Orphan Programming in Mozambique: Combining Opportunities for Development with Prevention and Care

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Photo: G. Pirozzi

Report of an Assessment of Programming in Mozambiqu for Families and Children Affected by HIV/AIDS

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Executive Summary

Purpose of Site Visit (Section I of Main Report)

The purpose of this national assessment of children and families affected by HIV/AIDS is threefold: to review Mozambique's overall programming and policy for orphans and other children made vulnerable by the AIDS epidemic, to identify opportunities for development of community based responses in a multisectoral planning context, and to work with UNICEF staff and others to mainstream programming across sectors.

To develop the assessment document, the assessment team (the consultant and members of the UNICEF/ Mozambique staff), discussed current programmes and opportunities for expanded programming with government personnel, non-governmental organisations, churches, other UN agencies, and bilateral donors operating in Mozambique; discussed programming opportunities with UNICEF staff in other sectors; and reviewed extensive literature and documentation.

The six objectives established for this assessment will meet some of the information needs for Ministério de Saúde's (MISAU's) new HIV/AIDS strategic planning process and also fall within the context of UNICEF's own goals for completing a situation analysis for Mozambique to set the tone of the new Agenda for Action for Children in Mozambique. Principal among them was to investigate alternative mechanisms to support community based programming for children and families affected by HIV/AIDS and promote further development of explicit policy and strategies of support for community based programmes for families and children affected by HIV/AIDS. Other objectives are listed in Section I.

In this assessment, it is assumed that community based approaches are the only viable and sustainable alternative for providing care and protection for children made vulnerable by the HIV/AIDS epidemic. This is dictated by the number of children affected by the epidemic, limited service availability in the country, and the relative desirability of alternatives in terms of their impact on long term child development and economic development for Mozambique.

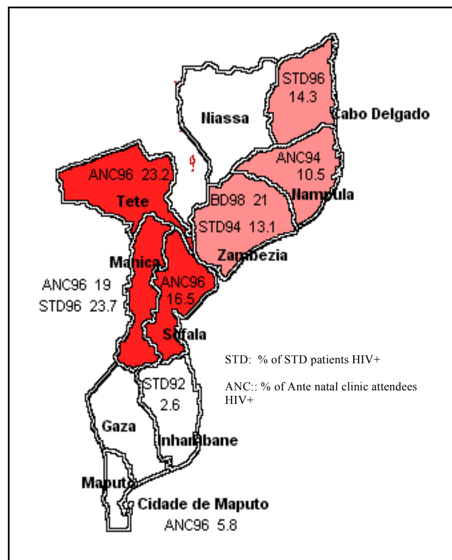
The AIDS Epidemic in Mozambique (Section II)

Infection Levels. With 1998 HIV seroprevalence at 14.2% among Mozambique's population 15 to 49 years of age, Mozambique's national epidemic appears to be younger than those found in most of its neighbouring countries. Infection levels are highest in males and females age 20 to 29, which also points to the same conclusion. There is as yet less downward drift into the adolescent population as seen in neighbouring countries. While Mozambique currently has the seventh highest HIV infection level in the world, its epidemic is not yet as deeply entrenched as those in nearby Botswana, Namibia, Swaziland, Zambia, and Zimbabwe.

This does not, however, mean that it is any less threatening to human life and the country's development, but instead that Mozambique now has a small and short lived opportunity to prepare

for its consequences among women and children in heavily affected areas. It will be necessary to act quickly with a comprehensive, national strategy, to develop the community resources base sufficiently to cushion impact in the heavily infected north.

Distribution. The epidemic's concentration outside of Maputo is unique in that Sub Saharan epidemics are typically more concentrated in the capital and large cities and less intense in rural and peri-urban areas during the epidemic's initial stages. In large part this is because the disease spread along refugee, migration and trade routes between Mozambique and the neighbouring highly infected areas of Malawi, Zimbabwe, and South Africa, rather than from the main urban centre of the country. Weak internal transport links within Mozambique limit widespread easy travel that can cause rapid diffusion of the disease from a densely populated centre.



In the absence of recent seroprevalence data, STD prevalence patterns also indicate that Nampula, Zambézia, and possibly Cabo Delgado Provinces may be in a more advanced epidemic stage. In addition, Gaza Province, for which there is no available sentinel surveillance data, is thought to be highly infected because there is extensive labour migration to South Africa. Lastly, it appears that rural areas in the central provinces have high infection rates, which may be due to refugee movements and the presence of peace keeping troops.

These patterns of infection not only present a different disease management problem than that found in other countries, but create a problem politically as well in the sense that the country's policy makers, situated in Maputo, do not experience an epidemic of the same severity and consequences as are experienced in the hinterland provinces of Tete, Manica, Sofala, Zambézia, Nampula, and Cabo Delgado. In addition, the population movements and resettlement that contributed to the spread of the disease may also hinder development of community solidarity and coping mechanisms.

In fact, it can be suggested that Mozambique has not one, but two epidemics, and that the one in the central provinces is much more severe than that occurring to the south. The northern province of Niassa is less affected only because settlement is sparse and transportation poor. Separating the central disease pattern from the southern makes it easier to see that the central provinces of Tete, Manica, Sofala, and Nampula, Zambézia, and possibly Cabo Delgado have epidemics nearly as severe as those found in neighbouring countries. These provinces are heavily populated, with 65% of the country's people, and poorly served by formal infrastructure. It is as though Mozambique has within its boundaries several Malawis or Swazilands in terms of seroprevalence levels, with the same pending severity and impact.

The Impact on Mozambique will be long term…
Even if no new infections occurred after 1999, infection levels will remain high through at least 2010, deaths will not level until after 2020, and the proportion of children orphaned will remain disproportionately high through at least 2030.

The populations in these areas are in relatively poor health, and illiteracy and poverty are widespread. It is unlikely that prevention efforts focussed on the over-15

population in this part of the country will be effective. Impact mitigation activities for women and children need to be strategically managed, massive, and widespread. There is no time for pilots, small demonstration projects and the like because Mozambique is starting from far back in the queue in terms of service delivery mechanisms. In these provinces, there will only be 5 years to put structures for mitigation into place (see Sections III and IV below).

