REPUBLIC OF MOZAMBIQUE
MINISTRY OF ECONOMY AND FINANCE

BOOKLET: MILLENNIUM DEVELOPMENT GOALS INDICATORES

Maputo, September 2015

REPÚBLICA DE MOÇAMBIQUE
MINISTÉRIO DE ECONOMIA E FINANÇAS

Booklet: Millennium Development Goals Indicatores

Maputo, 2015

TITLE:	Booklet, Millenium Development Goals Indicators
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Publisher:	MINISTRY OF ECONOMY AND FINANCE
Financing and Tecnhical Support:	United Nations Development Programme (UNDP)
Translater:	Laurence Hendrickx (COZMOZ, Lda)
Printing & Finishing :	Laranja, Lda
Print run:	300
Statistical Data:	Govermment of Mozambique, National Statistics Institute, and Official Sector Statistics

Maputo, 2015

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1. INTRODUCTION

When Mozambique, together with over 189 Nations, ratified the Millennium Declaration in September 2000, and through this, the Millennium Development Goals as well, it did justice to its commitment with not only the world but in particular with its people, to respect the principles of human dignity, equality and equity, principles that are considered priority areas for the Mozambican State.

In this context, and in order to better implement the 8 Goals, the country integrated and aligned the MDGs with the National Planning, Monitoring and Evaluation System. The Millennium Development Goals were translated into successive Government Five-Year Programs and its policy measures were reflected in the strategic sector plans, while the statistical system absorbed most of the 60 indicators in order to enable the availability of information for evaluating the progress of the targets set for 2015.

This alignment exercise, based on the State Budget, allowed the country to implement successful policy measures. Among these, the achievement of the target on the prevalence of underweight children under five years, the gender balance in Primary Education, as well as the targets on child and juvenile mortality rates need to be highlighted. Mozambique also recorded remarkable progress in the targets on access to universal education, women's empowerment, the fight against Malaria and Tuberculosis, and access to clean drinking water.

The progress made in reducing chronic food insecurity needs to be particularly highlighted, giving the country international distinction/recognition for having fulfilled the goal of reducing the proportion of people who suffer from hunger by half, a target set by the Heads of State and Governments during the World Food Summit in 1996.

Despite the progress, Mozambique is still facing enormous challenges for the coming years under the new Post 2015 Development Agenda and Sustainable Development Goals. Poverty levels in its different dimensions remain worrying; the chronic and moderate malnutrition levels are still high; maternal mortality rates are above the internationally acceptable levels; access to sanitation is still short of the desirable. These challenges should be faced and attacked in a sustainable way, while obeying the economic, social and environmental dimensions reflected in the new development paradigm, personalized in the Post 2015 Development Agenda and the 17 Objectives of Sustainable Development.

2. SUMMARY ON THE MDG SITUATION

ACHIEVED INDICATORS:

MDG 1: *Prevalence Rate of Underweight Children Under 5 years of age*

MDG 3: *Gender Parity Index*

MDG4: *Infant Mortality Rate and Child and Youth Mortality Rate*

INDICATORS WITH PROGRESS (Potential to achieve 2015 Target):

MDG2: *Net enrollment ration*

MDG3: *% of Seats held by Women in national parliament*

MDG4: *Proportion of 1 year-old children fully immunized*

MDG5: *Proportion of births attended by skilled health personnel*

MDG6: *Access to Antiretroviral treatment in children and adults*

MDG6: *Access to insecticide treated mosquito nets*

MDG7: *% of households with access to sources of safe drinking water*

INDICATORS OF CONCERN (Unlikely to achieve 2015 Target):

MDG1: *Chronic (height/age) and acute (weight/height) malnutrition*

MDG5: *Maternal Mortality rate*

MDG7: *% of households with access to improved sanitation*

3. BRIEF ANALYSIS OF MOZAMBIQUE'S SITUATION

The recent crises that the world has suffered, including the financial, fuel and food crises, and the continuous threats resulting from climate change effects, have also affected some countries outside the circle of the origin of these crises, including Developing Countries, as is the case of Mozambique. The country continued however to show economic growth and a relatively robust macroeconomic framework. The growth of the Gross Domestic Product in the last ten (10) years has hovered around an average of 7% to 8%, with inflation being contained at low levels (less than two digits). The state also reached an important milestone on its road to financial independence, when for the first time in Mozambique's recent history more than half of the State Budget was financed by the internal resources of the country.

Table 1: Macroeconomic indicators

Indicator	2008	2009	2010	2011	2012	2013	2014	2015*
Real growth of GDP (%)	6.8	6.4	7.1	7.4	7.1	7.4	7.4	6.5
Inflation (%)	10.3	3.3	12.7	10.4	2.1	4.2	2.3	5
GDP per capita (USD)	476.9	453.8	436.8	538.8	589.9	604.7	629.8	623.9

Source: INE; WEO 2015
**IMF estimates*

The achievement of the progress described above took place in the midst of the challenges imposed by, among others, the famine conditions that are still in force among Mozambicans, the relatively weak financial capacity of the State, the effects of floods and droughts that have been felt in the country at multiple times during the decade, and the effects of the HIV/AIDS epidemic. Despite these great challenges, Mozambique did not stop making significant progress in combating poverty and promoting development.

I. GOAL 1: ERADICATE ABSOLUTE POVERTY AND HUNGER

a. Reduce Absolute Poverty

Status and Trends

An update on the poverty situation in Mozambique will only be available in 2015, after the elaboration of the document of the 4th National Assessment of Poverty & Wellbeing in Mozambique, derived from the report of the ongoing 2014/2015 Household Survey. The poverty incidence is estimated at 54.7%[1] of the population in 2008/09 at national level. This is a reduction of poverty by 14.7 percentage points (pp) compared to the 1996/97 levels, when the incidence was estimated at 69.4%. In 2002/03, the poverty incidence rate was 54.1%, which means that there was no statistically significant change in poverty levels between 2002/03 and 2008/09.

b. Ensure employment

An update on the employment situation will also be provided by the Household Budget Survey which is expected to be completed still in 2015. According to administrative data from 2005 to 2009 the number of new jobs reached 924,168. In the period between 2010 and 2014, there was an annual increase both in terms of jobs created and in the volume of people trained at different (public and private) training centers in the country, reaching the cumulative level of about 1,350,000 jobs created and 500,000 people trained. Table 4 below numerically illustrates this trend.

1 *According to the 2013 Human Development Report, this estimate is also valid for the 2002-2012 period.*

Table 2: Summary of developments in employment and Training Activities

Employment	2010	2012	2013	2014
Jobs Created	**267,510**	**270,267**	**268,616**	**290,816**
Private Sector (of which)	152,891	178,127	234,697	137,442
Mining work (32,571) and Farms (28,765) in South Africa	61,336	n/d	33,919	n/d
Disctrict Development Fund and PERPU	29,520	64,649	n/d	45,814
Admissions in the Public Sector	17,320	10,606	n/d	n/d
Self-Employment and Support to Associations by INEFP	6,443	16,840	n/d	n/d
Traning Activities	**76,722**	**84,549**	**114,096**	**102,359**

Source: BdPES (2010-2014), MPD

Keeping up the current momentum of the economy's performance in terms of job creation and actions for job creation and promotion in general, the target of the Employment and Vocational Training Strategy, which is of 1,000,000 Employment and Vocational Training beneficiaries by 2015, has already been exceeded by more than 100% in terms of jobs created, and the target may be exceeded in terms of vocational training, with the development of the extractive industry sector, which is implementing various training and technical capacity building programs.

Another factor that could contribute to a significant excess of the target, would be the progressive improvement of the information gathering capacity on the labor market at District level, which in a way will increase the number of jobs registered by the Employment Services.

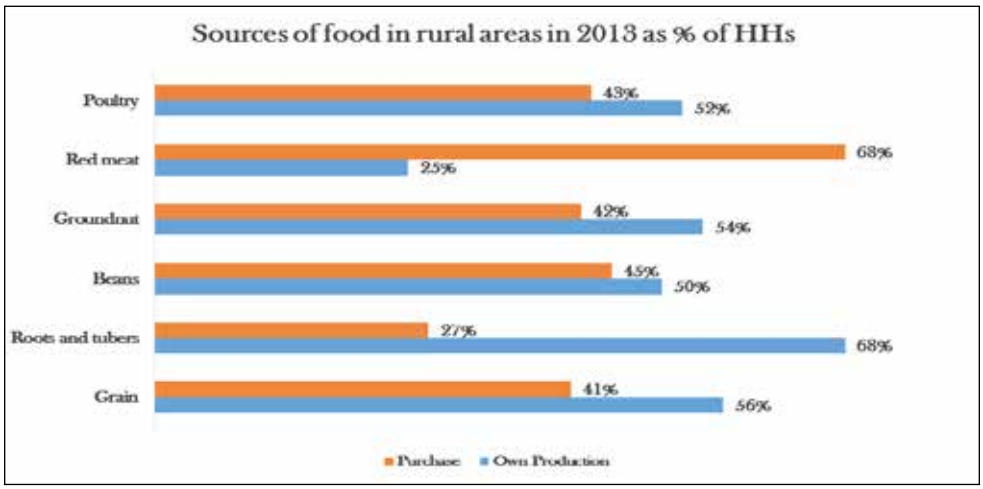
c. *Reduce Hunger*

In 2013, the Government, through SETSAN, conducted the second food and nutrition security baseline study, covering urban and rural areas. Compared to the first baseline study conducted in 2006, the second study indicates that there has been progress in the country in reducing chronic insecurity, which went from 35% to 24%. In the same period, chronic malnutrition in children under five years did not particularly improve, from 46% to 43%.-

The 2013 baseline survey data suggest that there was an increase in production per household, resulting in a reduction of the proportion of households with grain harvest lasting up to three months, from 41% to 33%. In the same period, there was an increase in the proportion of households with grain reserve from own production lasting at least ten months, from 14% to 32%.

In rural areas, own grain production plays an important role as a source of food for households. In 2013, most households (56%) consumed grain from its own production.

Figure 1: Sources of food in rural areas in 2013, as percentage of households



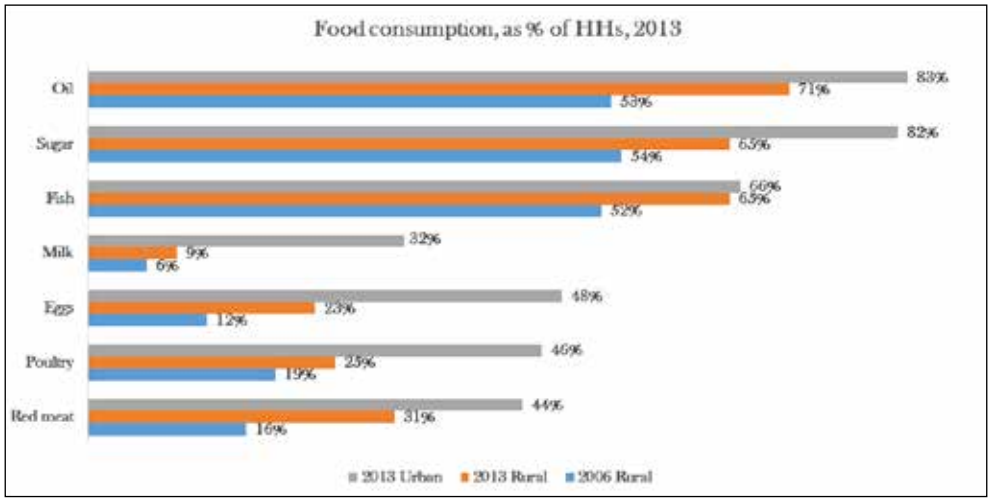
Source: SETSAN, 2014 Insan

d. Food consumption

The 2006 baseline study indicated that 50% of the households had an adequate diet. In 2013, this proportion rose to 67% nationally, 79% in urban areas and 61% in rural areas.

The improvement in proper diet consumption is associated with the consumption of foods rich in proteins, which showed substantial increases in the period of analysis.

