH WORKER INDICATORS	2000	2008	2015
Total human resources per 100,000 people	92,25	138,68	186,21
Total doctors per 100,000 people	2,52	4,49	6,13
Nursing personnel per 100,000 people.	21,25	23,36	38,56
Nursing personnel SMI* per 100,000 people	5,35	11,41	20,74
Doctors, nursing and SMI* per 100,000 people.	29,12	39,27	65,43
Total priority professional personnel per 100,000 people.	45,59	68,43	110,92

\*SMI = Safe Motherhood Initiative

Source: GoMoz, 2008 National health human resource development plan (2008–2015)

### PAST LEVELS (1980-2005)

Mozambique has an overall shortage of key categories of health workers. In 2000 there were 2,5 doctors and 21.25 nurses per 100,000 people, much lower than the African average of 21.7 doctors and 117 nurses. In 2004 there were only about 700 medical doctors, including expatriates from non-governmental organizations, with only 0.03 doctors and 0.21 nurses per 1000 people (WHO, 2007). This was well below the 2.5 doctors, nurses and midwives per 1000 estimated to be fundamental for health systems. Data on the distribution at primary care and district level or between rural and urban areas was not accessed.

The state invested in training medical personnel and up to 60 doctors a year were trained at the University Eduardo Mondlane. This was inadequate for the population of 18 million. Greater numbers could not be trained due to resource constraints and at that time international partners offered little support for basic medical education. By 2007 no international funds for AIDS programmes, for example, went to support the basic education of doctors (de Oñate, 2007).

Mozambique has a national list of 430 essential medicines (WHO, 2009e). However, constraints to procurement and distribution of medicines and has limited their availability at primary care and district levels of the health system. During the six months preceding the nationwide 2002 expenditure tracking and service delivery survey, over 50 per cent of facilities had been out of stock of one or more essential medicines, with an average stock-out time of six weeks. Facilities in rural areas and health posts were more likely to be out of stock. Primary facilities do not hold their own procurement budget. Survey interviews suggested that the criteria for allocating and distributing drugs and vaccines were not properly understood or implemented (Lindelöw *et al.*, 2004).

### CURRENT LEVEL (most recent data)

There has been some improvement in national availability of health personnel, as shown in the summary table, with an increase in the ratios of doctors and overall priority personnel but still limited increase in nursing personnel. Mozambique continues to face a critical shortage of health workers with 1.26 health workers per 1000 population (GoMoz, 2008).

Health workers are viewed in policy as the most valuable resource: to improve health services accessibility, especially for the poorest populations living in rural areas; to consolidate primary health care; to strengthen continuity of care through a well-coordinated referral system; and to improve the operation, quality and performance of the services provided at all levels. The deficits in numbers of health workers are seen as the main barrier to sustaining and expanding these and other health outcomes in Mozambique (MISAU, 2008b).



Figure 30: Population per health worker (all fields) by province, June 2007

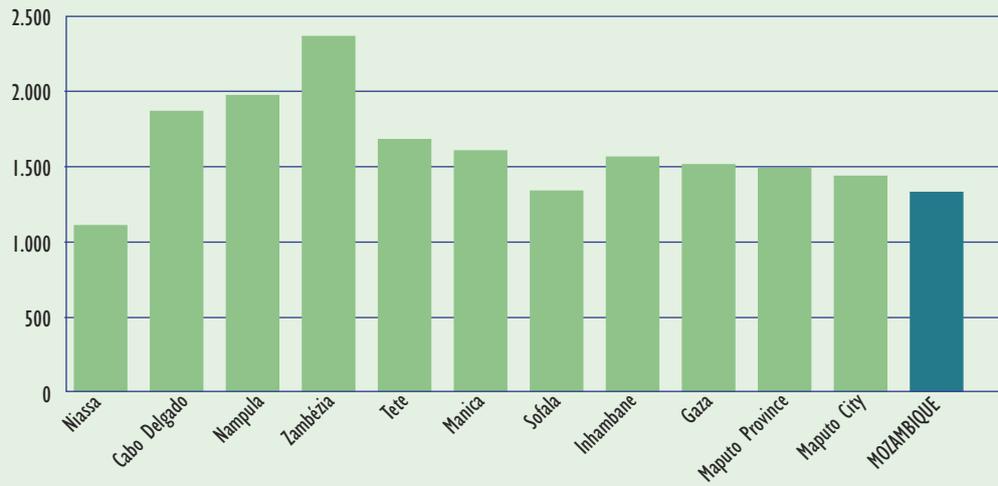


Figure 31: Population per doctor by province, June 2007

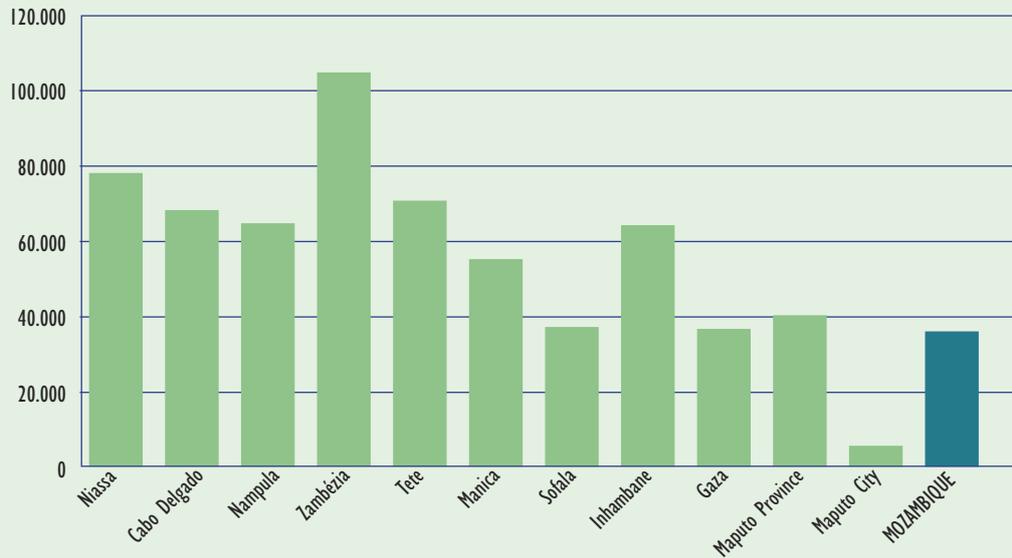
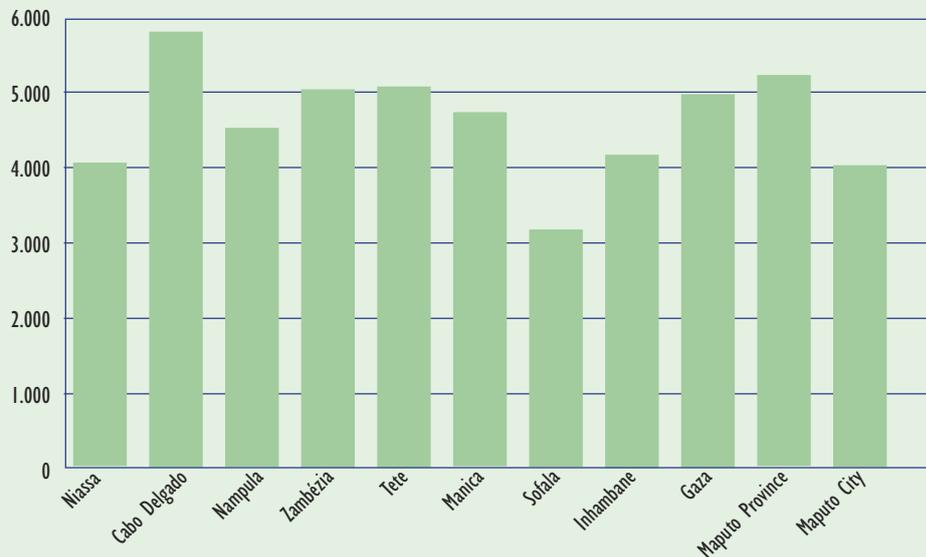


Figure 32: Population per nurse by province, June 2009

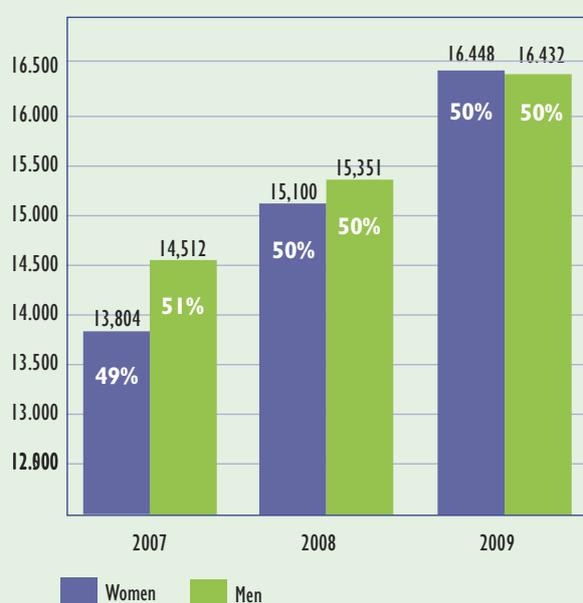


Source: (Figures 30, 31 and 32): GoMoz Human resources plan, 2008

As shown in Figures 30–32, while there are overall scarcities, there are also variations in the geographical distribution of health workers, with lower health worker densities in Zambézia, Cabo Delgado and Tete. The distribution of personnel at each level of the system within provinces points to a relative deficit of median level and university personnel, most evident in Manica, Zambézia, Niassa, Tete, Cabo Delgado, and Nampula. Inadequate salaries, family constraints and children’s education are the principal factors for internal and out migration of health professionals from the country (Ferrinho and Omar, 2006). Factors driving the uneven distribution between provinces need to be assessed and further evidence collected to analyse health worker distribution and densities for different levels of the health system.