The human and social costs of the epidemic in Mozambique are already high, with 83,000 deaths occurring in 1997 alone. The UN Population Division estimates that at least 4.5 million deaths will occur between 2000 and 2015, but used a seroprevalence level of only 11.92 rather than the current 14.2 in their projections. Not only will the social costs be high, they will be long term. **Even if no new infections occurred after 1999, infection levels will remain high through at least 2010, deaths will not level until after 2020, and the proportion of children orphaned will remain disproportionately high through at least 2030**.

While epidemics in neighbouring countries are approaching this level, the epidemic in Mozambique may be more disastrous for a number of reasons:

1. Loss of skilled personnel will have a more severe effect;
2. Developing social systems in health, education and welfare will be less flexible in absorbing loss of personnel and increased demand;
3. Lack of infrastructure and poor underlying health of the population makes the epidemic very difficult to control or address.

The impact of Mozambique's efforts to improve adult and child heath is likely to deteriorate given the impact of HIV/AIDS, most quickly in the north. Mozambique's infant, under-5 and maternal mortality rates will increase from already high levels. Recent UN Population Division projections using a seroprevalence rate of 11.92% estimate 3.4 million deaths in Mozambique before 2015, and a drop of life expectancy to 36.6 by 2010.

Government strategy for massive AIDS prevention activities in all sectors is waiting to be developed. It needs to be underpinned by realistic population estimates and costing of alternative scenarios and approaches more sophisticated than presently available in Mozambique:

The Impact Will Be Severe

- ✔ Skilled personnel lost to the epidemic will be harder to replace
- ✔ Social systems in health, education and welfare are under-developed and limited in their ability to respond
- ✔ Lack of infrastructure and poor underlying health makes the epidemic harder to control

Conclusions and Recommendations, Section II

1. First Steps for Developing an Effective AIDS Prevention Strategy

> **Costs of Failure to Develop an HIV/AIDS Strategy in Mozambique**
> - ✓ Loss of development gains and potential, skilled personnel and infrastructure
> - ✓ Social unrest
> - ✓ Large numbers of unprotected, poorly socialized and uneducated young people
> - ✓ Loss of human life
> - ✓ Retrenchment of other diseases
> - ✓ Greater increases in infant, child and maternal mortality

In no sector is the government prepared through planning exercises and scenarios to anticipate or shoulder epidemic-induced changes and increases in demand that will occur in the face of lost management capacity and labour productivity. A false sense of security prevails that the epidemic is not as bad in Mozambique as in neighbouring countries, that MISAU is taking care of the problem, and that other development challenges are much more serious. Ministries are unaware of the potential impact of HIV/AIDS and they lack the tools and motivation to visualise and launch effective interventions.

Fortunately, the government is gearing up for a multisectoral strategic planning exercise in HIV/AIDS. The cost of failure to develop an effective strategy will be enormous:

Loss of development gains and potential in all sectors, including skilled personnel and infrastructure that cannot be maintained through long term losses of productivity;
Social unrest from children and youth who are unprotected, underfed, under-schooled, and poorly socialised;
Losses of human life, adult and child, to HIV and other diseases as AIDS destroys the health sector's ability to respond by clogging hospitals and clinics with AIDS-related cases;
Retrenchment of other diseases, such as tuberculosis.

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Disaster, however, is not inevitable. Although public health experts around the world have been humbled by their limited success in controlling the spread of HIV/AIDS, it is not impossible to reverse epidemic trends. Uganda and Thailand are countries where increasing infection levels were reversed through deliberate public strategies. Parts of Tanzania, where resources are as limited as those in Mozambique, have also succeeded in limiting its spread. Finally, in areas where it will be impossible to contain the epidemic, a national HIV/AIDS strategy needs to put in place mechanisms to limit the impact. What is badly needed and will be developed through the strategic planning process is a clear vision and coherent strategy for carrying out activities in prevention and care.

The first step is for Ministries to undertake technical analyses of sectoral-specific impact and responses. These would include impact on Ministry personnel (losses, projected costs for replacement, key capacities lost) and on delivery of Ministry services. They would also include projections of increased demand for services due to increased AIDS deaths, illnesses, loss of family support services by geographic area.

A second important step is to understand the impact of policies in the various social sectors on the country's ability to slow epidemic spread and mitigate its inevitable impacts. Strategic and policy concerns are summarised by sector in the box above.

Population projections revised to reflect the reality of AIDS are essential. Central ministry economic and budgeting personnel who support line or sector functions may benefit from meeting and developing models for projection and analysis that they can then use when working with line Ministry planners.

In preparing these documents, Ministries will begin to understand the widespread and profound impact AIDS will have on their work and their ability to fulfil the development vision of Mozambique.

Strategic and Policy Concerns Related to Orphans

Health
- ✓ Delivery of services to households with elderly guardians and child headed households
- ✓ Monitoring health status of orphans and non-orphans to ensure equity

Social Welfare
- ✓ Develop family and community capacity to support orphaned children
- ✓ Provide on-going organizational and psychosocial support to community mechanisms for care
- ✓ Social welfare benefits may be needed by the poor so orphans can be maintained within the family and community
- ✓ Educating care givers and children to prevent abuse
- ✓ Developing community mechanisms to ensure child rights

Education
- ✓ Education as protection and socialization mechanism
- ✓ HIV/AIDS education in curriculum
- ✓ Alternative schooling in heavily impacted provinces

Women/Gender/Property
- ✓ Educating women concerning property and inheritance
- ✓ Community education on child rights

2. Costing Alternative Prevention Scenarios and Interventions

From the experience in Uganda and Thailand, we know that there are a variety of effective interventions, including:

Massive, *explicit* public education – the infection levels, behaviours that contract the disease, and ways to avoid infection; compulsory school programmes at the earliest ages; openness about the disease and discouraging stigma, so care and prevention can be linked;

STD diagnosis and treatment – aggressive case identification and syndromic management;

Widespread counselling and testing so that HIV positive people are aware of their status and act to avoid infecting others;

Widespread access to condoms. Limited access and distribution services through the Ministry of Health could be widened.

Each of these strategies has associated costs, infrastructural requirements, and timeframes for implementation. For example, it is likely that public information campaigns concerning the level of the epidemic can be launched immediately. Making AIDS a compulsory school programme will take longer, but will help to protect the next generation of Mozambicans against infection. In all, mass and peer education campaigns are less expensive, fast, and relatively effective with the young. STD and testing alternatives require professional inputs, infrastructure, and are considerably more expensive to implement. Prevention and care scenarios can be linked – must be linked – to be effective.