Figure 2: Food consumption as a percentage of households



Source: SETSAN, 2014 Insan

Figure x shows that there was an increase in the proportion of households consuming animal protein between 2006 and 2013, which suggests that there has been an improvement in the access to food by the households, resulting from the increased availability of food and household income. Improved access is also a result of the improved functioning of markets, including facilities for circulation of goods and services from the production areas to the consumption centers.

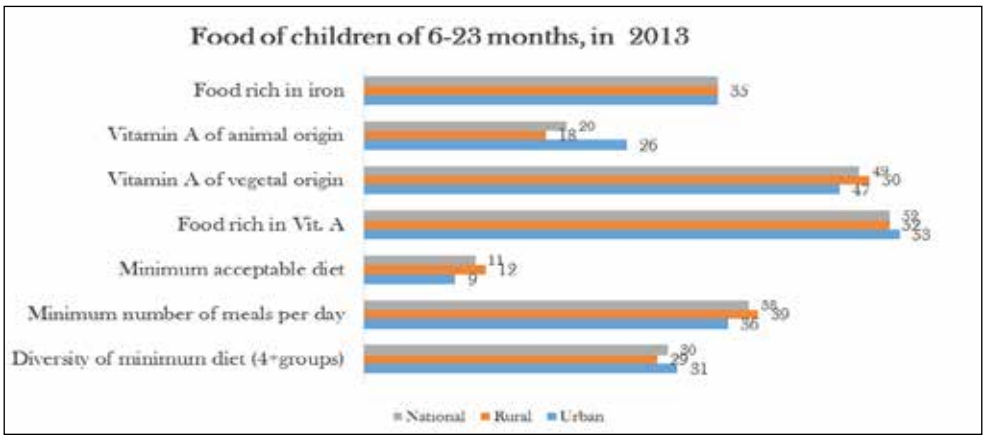
e. *Nutritional Status of Children*

The 2013 baseline survey indicates that 43% of children suffer from chronic malnutrition, 7% from acute malnutrition and 21% from current malnutrition. The nutritional status of children depends on the eating habits and their health status. The 2013 food and nutrition security baseline study gave special attention to food and occurrence of diseases in children under two years of age.

According to the 2011 DHS, 15% of under-five children are underweight for their age (general malnutrition). This value of general malnutrition (15%) is at an internationally acceptable level and surpassed the Millennium goal (17%), which implies that the millennium goal has been achieved. Children of 9-11 months are those with higher prevalence of low weight for their age (18%).

Table 4 data show that only 11% of children of 6-23 months in the country have an acceptable minimum diet, i.e. consumption of food of at least four groups simultaneously with the consumption of a minimum number of meals per day.

Figure 3: Food of children of 6-23 months in 2013, percentage of children



Source: SETSAN 2014

Compared to the 2011 DHS, the rate found in 2013 dropped slightly as it moved from 13% to 11%. These low rates do not always represent lack of food access for children, but lack of knowledge about optimal infant feeding practices.

Challenges for MDG 1:

- *Increased intervention in nutrition education, sanitation and individual and collective hygiene;*
- *Increase the capacity of the households to respond to seasonal variations in production, physical and economic access to adequate food;*
- *Accelerate the increase of food availability to remedy some hunger pockets cyclically affecting part of the country.*
- *Accelerate the national response to combat chronic malnutrition.*

II. GOAL 2: ACHIEVE UNIVERSAL EDUCATION

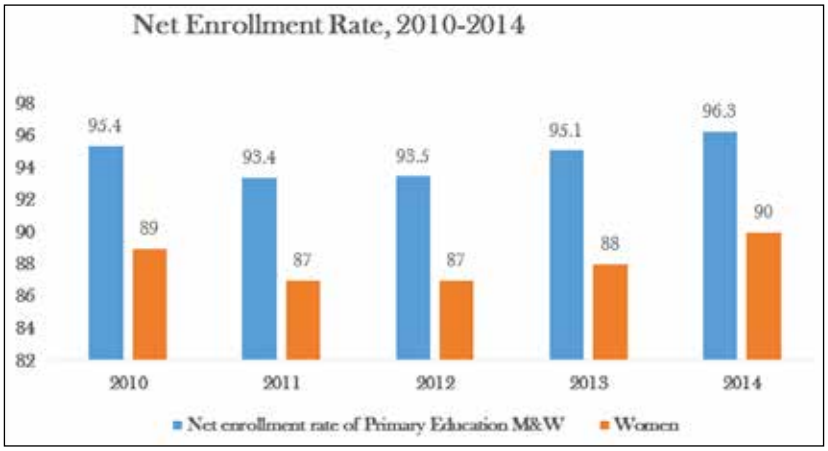
a. Access to Primary Education

Status and Trends

The net enrollment rate of Primary Education, which school attendance comprises students from 6 to 12 years, evolved about 3% between 2010 and 2014 with no significant variation between boys and girls. The lowest net rate in 2014 was found in Tete province at around 84.5%.

In absolute terms, Primary Education recorded an increase in the number of students of 6 to 12 years old, from 4,213,418 in 2010 to 4,767,782 in 2014, a phenomenon that contributes to the increase in net enrollment rate in 2014. The total number of primary school students, of all ages, is 5,705,343.

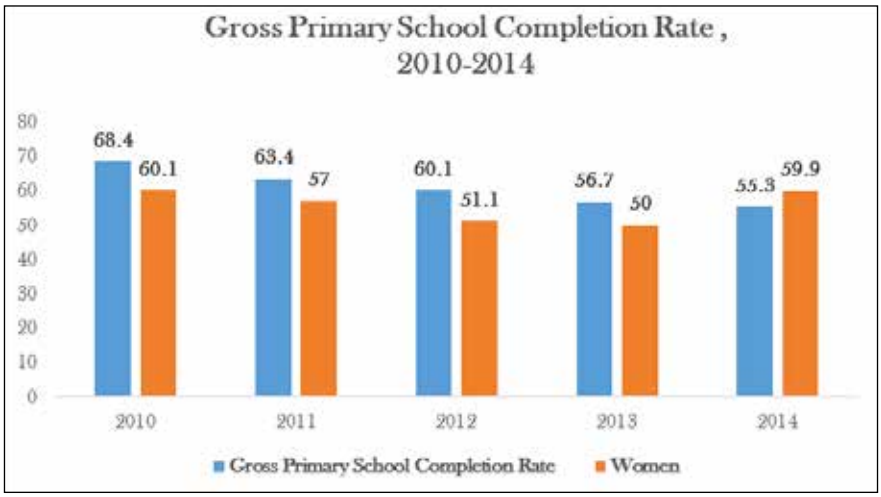
Figure 1: Net enrollment rate among children of 6-12 years, public and private, from 2010 to 2014



Source: MoE Statistics

The **gross completion rate in 7th grade** (last grade of primary school) is the ratio between the number of new entrants in this grade (of all ages) and the population of 12 years of age (official age to attend the 7th grade). This concept applies to the other levels of education, depending on their ages. Given that the number of new entrants is not disaggregated by age, it is not appropriate to present the behavior of the net completion rate.

Figure 2: Evolution of gross primary school completion rate (Grade 7), public and private, 2010-2014



Source: MoE Statistics

According to Figure 14, the gross Primary Education completion rate (7th grade) changed from 68.4% in 2010 to 55.3% in 2014 and girls show lower figures than boys throughout the period of analysis. This difference between boys and girls is influenced by the gender parity index, because as students progress to subsequent classes, the trend is of a reducing level of parity of girls compared to boys, due to the high dropout rate among girls.

For example, in 2014, the parity index in 1st grade is 0.94 while in 7th grade it is 0.87. In 2013, the percentage of dropout in 1st grade, among girls, was 5.8%, while in 7th grade it was 11.2%.

In general, the gross completion rate in 7th grade (EP) takes on a behavior of regression since 2010; the determining factor relates to the level of student flow between EP1 and EP2, i.e. graduates of the 5th grade are the source of students entering the 6th grade, and as the school performance of students in 5th grade is worrying due to the high rates of failure and dropouts, this reduces the student flow level for EP2.

In 2013 for example, the failure rate in 5th grade was 19.8% while the dropout rate was 13.9%, generating an accumulated loss in the order of 33.7%, a phenomenon that affects the number of graduates and, consequently, the student flow between the two levels of education. In absolute terms, the number of 7th grade students registered decreased from 452,119 in 2010 to 410,281 in 2014.

Another factor playing an important role in the flow of students is the full implementation of the new basic education curriculum, i.e. in some cases failure is no exception in the grades without exams (1st, 3rd, 4th and 6th grades).

Table 1: Evolution of gross primary school completion rate (Grade 7) by province, public and private

Year	Sex	NI	CD	NPL	ZB	Tt	MN	SF	IB	GZ	MP	MC	Average
2010	W	47.3	44.5	44.9	42.4	43.2	65.6	68.3	105.1	84.9	110.4	143.4	**63.0**
	MW	53.0	51.6	52.8	52.8	48.5	75.5	79.0	102.3	78.9	107.5	138.7	**68.4**
2014	W	38.0	38.0	39.4	37.3	37.2	54.2	55.6	77.3	68.6	97.1	106.5	**52.0**
	MW	42.4	42.1	44.6	44.8	41.3	60.9	62.0	73.8	64.0	92.6	101.4	**55.3**

Source: MoE Statistics

According to the table above, gross completion rate showed a significant regression in all provinces between 2010 and 2014 and shows significant disparities, as it includes an amplitude ranging from 41.3% (Tete province) to 101.4 % (Maputo City), figures for the 2014 academic year.

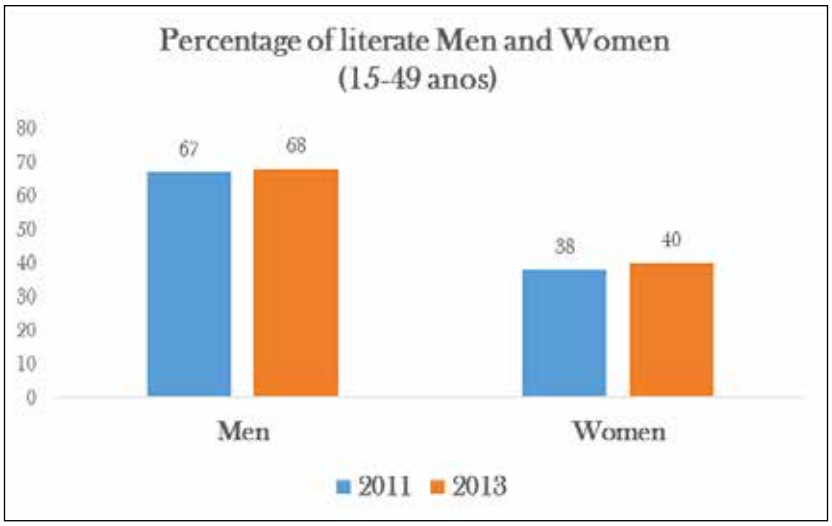
In this table, one can observe that there are 5 provinces below the national average, namely Cabo Delgado (42.1%), Nampula (44.6%), Niassa (42.4), Tete (41.3%) and Zambezia (44.8%), figures which reveal a worrying performance of the education system. In 2014, the extent of the gross completion rate fluctuates between 41.3% (Tete) and 101.4% (Maputo City). In these provinces, the completion rate for girls ranges from 37.2% to 39.4%, i.e. below the national average (52.0%).

In general, these data, the gross completion rates by province, with the exception of Maputo City, are worrying because they show that the education system is still far from achieving universal primary education, with highest incidence for those provinces that do not have half the population of 12 years of age finishing primary school in 2014.

b. Literacy rate of people aged 15-24.

The MDGs also measure the number of people aged 15-24 considered literate.

Figure 3: Percentage of literate men and women (15-49 years)



Source: DHS 2011

Generally, the percentage of people who are literate (can read and write) increased between 2011 and 2013. It is estimated that for 2014 the total number of people who benefit from Literacy and Adult Education (LAE) is close to 790,000 against the 670,000 registered in 2013, registering an increase of 17.7%.