In September 2008, a costed human resources development strategy was finalized which President Guebuza referred to in his speech to the 2008 MDG Call to Action meeting in New York. The plan, if fully funded, would increase the number of health workers by 20,000 by 2015, raising the density of health workers from 1.26 to 1.87 per 1000 people. While still below the 2.5 per 1000 people that WHO considers essential for good coverage, it would lead to a 67 per cent increase in access to skilled attendance at birth, a 50 per cent reduction in MMR and a 15–20 per cent reduction in neonatal mortality. Health worker numbers and density have improved since 2007, indicating some progress in availability (see Figures 30–35).

Figure 33: Trend in health workers by gender 2007–2009



Source: GoMoz, Ministry of Health Human Resources Directorate, 2010



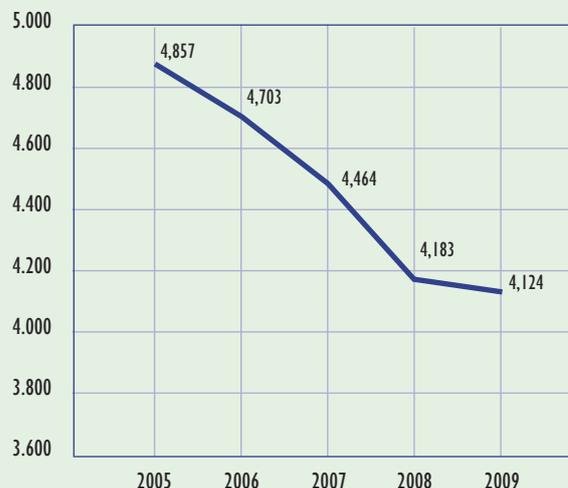
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Figure 34: Trend in doctors/population 2006–2009



Source (Figures 34 and 35): GoMoz, MISAU/Human resource directorate, 2010

Figure 35: Trend in nurses/population 2006–2009



Access to medicines has increased from 10 per cent of the population in 1975 to 80 per cent in 2007 (WHO, 2009e): 'In 2005, a joint mid-term evaluation of the Plano Estratégico do Sector de Saúde (PESS) 2001-2005-2010 confirms that the availability of high quality medicines in all provinces is one of the main achievements and the most important progress made in the pharmaceutical sector' (WHO, 2009e).

## Progress

Mozambique faces severe shortages of health workers and thus households lack access to this critical resource for health. The impact of the human resources development strategy and plan is beginning to show, with numbers and densities of health workers improving. However this is distributed differently by province so the determinants of this and of the shortfalls by level of care need to be further investigated and addressed. The plan needs an additional US\$70m in funds in 2009, rising to an additional US\$110m per year by 2015, with a significant share of these funds required from international partners. Resources are unequally distributed (budget, infrastructures and human resources) and it is suggested that measures be implemented to redress these imbalances, such as through the resource allocation formula.

While historically shortfalls in access to medicines have been severe, evidence in 2005 suggested that access had improved significantly in the provinces. A vital and essential medicines availability survey that disaggregates access by level of the health system is needed. This would better track whether the significant deficits at primary care level found in 2002 have been addressed through the improved overall drug availability in the provinces.



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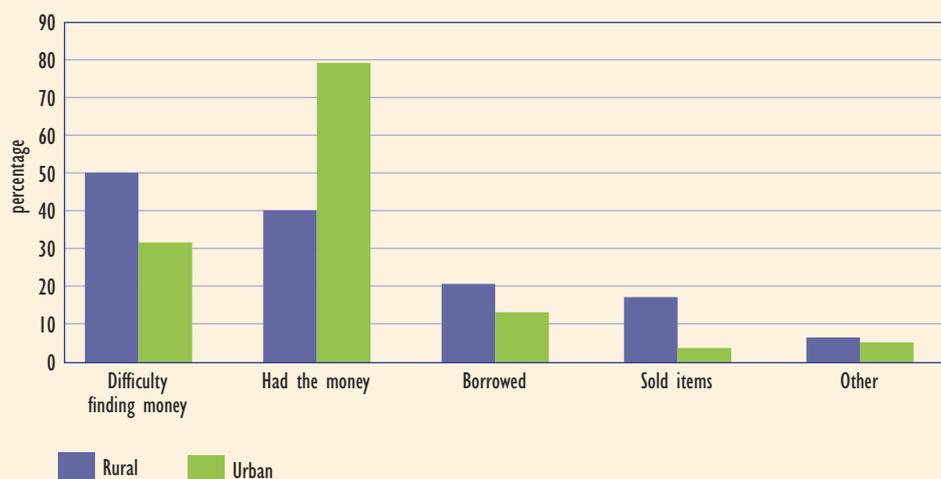
## Abolishing user fees from health systems, backed by measures to resource services

### PAST LEVELS (1980–2005)

The private health sector in Mozambique was abolished in 1976. The funding of public services through government revenue significantly reduced direct payments at point of care. User fee legislation in 1977 secured free drugs for inpatients, made basic drugs free for outpatients and established price reductions according to household income. However it did not clarify how to measure or verify income levels. The drug list was expanded in 1985 along with a fixed-price charge per prescription in rural primary facilities and a formula for calculating drug prices. In 2004, the fee at rural primary facilities was fixed at 500 MT (US\$0.01). The 1987 law on user fees specified that revenues from consultation fees should directly support operating costs (Lindelöw *et al.*, 2004).

In 2004 it was noted that fee charges for consultations and medicines varied between provinces, districts and facilities and did not appear to follow national guidelines. Five provinces charged the 500 MT user fee, while nine provinces provided inpatient care free. Exemption practices varied across facilities and districts. Overcharging was also reportedly commonplace (Lindelöw *et al.*, 2004). User fees retained constituted an average of 2 per cent of total spending, excluding drugs and in-kind resources (Lindelöw *et al.*, 2004). At the same time, as shown in the table below, where fees were charged, while they were not a barrier to access for nearly 80 per cent of urban households, they were a barrier for about 40 per cent of rural households. Those without the money to pay had to borrow or to sell items or had difficulty raising the fees (see Figure 36).

Figure 36: Problems paying for health care and source of money, percentage of users



Source: Lindelöw *et al.*, 2004

### CURRENT LEVEL (most recent data)

By 2006, a WHO survey reported that patients interviewed at the dispensing area of public facilities were paying a median of 2,800 MT (US\$0.09) for their medicines plus fees – equivalent to a half hour's wage for the lowest paid, unskilled government worker (WHO, 2009e).

Legislation is in place that seeks to harmonize user fee charging practices across public health facilities. It ensures that implementing user fees guarantees the government constitutional obligations to universal access to health. The law states that emergency treatment cannot be withheld on the grounds of failure to pay. It provides that fees are subject to regular review and that revenue is to be used to support operational costs at facility level. Exemptions are provided for in cases of care associated with childbirth and treatment of minors, the disabled, retirees, pensioners and the unemployed. Exemption is provided for specific diseases, such as malaria, tuberculosis and



other chronic diseases. Nevertheless government reports suggested there were still potential barriers to access from fee charges for poor households: *“User fees were charged in 2008 for most health services, and while exemption mechanisms exist (for some vulnerable groups and for specific illnesses) “they are not well understood by the majority of health sector clients”* (MISAU, 2008).

A 2008 study implemented to evaluate the impact of abolishing user fees for primary health care noted that out of pocket payments amounted to more than 70 per cent of household health spending. The study proposed a policy to alleviate this burden for poor households (MISAU, 2008). The policy and strategy aimed to remove user fees at primary care level, promoting use of primary health care services and encouraging early use of health facilities, thus avoiding unnecessary delays in patients consulting health facilities.

## Progress

Evidence shows that user charges are a barrier to the poorest households accessing care, particularly considering that exemption and fee policies vary across areas and facilities. Given the growth in urban poverty and the high HIV risk among young people, barriers to services uptake in such groups may exist, even in areas where user charges did not previously cause a barrier. The development of policy and strategy to remove user fees at primary care level is thus timely, with its aims being to increase use of primary health care services, to encourage early use of health facilities and to avoid unnecessary delays in patients consulting health facilities.

Experience in the region suggests that lifting user fees needs to be accompanied by adequate investment in service levels where increased uptake is likely, in order to meet demand. Further measures are needed to replace the lost local revenue from fee collection, particularly at primary care level, and to ensure that formal fee charges are not substituted by informal charges.



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# Overcoming the barriers that disadvantaged communities face in accessing and using health and essential services

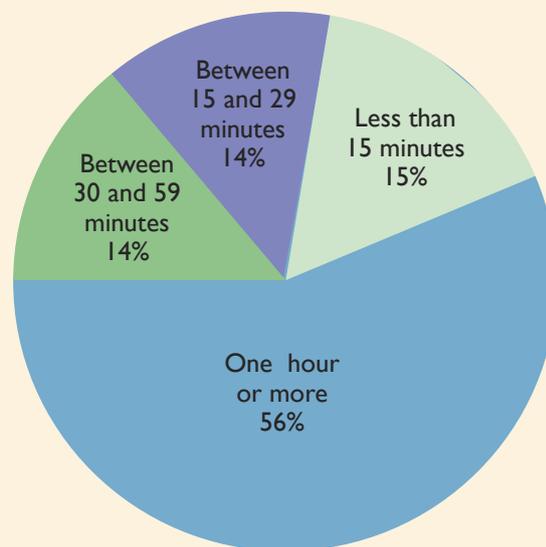
## PAST LEVELS (1980-2005)

The prior parameter indicated that for some households even relatively low user charges were a barrier to access to care. Evidence from a 2005 survey, shown in Figure 37, suggests that distance and cost of transport may be further barriers for half of households or more, especially for ill people with no family support.