The Strategic Planning Group needs to develop tools to evaluate alternative strategies along these three dimensions (cost, infrastructure and time), perhaps working with the Ministry of Finance. Once the options are better laid out and costed, Mozambique's central Ministries can better select those that optimise a country's preferences for effectiveness and health.

Effective AIDS Prevention and Care Requires Investment

Country	PLWHA	Investment in HIV/AIDS Donors	Government	Total $s/ PLWHA
Uganda	930,000	$12 million	$2.5 million	$15.59
Malawi	710,000	$8.4 million	$1.1 million	$13.38
Mozambique	1,200,000	$3.7 million	$0	$ .27
Zambia	750,000	$5.9 million	$200,000	$ 8.13
Zimbabwe	1,500,000	$13 million	$ 44,000	$ 8.70
Kenya	1,600,000	$6.6 million	$3.5 million	$ 6.31

Draft UNAIDS Data, 1998; last column calculated using columns 2-4

3. Linking Prevention and Care Alternatives

There are several important reasons why the issue of care, both for persons living with HIV/AIDS and their children, must be featured in the new Mozambican National AIDS Plan and linked clearly with strategies for prevention:

- From the implementation perspective, Mozambique is well past the period when prevention programmes will be effective, unless they are linked to programmes for providing care, especially in the central provinces;
- Financially and practically, care will be a major development burden to Mozambique. It must be integrated and mainstreamed into many sectors to be affordable and efficient.
- Simple projections of lost human resources in key sectors will begin to highlight requirements for mitigation of the human suffering caused by the epidemic for policy makers;
- The national strategic planning process will be tied to donor funding development. The cost of care for PLWHA and orphans must receive a fair share of the AIDS investment in Mozambique or donors will fail to anticipate its long term costs

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4. Collection of Additional Serodata to Better Document the Situation in the Provinces and Better Understand Epidemic Development in Mozambique.

With the current scheme of sentinel surveillance sites, it is impossible to determine prevalence rates in Zambézia, Cabo Delgado, Inhambane, and Gaza Provinces so a more realistic picture of the epidemic's distribution can be gained. Expanded serosurvey data may be required. Alternatively, an analysis of STD rates might suggest similarities in probable HIV rates. It would also be useful to map comparative data with bordering areas of neighbouring countries, and to display epidemic histories in other countries to show how the epidemic might explode in Mozambique.

While the epidemic has hit Mozambique hard and its impact will be felt well into the future, the country has considerable resources for preventing further spread and for intelligent planning to ameliorate the disease across sectors. Mozambique has considerable strengths for combating the epidemic (those observed during this assessment are listed on page 32), although the barriers to programme effectiveness are also sizeable (page 32). Sectoral preparedness and impacts are summarised on pages 30 to 33, but more details are needed from each Ministry, the NGOs and the commercial private sector.

Characteristic Vulnerabilities of Children and Care Givers in Heavily Infected Provinces

Children
- Underlying levels of orphaning high
- Low immunisation
- High malnutrition
- High infant and child mortality
- Low school attendance

Caregivers
- High maternal mortality

Any effective prevention and care programmes will require considerable investment in a number of sectors, not just health. The box above shows draft data from UNAIDS on government and donor investment, total and per person living with HIV/AIDS, in selected African countries. Government commitment to deal with AIDS, while measured by investment dollars, also signals a willingness to take action across all sectors to stop the disease and ameliorate its consequences.

Children Affected by HIV/AIDS Estimates for Mozambique

Existing Orphans, 1997 – IDS/INE
Mother: 325,619 (4.3%<15)
Both: 71,685 (0.9%<15)
Father: 505,338 (6.7%)
Total: 901,551 (11.9% <15)

Estimated AIDS Orphans, 2000 – PNCS
Mother or both: 400,000 (4.9%<15)
(Father: 400,000, 4.9<15)*
(Total: 800,000, 9.8%<15)*

HIV Positive Children, 2000 – Webb
Number: 247,000
Percent: 3.1% of children <15

Children Living in Families with HIV/AIDS, 2000
Number: 1,144,237
Percent: 14.2% of children <15
Percent: 14.2% of children < 15

Orphans and Care Givers in Mozambique (Section III)

Numbers. The prospects of children in Mozambique will worsen drastically because of AIDS in a number of ways:

- Infant and child mortality rates will double or triple;
- Many more infants will be born HIV positive;
- Orphan rates will be three to four times higher than normal;
- One quarter to one third of all children are living in families where a member is HIV positive, meaning that they are exposed to other infectious diseases in addition to the trauma resulting from caring for ill family members.

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The estimates in the box above are rough, but follow patterns substantiated in neighbouring countries using census and registration studies. The numbers of children needing care and protection in Mozambique are potentially enormous and will mushroom as AIDS deaths escalate. Orphaned children whose mother, father or both parents have died are likely to constitute close to one third of children under 15 years of age by the year 2005. Currently, 11.9% of the children under 15 are orphaned and anywhere from 400,000 to 800,000 will be added by AIDS by 2000 (see box above). An estimated 3.1% of children under 15 will be carrying the virus.

On the basis of seroprevalence data, it is clear that orphan populations will be disproportionately

high through at least 2030, given the lack of significant sexual behaviour change among sexually active groups to slow the spread of the virus. Projections and the development implications are summarised in Section III, which also includes an analysis of data gaps and needs.

Distribution. Given what is known about epidemic patterns in Mozambique, it is likely that the proportion of children orphaned will increase most rapidly in the provinces of Tete, Manica, and Sofala, followed by Zambézia, Nampula and Cabo Delgado. Gaza, as mentioned above, may also have high seroprevalence and see early increases in orphaning given its social and economic history. Levels are likely to reach 25 to 35% of the under 15 population of these provinces in the near future. The first three provinces contain 23% of Mozambican children under 15, and the second three are home to 49%, so a total of nearly three-quarters of children under 15 in Mozambique reside in the 6 provinces likely to be most heavily infected.