The population in rural areas has a higher percentage of individuals who did not attend school. Among women in rural areas, 41% of them did not attend school, while in urban areas this proportion is 13%. Among men, these ratios are set at 18% and 4%, respectively.

Challenges for MDG 2:

- *Continued expansion of the school network and transformation of primary schools of EP1 into complete primary schools teaching from 1st to 7th grade;*
- *Ensure the basic conditions for effective teaching and learning process, including, equipment and school furniture;*
- *Eliminate classes without classrooms;*
- *Improve student-teacher ratios in EP1*
- *Improve school management and increasingly expand adult literacy programs in order to eradicate illiteracy.*

III. GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWERMENT OF WOMEN

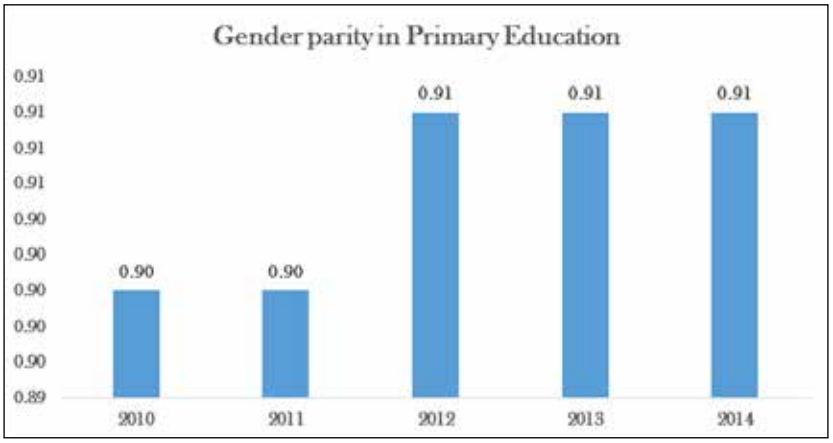
a. Girls' education

Status and Trends

As can be seen in Figure 19, gender equality in primary education (1st/ 7th grade), assessed by the parity index, recorded a slight increase between 2010 and 2014, rising from 0.90 to 0.91, and continues to show a higher frequency of boys than girls, especially in rural areas. It is important to note that the higher the grade attended, more girls are out of school than boys.

The gender parity index, among children attending primary school, is between 0.97 at 6 years of age and 0.95 at 9 years of age, i.e. there is a gender parity trend in the first schooling age. Therefore, it can be inferred that the older the children, there is a downward trend in the parity index of girls, which favors the increase of the rate of boys.

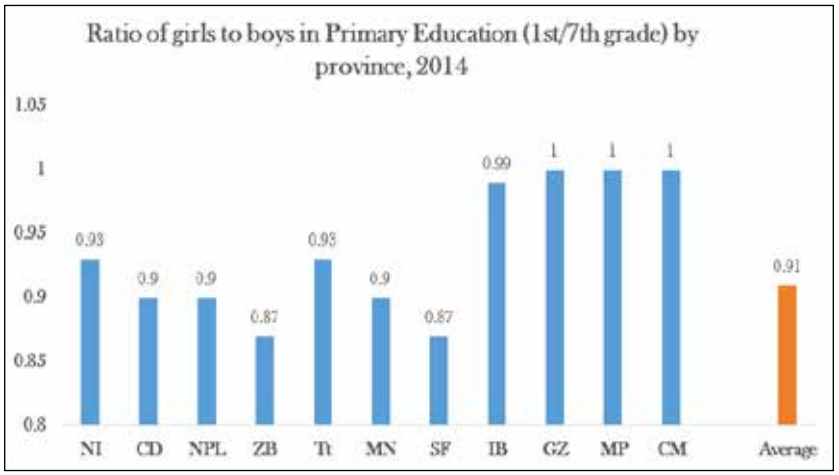
Figure 4: Ratio of girls to boys in primary education (1st / 7th grade)



Source: Sector Statistics MoE, 2014

According to the 2014 data, the gender parity index in primary education notes a regression of 0.94 at 10 years of age to 0.66 at 15 years of age. It should be noted that at 6 years of age, the same indicator is 0.97.

Figure 5: Ratio of girls to boys in primary education (1st/7th grade) by province, 2014



Source: Sector Statistics MoE, 2014

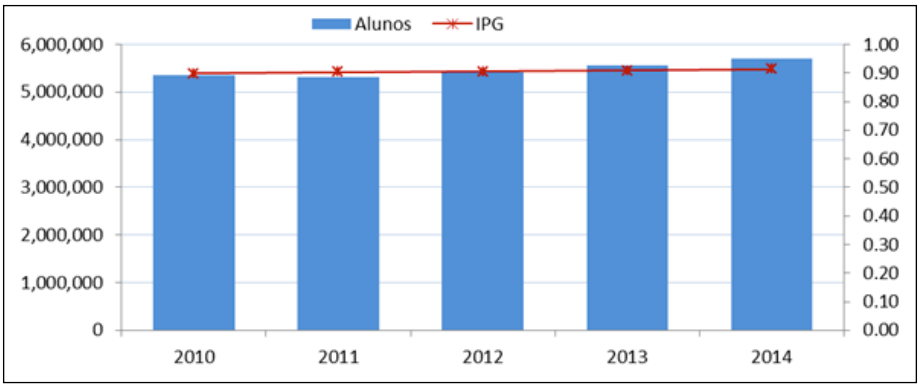
Figure x shows that the gender parity index in primary education ranges from 0.87 (Zambezia and Sofala provinces) to 1.0 (in all provinces of the southern region, including Maputo City).

Thus, it can be inferred that there are disparities in participation of girls in primary education; according to the figures calculated in Sofala and Tete and the remaining provinces, gender parity indices fluctuate between 0.90 and 0.93.

School access is determined, among other facilities, by the school network near the residence of the students, and in some regions, while the construction of new schools continues, some schools are still far from households which, in a way, influences the gender parity index.

Another important factor that underlies the difference of the gender parity index is the education level of the households, i.e. the literacy level of the parents, combined with economic factors and early marriage, contributes to the difference in school attendance rates between girls and boys.

Figure 6: Evolution of the number of students and ratio of girls to boys in primary education (1st/7th grade)



Source: Sector Statistics MoE, 2014

Primary education (1st/7th grade) registered a slight drop in the number of students between 2010 (5,354 million) and 2011 (5,313 million) while from then on to 2014, a systematic increase was recorded, with the number of students attending this level of education increasing from 5,313 million in 2011 to 5,700 million in 2014.

The increase in the number of students shows that access to education opportunities has improved over time, above all through the expansion of the school network and the recruitment of new teachers.

Gender parity, according to the ratio of girls to boys, as shown in figure 20, recorded a slight increase between 2010 and 2012, having stabilized since then around 0.91, a figure that is influenced by the provinces that are below average, namely Cabo Delgado, Manica, Nampula, Sofala and Tete.

In general, despite the growth in student numbers, the statistics illustrate that more efforts have to be made to improve gender parity, especially in the central and northern regions of the country.

b. Women's Participation in Governance

Mozambique has experienced remarkable progress in terms of women's participation in the organs of power and decision making and in Politics.

Besides being chaired by a woman, of the 250 existing members of Parliament, 100 are women, corresponding to 40% of seats held by women and 67% of women are heads of the parliamentary groups, therefore turning our Parliament into a reference for other countries in Africa and the world in general.

At the level of executive power, 28.6% of Ministers and 20% of Vice - Ministers in Mozambique are women. At local level, 36% of Provincial Governors are women, 45.4% of Provincial Permanent Secretaries and 41% of the members of the Provincial Government.

At district level, women represent 20% of the 128 existing District Administrators, 17.4% of Heads of Administrative Posts, 35.6% are members of the Provincial Assemblies and about 28.4% members of District Consultative Councils, which are bodies of governmental consultation that take decisions on projects to be implemented locally.

Progress is also registered on provincial governance, where the percentage of female Provincial Governors rose from 18.1% in 2009 to 36% in 2014, i.e. from 2 to 4 governors.

Table 2: Women's Participation in Governance

BODY	2009				2014			
	W	M	Total	%W	W	M	Total	%W
Permanent Secretary	2	15	17	11.7	9	16	25	36
Governor	2	9	11	18.1	4	7	11	36
Provincial Director	34	130	164	20,7	42	62	102	41
District Administrator	24	106	130	18,4	26	102	128	20
Heads of Administrative Posts	43	244	287	14,9	61	298	350	17,4
Members of District Consultative Councils	1425	3577	5002	28,4	1425	3577	5002	28,4
Mayor of the Municipalities	3	40	43	6,9	5	48	53	9
President of Parliament	–	1	1	100	1	–	1	100
Member of Parliament	96	154	250	38,4	100	150	250	40

Source: Sector Statistics MoE, 2014

Challenges of MDG3:

- *Improve school management, with a focus on the fulfillment of the educational programs, which requires improvement in controlling effectiveness of teachers and students.*
- *Ensure that children have opportunities to access education, and complete primary education;*
- *Adopt strategies that ensure that children obtain the necessary skills, according to the Basic Education curriculum;*
- *Ensure the implementation of all literacy methods to reduce the illiteracy rate, especially in rural areas;*

- *Improve the governance of the Education System at all levels, especially in educational institutions.*

- *Increase women's participation in decision-making bodies, especially at the local level, where the percentage of women's participation is still far from the target set in the SADC Protocol on Gender and Development of 50% by 2015.*

IV. GOAL 4: REDUCE CHILD MORTALITY

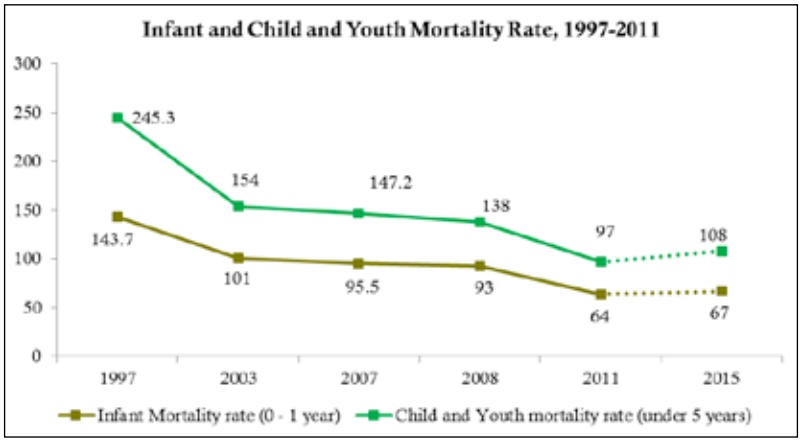
a. *Infant and Child and Youth Mortality Rate*

Status and Trends

The infant mortality rate (probability of dying during the first year of life, 0-11 months), measured in 1,000 live births was 64% in 2011. For 2015, the target set is 67 deaths per 1,000 live births. This means that the Millennium Goal has already been reached for this indicator.

The same can be said for the child and youth mortality rate (probability of dying before reaching five years of age), which was 97 deaths per 1,000 live births in 2011, against a millennium target of 108 per 1,000 live births. The Millennium Goal has been reached.

Figure 7: Infant and Child and Youth Mortality Rate, 1997 to 2011

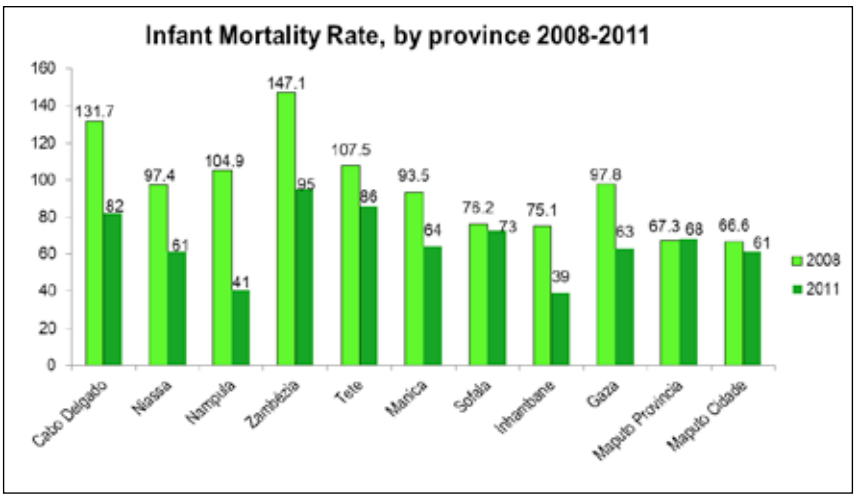


Source: DHS 2011

By geographic location, infant mortality levels showed marked decreases in almost all provinces except for Maputo province.