In 1999, as part of the safe motherhood programme, the health ministry carried out a study to identify the main determinants of maternal morbidity and mortality. This study identified three levels of delay, which can lead to the woman's death:

- Social and/or family reasons, where the delay is in taking the decision to go to a health unit. Women's lack of decision-making power over their own health exacerbates this delay;
- Lack of resources, such as infrastructure (roads and bridges) and ambulances;
- Conditions in the health units. This include delays in attending to women and providing treatment, inadequate health services, inadequate treatment and lack of blood for transfusions, lack of suitable conditions for surgery, staff incompetence, inadequate staffing, poor attendance and lack of qualified staff. The number of people attended by qualified staff has improved, rising from 44.2 per cent in 1997 to 47.7 per cent in 2003 (INE, 2003).

Figure 37: Access to health facilities: time taken by households to reach the nearest health facilities on foot, 2005



Source: IFTRAB 2004/5

## CURRENT LEVEL (most recent data)

There is limited further evidence on the barriers different communities face in accessing health services. In the meantime, various supply side barriers have been targeted for action. Efforts to remove fee barriers are discussed above, given that exemption mechanisms are not well understood by most health sector clients (MISAU, 2008). The community health programme, implemented through community health councils, has focused on reducing family or community level barriers and social mobilization. A further programme concentrated on overcoming barriers to reproductive health, for example, by constructing waiting mother shelters near facilities, revising abortion laws, involving men in programmes, using information outreach to both partners and increasing reproductive health services coverage with men's involvement (UNDP, 2005).

Progress

Efforts have been made to address the financial, social and physical barriers that particular groups face in accessing services and within specific programmes. It would be useful to periodically gather and review evidence (nationally and within district planning) on the barriers households are facing in accessing services. This would be a counterpart to the efforts to expand the availability and allocation of resources for health, ensuring that these resources do reach and are used by households, particularly those with greatest health need.

# EQUITY WATCH



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## Resourcing redistributive health systems

Progress markers

- Achieving the Abuja commitment of 15 per cent government spending on health
- Achieving US\$60 per capita public sector health expenditure
- Increasing progressive tax funding to health and reducing out of pocket financing in health
- Harmonizing the various health financing schemes into one framework for universal coverage
- Establishing and ensuring a clear set of comprehensive health care entitlements for the population
- Allocating at least 50 per cent of government spending on health to district health systems (including level I hospitals) and 25 per cent of government spending on primary health care
- Implementing a mix of non-financial incentives agreed with health workers organizations
- Formally recognizing in law and policy and earmarking budgets for training, communication and functions or mechanisms for direct public participation in all levels of the health system

# EQUITY WATCH



## Resourcing redistributive health systems

For health systems to promote health equity they need to work with other sectors to improve household access to the resources for health (for example, safe water and education) discussed in the previous section. However health systems also need to ‘get their own house in order’, to promote the features that enhance health equity. This section presents selected parameters of progress in this direction, for example: in the benefits, entitlements and framework for achieving universal coverage; in mobilizing adequate resources through fair, progressive funding; in allocating resources fairly on the basis of health need; and in investing in the central role of health workers, people and social action in health systems.



## Achieving the Abuja commitment of 15 per cent government spending on health

INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
% government spending on health including external funding	9.1	1998	13.6	2005–2007
	10.1	1999	14.7	2006
	13.9	2000		
	12.6	2005		

Source: WHO, 2008; Chao and Kostermans, 2002, Ministry of Planning and Development, 2006, 2007.

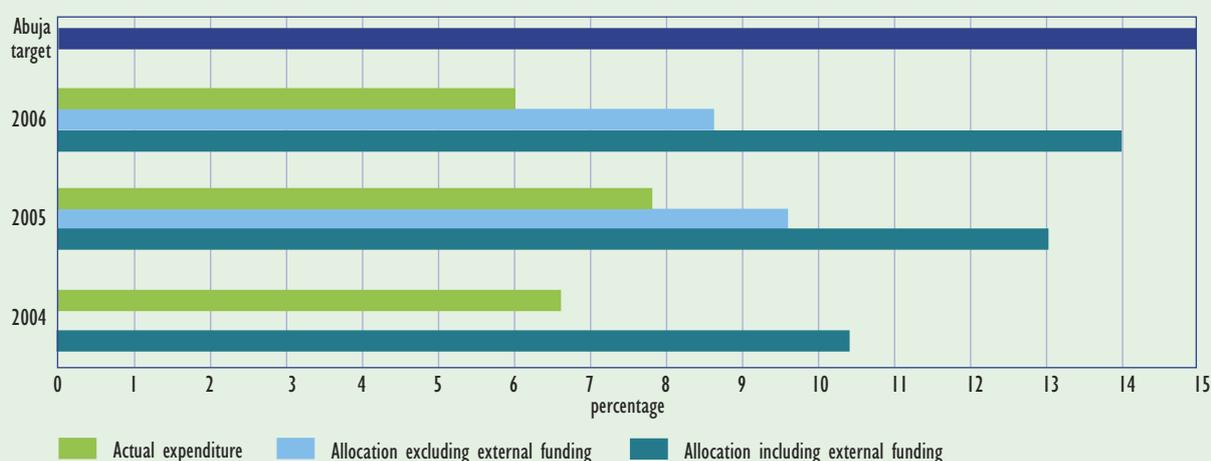
### PAST LEVELS (1980–2005)

The allocation to the health sector rose from 9.1 to 12.6 per cent between 1998 and 2005. The government of Mozambique signed the 2001 Abuja declaration in 2006, making the commitment to allocate 15 per cent of public funding to the health sector. The government share of the health budget has increased progressively since 1998.

### CURRENT LEVEL (most recent data)

By 2006 government budget share to health was 14.7 per cent, almost reaching the 15 per cent Abuja commitment. However, a large share of Mozambique's health care financing has been from external funds. In 2008, 73 per cent of health sector financing was funded by Mozambique's 26 development partners, comprised of bilaterals, multilaterals, global funds and development banks (MISAU, 2008). Figure 38 shows the allocation of resources to the health sector, including institutions at central and provincial levels of the Ministry of Health and the National Aids Council (CNCS). It indicates that while the allocation including external assistance in the budget has risen to 14 per cent, the proportional allocation of internal funds has fallen. The Abuja commitment refers to the domestic commitment and thus excludes external financing.

Figure 38: Health resources as percentage of total public resources



Notes:

- 1 Allocation including external funding is not available for 2004.
- 2 Allocation refers to funding allocated to the Ministry of Health and the NAC with respect to the total allocated to public institutions.
- 3 Actual expenditure refers to expenditure incurred on all Mozambican public institutions (including expenditure on health in military hospitals).

Source: Alocação: Contas Gerais do Estado de Moçambique, 2004, 2005 e 2006, Despesa Realizada: MISAU — DPC, CNS, 2004-2006

Mozambique has made important strides in raising government spending to meet the Abuja commitment. It needs however to protect its domestic contribution which has been falling so that the share, excluding external assistance in the state budget, rises to the 15 per cent commitment made at Abuja.



## Achieving US\$60 per capita public sector health expenditure

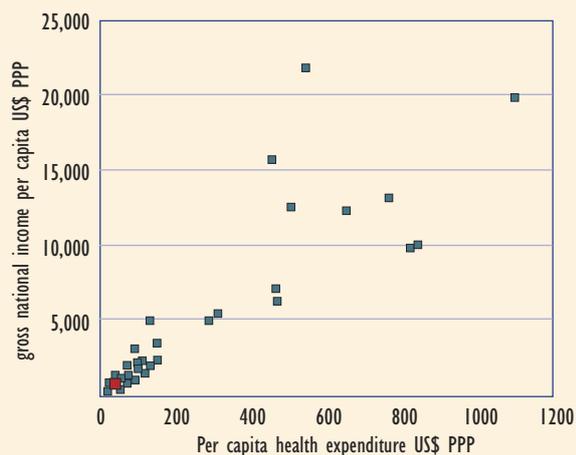
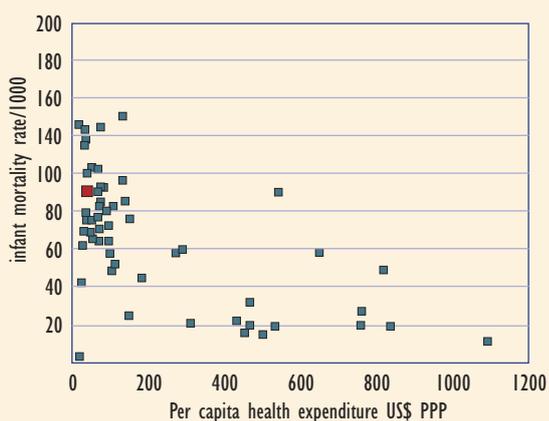
INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
Public sector per capita spending on health US\$	14	2004 19	21	2006

Source: WHO, 2006; 2007, 2008; Ministry of Health, 2004–2006.

### PAST LEVELS (1980-2005)

While government per capita health expenditure rose between 2000 and 2005, the total per capita was still below the US\$34 recommended by the Commission of Macroeconomics and Health (CMH) as the minimum required for a basic package of health interventions in developing countries, or the US\$60 estimated by WHO as a 'bottom line' level of funding for a health system. Government spending on health in 2004 was 61 per cent of total health expenditure, the balance largely coming from external funding. As Figures 28a and b indicate, Mozambique is among the African countries with a low GDP and level of per capita expenditure on health, at the mid level in IMR of countries with similar levels of health spending. This suggests the need to both increase expenditure on health and to make it more efficient.