The epidemic's concentration in the central provinces unfortunately coincides with many other vulnerabilities. First, underlying levels of orphaning are already very high compared to pre-AIDS epidemic levels in neighbouring countries. While some of these children will mature before the next generation of orphans is created by the epidemic, many will still be vulnerable.
Second, children in these provinces already suffer poorer health and nutrition status than in other areas of the country. Although there is no systematic study of orphans in Mozambique, limited data indicate that they are still being absorbed by the extended family, and their care-givers are predominantly women, many of whom are elderly and poor. Their care-givers are poor and suffer from low literacy. Children and care-givers both experience lower access to resources in health, education, and social welfare.

Conclusions and Recommendations, Section III

Conclusions concerning the situation of orphans and other vulnerable children in Mozambique and their care givers are as follows:

Additional Analysis of Existing Orphan Data

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The situation of orphans and other vulnerable children in Mozambique will rapidly become critical within the next 4 years as AIDS-related mortality escalates within the central provinces. Current data and reliable projections of the number of children by province needing assistance would facilitate realistic planning and strategy development for protection and care.

Fortunately, baseline data on the numbers of orphaned children in each Province are available from the *Inquérito Demográfico e de Saúde* (IDS/INE). Their findings are summarised in Section III. Additional analysis of this data showing the conditions of orphans, their living arrangements, care givers, schooling, education and health status can be obtained from a special tabulation of the IDS results. It is not yet known if more extensive, full count, data are available from the 1997 Census.

Obtaining Better Projections of Need at the Provincial Level

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Projections of future numbers of orphans and other vulnerable children are also need to show detailed patterns of distribution and "swells" in these populations by area so protection strategies can be introduced in provinces where children are likely to be most vulnerable. Ideally, these projections would be built using a new round of serodata. Lacking that, it may be possible to

develop a set of projection scenarios to guide development of service, policy, and community mobilisation. It would be useful to involve provincial and district authorities in the development of these projections so the results can be well understood and integrated into their thinking, planning, and implementation.

3. Collection of Data on Care Givers, Families and Communities

In addition, information is needed on their care-givers, and the size, composition and coping strategies of the households and communities where they live. Small sample surveys and focus groups conducted by competent researchers that document the condition of these children and their care giving patterns by region are essential for an effective strategy of community development and support.

Status of the Response (Section IV)

Mozambique's history of family reunification and adoption of children following the war demonstrates the ability of government, family and community to take action to respond to the needs of vulnerable children. To date, populations of street children are relatively small given the total number of orphans in the country. Conversations with NGO and government personnel developing volunteer programmes (community activists for health, child welfare, and the like) suggest that volunteerism is high and can be maintained in Mozambique with investments in training and support. Communities in Mozambique vary greatly in organisation and cohesiveness, much of the variation due to the history of resettlement.

Government commitment to combat the epidemic is diffused by the concerns of managing the Mozambique economy and rebuilding infrastructure destroyed by the war, both human and physical. Distribution of basic government services is very thin in rural areas, and clean water and sanitation is available to only one-third of the population.

Government efforts to address AIDS are hampered by lack of personnel in PNC DTS/SIDA and concern in the Ministério de Saúde with addressing a variety of other critical health problems. Understanding of the potential impact of HIV/AIDS on the country's ability to sustain its course of economic development is limited in other Ministries, but will be deepened by the preparation of sectoral and policy analyses described above.

Government social welfare services are extremely limited, with social agent to population ratios of more than 300,000 to 1 in some provinces. Budget allocation to the Ministério da Coordenação da Acção Social (MICAS) is the smallest of any Ministry, some 7% of the national budget. Mozambique's current social welfare policy has a deep community based orientation, but includes no provisions for orphans, the elderly, those who are chronically ill, or cash safety nets for vulnerable children and families.

In addition, government vision related to the development of social welfare is pinned to projections of need for services that fail to take the need for vastly expanded services into account. As a consequence, strategic vision and costing of alternatives is limited in the public sector.

Unfortunately, it was not possible to discuss the implications of HIV/AIDS for Mozambican development directly with individual businessmen or any of their organisations. However,

businesses and labour unions in Mozambique confronted issues of discrimination towards PLWHA several years ago, so it is likely that some analyses of human resource impact and policies have been made by larger employers.

There is a strong network of NGOs in Mozambique, a legacy of assistance to deal with the impact of conflict. A detailed map of the location of NGO services, particularly in the provinces likely to be most vulnerable, is needed.

Conclusions and Recommendations, Section IV

1. **Research on Community Development Approaches in Mozambique**. Preliminary work will soon be completed on a brief study identifying alternative approaches to community development in Mozambique. This can be expanded to fill out the picture of approaches and range of alternatives for supporting community capacity building.

2. **NGO/MICAS Committee for Planning**. Although government capacity for support to communities will develop over time, at present NGOs are clearly a major partner for community capacity building. A strategic plan for building family and community support for orphans unfolds, it will be critical to involve as many creative voices as can be found. A combined MICAS/NGO committee could be formed to review research, data, and build models and project direction and strategy from these inputs. Development of national network to support family and community response would improve dissemination of policy, stimulation of equitable distribution of services, and quality of services delivered.

3. **Develop a Strategic Plan for Increasing Social Welfare Capacity.** The capacity of MICAS is currently so limited that capacity building for the Ministry must be a central part of any strategic plan. In addition, it may be necessary to provide MICAS additional capacity and technical assistance through the next few years to cope with the demands of planning, sectoral review and policy development.

4. **NGO Services Inventory.** The preliminary mapping of NGOs providing AIDS-related surveys done as part of this assessment provides only a tiny fraction of the information needed to support strategically driven allocation of NGO resources to communities affected by HIV/AIDS. The NGO/MICAS Committee can work together to expand this map and complete an inventory of services being provided to families and children affected by HIV/AIDS. This can be used to plan for rapid service expansion, partnerships, and co-ordination mechanisms. Review of the distribution of services, which at present is skewed toward urban areas and certain regions of the country:

Urban	Rural
Social Welfare Agents	Some Community Health Workers
Access to Social Welfare Benefits	Some NGOs
Child Care Institutions	Some Churches
Programmes for Neglected/ Displaced Children	

5. **Site Visits to Neighbouring Countries.** Mozambique's neighbours, Malawi and Zimbabwe, have developed comprehensive government-NGO-community partnerships and policies

for supporting families and communities affected by HIV/AIDS. It will be imperative to sponsor site visits by a combined NGO-government team to these two countries to review the development of their systems, diffusion of their models, and the extensive policy review that has taken place. In addition, the team can identify resources in those countries that can assist in strategy building and expansion of the Mozambican effort. Zambia is now revising its entire educational policy to expand access for children as a means of addressing the need for orphan care and socialisation. Education Ministry planners might benefit from a brief visit to Lusaka to discuss the rational and approaches for this plan.