Inhambane and Nampula have the lowest mortality rates compared to other provinces. The extreme levels of infant mortality are between 39 per thousand live births in Inhambane and 95 per thousand live births in Zambezia Province. Other provinces with high infant mortality rates are Tete (86 per thousand live births) and Sofala (73 per thousand live births).

Figure 8: Infant Mortality Rate by Province

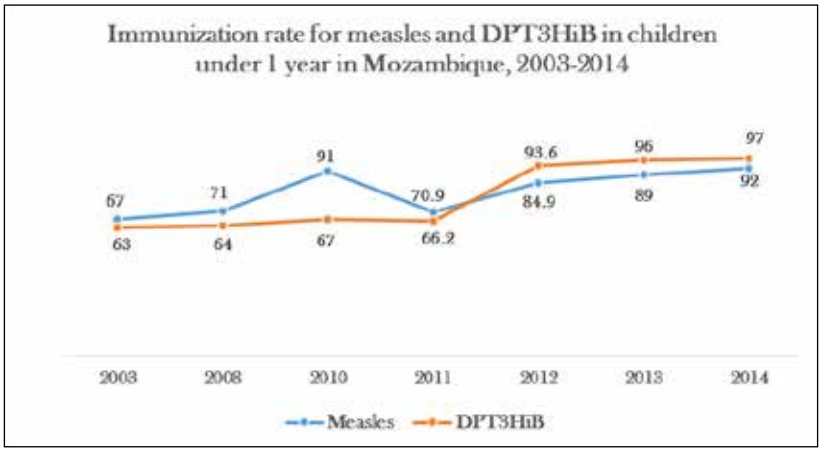


Source: DHS 2011

b. Immunizations

One of the interventions that most contributes to the reduction of child mortality is immunization. Immunization leads to decreased incidence of preventable diseases. The health sector data show progress in the immunization coverage against major preventable diseases of children under one year, as shown in Figure 9.

Figure 9: Immunization rate for measles and DPT3HiB in children under 1 year



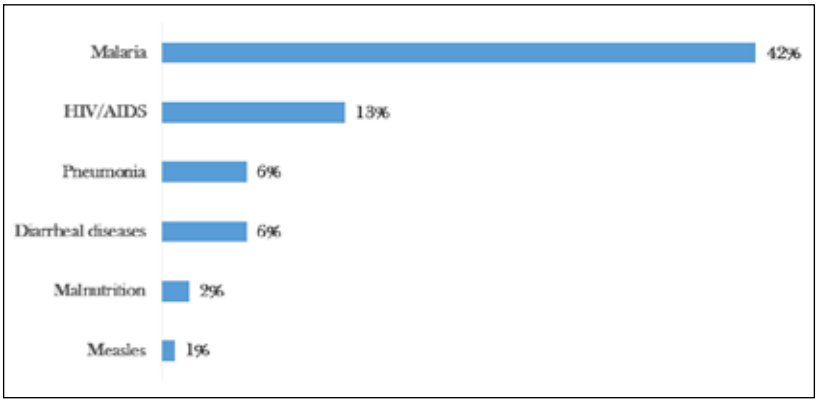
Source: DHS 2011

The percentage of fully immunized children is 75% in urban areas and 60% of children who received all vaccines in rural areas. The coverage rate decreases with the birth order and increases with the mother's education level.

Geographically, Maputo Province (88%), Maputo City (77%) and Niassa (77%) have the highest immunization coverage percentages, while Zambezia (47%), Tete (58%) and Cabo Delgado (59%) have the lowest. In total, 91% of children are protected with BCG and 75% are protected with three doses of DPT and three doses of polio.

The National Survey on Causes of Mortality in Mozambique shows that malaria is the leading cause of death in children under five years (42.3%), followed by AIDS (13.4%), pneumonia (6.4%) and diarrhea (5.9%).

Figure 10: Causes of Infant Mortality



Source: DHS 2011

About 32% of neonatal deaths take place in the first 24 hours after delivery, and 49% after the first 24 hours but before the seventh day after birth. These data show the consequences of poor maternal health, inadequate care during pregnancy, childbirth and the first few days after delivery and the urgent need to increase institutional deliveries coverage, essential care for newborns and coverage of consultation until the seventh day.

Challenges of MDG4:

- *Need to reinforce efforts to expand preventive measures against malaria such as intra-domiciliary spraying and distribution of mosquito nets, as well as to increase the percentage of cases treated with anti-malarial drugs within 24 hours of the onset of symptoms.*
- *Strengthening of preventive activities and activities to reduce mortality from severe acute malnutrition and chronic malnutrition.*
- *Promotion of actions aimed at improving the nutritional status of pregnant women and children;*
- *Strengthening the logistics system of the health sector for medicines and equipment as a key strategy for providing quality care to newborns and children.*

V. GOAL 5: IMPROVE MATERNAL HEALTH

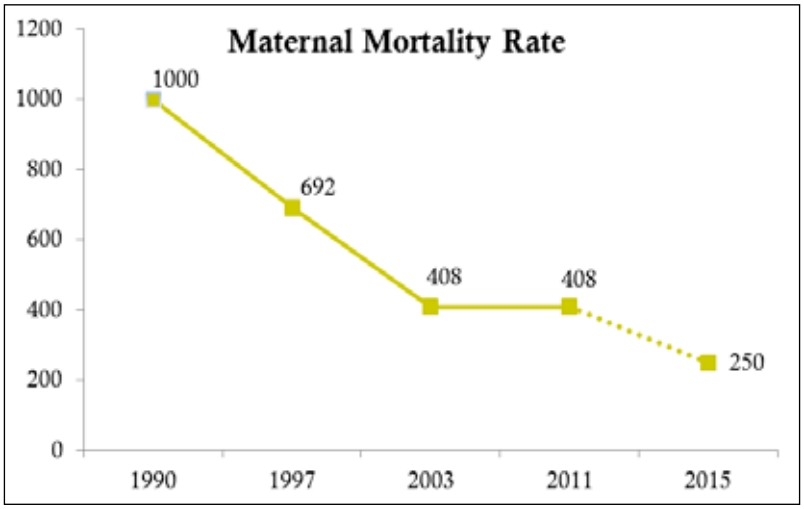
a. *Maternal Mortality*

Status and Trends

Current data show little progress in reducing maternal mortality and achieving universal access to sexual and reproductive health services. Although the maternal mortality ratio has decreased by 60 percent during the 1997-2003 period, progress has stagnated in the last decade, and the ratio remained at 408 deaths per 100,000 live births from 2003 to 2011(INE, 2013). Disaggregated data by province (Census 2007) reveal significant differences between provinces, with Cabo Delgado, Sofala, Nampula, Inhambane and Zambezia being the provinces with the highest number of maternal deaths per 100,000 live births. According to the mortality survey after the 2007 census, approximately 20% of maternal deaths occurred in girls who had not reached 20 years of age.

Although many factors contribute to the high maternal mortality ratio of Mozambique, the most significant factors are the limited use of modern contraceptive methods, coupled with the high unmet need for contraceptives and inadequate access to maternal health services, particularly institutional births attended by qualified staff and, when necessary, emergency obstetric and neonatal care (EONC).

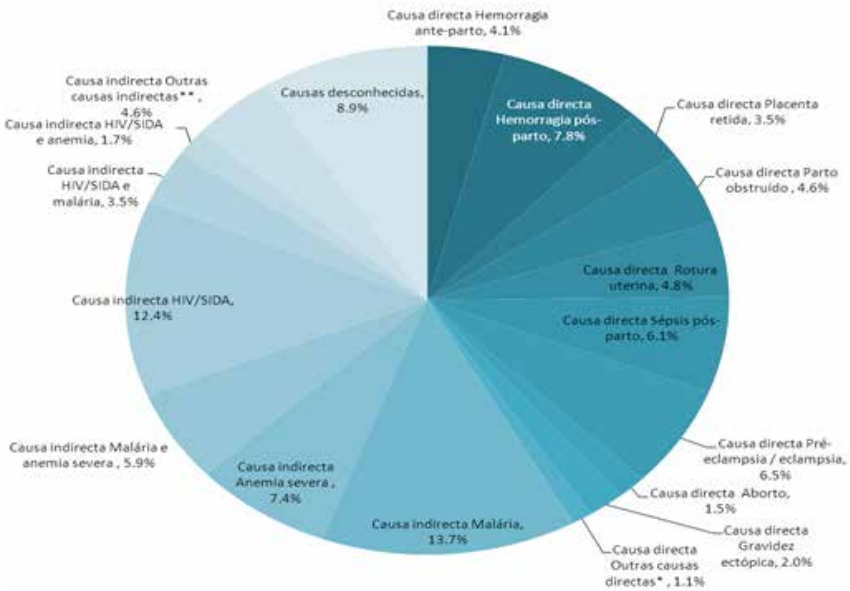
Figure 11: Maternal mortality rate in Mozambique 1990-2007.



Source: DHS 2011

According to the last national maternal and neonatal health needs assessment (2012), the indirect causes of maternal deaths were more important than the direct causes. The indirect causes to be highlighted are malaria, HIV and AIDS and anemia. Among the direct causes are postpartum hemorrhage, pre-eclampsia/eclampsia and postpartum sepsis.

Figure 12: Percentage of Maternal deaths and its causes in Mozambique



Source: DHS 2011

Of the 947 nationally surveyed health facilities (HFs), only 35 offer Basic EONC and 33 have been offering full EONC (Indicator 1). The remaining 879 HFs offer an incomplete package of vital functions, which are therefore not being considered as EONC.

According to WHO, UNICEF, UNFPA and AMDD standards (WHO, 2009), there should be at least 5 HFs with EONC for every 500,000 inhabitants, and at least one of these HFs should provide full care. As in 2012, Mozambique had a total population of 23,569,908, the standard of availability should be at least 236 HFs offering at least basic EONC (and if possible full) and at least 47 HFs with full EONC. Thus, in relation to the availability of (basic + full) EONC, the country only has 28.9% of the recommended minimum, but the availability of full EONC was higher, with 70% of the minimum recommended HFs providing the full set of vital functions. The provinces presenting major challenges to provide (basic + full) EONC are Nampula, Maputo province and Zambézia.

The coverage rate of institutional deliveries in HFs offering EONC at national level was only 19%. The provinces with the lowest percentages of institutional deliveries were Maputo Province and Zambezia with 5% and 10% respectively, followed by Nampula with only 12%. The highest percentages of institutional deliveries in the HFs with EONC were observed in the provinces of Sofala and Manica with 27%, with the highest being observed in Maputo City with 55%.

Regarding the met need for EONC, nationally 28% of women with obstetric complications were treated in all HFs, but the rate falls to 13% when considering only the HFs with basic and full EONC. This means that about 50% of women with complications are being treated in HFs without EONC conditions. The percentage of HFs with EONC availability is low because most of the HFs were not classified as they are not carrying out one or two of the vital functions.

According to this assessment and data limited to the months of August, September and October 2012, of the total of 9,357 women with direct complications, half (50%) were treated in health posts and centers and only 7% were treated in Central Hospitals.

The national cesarean sections rate, considering all the HFs, is 3%, below the 5% considered as minimum recommended by WHO, and at the HFs offering the EONC package, the proportion of births by cesarean section in Mozambique was 2.6%.