Figure 39a: Per capita health expenditure and IMR, 2006      Figure 39b: Per capita health expenditure and GDP, 2006



■ shows Mozambique's position in Figures 39a and 39b

Source: WHO, 2010

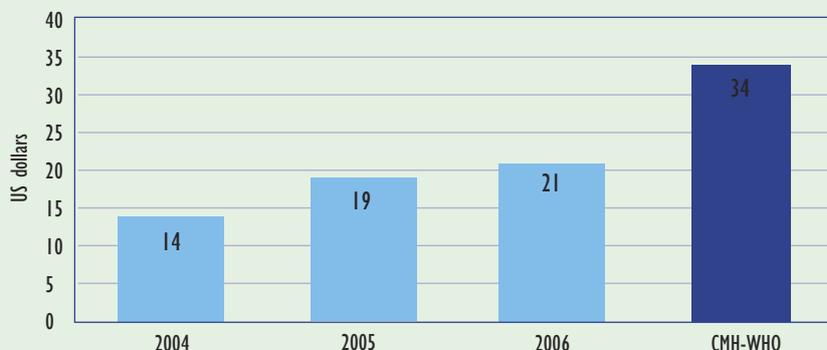


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## CURRENT LEVEL (most recent data)

Per capita health expenditure rose further between 2005 and 2006 to US\$21 (see Figure 40). Using national health accounts, ECSA HC and WHO data, Mozambique's per capita public spending rose by 81 per cent between 1998 and 2004, while funding from donor sources rose by 78 per cent.

Figure 40: Per capita health expenditure in US\$, 2004–2006

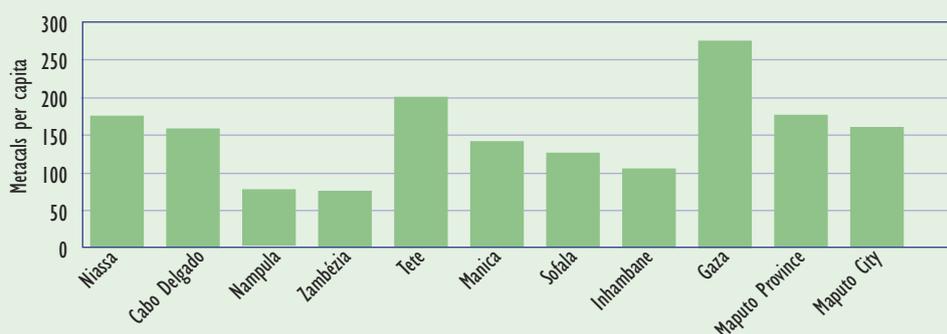


Source: Ministry of Health-DPC, CNS 2004–2006

The health budget allocation per capita in 2009 was at US\$10. If total health funding available to the sector from the state budget and other off-budget sources is used to calculate per capita health funding, this figure increases to US\$17.70 per person. Of this, US\$10.40 per person was spent in 2008 (excluding vertical funding outside the budget). This budget allocation to health is in line with the *PARPA II* objective to increase per capita health spending to US\$15 by 2009 (GoMoz, 2005). Nevertheless this level remains below the recommended minimum to meet basic health needs in low-income countries, such as the US\$34 set by the Commission of Macroeconomics and Health (CMH) or the US\$60 needed for a functioning health system. It is also below the sub-Saharan Africa average, which was estimated at US\$ 31.90 in 2002 (UNICEF, 2009).

As shown in Figure 41, the allocations of this budget varied by province, with provinces with relatively high health need, such as Cabo Delgado and Zambézia, having low per capita allocations. This is further discussed in a later progress marker.

Figure 41: Per capita health allocations per province, 2009



Source: Fundação para o Desenvolvimento da Comunidade (FDC) (Foundation for the development of the community), GoMoz, UNICEF, 2010



## Increasing progressive tax funding to health and reducing out of pocket financing in health

### PAST LEVELS (1980–2005)

In 1997, Mozambique external aid financed more than 50 per cent of total health expenditure, while government covered 22 per cent, individual households financed 19 per cent and employers covered 7 per cent (Chao and Kostermans, 2002). Income tax as a percentage of GDP was only 9.9 per cent in 1996, limiting tax-based funding (HDNR, MOZ, 2005).

By 2000, out of pocket expenditure on health had risen to 40.7 per cent of private expenditure on health, falling to 37.3 per cent in 2004 and rising to 40.5 per cent in 2005 (WHO, 2006, 2008). The private share of health expenditure was 39.5 per cent in 2004.

### CURRENT LEVEL (most recent data)

Improved per capita public spending on health depends partly on improved tax collections. Mozambique has designed and is implementing public sector reforms whose objectives are to gradually increase the ratio of tax revenue to GDP, make tax administration more efficient and broaden the tax base. This includes:

- Eliminating the cascading taxes that increase at every stage in the sales chain, replacing them with value added tax (VAT) in 1999;
- Rationalizing fiscal incentives with the new Code of Fiscal Benefits for Investments approved in 2002;
- Replacing the previous taxes on income with a new corporate tax (IRPC) for companies and a new personal income tax (IRPS);

The tax reforms have meant that tax revenue as a percentage of GDP rose from 9.9 per cent in 1996 to 11.3 per cent in 2004 (UNDP, 2005).

Evidence on the share of out of pocket financing in health after 2004 was not available.

### Progress

With the tax share of GDP rising after tax reforms were implemented and the growth in GDP, improved health financing from tax revenue is possible. Given the country's relative reliance on external funding, this is an important trend for domestic financing.

Out of pocket financing, while not among the highest in the region, is still relatively high with no evidence of significant decline. The rise in tax funding in the GDP thus presents an opportunity to improve the domestic public allocation to health (which as shown in Figure 27 has fallen in recent years) and reduce the share of out of pocket spending. This is also important to support proposed measures to remove user fees, noted earlier.



## Harmonizing the various health financing schemes into one framework for universal coverage

### PAST LEVELS (1980-2005)

The private health sector in Mozambique was abolished in 1976 but this ban was lifted in the 1990s. Nevertheless in the strategic plan for the health sector in 2001–2005 setting out the policy intention of universal coverage, the public sector is cited as the primary source of finance in the health system (MISAU, DPC, 2001).

### CURRENT LEVEL (most recent data)

Several documents set the framework for harmonized health financing and universal coverage:

- Strategic plan for the health sector 2007–2012 (MISAU-DPC, 2007)
- Social economic plan 2005, 2006, 2007, 2008, 2009
- Second strategic national plan to combat HIV/AIDS (NAC, 2004)
- National plan to combat STIs, HIV/AIDS, 2004–2008 (MISAU, 2004–2008)
- PARPA II 2005–2009 (Government of Mozambique, 2005)

The health sector strategy plan 2007–2012 defined the health sector contribution to poverty reduction through providing universal access to health care, strengthening individuals and communities and promoting health advocacy. The role of the public sector is key in establishing this framework and coordinating the other three significant sources of resources and provision: the international community, the private sector and the community. In terms of donor coordination, Mozambique has made significant advances. In 2008, government signed a new Memorandum of Understanding with common funding partners in the health sector which outlined a set of clear principles for all partners in the sector-wide approach (SWAp) to increasing alignment. This reinforces the existing code of conduct which governs both donor and government behaviour in support of the health sector. The common funding partners in Mozambique have committed to providing funds based on performance in the preceding year – with no in-year conditionality for fund release. The government needs to demonstrate performance for the following year and the external partners need to ensure funds arrive in good time.

There is less evidence of the emergent private health sector being coordinated to ensure that it aligns to national goals and policies for universal coverage. The community health programme, implemented through community health councils and including social mobilization, provides a means of harmonizing community resources and contributions and reducing more inequitable forms of financing such as individual out of pocket payments (discussed earlier). The mechanisms to coordinate and involve communities are discussed later.

### Progress

Mozambique's primarily public funded and provided health system creates a harmonized framework for universal coverage. Positive efforts have been made to coordinate the significant share of external funding to avoid segmentation. Harmonizing health financing continues to be a key issue in ensuring accountable use of funds in line with national goals. Further assessment is needed of the coordination of private sector and community (including national non-governmental organizations and civil society) resources in the health sector within one framework in line with key national goals and strategies for universal coverage.



## Establishing and ensuring a clear set of comprehensive health care entitlements for the population

### PAST LEVELS (1980-2005)

As noted earlier, state obligations to provide constitutional entitlements to health care were provided for through the establishment of a national health system. Mozambique adopted primary health care in 1997 and government set a policy goal for all Mozambicans to have access to quality health care based on expanding access to primary health care (Chao and Kostermans, 2002).

### CURRENT LEVEL (most recent data)

Mozambique continued to articulate a commitment to universal coverage and primary health care in the health sector strategic plan for 2007–2012 (PESS) which provides for stated cornerstones of ‘primary health care, equity and better quality of care’ (MISAU, 2008). This is also articulated in the five year government plan (2005–2009), the poverty reduction strategy paper (*PARPA II*), the social and economic plan (PESS), and the medium-term expenditure framework (CDFMP, or MTEF).

In 2005, the Ministry of Health set the provisions for essential health services and the measures to reinforce the primary health care approach. Further monitoring and assessment is needed of the costing and delivery on these provisions.

Progress

Mozambique has a policy framework for the provision of health care entitlements centred on the primary health care approach. Further monitoring and assessment is needed of the costing and delivery on these provisions.



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## Allocating at least 50 per cent of government spending on health to district health systems (including level I hospitals) and 25 per cent of government spending on primary health care

### PAST LEVELS (1980–2005)

The national health system allocates resources from the central Ministry of Health to provincial directorates of health, which in turn allocate to district directorates of health below them, based on an analysis of past performance and needs (Chao and Kostermans, 2002). However, in 2002, no reliable data on expenditure by level of care was reportedly available. Unreliable and inconsistent data on district budgets at the provincial level – both for salaries and non-wage recurrent expenditures – made it difficult to assess whether resources allocated to the districts reached their intended destinations (Lindelöw *et al.*, 2004).

