34. Country profile: Mozambique

1. Development profile

Mozambique endured almost five centuries under Portuguese colonial rule. After gaining independence in 1975, "large-scale emigration, economic dependence on South Africa, a severe drought and a prolonged civil war hindered the country's development until the mid 1990s".[1] The country was one of the poorest nations in the world, a situation exacerbated by socialist mismanagement and a 12-year civil war.

In 1987, the government instituted a series of macroeconomic reforms, which were designed to stabilise the economy and encourage foreign investment. Since these reforms, Mozambique's growth rates have improved and inflation has slowed. A value-added tax and reforms in the customs service have led to an increase in government revenues. The year 2004 marked a peaceful but fragile political transition, as President Chissano stepped down after 18 years in office and handed power to Armando Guebuza, who "promised to continue the sound economic policies that have encouraged foreign investment".[2]

Mozambique remains dependent on foreign aid for more than half of its annual budget, and 54.1 percent of the population lives below the poverty line. While the opening of the Mozal aluminium smelter has increased export earnings, Mozambique's economy continues to rely heavily on aluminium, which now accounts for one-third of exports, rendering the country extremely vulnerable to fluctuations in international prices. In 2007, the government took over Portugal's majority share of a hydroelectricity company. The garment industry is also growing.[3]

To sustain these growth rates, of about 8 percent between 1996 and 2008, will require further investments and reforms to improve the business environment, make the legal and judicial sector more effective, strengthen public financial management and the overall governance framework, and further decentralise and bolster the delivery of key services, especially in rural areas. Reducing the high HIV/AIDS infection rate, at 16 percent, is also critical.[4]

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[1] *Mozambique.* (2010, January 26). Retrieved from United States Government, Central Intelligence Agency: https://www.cia.gov/library/publications/the-world-factbook/geos/mz.html

[2] Ibid.

[3] Ibid.

As a result of recent economic growth, almost 3 million people were lifted above the poverty line; there has been a 40 percent decrease in infant and under-five mortality; and primary school enrolment has increased by 76 percent. [5]

Mozambique qualified for debt rescheduling and forgiveness under the IMF's Heavily Indebted Poor Countries and Enhanced HIPC Initiatives and its debt is now at a manageable level. [6]

Drought and natural disasters exacerbate humanitarian situations, and "vulnerable populations face the constant threat of cholera outbreaks due to the poor availability of clean water and sanitation facilities". [7] Nutritional problems and malaria contribute to a large proportion of child deaths, and child mortality is high: of about 715,000 children born each year, approximately 89,000 will die before reaching the age of one, and another 39,000 will die before they reach the age of five. Health service providers at national, provincial and district levels "lack the capacity to address the basic health needs of children and women – especially in areas affected by drought, natural disasters and other emergency situations". [8]

Socioeconomic indicators[9]	
Population (millions)	21.8
GNI per capita, PPP (current USD)	$770
GDP (current USD) (billions)	$9.7
GDP composition by sector (%)	Agriculture - 28 Industry- 26 Services- 46
GDP growth rate (%)	9.5
% below poverty line (%)	54.1
Inflation (%)	6.5
GINI index	47.1
Adult literacy rate (%)	55.6
Life expectancy (years)	48
Child dependency ratio	83
Elderly dependency ratio	6.2
HIV prevalence (%)	12.5
Overseas development aid per capita (current USD)	$83
Net official development assistance 2005 (USD	$1.286

[4] *Mozambique: From Post-Conflict Recovery to High Growth*. (2010, September). Retrieved from International Development Association, World Bank: http://siteresources.worldbank.org/IDA/Resources/73153-1285271432420/IDA_AT_WORK_Mozambique_2010.pdf

[5] *Mozambique: Country Brief*. (2009, September). Retrieved from World Bank: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/MOZAMBIQUEEXTN/0,,menuPK:382142~pagePK:141132~piPK:141107~theSitePK:382131,00.html

[6] *Mozambique.* (2010). US Government, CIA.

[7] *UNICEF Humanitarian Action: Mozambique in 2007*. (2007). Retrieved from UNICEF: www.unicef.org/har07/files/Mozambique.pdf

[8] Ibid.