Considering all the HFs, the national mortality rate was 2.0% above the target set by WHO (less than 1%) and of 2.4% above the target in the HFs with availability of the EONC package. The province with the highest mortality rate for direct obstetric complications was Cabo Delgado with 5.3%, followed by Nampula with 4.9%. The provinces with mortality rate below 1% were Maputo City, Gaza and Inhambane.

Nationally, the intrapartum fetal and early neonatal mortality rate in all HFs was 7/1,000 and in the HFs with EONC, this rate was 15 per 1,000 births.

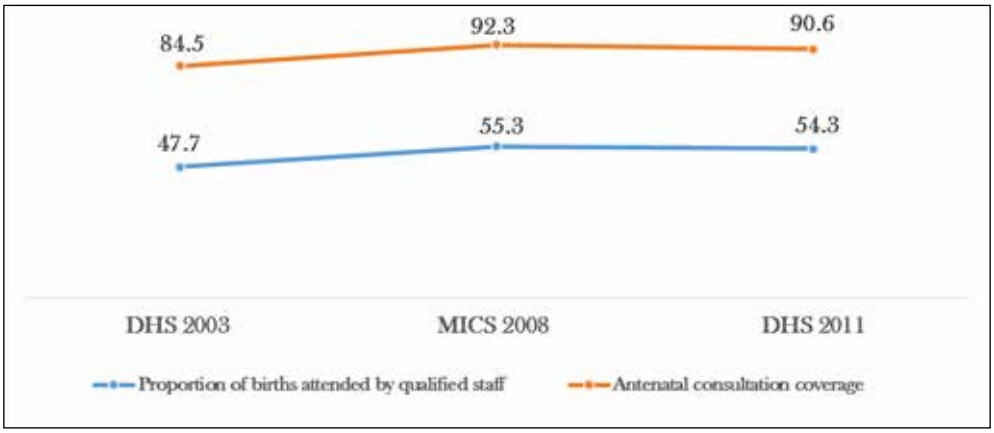
According to the evaluation at national level, the proportion of maternal deaths due to indirect causes in all HFs was 49% and in the HFs with EONC, the percentage was higher at 51%.

b. Coverage of births attended by skilled personnel and Ante-natal consultation coverage

The coverage of births attended by skilled personnel only shows progress since 2008 and is particularly low in rural areas (44.3% against 80.3% in urban areas), meaning that the country still faces challenges with the availability of human resources with the required skills for the provision of quality sexual and reproductive health services.

Antenatal consultation coverage (at least one visit) has increased significantly in recent years (84.5% in 2003 against 90.6% in 2011). However, coverage of at least four antenatal visits (recommendation of the World Health Organization) does not present progress in the last decade.

Figure 13: Percentage of births attended by trained health personnel and antenatal visit coverage (at least one consultation)



Source: DHS 2011

There are also marked differences by provinces, with Maputo City and Maputo Province having the highest coverage and Zambezia and Cabo Delgado presenting the worst.

Table 3: Coverage of Institutional Births by province, 2003-2011

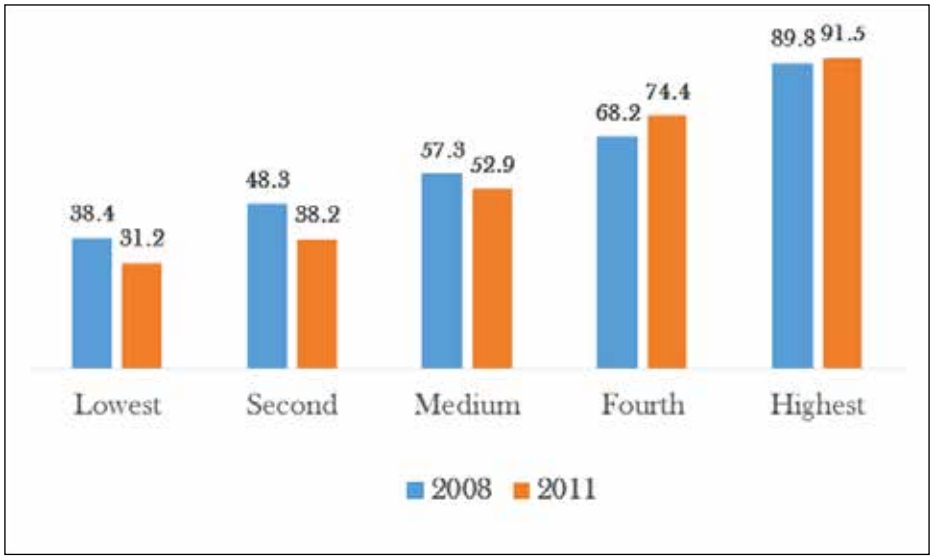
	National	Niassa	Cabo Delgado	Nampula	Zambézia	Tete	Manica	Sofala	Inhambane	Gaza	Maputo Prov	Maputo City
2003 DHS	47,6	46,0	29,6	36,8	32,7	47,4	56,0	51,6	49,8	63,2	85,4	90,1
2008 MICS	58,0	74,6	45,2	61,6	39,8	49,2	56,5	64,4	61,6	68,9	75,3	92,9
2011 DHS	54,8	61,4	36,2	53,3	27,8	50,7	75,3	73,4	57,7	70,7	88,3	91,8

Source: DHS 2003 and 2011, MICS 2008

The proportion of births that took place in health facilities also varies with the socio-

economic characteristics of the women. By wealth quintiles, the percentage of births taking place in the health facilities of the highest quintile of women is almost three times more than those in the lowest quintile.

Figure 14: Institutional delivery coverage by wealth quintile



Source: DHS 2011

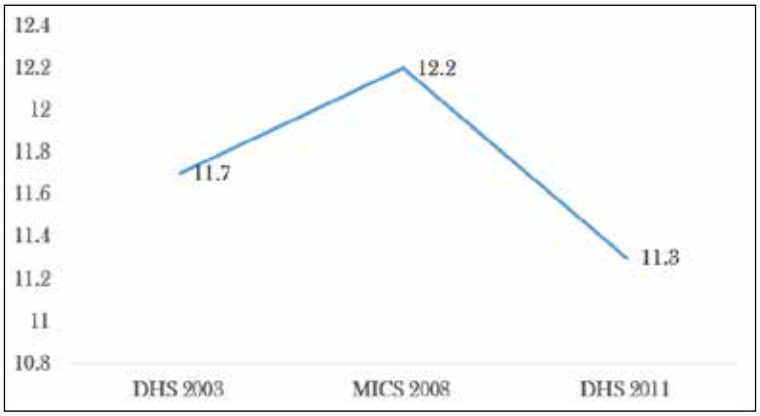
c. *Family Planning*

In Mozambique, the contraceptive prevalence rate is still very low, and has not been improving much over the last few years. The contraceptive prevalence rate for modern methods among married women/women in marital union in 2011 was 11.3%, and compared to the countries of Southern Africa, the level of contraceptive use in Mozambique is still one of the lowest in the region. The unmet need for family planning remains high at 28.5%. In other words, about 3 in 10 women do want to use some method of family planning, but don't.

In 2011, among women using modern contraceptive methods, the methods mostly mentioned were the injectable ones, followed by oral contraceptives. There is a very low use of long-acting family planning methods and only 1.1% mentioned the use of condoms as a contraceptive method.

Figure 15: Prevalence of use of methods and types of contraceptives for

married women and women in marital union aged 15-49 in Mozambique

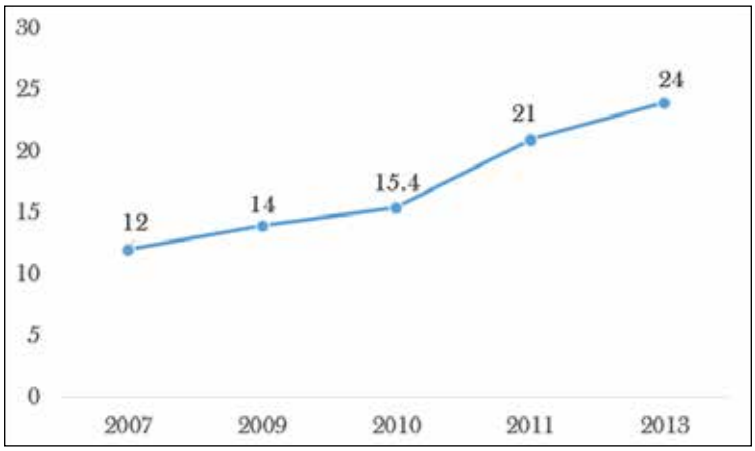


Source: DHS 2003, 2011 and 2008 MICS

There are major differences in the prevalence of contraceptive use by residence area, province and other socio-demographic characteristics. For example, the use of modern family planning methods is three times higher in urban areas than in rural areas. Much of the advantage shown by urban areas is due to the role of Maputo Province and City, whose percentages are very high compared to provinces such as Cabo Delgado and Zambezia. In socio-economic terms, the prevalence of modern contraceptive use among women in the highest wealth quintile is ten times higher than in women of the lowest quintile.

Coverage of new family planning users has increased substantially in recent years. In other words, the capacity of the National Health System to "attract" women to start family planning has grown tremendously. However, the continued use of family planning methods remains a challenge.

Figure 16: Coverage of new Family Planning Users

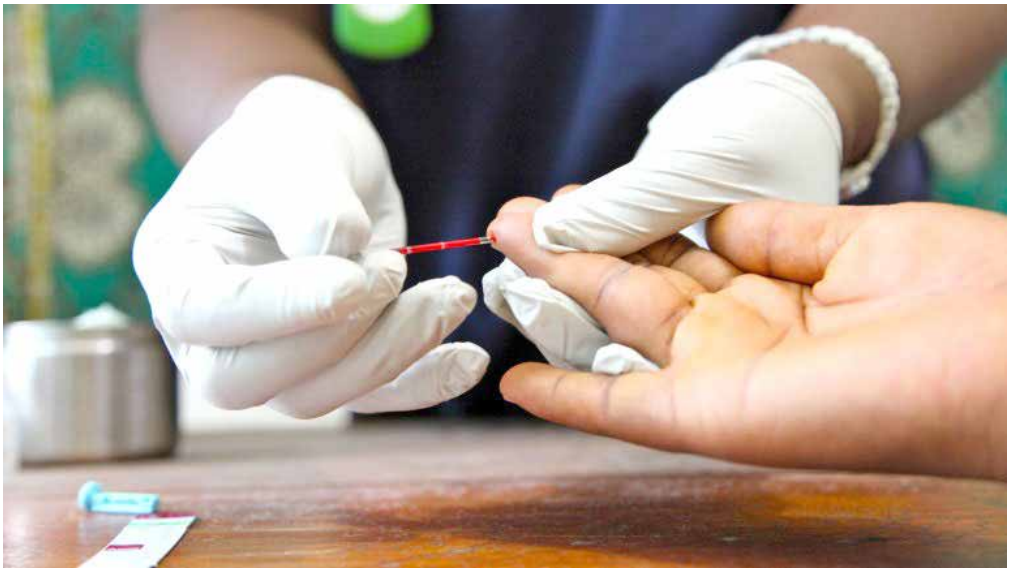


Source: Sector Statistics MoH

Challenges of MDG5:

- *More equitable distribution of existing qualified human resources and provision of quality services.*
- *Invest massively in the initial training of specific professionals in the area of Maternal Health, and their availability at District level (Maternal and Child Health Nurses, Surgery Technicians and Doctors);*
- *Continued training in and expansion of Emergency Obstetric Care and Essential Obstetric Care;*