Estimates indicate that government and donors spent US\$2.42 per capita on primary and secondary care and US\$ 4.89 on all levels of care in 1997 (Chao and Kostermans, 2002, citing Management Sciences for Health, 1999). This suggests that in 1997, 49 per cent of public spending in Mozambique was at district level and below. There was evidently some potential to increase allocations to the primary care units, make interface with the community more effective and enhance pro-poor delivery of care. In 1999, while primary level facilities accounted for 37 per cent of the activity in health care units, they received only 22 per cent of government resources. The three central hospitals produced 15 per cent of the services but received 37 per cent of the funds (Chao and Kostermans, 2002).

### CURRENT LEVEL (most recent data)

In 2008, 30.8 per cent of the government budget was allocated to the district level (Government of Mozambique, 2008) and this increased to 39 per cent in 2009 (GoMoz budget, 2009). This is difficult to compare with the 1997 figure of 49 per cent as it reflects allocation rather than expenditure and the calculation methods may be different. It is also difficult to assess whether allocations to primary care level have improved.

Work is underway to integrate indicators of health need into the resource allocation formula for the recurrent budget now that budgets are increasing. This excludes central level expenditures for the Ministry of Health like administration, training institutions, central hospitals, drugs and other supplies procurement expenditures and management and distribution expenditures, foreign doctors' salaries and top up salaries for health specialists working in the countryside, and provincial administration and training budgets. A pilot proposal has been developed to integrate measures of need and access into the formula, through population density, infant mortality rate and the fuel price. Since the allocation of money from the donors' common fund, managed by the Ministry of Health, is relatively flexible, such a formula could be applied to it in the first instance. A resource allocation formula applied to recurrent expenditure will be done concurrently with a gap analysis to determine the resource gaps. The former indicates priorities and the latter the levels of financing needed to cover gaps. Other issues will also be considered in allocations, including the long-term sustainability of recurrent expenditure and capacity to absorb, such as through sufficiently staffing existing facilities.

## Progress

With the last recorded data of 22 per cent of public spending to primary care level in 1999 and 49 per cent to district level in 1997, Mozambique's performance on allocation to these levels is better than many other countries in the region. However in the absence of more recent data, it is difficult to assess trends and ascertain whether improvements in public health financing shares have translated into improvements in key 'pro-poor' areas of delivery in the health system, such as the primary care level. This needs further assessment using methods comparable to those used in 1999.

The work underway on integrating equity into the allocation of increasing recurrent resources will strengthen the work on addressing availability gaps and could improve needs-based allocation. It calls for collecting the relevant parameters at district level that are also important in assessing equity in the health system (see the concluding summary).



## Implementing a mix of non-financial incentives agreed with health workers' organizations

### PAST LEVELS (1980-2005)

Mozambique emerged from a long civil war with a fragile health system. The inadequate and uneven distribution of skilled health workers was described in an earlier section. With its high share of external financing in health and use of the sector-wide approach (SWAp) or direct financing of existing programmes, an opportunity arose for external funding support to health workers. However, public service pay rules did not allow special payments for any sectors (Vio, 2006). Mozambique thus entered a 'pooling' agreement with funders from Switzerland, the Netherlands and Norway in 1996 to facilitate salary top-ups to be paid to specialists working outside Maputo City via 'off-budget' funds (Vio, 2006).

In 2004, the sector-wide approach replaced the pooled donor fund to finance the salary top-ups and even more specialists were expected to be supported (Vio, 2006). Benefits offered to physicians included housing and fuel subsidies, the use of service cars and a medical assistance fund for civil servants, drawing monthly salary deductions (Pfeiffer, 2003). Health workers in rural areas received a 50 per cent bonus when calculating their years of service, thereby progressing faster along the career ladder. Other non-financial incentives at the time included free or subsidized food in some facilities outside Maputo (Lindelöw *et al.*, 2004).

In 2005 the Ministry of Health received funding from USAID and technical assistance from Management Sciences for Health to design a management and organizational sustainability tool to evaluate the health sector support programme. The results showed improved communication between managers and subordinates, higher levels of self-confidence and initiative among lower cadres of staff and a general improvement in the working climate (Perry, 2005).

By 2005, one of the most significant pull factors identified was that of international agencies drawing health workers away from public services through financial incentives such as per diems, seminar training with per diems, extra contracts for after-hours work, travel opportunities and temporary salary top-ups (Pfeiffer, 2003; Ferrinho and Omar, 2006). This problem was more serious in provinces outside Maputo, affecting the normal running of the health system, especially when per diems amounted to as much as monthly salaries in some cases. Mozambican health workers also reportedly used dual employment (including second jobs for non-governmental organizations) and received under-the-table payments (Pfeiffer, 2003; Ferrinho and Omar, 2006).

### CURRENT LEVEL (most recent data)

As noted earlier, Mozambique recognizes that the availability, distribution and skills of health workers are key determinants in the performance of health systems and health outcomes and it has developed a policy framework to address this. The human resources for health development plan 2001–2005 included strategies to develop a personnel information system to collect data on health worker trends. The plan is analysed annually, paying particular attention to personnel losses associated with AIDS and to the financial performance of the system (with indicators from the system used to monitor progress towards equity in human resource developments) (Ferrinho and Omar, 2006). In September 2008, a costed human resources development strategy was finalized and the investment resources needed to implement it (US\$100 mn by 2015) were raised with the international community. It was critical if the country was to achieve its health MDGs.

A national and provincial incentive scheme has been defined and mechanisms set up to identify and reward performance to retain health workers in the national health system. (GoMoz, 2008).

The incentives currently include:

- Social welfare incentives: Food, clothes, accommodation, health care without payment and subsidies for children's education, uniforms;
- Professional and career path incentives: Access to continuous training; access to specialization; in-service and continuing education (seminars, conferences, professional congresses); more rapid promotions. Databases have been created in provinces to support continuous training;
- Other incentives: Recognition through non-cash rewards, offices, titles, flexible increments on salary and more vacation time are also used. A subsidy is provided to all those working at emergency services and to surgeons and specialist doctors in the districts to keep them there (UNDP, 2005; GoMoz, 2008).

The incentives address issues raised by health workers as push factors in prior surveys. However information was not available on whether they have been implemented at all levels of the health system and whether they have the management capacities to do so. There is no evidence yet on outcomes in health worker retention or attrition which would enable government to review and revise incentives (implementation issues were raised in other countries in the region).

International support to health worker retention incentives through global and international funding has evidently increased. The allocation of international resources to sector-wide and budget support funds makes this more feasible. Evidence on the allocation of these resources to health worker retention is discussed in a later section.

## Progress

Increased policy recognition has been given to health worker adequacy and retention. An investment programme and incentive scheme has been designed and costed and the need for resources to fund it has been raised at the highest levels. Databases have been established to manage and assess the performance of the incentive scheme and to provide evidence. This is important to inform strategic review and to build management capacities to implement incentives at all levels of the health system. Improved investment from international agencies in professional and welfare incentives to support the retention of health workers in the public system is evident, after concerns of out-migration to this sector.

Evidence was not available on the extent or impact of informal practices such as dual employment in private/ non-governmental organizations and the public sector or of the extent of involvement of health worker organizations in developing and reviewing incentive schemes.



## Formally recognizing in law and policy and earmarking budgets for training, communication and functions or mechanisms for direct public participation in all levels of the health system

### PAST LEVELS (1980-2005)

The promotion of community involvement in health is a core value of the health system and the country. The Mozambique constitution provides that *'The State shall promote the participation of citizens and institutions in the raising of the level of public health care'* (GoMoz, Constitution, 1990). Documented evidence was however not available on the role or impact of communities, community health workers and local and national civil society organizations in implementing this constitutional provision.

### CURRENT LEVEL (most recent data)

Promoting community participation, as recognized in the constitution, has been included in the national health strategy. However, with no specific indication of mechanisms and skills to organize it, there are no budgets earmarked for it and few non-governmental organizations are actively promoting participation.

The strategies proposed in the health strategy for strengthening participation include:

- Promoting partnerships among community actors,
- Training health workers and non-governmental organizations in participatory methodologies, interpersonal communication and counselling,
- Following up community involvement activities at all levels,
- Mobilizing resources to implement community involvement activities,
- Developing training curricula, programmes and manuals for community health workers. In 2010 training of community health workers will restart, jointly financing by the government, World Bank and other partners.

## Progress

Mozambique has strong constitutional provisions for community roles in the health sector and has made this a priority in its 2008–2010 annual plans for the health sector. It plans to reinvest in community health workers.

This area, however, provides scope for significant further developments to operationalize policy commitments, strengthen health literacy, promote community and civil society awareness, organization and involvement around health, and mobilize social resources and action for public health and the health system. More organized links need to be made with social and community support for vulnerable groups. The mechanisms for participation coordinated within the health system need to be formalized, capacitated and resourced.



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# EQUITY WATCH



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## A just return from the global economy

Progress markers

- Reducing debt as a burden on health
- Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers
- No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws
- Health officials included in trade negotiations and clauses included for protection of health in trade agreements
- Bilateral and multilateral agreements to fund health worker training and retention

# EQUITY WATCH



## A just return from the global economy

Household access to the resources for health and the promotion of equitable health systems are both increasingly influenced by policies, institutions and resources at the global level. The final section examines selected parameters of the policy space and support for health equity at global level. These include the debt burden on health, the use of flexibilities in world trade agreements, the support from international institutions for health worker incentives, protecting women smallholders' food production in trade policies and including health officials and health protection in trade negotiations and agreements.



## Reducing debt as a burden on health

### PAST LEVELS (1980-2005)

Debt cancellation was negotiated under the Heavily Indebted Poor Countries Debt Initiative (HIPIC) and enhanced HIPIC initiative in 2001. The total relief received from both initiatives was almost US\$2 billion in nominal value or US\$4.3 billion in current value (Chao and Kostermans, 2002).