[9] Data drawn from: *World Development Indicators* (2009). Retrieved from World Bank: http://data.worldbank.org/data-catalog/world-development-indicators. *Human Development Report 2009* (2009). Retrieved from the United Nations Development Programme: http://hdr.undp.org/en/reports/global/hdr2009/

Millions)	
Remittances as % of GDP	1.3
2009 Human Development Index (HDI) ranking	172/182

2. Vulnerability analysis

2.1 External shocks

The successive international food, fuel and financial crises created serious challenges for Mozambique. High prices increased inflation and revealed social vulnerabilities. In order to minimise the crises' impact, the government took a series of efficient measures which were praised by its international partners, which included deferring customs duties and VAT payments for diesel and paraffin, extending subsidies to minibus transporters, and increasing food aid and income supplement programmes for the poorest families. These measures were financed through expenditure cuts in other areas, as well as through additional external support.[10]

However, Mozambique remains vulnerable to global financial and economic crises, and must take additional measures to meet these challenges and ensure that macroeconomic growth benefits vulnerable groups. This can be accomplished through creating and expanding opportunities for employment and income generation, and through increasing access to food and health care.[11] The most vulnerable segments of the population, especially those in urban areas, are still feeling the negative effects of the food price crisis, and continuing and expanding food aid and income support programmes for the poorest "continues to be a point of special attention".[12]

Mozambique is constantly threatened by natural disasters, including cyclones, prolonged droughts and seasonal floods. This "disrupts livelihoods and services, exhausts limited coping mechanisms and exacerbates populations' vulnerabilities – especially women and children".[13] Drought plagued the country from 2002 to 2007, which decreased food security throughout the country. Education is also disrupted by natural disasters; national authorities lack the capacity to deal with crises quickly and resume school activities following seasonal floods and droughts.[14]

2.2 HIV/AIDS

During the 1990s, the HIV epidemic grew rapidly in Mozambique, exacerbated by deep poverty, low literacy levels, rural-urban migration, and the post-war return of refugees from neighbouring Malawi, Tanzania and Zimbabwe, where HIV infection rates were higher.[15] Today, the pandemic poses a major

[10] Republic of Mozambique and Programme Aid Partners. *Joint Review 2009: Aide-Memoire.* (2009, April 27). Retrieved from Programme Aid Partnership: http://www.pap.org.mz/jr_09.htm

[11] Ibid.

[12] Ibid.

[13] *UNICEF Humanitarian Action: Mozambique in 2007*. UNICEF.

[14] Ibid.

challenge for the nation: 16 percent of Mozambicans have HIV/AIDS, and 58 percent of those infected are women.[16] Although the average prevalence has remained relatively stable since 2005, HIV rates have reached very high levels in some provinces, where up to 38 percent of pregnant women are seropositive.[17]

Recently, legislative strides have been made in the fight against HIV: the new Multisectoral Strategy for Accelerating the Prevention of HIV/AIDS Infection and the Law on the Defence of Human Rights and Fight against the Stigmatisation and Discrimination of People Living with HIV/AIDS have both been approved.[18] However, the response to HIV/AIDS must be accelerated and optimised in all sectors, with a special focus on prevention. Crucial priorities include implementing HIV/AIDS prevention and coping programmes in the workplace to mitigate the pandemic's negative impact on workers, and integrating Mozambique's National Prevention Strategy with the extension of social security programmes, especially for orphaned and vulnerable children and their caretakers.[19]

2.3 Foreign aid and remittances

Mozambique is dependent on foreign aid for half of its budget, and official development assistance (ODA) represents 23 percent of its GDP.[20] Foreign aid continues to be extremely important for financing the deficit in the current account and ensuring the stability of the economy in relation to global economic forces.[21] The country has not yet attained a level of sustainable economic growth that would allow a substantial cut in the volume of assistance in the short or medium term.[22] Remittances to Mozambique account for 1.3 percent of GDP.[23]

2.4 Political conflict

During the civil war, Mozambique's infrastructure for basic social services was devastated. Today, Mozambique is still in the process of rebuilding after more than a decade of civil war, which creates particular challenges for social protection. [24]

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[15] Keough, L. and K. Marshall. (2006, April). *Mozambique's Battle Against HIV/AIDS and the DREAM Project*. Retrieved from World Bank Global HIV/AIDS Program: http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1132695455908/GR-Mozambique-StEgidio-April25.pdf

[16] Republic of Mozambique and Programme Aid Partners (2009).

[17] Ibid.

[18] Ibid., page 12

[19] Ibid.

[20] Ibid.

[21] International Monetary Fund. (2009, April). *Republic of Mozambique: Poverty Reduction Strategy Paper—Annual Progress Report—Joint Staff Advisory Note.* IMF Country Report No. 09/177. Retrieved from International Monetary Fund: http://imf.org/external/pubs/ft/scr/2009/cr09117.pdf

[22] Ibid.