VI. GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

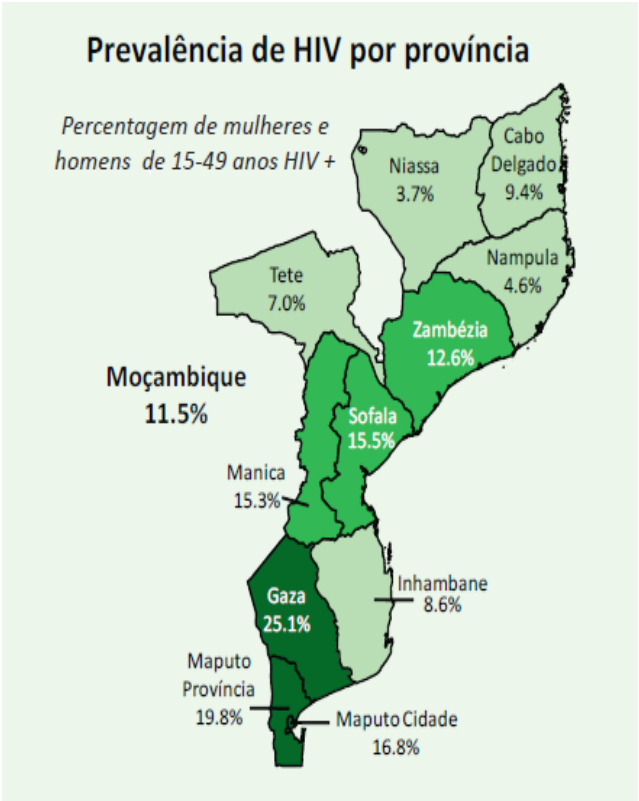


a. Combat HIV and AIDS

Status and Trends

HIV/AIDS is one of the major threats to development in Mozambique. HIV prevalence among young people and adults (15-49 years old), estimated from blood tests collected during the "National Survey on Prevalence, Behavioral Risks and Information on HIV/AIDS in Mozambique – INSIDA 2009" and from calibrations to results of years prior to the survey made based on the results of INSIDA 2009, indicate that HIV prevalence among adult Mozambicans aged 15-49 is 11.5%. The prevalence among women is higher than the prevalence among men (13.1 and 9.2%). It should be noted that the risk of HIV infection among adults aged 15-49 is higher among urban residents (15.9%) compared to residents of rural areas (9.2%).

Figure 17: HIV/AIDS Prevalence rate among adults 15-49 years of age in Mozambique

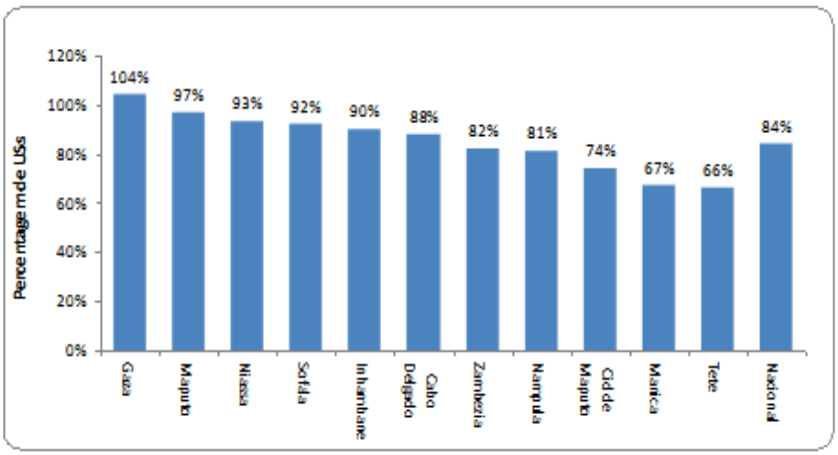


Source: INSIDA 2009

The results of INSIDA indicate that 11.5% of adult Mozambicans aged 15-49 are infected with HIV. Figure 50 shows that there are more infected women (13.1%) compared to men (9.2%). Urban residents aged 15-49 have a higher HIV infection prevalence rate (15.9%) compared to residents in rural areas (9.2%). This applies to both sexes: the prevalence among women in urban areas is 18.4% compared to 10.7% in rural areas, and the prevalence among men in urban areas is 12.8% compared to 7.2% in rural areas.

The number of HFs that offer PMTCT services exceeded the target set for 2013 (1063), confirming its consistent upward trend of the last six years. As per the reported data, the indicator already fulfilled the target set for the five-year period 2010/2014 of 1063. Option B+ was implemented in 534 of the 496 foreseen health facilities, corresponding to a degree of compliance of the target of 108%.

Figure 18: Percentage of health facilities administering PMTCT, by province, 2013



Source: Sector Statistics MoH

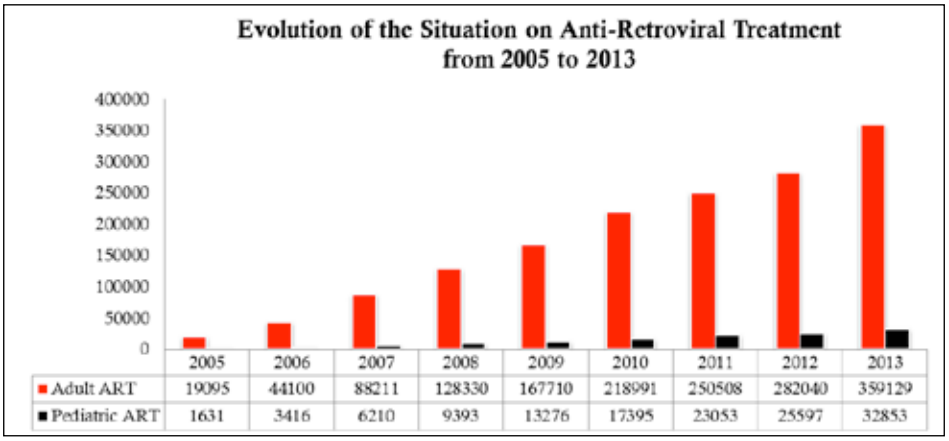
Among the main drivers of the epidemic, the following can be highlighted: (i) multiple and concurrent sexual partners; (ii) low levels of condom use; (iii) high mobility and migration associated with high vulnerability; (iv) engaging in sexual relations between people of different generations; (v) transactional relationships; (vi) gender inequality; (vii) sexual violence; and (viii) low levels of male circumcision.

Over the past few years there has been progress in the field of prevention, care and treatment. Various actions have been developed in these areas, and in order to increase efforts to eliminate this disease, Mozambique has adopted several global strategies with emphasis on the Political Declaration on HIV and AIDS of the General Assembly of the United Nations of 2011, which is a political document concentrating 10 updated fundamental goals for the implementation of the response by the signatory countries.

b. Proportion of population with HIV infection at an advanced stage with access to antiretroviral drugs

Considerable progress is registered in the access to ART. Access to Pediatric ART shows an increase in the ability to provide care, from 1,631 children in 2004 to 32,853 children currently under treatment in the country. Adult ART also increased, from 19,095 adults in 2005 to 359,129 in 2013.

Figure 19: Antiretroviral Treatment in Adults and Children

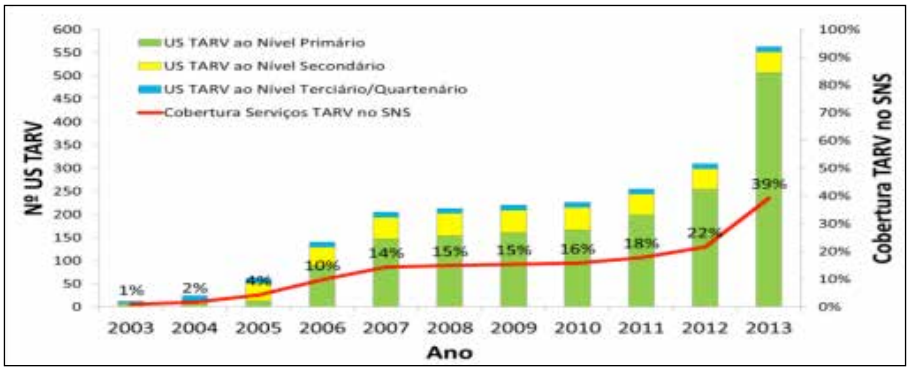


	2005	2006	2007	2008	2009	2010	2011	2012	2013
Adult ART	19095	44100	88211	128330	167710	218991	250508	282040	359129
Pediatric ART	1631	3416	6210	9393	13276	17395	23053	25597	32853

Source: Sector Statistics, MoH

The number of Health Facilities administering Prevention of Vertical Transmission increased from 96 in 2005 to 1,223 in 2013. As a result, the number of children and pregnant women benefiting from prevention increased from 13,129 in 2004 to 58,351 in 2013.

Figure 20: Evolution of the number of HFs providing HAART (2003-2013)



Source: Sector Statistics MoH

Challenges in the Fight Against HIV/AIDS:

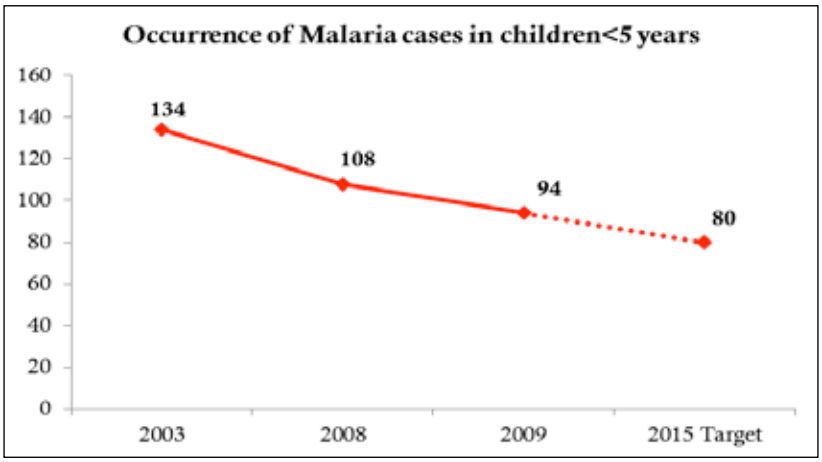
- *Popularize the consistent use of male and female condoms;*
- *Develop specific communication strategies for social and behavioral change;*
- *Popularize the Prevention of vertical transmission;*
- *Strengthen the links between the services to reduce dropouts and missed opportunities. Continue with the expansion of quality Adult and Pediatric ART.*

c. Malaria

Malaria remains a major public health problem in Mozambique. Although there has been a decrease in the malaria fatality rate in recent years, this disease is still one of the major causes of morbidity and mortality.

The performance of the Malaria program is measured by three indicators related to the prevention and/or intermittent preventive treatment with sulfadoxine pyrimethamine, coverage of intra-domiciliary spraying and access to long term insecticide-treated nets in antenatal clinics.

Figure 21: Occurrence of Malaria cases in children under 5, per 10,000 children



Source: MICS 2008

Across the country, 19% of households did undergo intra-domiciliary spraying (IDS) during the 12 months preceding the survey (DHS 2011). The percentage of households whose homes were sprayed is 30% in urban areas and 13% in rural areas.

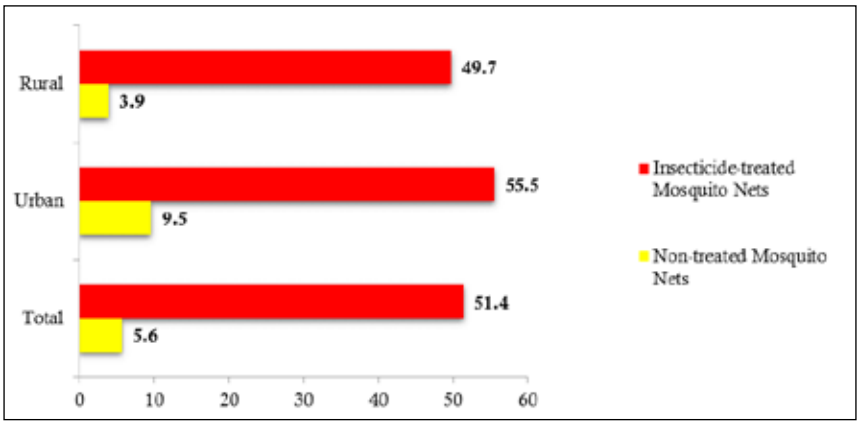
In terms of provinces, Gaza, Maputo City and Zambezia made greater use of IDS (38%, 28% and 26% respectively), while the use of this service was minimal in the provinces of Inhambane and Nampula (8% and 6 %, respectively).

d. Proportion of children under 5 sleeping under treated mosquito nets

About 37% of the population has access to an ITN (insecticide-treated Mosquito Net). The proportion of people with access to an ITN is 43% among households of two people, but only 29% in aggregate of eight or more members.