6. Commercial Private Sector Activities. As noted above, it will be important to include the commercial private sector as full partners in the development of systems of prevention and care. This has been done with great success in a number of countries, including Zimbabwe.

7. Planning and Costing Models. Three things are essential to promote more realistic views of future needs:

Estimates for planning. Reliable orphan estimates, discussed above, which clarify the size of the population needing care and support;

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Costing of alternative models or scenarios for care. For example, if only one third of the current number of orphans (901,551 = 300,517 children) were provided minimal government support (5433 meticais or US$ 0.5 per month), the cost per year would be 19,592,506,330 meticais (US$ 1,580,041) per year. It can be assumed that institutional solutions of any type will be more costly.

The cost of not caring. Additionally, scenarios that estimate the future social costs of not caring in terms of delinquency, correction or remand facilities, social unrest and the like might help build social commitment for mobilising and strengthening local resources.

8. **More deliberate inclusion and acknowledgement of people living with HIV/AIDS** will stimulate diffusion of their considerable knowledge of positive living to HIV positive people in Mozambique.

Technical Requirements for Programme Expansion (Section V)

Mozambique has some additional data, training, community, volunteer and research requirements for strategic, long term, needs based planning:

1. Data

a. Cost and Quality Data. Costing data is unavailable from most organisations at the present, but would be useful to compare implementation approaches. This could be coupled with the collection of data indicating the quality or effectiveness of support services provided to implementing communities.

b. Investment Data. Data is also unavailable which describes the contribution of various sectors to programme implementation. It would be desirable to know the investments being made by government, donors, and communities are making to ensure the welfare of orphans and other vulnerable children. Cash and in kind contributions need to be evaluated to fairly represent the balance of investments and to evaluate their sustainability.

Mise en forme : Puces et numéros

2. Training Needs. A variety of training programmes is needed to build capacity, all of which will have to be updated and scheduled on a periodic basis as the epidemic and community response evolve:

a. Training for Communities. Communities have already identified psychosocial training and community organisation as two high priorities, and other needs will emerge as the epidemic progresses.

b. Training for Social Welfare Agents. A training programme for Social Welfare Agents could be implemented, and will have to be updated periodically. In addition, the country's lack of training capability for social welfare agents/officers/workers needs to be examined closely. A paraprofessional or certificate level course may need to be introduced. In Uganda, distance learning courses were being prepared with the assistance of SCF/UK for this purpose.

c. Training for Teachers. A training programme for primary and secondary school teachers will help them understand national commitment to equity in education for all students, and can also be used to encourage organisation of students to assist vulnerable children in their midst.

d. Training in Other Sectors. With the encouragement of multisectoral planning and management of implementation, selected training opportunities might be useful to equip officers from other Ministries to participate more fully.

3. Community Resource Access. There may be a need for a systematic way to promote community access to resources in such areas as credit for income generating activities, agricultural technology, and skills in small business development. This information will encourage sustainability and can be integrated into community development modules.

4. Volunteer Development. Implementation organisations employ a variety of volunteers. It may be easier to sustain their interest and commitment with training programmes that build their competency and endow them with semi-professional status. This is likely to improve volunteer retention and increase the availability of semi-skilled personnel over the coming decades.

Planning Data and Tools

Data
- Cost and Quality Data
- Investment Data

2. Training Needs
- Training for Districts and Communities
- Training for Social Welfare Agents
- Training for Health Care Providers
- Training for Primary and Secondary School Teachers
- Sensitising Children
- Training in Other Sectors

3. Community Resource Access

4. Volunteer Development

5. Research Needs
- Research Capacity
- Models for Evaluating Community Response Over Time
- Models for Community Participation in Research
- Urban/Peri-Urban/Rural Models
- "Grand" or Second Generation Orphans
- Child and Community Vulnerability Indicators

5. Research Needs. A variety of research needs can be identified:

a. Research Capacity. It may be desirable to cultivate a research capability within Mozambique, which can be called upon to undertake short term, operational research and produce quick, easy-to-understand information. Additionally, it may be necessary to orient developing academics to aspects of this problem and to encourage them to pursue the issue in their training.

b. Models for Evaluating Community Response Over Time. The impact of the AIDS epidemic on communities in Mozambique over time has yet to be described or measured. It will be important to track this development, especially in heavily affected areas.

c. Models for Community Participation in Research. Participation of community members in design as well as data collection will encourage communities to satisfy their own research needs and improve long term sustainability.

d. Urban/Rural/Peri-Urban Sector Models. Implementation of community based interventions will vary by community type. These variations might be systematised into urban, rural and peri-urban models by such factors as population density, resource availability. Approaches are being systematised in Zimbabwe along these lines so that implementation is facilitated by type.

e. "Grand Orphans" or Second Generation Orphans. Given the early age at which many women in Mozambique begin childbearing, the birth of children to orphans may create considerable family and community stress. Care taking patterns for these children could be researched.

f. Child and Community Vulnerability Indices. The development of indices or checklists of criteria to assist communities in assessing the vulnerability of their children might be needed. It may be possible to develop indices with universal applicability across communities; however, these will vary considerably by such factors as population density, socio-economic status, and variable access to resources. It may be advisable to research the ways in which communities establish their own criteria for vulnerability and apply them given the community's resources.

5. Programming Planning, Monitoring, and Evaluation

a. Programme Planning. Need for data for national programme planning has been described above. Additional needs are likely for the development of planning and data collection tools for use by NGOs, CBOs, and religious organisations.

b. Programme Monitoring. The need for the systemisation of monitoring tools and for community participation in their development and use could be considered.

c. Programme Evaluation. Consistent development of programme evaluation tools will be important.

A vital need in programme development is in indicator development, where there is little guidance. *Process indicators* are needed in the early stages of programming to measure progress of programme implementation, functioning, and sustainability of community organisations. *Impact or outcome indicators*, which measure the success of programmes by their ability to support family and community survival and maintenance of child well being and health, are more useful in later stages of programme development. These measures will be necessary to attract and maintain funding from

donor and private sector agencies. It might be useful to begin more serious investigation and development of these measures. Their development is vital to guide programme design, implementation, and evaluation design.