[23] *World Development Indicators.* (2009). World Bank.

[24] *UNICEF Humanitarian Action: Mozambique in 2007*. UNICEF.

3. Monitoring and evaluation

Mozambique has established 'Development Observatories' (DO) as consultative forums to discuss poverty reduction issues. These forums are set up on national and provincial levels, and include representatives from the government, civil society and international partners. The DOs are designed to collect and analyse data on poverty, and to monitor the implementation of the Action Plan for the Reduction of Absolute Poverty (PARPA). At the provincial level, DOs aim to facilitate dialogue and consultation at a decentralized level.[25] While a 2009 International Monetary Fund report found that annual reporting provides adequate information on the progress of implementing the PARPA programme, "additional efforts are required to improve the mechanisms for poverty monitoring, as well as to continue developing transparent mechanisms for the allocation of public resources for strategic objectives".[26]

4. Social assistance programmes overview

*All currency conversions are based on 17 February 2010 rates:

- 1 MZN = 0.03611 USD
- 1 EUR = 1.369 USD
- 1 GBP = 1.57161 USD.[27]

Programme# 1: conditional cash transfer	**Programme name**	**Minimum Income for School Attendance (MISA)[28]**
	Programme objectives	▪ To improve education. ▪ To increase employment opportunities for the poorest people. ▪ To reduce gender inequality.
	Programme components	▪ Provides a cash transfer to poor households with children of school-going age. ▪ Promotes economic growth by investing in human capital and addressing the lack of technical skills. ▪ Compensates households for the cost of children's schooling, thus raising school enrolment rates.
	Programme coverage	▪ Around 5,000 families are covered.
	Beneficiary determination process	▪ Targets the poorest households in rural areas with children of school age.

[25] International Monetary Fund. (2009).

[26] Ibid.

[27] *Currency Converter*. (n.d.). Retrieved from OANDA: http://www.oanda.com/currency/converter/

[28] Barrientos, A., R. Holmes and J. Scott. (2008, August). *Social Assistance in Developing Countries Database Version 4.0.* Brooks World Poverty Institute, The University of Manchester and Overseas Development Institute. Retrieved from Chronic Poverty Research Centre: http://www.chronicpoverty.org/uploads/publication_files/Social_Assistance_Database_Version4_August2008.pdf

		▪ Girls are especially targeted.
	Finance	▪ $ 2 USD a month per member for each family.
	Monitoring and evaluation	▪ Internally by the Ministry of Education. ▪ Externally by ILO and UNCTAD.
	Programme barriers	▪ The pilot project has not yet been properly evaluated. ▪ There are concerns about sustainability because of the macroeconomic constraints facing the country. ▪ If international aid were withdrawn, the government of Mozambique would find it impossible to allocate long-term budget resources to the programme.

Programme# 2: unconditional cash transfer and in-kind food transfer	**Programme name**	**Food Subsidy Programme (PSA)**[29]
	Programme overview	▪ Previously confined to urban areas. ▪ Recently, coverage has been expanded to selected rural areas. ▪ The Council of Ministers has recently approved expansion to rural villages. ▪ Set up after GAPVU closed due to corruption.
	Programme objective	▪ Provides a monthly cash transfer to ○ people who are destitute and have no capacity to work, including older, disabled and chronically ill people (but not those living with HIV/AIDS and TB) ○ pregnant women who are malnourished. ▪ The cash transfer is intended to be used by poor Mozambicans to buy food. It aims to support entitlements to food through raising household income.
	Programme components	▪ Unconditional, targeted cash transfer. ▪ Distributed monthly to recipient households. ▪ The value of the transfer is low and depends on the size of the household. ○ Minimum: Mzm 70,000 ($2.39 USD) per month for a one-person household ○ Maximum: Mzm140,000 ($4.78 USD) for households with five or more members. ▪ National Institute of Social Action (INAS) also provides direct social support, including: ○ cash (for example, to cover travel expenses for medical treatment), ○ psycho-social support, ○ support to income-generating projects.