The socio-economic differences in respect of access to ITNs are illustrated in Figure 21. It should be noted that although there are differences between households according to the place of residence or socio-economic characteristics, these differences are relatively small. This may have been influenced by programs of free distribution and subsidization of mosquito nets in order to reduce its sale price.

Figure 22: Possession of Mosquito Nets in Households



Source: DHS 2011

In total, 44% of the population has some protection against malaria, either by sleeping under an ITN, or by sleeping in a house that was subject to intra-domiciliary spraying in the previous 12 months. In relation to this variable, we observe significant differences according to the household characteristics. Thus, 56% of the population in households in urban areas have some protection against malaria, compared to 38% of the population in rural areas

According to geographical location, it is observed that the highest protection can be seen in Cabo Delgado, with 52% of the population having some protection, in contrast to 28% in Inhambane.

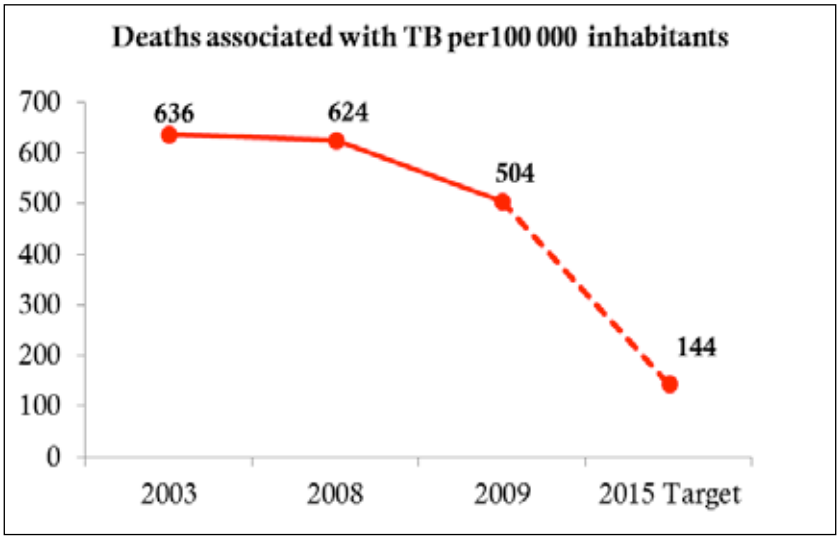
Challenges in Combating Malaria:

- *Implementation of Intra-domiciliary Spraying campaigns in 59 districts not yet covered, covering 90% of the sprayed houses;*
- *Conduct universal mosquito net distribution campaigns in districts not yet covered by PIDOM;*

e. *Prevalence and fatality rates associated with tuberculosis*

Another serious public health problem in Mozambique is tuberculosis. The target with respect to this disease is to lower the prevalence from 298 to 149 cases per 100,000 inhabitants by the end of 2015, and to reduce mortality from 36 to 18 deaths per 100,000 inhabitants.

Figure 22: Deaths associated with tuberculosis (TB)



Source: MICS 2008

The target for the cure rate by DOTS treatment was achieved. According to the NTP data 16,608 patients were cured, corresponding to a cure rate of 85%.

This is an indicator that has remained stable over the past two years. It should be noted that the performance of this program component was facilitated by the active search for patients with cough carried out by activists, and the expansion in Community DOTS coverage facilitated by the existence of organizations working within the Community DOTS component, which has made it possible to reach more districts implementing the Community DOTS activities every year.

Challenges in Combating Tuberculosis:

- *Increase the BK+ (smear positive) detection rate to 75%; Increase the detection rate of all forms of tuberculosis cases from 45% in 2013 to 55% in 2014;*
- *Increase the proportion of co - infected patients (TB/HIV) benefiting from antiretroviral treatment; Create the National Partnership to combat tuberculosis; Continue to expand access to ART for Adults and Children.*

VII. GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

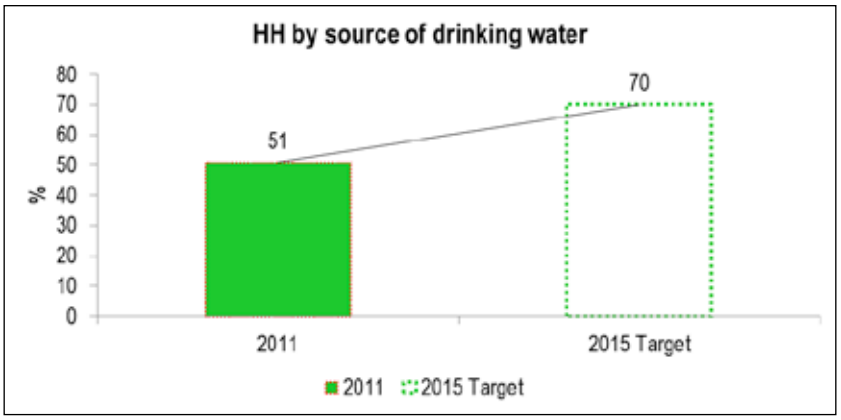
a. Access to clean water

Status and Trends

The percentage of population using safe sources of drinking water reached 52.5% in 2011, including running water inside and outside the home, protected boreholes, wells with hand pump and bottled water. The Millennium target is 70%.

In urban areas the percentage covers 84.6%, while in rural areas only 37.8% of the population uses safe sources of drinking water. In the latter area, the main sources of water are unprotected wells (42%), and water surface, such as rivers and lakes.

Figure 23: Access to drinking water sources



Source: DHS 2011

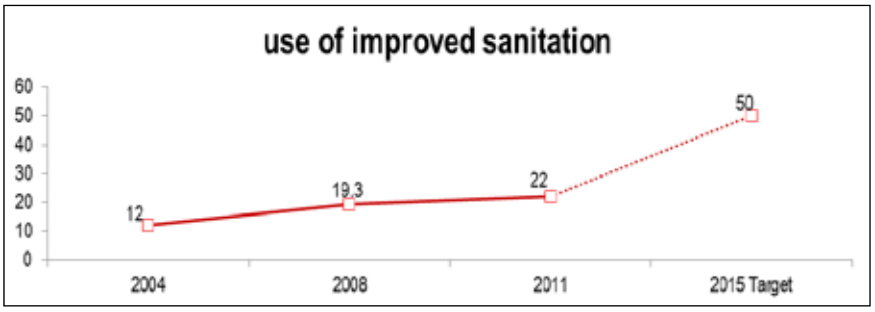
All Southern provinces, including Manica and Sofala, have percentages of reliable sources of drinking water above 60%, while the Northern provinces, including Zambezia and Tete, have percentages of reliable drinking water sources below 50%.

At national level, about 15% of households have water nearby the house, 43% take water less than 30 minutes away and 39% walk more than 30 minutes to get drinking water.

In rural areas, only 5% of households have water nearby, 43% at less than 30 minutes away and 49% at more than 30 minutes away. In urban areas, 38% of households draws water nearby and 42% within 30 minutes. By provinces, only Maputo City is presenting most of households with access to water nearby, followed by Maputo Province. In the other provinces, households have to walk 30 or more minutes to get drinking water.

Regarding sanitary access, only 23.8% of the population use a bathroom/improved non-shared latrine, with higher percentage in urban areas (47.8%) compared to rural areas (12.8%). The millennium goal of the country is to cover 50% of its population in terms of improved sanitation.

Figure 24: Use of improved sanitation



Source: DHS 2011

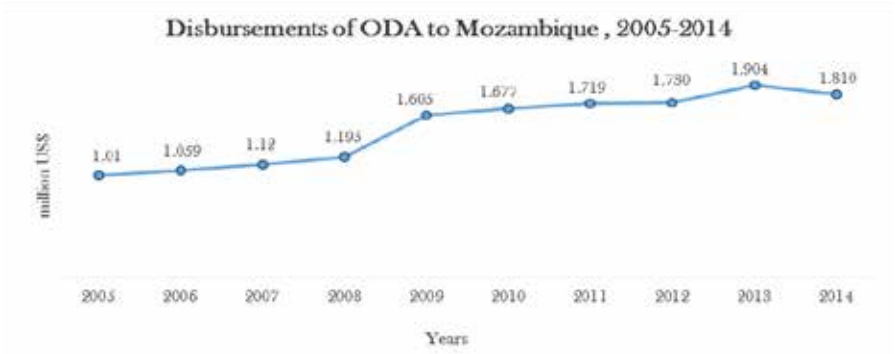
Among the provinces, Maputo City is the one with the highest percentage of households using improved sanitation facilities used only by the household; while in Cabo Delgado and Zambezia provinces, over 90% of the households do not use improved sanitation.

VIII. GOAL 8: CREATE A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Status and Trends

Mozambique remains a country receiving Foreign Development Assistance. The total volume of Official Development Assistance (ODA) registered a slight contraction of 4.9%, down from 1,904 million US$ in 2013 to 1,810 million US$ in 2014, a change that also reflects a global trend of reduction in ODA flows in recent years, derived from an unfavorable international situation, especially for the advanced economies.

Figure 25: Disbursements of Official Development Assistance to Mozambique



Source: MEF, 2015

The 4.9% reduction in aid may be largely due to the following factors:

i. *Non-disbursement of DPOs of the World Bank for Agriculture and Climate Change (US$ 50 million each[2]);*

ii. *Sharp drop in US disbursements with the closure of the Millennium Challenge Account Project[3], and*

iii. *Non- disbursement of a significant portion of commitments to the Common Funds.*

The channeling of ODA (by receiving entities) continues to predominantly favor the Government at the expense of non-governmental entities.

Table 4. Disaggregated profile of Government aid in 2014

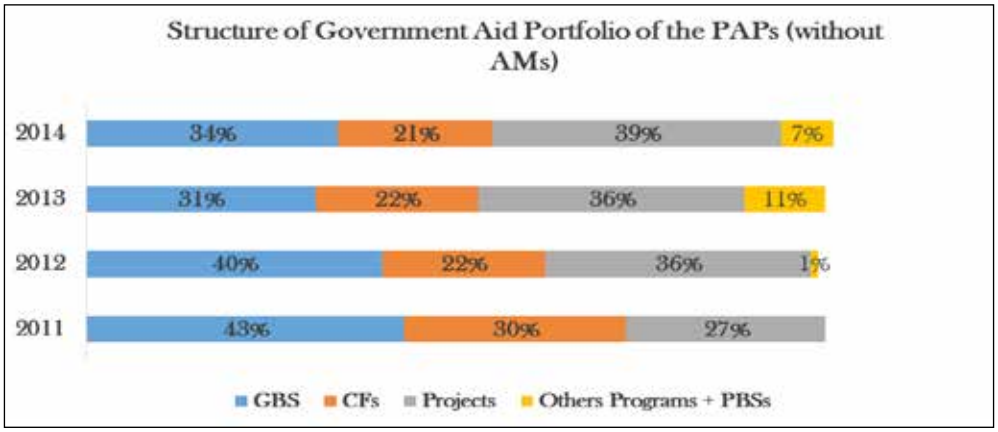
	PAPs	%	Total (PAPs + AMs)	%
Government Aid				
General Budget Support (GBS)	388,645,369	34%	388,645,369	24%
Sectoral programs (CFs)	237,756,152	21%	255,377,763	16%
Other Programs	73,233,190	6%	207,375,009	13%
Programmatic ODA	699,634,711	61%	851,398,140	52%
Projects	449,466,752	39%	779,474,881	48%
Provincial Budget Support	5,393,354	0.5%	6,282,982	0.4%
Total ODA to the Government	1,154,494,816	88%	1,637,156,003	90%
Non-Government Aid				
Support to Municipalities	8,969,235	9%	8,969,235	5%
Private Sector Support	27,839,069	18%	33,257,992	19%
National NGOs	29,076,834	18%	31,549,692	18%
International NGOs	66,806,704	41%	75,879,306	44%
Others	23,323,099	14%	23,607,307	14%
Non-Gov.ODA	156,014,941	12%	173,263,533	10%
Aggregated Total	1,310,509,757	100%	1,810,419,536	100%

Source: MEF, 2015

With regard to **Program Aid**, the structure of the portfolio of Government aid in the last five years was characterized by a gradual corrosion of the proportion of program aid (General Budget Support + Common Funds), which however, is interrupted in 2014. On the one hand the proportion of aid in the form of Projects continued to increase, on the other, the proportion of Program Aid rose from 53% in 2013 to 55% in 2014, driven by the increase in General Budget Support.