On the basis of its positive economic performance, Mozambique has benefitted from successive rounds of debt relief and increased financial support. In the context of the Multilateral Debt Relief Initiative, Mozambique benefitted from additional debt relief. Consequently, the International Monetary Fund approved the cancellation of US\$154 million (100 per cent) of debt contracted and disbursed up to the 31 December 2004, and the World Bank provided debt relief amounting to US\$1.3 billion in respect of debt contracted and disbursed up to December 2003 through HIPIC.

### CURRENT LEVEL (most recent data)

Building on the debt cancellation prior to 2005, the Africa Fund for Development (AFD) cancelled about US\$500 million of debt contracted and disbursed up to December 2004. Debt cancellation has been negotiated with the multi-lateral creditors (World Bank, International Monetary Fund, the African Development Bank, Arab Development Bank for Africa, International Fund for Development of Agriculture, Nordic Fund for Development, OPEC Trust Fund and European Bank of Investment) and bilateral creditors in the Paris Club and others. There are a number of commercial creditors from whom Mozambique has not yet obtained debt relief (Poland, Bulgaria, India, Yugoslavia, Angola, Algeria and Libya).

The debt stock has thus decreased from US\$4.6 billion in 2005 to US\$3.3 billion in 2007. However the annual average debt servicing level rose from US\$52 million in 2005 to US\$62 million in 2006, falling to US\$48 million in 2007 (GoMoz MDG report, 2008; and see Table 4 below). Debt servicing ranges from 2–3 per cent of export earnings, below the 20 per cent identified as unsustainable.

Table 4: External debt servicing relative to export earnings 2005–2007

DESCRIPTION	2005	2006	2007
Debt servicing (US\$ million)	51.6	61.8	47.6
Export goods and service earnings (US\$ million)	1,745.30	2,381.10	2,412.10
% debt servicing / export goods and service earnings	2.96	2.60	1.97

While multilateral debt has significantly reduced, internal public debt has begun to play a more important role, not only in financing the deficit in the state budget but also in promoting public savings, maintaining macroeconomic equilibrium and stimulating the functioning of the financial markets in general and the capital market in particular.

Mozambique has benefitted from debt cancellation and the current debt service percentage of earnings from export of goods and services is not high, signalling a reduced burden of debt to health. Commercial, internal public debt and household debt would need to be monitored to ensure that these do not create new burdens for spending on health.



## Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers

INDICATOR	PAST LEVELS (1980–2005)		CURRENT LEVEL (most recent data)	
% budget allocation to agriculture	5.2	1999	3.3	2006

Source: Ministry of Planning and Development, 2009.

### PAST LEVELS (1980-2005)

SADC policy forums and evidence have noted the need for adequate investment in agriculture (10 per cent of budgets) and protection of food production by smallholder women farmers as one means of addressing the food availability crisis and poor performance on nutrition.

In 1999, government allocated 5.2 per cent of the budget to agriculture (Ministry of Planning and Development, 1999).

In addition, since 1975, government policy has provided for several forms of social protection to protect food, income and social security in vulnerable groups. These include state-provided free social services, extremely limited pension schemes, emergency response aid and food subsidies for the elderly (following liberalization).

### CURRENT LEVEL (most recent data)

Agriculture grew by 10.7 per cent in 2007 and employs about 78.5 per cent of the economically active population, remaining the pillar of the economy. It had approximately 23.6 per cent share of GDP in 2006 (UNDP, 2008). In *PARPA I*, the government set a target of allocating 65 per cent or more of total government expenditures (internal resources plus external aid) to six 'priority sectors', namely education, health, infrastructure (including water), agriculture and rural development, governance and 'other' key areas (social action, work and employment and energy and mineral resources). Despite this, in 2006, the allocation to agriculture declined to 3.3 per cent of the budget (Ministry of Planning and Development, 2009).

In recent years, however, increased attention has been given to strengthening social protection across the country, particularly for vulnerable children. The medium-term fiscal framework 2010–2012 identifies the following key strategic programmes for social development:

- 1 Primary education and professional training;
- 2 Health promotion and disease prevention;
- 3 Medical services;
- 4 Development of human resources for health;
- 5 Development of the health network;
- 6 Water and sanitation;
- 7 Justice;
- 8 Promotion of gender equity;
- 9 Social assistance for the most vulnerable.

Building on the health and education sector programmes for children with specific needs (0–5 years old, children suffering from malnutrition and education material support for vulnerable children), in 2008 a food subsidy programme went through two important reforms: an incremental increase of the subsidy scale and an increased focus on including eligible dependants as indirect beneficiaries in the payment scheme.

Children represent a significant proportion of these indirect beneficiaries and many vulnerable children were excluded in the past as they did not meet the eligibility criteria due to lack of a birth registration document,



orphanhood status or as non-orphans living with elderly family members. A planned census of direct and indirect beneficiaries in 2010 will shed more light on the number of potentially eligible children in the beneficiary households who do not currently have entitlement. The criteria that determine the inclusion of dependant children is under review and a birth registration campaign is underway which will also help vulnerable children gain entitlement.

The draft basic social protection strategy is expected to be approved by the Council of Ministers in 2010. It identifies three of the current programmes as being part of the future basic social protection package: two cash transfer programmes (the current food subsidy programme and a child grant for families taking care of orphans and vulnerable children), the current in-kind social transfer programme (PASD) and the social benefit for work programme (PBST). The plan is to scale up the first two programmes to focus more on orphans and vulnerable children as direct or indirect beneficiaries.

An ongoing impact assessment of the food subsidy programme will be used to inform the political and policy dialogue regarding the approval and implementation of the basic social protection strategy, with a specific focus on the food subsidy programme and the in-kind social transfer programme (PASD). The basic social protection strategy anticipates scaling up the food subsidy programme to 452,000 households by 2014. These households are predicted to consist of 1,356,000 direct and indirect beneficiaries, of whom 795,520 indirect beneficiaries are projected to be children. The impact assessment is also expected to inform the political and technical dialogue regarding the introduction of a child grant, as proposed in the basic social protection strategy. The proposed grant targets families that care for orphans and vulnerable children and is expected to be introduced in phases as outlined in Tables 5 and 6 below.

Table 5: Cash transfers to elderly headed households, people living with HIV and the chronically ill

	2010	2011	2012	2013	2014
Number of extended families	242,296	312,592	382,888	453,183	523,479
Allocated amount (Millions of Mts)	668.74	862.75	1,056.77	1,250.79	1,444.80
% of state funds	0.24%	0.29%	0.34%	0.38%	0.42%
Elderly as direct and indirect beneficiaries	300,447	387,614	474,781	561,947	649,114
Children as indirect beneficiaries	426,441	550,161	673,882	797,603	921,324

Source: GoMoz Child Poverty Study, 2008.

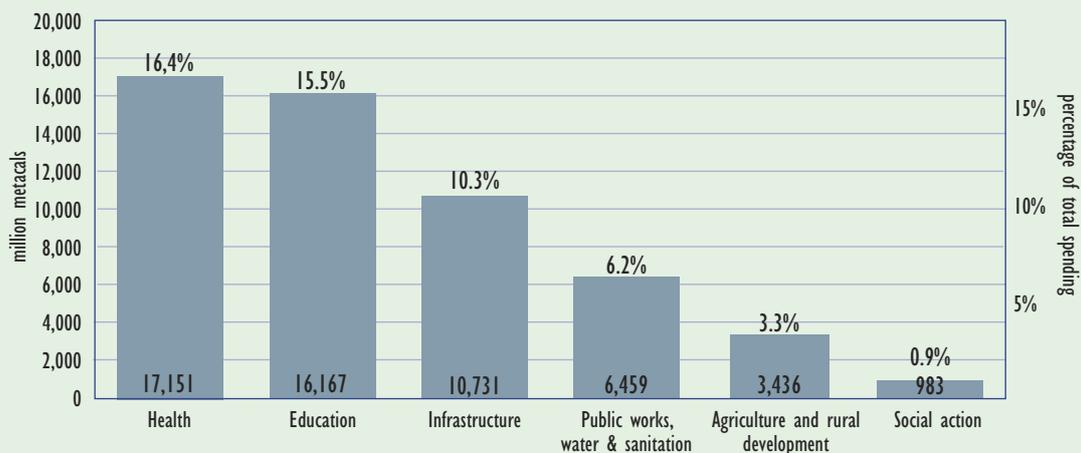
Table 6: Cash transfers to families with orphans and vulnerable children

	2010	2011	2012	2013	2014
Number of extended families	66,780	133,559	200,339	267,119	333,899
Allocated amount (Millions of Mts)	186.51	373.03	559.54	746.06	932.57
% of state funds	0.20%	0.39%	0.55%	0.71%	0.85%
Number of child beneficiaries	203,531	407,062	610,594	814,125	1,017,656

Source: GoMoz Child Poverty Study, 2008.



Figure 42: Allocation of expenditure in social sectors (in million meticaís and percentage)



Source: Ministry of Finance, Proposta OE, 2009

## Progress

The budget allocation to agriculture declined between 1999 and 2006 and has not reached the 10 per cent SADC commitment. It is not clear how far available public resources reach women smallholder farmers or their impact on household food production. There is also need to assess the extent to which food security and nutrition vulnerability is being managed in low-income urban households.

Nutritional and other forms of vulnerability are being addressed through the proposal to establish a wider social protection strategy that will include indirect beneficiaries and vulnerable children and households. Supporting measures are being implemented, such as impact assessment of the food subsidy scheme, and could be complemented by sentinel surveillance and community level participatory approaches to monitor outreach, coverage and impact.



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## No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws

### PAST LEVELS (1980–2005)

In 2001, Mozambique's commitments under the General Agreement on Trade in Services (GATS) were limited to financial services (excluding insurance). No horizontal limitations were made by Mozambique (WTO, 2001).