Funding Development (Section VI)

Although bilateral funding has come to Mozambique from many sources over the past few years, the country must exploit indigenous sources of support for programming so that they are more sustainable. These are described in Section VI. Among the objectives of the new UNICEF Headquarters programme for families and children affected by HIV/AIDS is to assist heavily affected countries interested in assembling the plans and resources needed to expand their current programmes. In addition, Mozambique is one of the countries identified by the WHO/ World Bank/ UNAIDS initiative for Africa.

Next Steps and Actions

1. Data Development and Modelling

Develop an Additional Round of Serodata. The UN Theme Group on HIV/AIDS should consider the need for a more comprehensive round of serodata collection, including at least one site in every province of Mozambique, at the nearest possible timeframe. The data should be collected from antenatal clinics so it is as representative of trends in the adult population as possible. Logistic and financial requirements need to be estimated, but can be built on the prior experience of Mozambique's PNC DTS/SIDA with sentinel surveillance. Lastly, financial support may be available if this is envisioned as a "pre-planning" requirement to develop a proposal for support to Mozambique under the new UNAIDS Initiative for Africa.

Review of Paradigms for Epidemic History in Mozambique. The current paradigm concerning the spread of HIV/AIDS in Mozambique explains diffusion of the infection as occurring from transportation corridors into surrounding populations. In fact, there is substantial reason to believe on an epidemiological and historical basis that refugee and soldier movements related to the conflict in Mozambique have more to do with diffusion than recent movement along transportation corridors, although that may fuel additional spread. In addition, it is likely that labour migration into South Africa plays a substantial role in continued infection of people in Mozambique's southern provinces.

Since beliefs about how the epidemic spread condition efforts to control it and strategies for prevention in adults and young people, it is important to discuss the possible mode and patterns of spread of HIV. In addition, population movements from neighbouring countries have effected the organisation and coherency of communities in the central provinces. Hypotheses underpinning strategies for care should be examined in this light. These migrations may make the importation of models of care from neighbouring countries more acceptable.

Population Projections Including the Impact of HIV/AIDS. The INE is preparing the data from the 1997 census. Once this is available, planners will begin to work on population projections for the next decade. It would be possible to obtain technical assistance from UNAIDS, the UN Population, or the US Census Bureau to factor in the likely impact of HIV/AIDS on the population of Mozambique. These projections would be essential for preparing sectoral impact assessments described below. Mozambican planners might also be able to adapt the computer models used by UN and UNAIDS planners for use in Maputo.

Estimate and Projection Models for Provinces. Projection of the number of children who will be orphaned by AIDS for each province, including estimates of when those numbers are likely to increase, can be made using epidemic and demographic models. Several technical experts in the world specialise in developing these types of models and exploring the ramifications of the growth in orphans on demand for services.

Modelling/Costing Alternative Scenarios for Care. Models of alternative approaches to care can be developed by the NGO/MICAS committee. These would include strategies to expand home care, the contribution of the community, the role of MICAS and the NGOs, need for institutional or cluster foster care, and other aspects of care. Rough costing can be done, especially when the total numbers of children have been estimated.

Sectoral Impact Assessments and Barrier Analyses. The Ministries of Health, Education, Agriculture, and Social Welfare could undertake technical analyses of sectoral-specific impact and responses. These would include impact on Ministry personnel (losses, projected costs for replacement, key capacities lost) and on delivery of Ministry services. They would also include projections of increased demand for services due to increased AIDS deaths, illnesses, loss of family support services by geographic area.

Prototypes of these models have been used in Swaziland (Whiteside and Wood, 1993), and Botswana has undertaken a series of impact assessments late last year. World Bank planners have also undertaken these types of analyses. In addition the Food and Agriculture Organisation of the United Nations has assisted about 6 countries – Uganda, Zambia, and Tanzania in East Africa – to analyse the impact of AIDS on commercial and subsistence agriculture using vulnerability

assessments

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In addition, it will useful for Ministry planners and policy makers to complete barrier assessments to understand the impact of policies in the various social and productive sectors on the country's ability to slow epidemic spread and mitigate its inevitable impacts.

Regional Implications. Most of the activities suggested above will be conducted on an experimental basis by Mozambique because few countries have developed these types of projections. However, after Mozambique completes such an exercise, these models and approaches will be very useful for planning exercises in other countries.

2. Management and Planning

Form NGO/MICAS Committee for Planning and Strategy Development. A collaborative NGO/MICAS planning committee could foster review of data based exercises described above and development of strategic plans for rapid expansion of support services for community based care. This committee should include churches, MULEIDE and other NGOs involved in educating women about their rights to property, land and inheritance, and their rights under CEDAW, and private sector groups which might be providing AIDS prevention and care services. The US Peace Corps, VSO and other volunteer groups should be considered for membership. The interest of Peace Corps volunteers in AIDS prevention and care activities as a community service activity should be investigated. Peace Corps volunteers in several neighbouring countries (Tanzania, Zambia, Malawi) provide services in AIDS-related activities, and the offices are in close contact.

Complete Provincial/District Services Inventory. The development of a map and inventory of NGO services being provided in each district that might be adapted to HIV/AIDS prevention and care activities would enable the committee to assess gaps in service delivery. This exercise might involve with the district agents of social action, as well as with the NGOs and churches as a capacity and partnership building opportunity.

Develop Strategic Plan. The committee could undertake the development of a strategic plan for Mozambique to serve as a simple guide for filling gaps in service delivery and expanding services.

Policy Review. The group could also serve as a sounding board for MICAS in the expanding Mozambique's social welfare policy. Comprehensive child law review could be included also, following the model of the National Orphan Task Force in Malawi or Zimbabwe's Child Welfare Forum.

3. Site Visits

A number of countries in the region are more advanced in various planning and service development activities than Mozambique (see Appendix 6). Their activities are also summarised in their programme assessment reports, listed in Appendix 3. It would be very useful for capacity building in Mozambique if Ministry and NGO representatives considered the following site visits or study tours to build their knowledge of possibilities for community based support:

MICAS and NGO representatives should visit Malawi and Zimbabwe, which have well-thought out, comprehensive systems to respond to the orphan crisis partnering NGOs and government actors.