2 *The disbursements for these DPOs reinitiate in 2015. However, the recent lowering of the risk of over-indebtedness (debt distress) for Mozambique from low to moderate in DSA 2014 will mean a reduction of about 10% of the concessional loan disbursements level of the World Bank the next three years.*

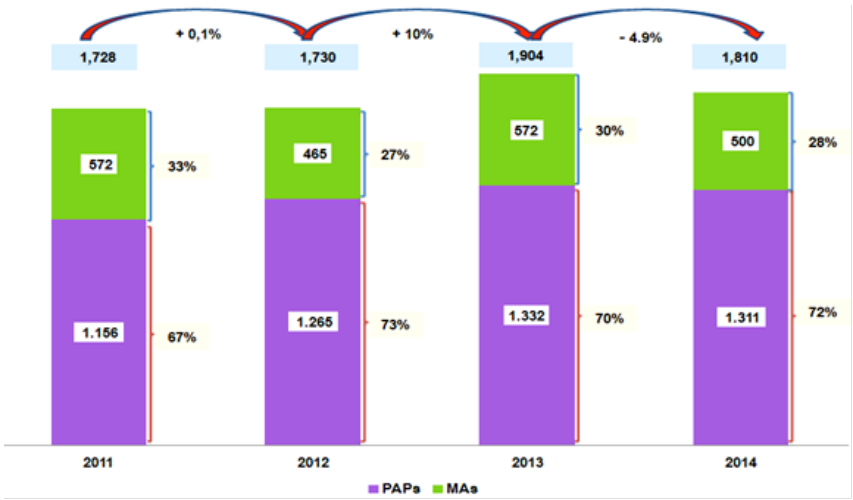
3 *According to the BER 2014, the volume of expenditure executed in the MCA fell by 97.6% as a result of being in the final stage of the works related to the project.*



Source: MEF, 2015

From the perspective of the contribution of the Program Aid Partners (PAP's) and the Associate Members (AM's) as part of the total Official Development Assistance to the Country in 2014, it is noted that the total weight of the AM's dropped from 30% in 2013 to 28% in 2014, driven by the significant reduction in the volume of Aid disbursed by the US. Meanwhile, the total weight of aid disbursed by the PAP's registered a positive variation of 2%, rising from 1.2 million USD in 2013 to 1.3 million USD in 2014.

Figure: Share of PAPs and AMs in total ODA (in millions of US $ and %)



Source: MEF, 2015

In table x we could observe the behavior of each Partner from the perspective of the total amount disbursed in million USD between 2013 and 2014. Even with the reduction of disbursements by the World Bank, the Partner with the greatest weight of the PAP's, the increase in aid volume made by DFID (23%), France (128%), Germany (28%) and Norway (36%) allowed for a 2% increase in the total volume of Aid disbursed by the PAPs, as shown in the table below.

Table X: Total ODA to the Country in 2013 and 2014 (in US$)

PAP	Total volume Disbursed in 2013	Relative weight of the Donor in 2013	Total volume Disbursed in 2014	Relative weight of the Donor in 2014	! nominal Absolute 2013 - 2014	! Percentage 2013 - 2014
World Bank	375,890,821	20%	363,998,326	*20%*	-11,892,495	-3%
DFID	109,832,715	6%	135,124,550	*7%*	25,291,835	23%
European Union	106,157,508	6%	121,748,250	*7%*	15,590,741	15%
Sweden	127,186,122	7%	108, 794.503	*6%*	-18,391,619	-14%
ADB	53,899,652	3%	81,267,273	*4%*	27,367,621	51%
France	35,461,292	2%	80,753,714	*4%*	45,292,421	128%
Germany	62,177,916	3%	79,368,529	*4%*	17,190,613	28%
Canada	91,232,713	5%	64,112,664	*4%*	-27,120,049	-29.7%
Portugal	64,536,331	3%	50,741,861	*3%*	-13,707,803	-21%
Norway	37,122,392	2%	50,400,379	*3%*	13,277,987	36%
Ireland	49,814,910	3%	48,932,968	*3%*	-881,942	-2%
Denmark	48,874,609	3%	42,240,193	*2%*	-6,634,415	-14%
Switzerland	33,724,956	2%	34,296,716	*2%*	571,760	1.7%
Finland	32,149,761	2%	21,948,000	*1%*	-10,201,761	-32%
Italy	19,579,017	1%	21,058,601	*1%*	1,479,584	8%
Austria	4,664,233	0.2%	5,723,231	*0.3%*	1,058,998	23%
Total G16	**1,252,304,948**	**66%**	**1,310,509,757**	**72%**	**58,204,809**	*4.6%*
U.S	507,364,000	27%	364,664,500	20%	-142,699,500	-28%
United Nations	65,093,899	3%	76,433,781	4%	11,339,882	17%
Netherlands	55,423,246	3%	41,814,978	*2%*	-13,608,268	-25%
Belgium	10,817,374	1%	10,464,257	*1%*	-353,117	-3%
Spain	13,457,113	1%	6,532,262	*0.4%*	-6,924,851	-51%
Total MAs	**652,155,632**	**34%**	**499,909,778**	**28%**	**-152,245,854**	*-23%*
Total G16 + MA	**1,904,460,580**	**100%**	**1,810,419,536**	**100%**	**-94,041,045**	**-4.9%**

Source: MEF, 2015

In terms of total expenditure of the State Budget, the table below shows that on average 60% of expenditure in the last five years is allocated to the priority sectors, which shows the commitment of the Government to streamline the focus areas for poverty reduction.

Total Expenditures of the State Budget in the Priority Areas

	2010	2011	2012	2013	2014
	CGE	CGE	CGE	CGE	LEI
TOTAL EXPENDITURE	**103,037.0**	**127,935.3**	**145,245.2**	**172,855.2**	**240,891.4**
Total Expenditure excl. Interest and Financial Operations	**95,672.6**	**118,499.7**	**133,136.6**	**154,549.3**	**210,088.5**
Total Expenditure in Priority Sectors	**57,340.5**	**74,446.3**	**89,816.0**	**113,307.4**	**134,971.2**
Education	**19,870.9**	**24,031.3**	**26,802.5**	**31,703.0**	**37,940.9**
General Education	16,389.6	20,986.3	23,384.1	27,703.0	31,636.3
Higher Education	3,481.3	3,044.9	3,418.5	4,655.0	6,304.6
Health	**7,964.6**	**9,670.1**	**15,659.7**	**20,868.0**	**19,073.3**
Health Systems	7,707.9	9,491.3	15,555.4	20,715.0	18,878.1
HIV/AIDS	256.7	178.7	104.4	153.0	195.3
Infrastructure	**15,623.5**	**20,623.5**	**21,508.2**	**26,219.4**	**31,142.5**
Roads	9,300.0	13,055.3	12,975.9	17,180.0	19,938.4
Water and Public Works	5,278.2	6,314.3	7,129.4	7,686.0	8,405.6
Mineral Resources and Energy	1,045.3	1,253.9	1,402.9	1,353.4	2,798.5
Agriculture and Rural Development*	**4,060.0**	**9,314.0**	**10,556.7**	**13,548.0**	**21,964.4**
Governance, Security and Judicial System	**8,420.7**	**8,793.3**	**10,514.2**	**15,174.0**	**17,543.1**
Other Priority Sectors	**1,164.7**	**1,682.5**	**4,328.2**	**5,272.0**	**7,306.9**
As percentage of total expenditure excluding debt charges and financial operations					
Total	**59.9%**	**62.8%**	**67.5%**	**73.3%**	**64.2%**
Education	**20.8%**	**20.3%**	**20.0%**	**21.0%**	**18.0%**
Health	**8.3%**	**8.2%**	**12.0%**	**14.0%**	**9.0%**
Health Systems	8.1%	8.0%	12.0%	13.0%	9.0%
HIV/AIDS	0.3%	0.2%	0.1%	0.1%	0.1%
Infrastructure	**16.3%**	**17.4%**	**16.0%**	**17.0%**	**15.0%**
Roads	9.7%	11.0%	10.0%	11.0%	9.0%
Water and Public Works	5.5%	5.3%	5.0%	5.0%	4.0%
Mineral Resources and Energy	1.1%	1.1%	1.0%	1.0%	1.0%
Agriculture and Rural Development*	**4.2%**	**7.9%**	**8.0%**	**9.0%**	**10.0%**
Governance, Security and Judicial System	**8.8%**	**7.4%**	**8.0%**	**10.0%**	**8.0%**
Other Priority Sectors	**1.2%**	**1.4%**	**3.0%**	**3.0%**	**3.0%**

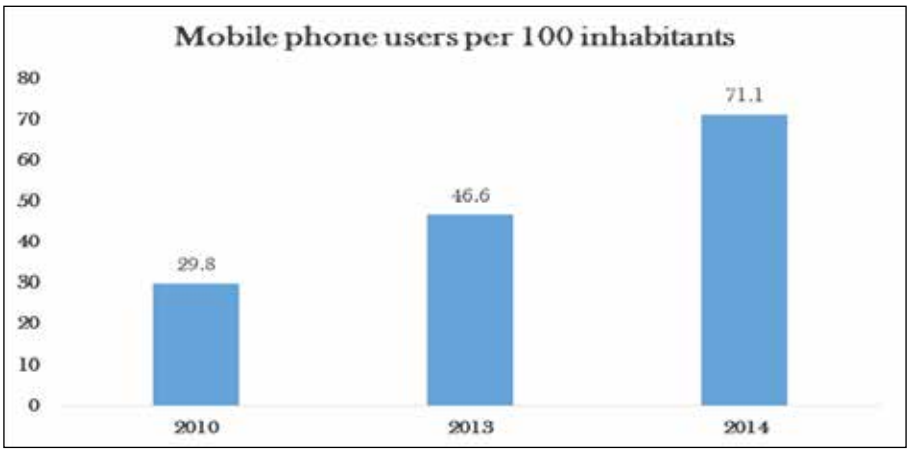
Source: MEF, 2015

a. *Information and Communication Technologies (ICTs)*

Situation and Trend

The use of information technology has increased in Mozambique. An important technology adopted in Mozambique is the use of mobile phones. The number of mobile phone users increased from 0.01 per 100 inhabitants in 1997 to 69.0 per 100 inhabitants in 2015. The mobile phone is the fastest adopted technology by Mozambicans, in comparison to other information technologies, and may be behind the slight decrease in the number of fixed phone users in Mozambique.

Figure x: Number of subscribers of mobile telephones in Mozambique in 2010 -2014



Source: Ministry of Transport and Communication, 2015

Additional information of the communications sector indicate that of the population using phones, 69% use mobile services opposed to 0.34% using a landline; The coverage of telephony in rural areas is of 1% of phone users, the remaining 99% resides in urban areas.

Challenges to achieve the 2015 targets

- *Within ICT, the challenge lies in the need to ensure the horizontal integration of organizations and their key services because ICTs offer a powerful channel for information and services that support economic growth and human capacity building, so that the need increases for inter-ministerial, inter-provincial/district communication and the development of common processes and the provision of services by the Government;*
- *Continue reducing the price of cellular services;*
- *Continued support from the government and donors in spreading the use of information technology in the country;*