Mozambique is required to be compliant to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) by 2016. Mozambican law provides for government authority to issue compulsory licences for the local manufacture of essential drugs for public health. It does not yet provide for parallel importation of medicines that are patented in one country but sold more cheaply by another.

Using TRIPS flexibilities, Mozambique has granted a compulsory licence to a local company, Pharco Mozambique Ltd., for the local manufacture of the triple compound of generic antiretroviral drugs (EQUINET SC, 2007).

### CURRENT LEVEL (most recent data)

Mozambique has not committed its health services under GATS. The Mozambique Industrial Property Code 2006 provides that compulsory licences may be granted for reasons of public interest (Article 85 of the Industrial Property Code). An invention is of public interest if it is important to public health, national defence and economic and technological development (Government of Mozambique, 2006). Mozambique's inclusion in the United States/Africa Growth and Opportunities Act (AGOA) scheme and its emphasis on the protection of private property rights as a requirement for accessing the US market under AGOA provisions could put bilateral pressure on the country to avoid diluting pharmaceutical patents rights.

## Progress

Mozambique has maintained its authority to regulate its health sector through non-commitment of health services under GATS. TRIPS flexibilities for compulsory licensing are included in law and being applied, especially through bilateral relations to support local production of essential drugs. There may be some policy constraints exerted through the conditions of the AGOA scheme.

Mozambique needs to formally adopt the proposal to endorse the Doha clauses in the TRIPS amendment before December 2011.



## Health officials included in trade negotiations and clauses included for protection of health in trade agreements

### PAST LEVELS (1980-2005)

Ministry of Health officials have been included in trade negotiations.

### CURRENT LEVEL (most recent data)

Ministry of Health officials are included in trade negotiations. International trade is viewed in policy as a tool for poverty reduction, within the context of SADC and wider regional trade agreements. Trade agreements occur at bilateral level, particularly with Malawi and Zimbabwe, to the level of membership in the World Trade Organization (WTO) and the generalized system of preferences offered by countries such as China, Canada and Japan. Evidence was not available of the extent to which these trade agreements include standard provisions protecting public health.

Government has improved the regulatory instruments for overseeing business activities with a focus on: agricultural trade strategies 2006–2009, law and competition policy, competition law, regulation on commercial activity and licensing for agriculture, commerce and service delivery, construction, industry, transport and communication. Evidence was not available of the extent to which these trade agreements include standard provisions protecting public health.

## Progress

Involving health officials in trade discussions provides an opportunity for the range of trade agreements to include standard provisions protecting public health. Such provisions could be developed, for example, as in the EU-SADC agreement where Article 3 states that the application of the agreement shall fully take into account the human, cultural, economic, social, health and environmental interests of the population and future generations.

The competition law provides another important tool for avoiding monopoly linkages in the health sector (for example, insurers buying ambulance, pharmaceutical or health care services).



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## Bilateral and multilateral agreements to fund health worker training and retention

### PAST LEVELS (1980–2005)

Investments in health worker retention were discussed earlier. Added to this the Universidade Eduardo Mondlane in Mozambique has had bilateral agreements with a number of universities since 1997 (Oslo in Norway since 1997; the 2001 NORAD-funded Integrated Masters Programmes in Informatics and Public Health between Universidade Eduardo Mondlane, University of the Western Cape and the University of Oslo) including support for Mozambicans to attend doctoral programmes in Oslo through a quota programme. The prior discussion also pointed to the support that non-governmental organizations can provide to health worker incentives. In 2003, 16.3 per cent of districts reported receiving financial or in-kind support for training from non-governmental or church organizations and 15.8 per cent received training support from an external funder (Lindelöw *et al.*, 2004).

### CURRENT LEVEL (most recent data)

As noted earlier government has taken the lead in raising and costing health worker needs up to 2015 and in negotiating international support for this. Twenty-six multilateral and bilateral funders contribute to the health sector and 14 through pooled funding to implement priorities articulated in the PESS. This includes implementing the human resources strategy and expanding the training network to include the Institutes of Health Sciences in Nacala, Tete, Maputo Province (after building the General Hospital), Gaza as well as training institutions in Chokwe or Chibuto. It also includes developing capacity for distance training and allocating sufficient qualified teachers to training institutions (MISAU, 2008).

Support has also been obtained to stimulate the participation of elementary polyvalent agents (APEs) in health promotion (MISAU, 2008).

A partnership was established in Mozambique in 2004 involving 18 cooperation partners to support the government budget and balance of payments which includes payments for personnel. The partners are: Germany, African Development Bank (ADB), World Bank, Belgium, Canada, European Commission, Denmark, Spain, Finland, France, Holland, Ireland, Italy, Portugal, United Kingdom, Sweden and Switzerland (HDNR, MOZ, 2005). In 2009 Canada further supported the University of Saskatchewan's partnership with Massinga Health Training Centre, founded by the Mozambican Ministry of Health in collaboration with the University of Saskatchewan. The centre has trained 800 students since 2002, with a five-year goal to triple the training capacity (CIDA, 2009).

Progress

Government has taken the lead in raising and costing health worker needs up to 2015 (US\$110 million annually) and in negotiating international support for this. There is a high level of multilateral and bilateral funding support for the health sector, with 14 funders pooling funds to implement the priorities articulated in the PESS, including the human resources strategy.



# EQUITY WATCH



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## Summary table

**Key features** The context for this analysis of health equity and progress towards advancing health equity is a high level of historical poverty and under-development, with a decade of macro-economic progress and improvements in human development. This positive trend has been shared between different areas and groups to varying degrees, with poverty and inequality acting as barriers to such benefit. The table that follows summarizes the trends found in the selected parameters of social determinants of health and features of the health system that have been shown to make a difference in reducing social inequalities, including in health.

PROGRESS MARKER	STATUS/TREND	DISTRICTS/ GROUPS / ACTIONS PRIORITIZED
<b>EQUITY IN HEALTH</b>		
Formal recognition of equity and health rights	Positive. Strong values, constitutional, policy provisions for health equity backed by a national health system	Sign the ICESR. Raise awareness and involvement of civil society, parliament and professionals to operationalize rights and policies.
Halving the number of people living on US\$1/day	Mixed. Significant improvement in rural poverty; Slower improvement, some growth in urban poverty. Uneven distribution of growth to higher income groups and regions.	Strengthen focus on disparities and poverty, and attention to urban poverty. Poverty higher in Inhambane, Gaza, Maputo, Cabo Delgado. HDI and GDI growth lower in Maputo City, Gaza, Maputo province, Inhambane, Tete
Reducing the gini coefficient of inequality	Mixed. Lower than regional average and static/ some evidence of small increase.	Understand and address socio-economic, access drivers of increases in inequality in Maputo, Cabo Delgado.
Eliminating differentials in CMR, IMR, MMR and undernutrition	Positive. Aggregate improvements in IMR, USMR, MMR. Reduced urban-rural differentials. Wide wealth /income and education differentials for CMR, stunting.	Address socio-economic (SE) determinants of mortality differentials; – support to mothers with no education – support to lowest income h/holds – support to urban poor h/holds Highest CMR: Cabo Delgado, Niassa, Tete. Address social determinants of maternal health service uptake
Universal access to PMTCT, ART and condoms	Mixed. Improvement in aggregate ANC, skilled delivery coverage but education, income differentials widened in access to all interventions.	Sustain plans to improve universal coverage of services. Address low coverage of assisted deliveries in Cabo Delgado, Nampula, Zambesia and low rural immunization coverage. Additionally provide family focused intervention to address social, economic determinants of access, uptake in services.
Eliminating differentials in access to immunization, ANC, skilled deliveries	Mixed. Impressive expansion of VCT, ART services, especially in urban Maputo. Unmet need in children and expansion constrained by lack of health workers. HIV prevalence rise in youth, southern regions.	Sustain plans to improve universal coverage of prevention and ART services. Address child ART coverage, especially in north and central regions. Target HIV prevention for youth, southern regions. Identify and address barriers to service uptake and compliance.
<b>HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH</b>		
Closing gender differentials in access to education	Positive. Improvement and closing gender gap in primary education. Still low secondary, literacy rates. Income differentials now greater than area, gender differentials.	Address coverage gaps: Lowest ETPI NER in Inhambane, Maputo city. Lowest attendance in Tete, Nampula, Cabo Delgado; Worst teacher ratios in Zambizia, Tete, Sofala, Nampula. Improve overall coverage rates and promote education access, enrolment and completion in girls and poorest families.
Halving the proportion of people with no safe drinking water and sanitation	Shortfalls. Policy commitment but low coverage and limited improvements, with some decline in urban areas. Warning signals from cholera epidemics.	Lowest safe sanitation coverage in Zambizia, Sofala, Nampula. Lowest safe water coverage in Niassa, Zambesia. Promote national intersectoral action to expand coverage. Address urban area decline in safe water coverage. Monitor impacts on environmental disease.
Increased ratio of wages to GDP	Uncertain. Inadequate data	Needs further investigation
Provide adequate health workers and drugs at primary, district levels	Progress being made in health worker availability, but with sustained provincial variations. Improvement in access to medicines in districts. Unclear if improved provincial availability reaches clinics.	Poorest HCW densities in Zambesia, Nampula, Cabo Delgado. Best in Niassa, Sofala. Align resource allocation to improving HCW in these provinces to ensure capacity to absorb. Carry out drug availability survey to assess availability at district and primary care level by province and address barriers.
Abolish user fees	Mixed. Evidence of variable charges, variable application of exemption policies despite national policies and cost barriers for 40% rural households.	Implement policy proposals to remove fees at point of care for primary care backed by investments to support uptake/ lost revenue and measures to monitor and ensure formal charges are not substituted by informal charges.
Overcoming barriers to access and use of services	Mixed. Evidence of social service availability, operation barriers; community health programmes to support reach and uptake.	Implement district level analysis of availability, access, acceptability, contact and effective coverage barriers and use participatory approaches to identify and support uptake in those affected