Ministry of Education planners might consider a visit to Zambia or Malawi to review changes in education policy related to the epidemic.

Ministry of Agriculture planners might benefit from a visit to Zambia to review their vulnerability mapping exercise.

Lastly, it would be useful for Mozambique to sponsor a Mozambican Sub-regional Conference on orphan care toward the end of the year, following completion of some of the activities listed above. These types of conferences were sponsored in Malawi, South Africa and Botswana last year, and provide an opportunity for a large number of people to be exposed to both the activities of the NGO/MICAS committee, the findings of the site visits, and to visiting experts from other countries in the region.

4. Research

Short term, operational, action oriented research on the following subjects would inform development of a realistic plan for expansion of services. Ideally, such research would work within:

1. **Traditional family and community care mechanisms**, including variations between matrilineal and patrilineal systems of care. Researchers in Malawi and Zimbabwe have completed studies of this type, and might be interested in working with local researchers to develop local capacity for this work.

2. **Alternative community development approaches**. Work has begun on an analysis of alternative approaches to community development by NGOs working in Mozambique. This could be a useful start to understanding where and when they are most effective.

3. **Local government organisation and management** reportedly differs in Mozambique, and it is reported that local government officials have not fully clarified their roles. It is possible that a donor in Mozambique working in the development of civil society might be helpful in providing information or reports or would be familiar with related research.

5. Funding

All of the proposed activities have far reaching implications for donors in Mozambique in many sectors. A donor round table in Mozambique to review the work and describe anticipated activities will be important to gain their support.

I. Purpose and Nature of the Programme Assessment

A. Background

The 1997 World AIDS Day release of ***Children on the Brink*** represented a "wake up call" for the international development community on several levels. First, the report estimates that there will be more than 40 million orphaned children in the 19 Sub-Saharan African study countries by 2010, largely due to the AIDS epidemic. In addition to detrimental impacts on adult and child health in the region, the report anticipates the deleterious socio-economic impacts of increased AIDS mortality over the next 20 to 30 years. ***Children on the Brink*** portrays the scale and urgency of this demographic event in an unprecedented fashion, a clear picture of the massive impact the pandemic will have on children, families, societies, and economies in Sub-Saharan Africa through the first third of the next century.

In 1997, UNICEF Headquarter's management team decided to assess and intensify its programming efforts in the most affected countries as a result of the recent publication of an international report on orphans. Among the objectives of UNICEF's new strategy is to document programming efforts for families and children affected by HIV/AIDS to date, develop tools to improve and intensify programmes, and initiate or expand them to scale in 19 of the most heavily affected countries in the region. Realisation of this goal will require the combined efforts of country governments, non-governmental and religious bodies, UN agencies, donors, and the research community in developing programmes sustainable for the next two to three decades.

Many Sub Saharan African countries are re-examining their programming for families and children affected by HIV/AIDS as a part of new strategic planning for HIV/AIDS or as part of extended social policy review. Mozambique's *Programa Nacional de Combate ao DTS/SIDA* (PNC DTS/SIDA) is in the early stages of the process to develop a new HIV/AIDS strategic plan, where the issue of orphaned children will have high priority. When the second Medium Term Plan (MTPII) was developed (1992/93), HIV infection rates were at such low levels that the issue of families and children affected by HIV/AIDS was not in mind.

Mozambique is also developing a new Agenda for Action for Mozambican Children that includes an assessment and analysis of the situation of children in Mozambique. Since the HIV/AIDS epidemic will have a major impact on the health, social and economic status of Mozambican children and their families, it is important to document and project the changes that have occurred to date and those anticipated in the next 10 and 20 years.

With these opportunities in mind, UNICEF/Mozambique decided to participate in a new international UNICEF initiative to expand programming for children and families affected by HIV/AIDS by availing itself of technical assistance for programme assessments in countries heavily affected by HIV/AIDS. UNICEF has been programming for families and children affected by HIV/AIDS at the international and country level since 1989. Several Sub-Saharan African countries are recognised as having developed laudable and replicable programmes for assisting families and children affected by AIDS (Malawi, Uganda, Zimbabwe). Other offices, such as Mozambique and

South Africa, have Child Protection projects or activities that are now expanding to include support for community based activities for orphans, and can benefit from insights in project development of more experienced countries. The consultant, working with the new UNICEF initiative completed assessments of national programmes in Botswana, Malawi, Uganda, South Africa, Zambia and Zimbabwe in 1998 and Mozambique in 1999.

Objectives of the Assessment

Primary Objectives

To investigate mechanisms of support for family and community based programmes for children affected by HIV/AIDS;

To review existing safety nets for children;

Secondary Objectives

To encourage planning in all sectors to mitigate the impact of the epidemic on children;

Heighten awareness of the impact of women's status on the well being of children in AIDS-affected families.

Programmatic Objectives

To integrate findings into UNICEF's work programme;

To identify additional research needs for examining impact of HIV/AIDS on women and children

Mise en forme : Puces et numéros

Mise en forme : Puces et numéros

Mise en forme : Puces et numéros

B. Schedule

The programme assessment consultant arrived in Mozambique on 10 February1999 and left Mozambique on 19 February 1999. A timetable for her activities is shown in Appendix 1. A summary of the persons interviewed and meetings attended is shown in Appendix 2. Key documents reviewed during the site visit are listed in Appendix 3.

C. Consultant

The UNICEF consultant engaged for the site visit was **Susan Hunter, Ph.D.** Dr. Hunter has been working with UNICEF on the development of programmes for families and children affected by HIV/AIDS since 1989, when she worked with UNICEF's Kampala office to develop the first prototype programmes for the region. Dr. Hunter was principal author of ***Children on the Brink***. She has worked for UNICEF and USAID at headquarters level and on residential and short-term missions to Botswana, Ethiopia, Malawi, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe for programme development in this area. Most recently, she worked with regional and country offices to develop UNICEF's new programme strategy for families and children affected by AIDS, and is currently overseeing its implementation. She is a medical anthropologist and demographer with substantial publications in HIV/AIDS and health systems management.