[29] Waterhouse, R. (2007, July). *The Political and Institutional Context for Social Protection in Mozambique: A Brief Overview*. Retrieved from International Policy Centre for Inclusive Growth, United Nations Development Programme: http://www.ipc-undp.org/publications/cct/africa/REBABriefingPaperSPPolInstContextJuly07.pdf

	Programme duration	▪ Set up in 1997
	Programme coverage	▪ Running in every province in Mozambique, but not all districts. ▪ Coverage is low: approximately 1% of population is targeted. ▪ Number of beneficiaries: 96,600 in 2006; rose to 101,800 in March 2007. ▪ Beneficiary demographics: of the 96,582 PSA beneficiaries in 2006: o 89,819 (92 percent) were older people (59,069 women and 30,750 men) o 5,606 were disabled o 933 were chronically sick o 222 were female heads of households. ▪ Highest numbers of beneficiaries: o Chimoio city (central, Manica Province): 10,840 o Nampula city (northern, Nampula Province): 8,052 o Beira (central, Sofala Province): 7,264.
	Beneficiary determination process	▪ Targets households living in absolute poverty, where the household head: o is unable to work and is an older woman (55+) or older man (60+), o is physically 'handicapped' or chronically sick and is over 18 years old, o is a malnourished pregnant woman. ▪ Aimed at people who are temporarily or permanently unable to work and unable to satisfy their subsistence needs. ▪ Targeting is complex, based on multiple eligibility criteria, including: o proxy indicators (age, disability), o means testing (per capita monthly income below Mzm 70,000: $2.39 USD), o health status (chronically sick' or malnourished).
	Finance	▪ Financed entirely through the state budget. ▪ Recent budgets: o 2006: 164.2m Mtn ($5.608 million USD). o 2007: 188.6m Mtn ($6.441 million USD) in 2007. ▪ It costs INAS $66 USD to provide beneficiaries in Quelimane with Mzm 840,000 per year ($29 USD), which will purchase 168-280kg of maize.
	Legal framework	▪ National Action Plan for the Reduction of Absolute Poverty (PARPA).
	Administrative framework	▪ Implemented by the National Institute of Social Action (INAS), a semi-autonomous agency of the Ministry of Women and Social Action (MMAS). ▪ INAS delegations in all provincial capitals respond to INAS at central level; also accountable to Provincial Directorates for Women and Social Action. ▪ *Permanentes:* at the community level, INAS works through local volunteers (*Permanentes*), chosen by the community to act as its community agents.

		▪ *Permanentes*: ○ are appointed only in communities with a minimum of 25 beneficiaries (urban areas) or 15 beneficiaries (rural areas). ○ Sign a Terms of Agreement with INAS, and receive an incentive payment of 300 Mtn per month ($10.25 USD). ○ Serve as the link between INAS and the community, and therefore should be available (that is, ready to carry out activities for INAS whenever asked), suitable, serious, honest and elected by the community. ○ Inform the community about the PSA, actively participate in the identification of vulnerable people as potential beneficiaries, make home visits to beneficiaries, advise beneficiaries of payment dates, are present at Payment Posts on payment days and help to check the payment list.
	Programme barriers	▪ Limited coverage, due to: ○ stringent targeting (see above), ○ registration criteria (beneficiaries and registered dependants require identity cards or birth certificates), ○ limited management capacity, ○ insufficient funding. ▪ Financing: INAS depends on annual allocations from the Ministry of Finance to determine how many beneficiaries it can cover; to date this has permitted only a small proportion of potential beneficiaries to be covered, mostly in urban areas. ▪ Administration: the administrative apparatus for delivering the PSA is somewhat top heavy, and administrative costs are high in relation to the value of the subsidy. ▪ Low transfer value: originally set at one-third of the minimum wage, transfer value has fallen to just 9 percent of the minimum wage, and will soon fall further to just 5 percent when the minimum wage is raised. At the household level, beneficiaries complained the transfer was “insufficient” or even “insignificant”.[30] ▪ Depends heavily on underpaid *Permanentes*: the programme relies heavily on the goodwill of the *Permanentes*, who are remunerated at the trivial rate of Mtn 300 ($10.25 USD) per month, and for whom any increase in caseload would need in the future to be treated as proper employment.

[30] Barrientos et al. (2008).