PROGRESS MARKER	STATUS/TREND	DISTRICTS/ GROUPS / ACTIONS PRIORITIZED
<b>REDISTRIBUTIVE HEALTH SYSTEMS</b>		
Achieving the Abuja commitment	Mixed. Improvement in health budget allocation but falling share of domestic allocation excluding external funds	Monitor and ensure the domestic allocations rise to 15% government spending excluding external funding.
Achieving US\$60 per capita funding for health	Positive. Steady improvement in public and overall health financing. Improved additional resources enables allocation to provinces, areas of spending where need is high	Continue to increase overall per capita spending on health. Ensure allocative efficiency of additional spending and apply and monitor an equitable resource allocation formula to increased recurrent funding.
Improve tax funding and reduce out of pocket spending to health	Mixed. Tax revenue as a share of GDP has increased but not yet associated with reduced out of pocket spending or increased domestic funding.	Improve domestic resource allocation to health, support investments to remove user fees to reduce out of pocket spending and monitor informal and other out of pocket spending
Harmonize health financing into a framework for universal coverage	Positive. Basis for harmonized framework in national health system supported by negotiation of harmonized funding with external partners.	Sustain and strengthen harmonized pooling of external funding. Review and strengthen the coordination of private sector and community resources.
Establish and ensure clear health care entitlements	Mixed. Constitutional and policy provisions for essential health services. Unclear evidence on knowledge and implementation.	Entitlements and their costing to be clarified and monitored for implementation. Engage civil society to raise awareness and accountability on entitlements.
Allocate at least 50% public funding to districts and 25% to PHC	Mixed. Greater shares than regional average to district and PHC in 1997 but evidence on subsequent trends unclear.	Assess and report on funding levels of districts and primary care level within provinces. Integrate equity into allocation of recurrent resources, e.g. in donors common fund
Implement non-financial incentives for health workers	Positive. Increased policy attention, measures, resources, data to promote incentives for retention.	Monitor and assess the implementation of incentives at all levels and strengthen capacities for management and review of incentive schemes.
Formal recognition of and support for mechanisms for public participation in health systems	Shortfalls. Strong legal and policy positions not yet translated into the same level of public participation. CHWs to be revitalized.	Scope for operationalizing policy commitments, strengthen health literacy, community and civil society awareness, organization and involvement around health, to mobilize social resources and action for public health and the health system; to make more organized links with social and community support for vulnerable groups and to formalize, capacitate and resource the mechanisms for participation within the health system.
<b>A JUST RETURN FROM THE GLOBAL ECONOMY</b>		
Reducing the debt burden	Positive. Debt cancellation achieved and relatively low debt service ratio.	Monitor commercial, internal public debt and household debt to prevent new burdens on health spending
Allocate resources to agriculture and women smallholder farmers	Mixed. Falling budget share of agriculture and below SADC commitment. Proposals developed for a social protection strategy including food security.	Assess support to women smallholders and links to household nutrition to inform subsidy and social protection strategies. Complement existing measures and proposals by sentinel surveillance and community participatory tools to assess and monitor outreach, coverage and impact.
Ensure health goals in WTO (TRIPS, GATS) agreements	Positive. No new health sector commitments made. TRIPS flexibilities used to license local drug production.	Maintain policies on TRIPS and GATS. Endorse at WTO the TRIPS amendment before December 2011
Health officials included in trade negotiations	Mixed. Health officials included. Clauses to protect public health not yet in many new trade agreements.	Use opportunity of health official involvement in trade discussions to include standard provisions protecting public health in agreements. Ensure capacities to enforce competitions commission rules preventing monopolies in the health sector.
Bilateral and multilateral agreements to fund health worker training	Positive. Agreements negotiated and implemented through pooled funding arrangements.	Continue current approach on mobilizing shortfalls on the US\$110 million annually for HCW through pooled funding.
<b>KEY:</b>	 Improving	 Static, mixed or uncertain
		 Worsening

# EQUITY WATCH

The analysis indicates that opportunities for health equity arise in the wider socio-economic and political conditions:

- good economic growth, a rise in trade, reduced debt burdens, peace,
- strong values, constitutional and policy framework centred on universal provision of social services, rights to health and on a public sector led national health system, used to navigate and negotiate policy choices nationally and globally.
- gains in just relations with the international community, such as through debt cancellation, support for pooled funding for the health sector and for investment in key national resources like health workers.

The impact of these 'equity assets' is evident in the improvements in IMR, U5MR and MMR, in reduced urban–rural differentials and gender differentials in education, less rural poverty and an expansion of the key areas of primary health care and service delivery.

There are challenges; some are historical and some appear to emerge from recent trends:

- sites of historical poverty and inequity between health need and health services persist. Inhambane, Tete, Cabo Delgado, Nampula have both poor health outcomes and poor health service coverage, indicating the potential for inequity between health need and health care response.
- new dimensions of poverty, inequality and health risk appear to have arisen even in areas that previously had better socio-economic indicators, including:
  - A rise in urban poverty increasing health need, with reduced coverage in Maputo City, suggesting the need for stronger models of urban primary health care;
  - Wealth and social differentials in health outcomes and health care and education coverage exceeding rural–urban differentials, suggesting the need to complement geographical approaches to service coverage with specific measures to identify and support outreach and uptake in vulnerable families and individuals;
  - An increase in groups susceptible to new HIV infection, such as populations in southern districts, youth and especially young women, suggesting approaches need to be oriented towards the needs and culture of these groups.

At policy level this suggests that the measures Mozambique is taking to improve universal coverage through a national health system need to be sustained. Measures are needed to track and address geographical differences in capacities and coverage, including by integrating equity in the resource allocation formula.

One area that needs greater attention and intersectoral action on this is the coverage of safe water and sanitation, including in low-income urban areas. This is raised as an urgent priority not only given the significant risk and burden to poor households of epidemic disease such as cholera, but also given the positive role these facilities play in reducing women and children's work time.

The evidence suggests further that within the framework for universal coverage, measures are needed to identify and encourage outreach to and uptake in vulnerable families and households in urban and rural areas. Some of these are raised in the report and the groups and approaches can also be identified through stakeholder discussion. At district level participatory methods can be used to identify such groups, working with the community.

Follow up analysis can also be done using district level data (Multiple Indicator Monitoring Surveys, DHS and health information system) to assess by district where and for whom the gaps in coverage are emerging and whether they arise due to:

- Availability (provision of infrastructure and services)
- Accessibility (financial and geographical)
- Acceptability (culture, communication )
- Contact coverage (or uptake), or
- Effective coverage (or contact translating into effective diagnosis and response).

This could, for example, be done first as a pilot in some of the districts identified as having larger gaps between need and coverage, such as Maputo City and Cabo Delgado.

The evidence suggests that government has focused on important areas to negotiate and navigate equity and universal coverage with partners, such as in the pooling of external funds within the public sector, policy measures to increase the numbers of health workers and incentives to retain them or using TRIPS flexibilities to encourage local pharmaceutical production. Ensuring equity in the private–public mix is an area that may need greater policy attention in the future.

The role of national civil society and mechanisms for public and community participation in health were identified as serious gaps in strengthening equity and monitoring and supporting the reach of essential services, primary health care and other measures being implemented. Beyond the planned community health worker programme there is scope to promote health literacy and awareness and develop health system mechanisms and capacities to strengthen community roles in health. This has often proved to be the vital element in advancing equity in health.



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# EQUITY WATCH

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. It is achieved through the distribution of societal resources for health, including but not only through the actions of the health sector. All countries in East and Southern Africa have policy commitments to health equity, as do the regional organisations, the Southern African Development Community and the East Central and Southern African Health Community. In February 2010, the ECSA Regional Health Ministers resolved to track and report on evidence on health equity and progress in addressing inequalities in health. EQUINET is working with countries and the regional organisations to implement the Equity Watch, to monitor progress on health equity, through gathering, organising, analysing, reporting and discussing evidence on equity in health, at national and regional level.

This report of the Mozambique Equity Watch has been produced by the Ministry of Health Mozambique working with EQUINET through Training and Research Support Centre. The summary table below shows the progress markers that were assessed, the trends, with green for improving progress, red for worsening trends and yellow for uncertain or mixed trends. The report provides the evidence on these trends and proposes areas for action.

PROGRESS MARKER	TREND
<b>EQUITY IN HEALTH</b>	
Formal recognition of equity and health rights	
Halving the number of people living on US\$1 per day	
Reducing the gini coefficient of inequality	
Eliminating differentials in child, infant and maternal mortality rates and undernutrition	
Eliminating differentials in access to immunization, ante-natal care, skilled deliveries	
Universal access to prevention of mother to child transmission, antiretroviral therapy and condoms	
<b>HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH</b>	
Closing gender differentials in access to education	
Halving the proportion of people with no safe drinking water and sanitation	
Increased ratio of wages to gross domestic product	
Provide adequate health workers and drugs at primary, district levels	
Abolish user fees	
Overcoming barriers to access and use of services	
<b>REDISTRIBUTIVE HEALTH SYSTEMS</b>	
Achieving the Abuja commitment	
Achieving US\$60 per capita funding for health	
Improve tax funding and reduce out of pocket spending to health	
Harmonize health financing into a framework for universal coverage	
Establish and ensure clear health care entitlements	
Allocate at least 50% public funding to districts and 25% to primary health care	
Implement non-financial incentives for health workers	
Formal recognition of and support for mechanisms for public participation in health systems	
<b>A JUST RETURN FROM THE GLOBAL ECONOMY</b>	
Reducing the debt burden	
Allocate resources to agriculture and women smallholder farmers	
Ensure health goals in World Trade Organization (TRIPS, GATS) agreements	
Health officials included in trade negotiations	
Bilateral and multilateral agreements to fund health worker training	