Programme # 3: social insurance	**Programme name**	**Mozambique Health Service Delivery Project (HSDP)[31]**
	Programme overview	▪ The project will help increase the population's access to health services in the three most disadvantaged provinces
	Programme objective	▪ The project will help strengthen the capacity of the health sector to reduce the incidence of TB, improve treatment continuity, and increase cure rates; and strengthen the capacity of the Ministry of Health in effective case management of malaria.
	Programme components	▪ Strengthening community-based service delivery. ▪ Scaling up outreach services. ▪ Improving and expanding facility-based services.
	Programme duration	▪ Project was approved in April 2009.
	Programme coverage	▪ Active in the three most disadvantaged provinces: Cabo Delgado, Nampula and Niassa.
	Finance	▪ Total project cost: $472.4 million USD, financed by: ○ The World Bank ($44.6 USD), ○ CIDA ($15.6 million USD), ○ Russia ($7.9 million USD), ○ Swiss Development Cooperation ($4.3 million USD).
	Legal framework	▪ Government's medium-term development objectives are spelled out in the PARPA II (2006), the country's Poverty Reduction Strategy, and supported by the Country Partnership Strategy (CPS), prepared jointly by the government and the World Bank. ▪ The first objective of the 2007-12 Health Sector Strategic Plan (PESS II) is to reduce child and maternal mortality.
	Administrative framework	▪ The Ministry of Health will have the overall responsibility for the management of the HSDP. ▪ The National Directorate of Public Health will be responsible for the technical aspects of the project management by providing overall technical guidance and support to the implementing agencies within the Ministry of Health. ▪ The Directorate of Administration and management will be responsible for the financial management of the HSDP. ▪ The Human Resource Directorate will be in charge of the planning and training of incremental human resources needed for the HSDP.
	Monitoring and evaluation	▪ The Directorate of Planning and Cooperation will support the National Directorate of Health Promotion and Disease Control (DNPSCD) in the areas of monitoring and evaluation of the project and will be responsible for the updating of the investment plan.

[31] *Project Appraisal Document... for a Health Service Delivery Project (HSDP).* (2009, March 20). Retrieved from World Bank: http://go.worldbank.org/E9097H40Q0

Programme# 4: unconditional cash transfer	**Programme name**	**Gabinete de Apoio à População Vulnerável (GAVPU)** [32]
	Programme overview	▪ Urban safety net programme. ▪ Benefits adjusted to reflect household size, increasing with household size. ▪ Closed due to corruption scandals.
	Programme objective	▪ To reduce poverty among urban households made destitute by the civil war in Mozambique.
	Programme components	▪ Monthly cash payments of about 7,611 Mt ($259.9 USD).
	Programme duration	▪ Began in September 1990. ▪ Suspended in 1997 because of fraud and corruption.
	Programme coverage	▪ Approximately 70,000 households each month. ▪ Reached 16% of all urban households in Mozambique.
	Beneficiary determination process	▪ Targeted destitute urban households, defined as households where: ○ Household income is so low that the under-consumption of food reaches a level that endangers the health and lives of household members (apparently about 1,300 to 1,400 kilocalories per person per day), ○ Household income is less than 32,000 Mt. per person per month ($1,092.9 USD), ○ There are no individuals of working age working abroad in a contiguous country, ○ The household has lived in the city for more than 1 year, ○ There is a child less than 5 years old with nutritional problems associated with risk factors (clinically diagnosed kwashiorkor, or weight-for height at or below the third percentile of the reference standards), ○ There is a pregnant woman with nutritional problems associated with risk-factors (clinically diagnosed anemia, or for single-births, monthly average weight gain of 500 grams or less; for twin-births, monthly average weight gain of 900 grams or less), ○ Unemployed elderly persons more than 60 years old are living alone or in households without any individuals of working age (between 18 and 59), ○ Physically disabled persons more than 18 years old reside who suffer from some incapacity for work, who are unemployed, and who live alone or are heads of households without any other persons of working age (between 18 and 59), ○ Households are female-headed with five or more children and no other person of working age living in the same household.
	Finance	▪ Funded by the government of Mozambique. ▪ 24,000 meticais (Mt.) per month ($819.67 USD).

[32] Datt, G., E. Payongayong, J.L. Garrett and M. Ruel. (1997, October). *The GAPVU Cash Transfer Program in Mozambique: An Assesment*. Retrieved from International Policy Centre for Inclusive Growth, United Nations Development Programme: www.undp-povertycentre.org/publications/cct/dp36.pdf

	Administrative framework	▪ Operated under the jurisdiction of the Ministry for Coordination of Social Action. ▪ Strong links to the Ministry of Finance. ▪ Administration was decentralised at the provincial level, where GAPVU delegations were headed by the provincial directors of the Ministry of Planning and Finance.
	Monitoring and evaluation	▪ Monthly reports: delegations headed by the provincial directors of the Ministry of Planning and Finance send monthly reports to the central GAVPU office.
	Programme barriers	▪ Delays: beneficiaries wait a long time, at least 7 hours at the office, to receive payment. ▪ Interruptions: Many beneficiaries reported interruptions in their monthly payments. ▪ Corruption.