The consultant worked closely with **Ian Macleod**, UNICEF/Mozambique's Child Protection Officer, and with **Sally Griffin**, a local consultant working with UNICEF/Mozambique to develop their approach to orphan issues, who not only made all appointments, and arranged logistic support, but also contributed the sections of the report on NGO activities. Both Sally and **Jonathan Cauldwell**, in UNICEF's evaluation and monitoring section, were invaluable in conceptualising much of the material in this document, and Jonathan created all of the maps and charts and gathered most of the data.

D. Objectives

The primary objectives of the programme assessment in Mozambique, established through consultation with the UNICEF country team, are as follows:

1. To investigate alternative mechanisms to support community based programming for children and families affected by HIV/AIDS and promote further development of explicit

policy and strategies of support for community based programmes for families and children affected by HIV/AIDS;

2. To review the extent and adequacy of safety nets for protection of vulnerable children in Mozambique given the expected severity of the impact of the HIV/AIDS epidemic;

   The safety nets to be explored include public welfare assistance, access to health, education and welfare systems, and food security.

The assessment also had several secondary objectives:

3. To encourage sector specific planning to identify, project and monitor the impact of HIV/AIDS on development and the care and protection of children through interviews with Ministries of Health, Education, Social Action, Youth, Sport and Culture, Agriculture (nutrition, food security), and others as appropriate.

4. To heighten awareness of the importance of women's rights in child protection and care.

In addition to preparation of the assessment document, the consultant helped UNICEF's staff to integrate programmes for families and children in their work programmes in health, education, child protection, and water and sanitation, and to identify additional research needs to guide new programming.

E. Interviews and Meetings

For the purposes of completing these objectives, the consultant conducted interviews and meetings with a variety of local, district, and national actors (government, NGO, UN agency, and donor representatives). A debriefing was held on 18 February 1999 to review findings and recommendations of the assessment. Participants are listed in Appendix 2.

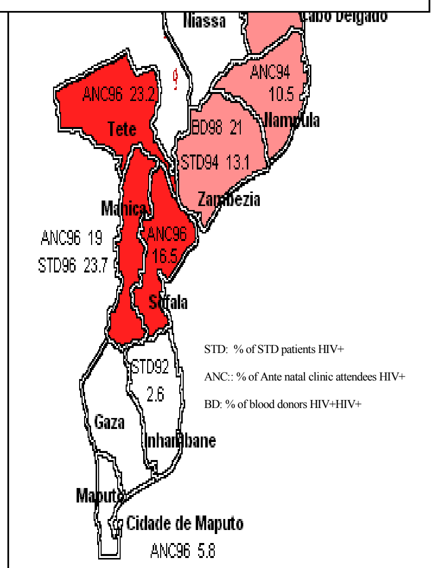
In addition, separate interviews were conducted with key Ministries responsible for various aspects of children and families affected by HIV/AIDS, and these are also listed in Appendix 2. In addition to personal interviews and meetings, documented in Appendix 2, the consultant reviewed available written documentation on the status of the epidemic in Mozambique, the status of orphans of the epidemic and children generally, national policy and strategy development, donor activity and strategies, and UNICEF programming (listed in Appendix 3).

II. The Status of the AIDS Epidemic in Mozambique

HIV and STD Rates by Province

1996 HIV Rates in Antenatal Clinic Attendees

Manica - Chimoio (non-urban)	19.2%
Tete – Tete (non-urban)	23.2%
Sofala – Beira (non-urban)	16.5%
Maputo – Maputo (urban)	5.8%



A. Seroprevalence Levels and Patterns

Levels. With 1998 HIV seroprevalence at 14.2% among Mozambique's population 15 to 49 years of age, Mozambique's national epidemic appears to be younger than those found in neighbouring countries. Infection levels are highest in males and females age 20 to 29, pointing to the same conclusion. There is as yet less downward drift into the adolescent population than seen in neighbouring countries, and less ageing of cases out of their 20s to fatten seroprevalence rates in older age brackets. While Mozambique currently has the seventh highest HIV infection level in the world, its epidemic has not yet become deeply entrenched like those in nearby Botswana, Namibia, Swaziland, Zambia, and Zimbabwe. This does not, however, mean that it is any less threatening to human life and to the country's development, but instead that Mozambique now has a small and short lived opportunity to prepare for its consequences among women and children in heavily affected areas. It will be necessary to act quickly with a comprehensive, national strategy, to develop the community resources base sufficiently to cushion impact in the heavily infected north.

Distribution. The epidemic's concentration outside of Maputo is unique in that Sub Saharan epidemics are typically more concentrated in the capital and large cities and less intense in rural and peri-urban areas during the epidemic's initial stages. In large part this is because the disease spread along refugee, migration and trade routes between Mozambique and the neighbouring highly infected areas of Malawi, Zimbabwe, and South Africa, rather than from the main urban centre of the country. Weak internal transport links within Mozambique limit widespread easy travel that can cause rapid diffusion of the disease from a densely populated centre.

In 1994, seroprevalence rates among antenatal clinic attendees in Nacala, Nampula Province were at a level comparable to Chimoio in Manica, suggesting that the epidemic is equally virulent there. This is probable given that the major rail line from the shores of Lake Malawi cuts through Nampula and terminates in Nacala. HIV prevalence among STD clinic patients indicates that Cabo Delgado may also be heavily affected. Blood donor seroprevalence of 21% in 1997, high STD rates among people under 20, and anecdotal evidence implies Zambézia Province may be in a more advanced epidemic stage as well.

In the absence of recent seroprevalence data, STD prevalence patterns also indicate that Nampula,

Zambézia, and possibly Cabo Delgado Provinces may be in a more advanced epidemic stage. In addition, Gaza Province, for which there is no sentinel surveillance data at all, is thought to be highly infected because there is extensive labour migration to South Africa. Lastly, it appears that rural areas in the central provinces have high infection rates, which may be due to refugee movements and the presence of peace keeping troops.

These patterns of infection not only present a different disease management problem than that found in other countries, but it creates a problem politically as well in the sense that the country's policy makers, situated in Maputo, do not experience an epidemic of the same severity and consequences as are experienced in the hinterland provinces of Tete, Manica, Sofala, Zambézia, Nampula, and Cabo Delgado. In addition, the population movements and resettlement that contributed to the spread of the disease may also hinder development of community solidarity and coping mechanisms.

In fact, it can be suggested that Mozambique has not one, but two epidemics, and that the one in the central provinces is much more severe than that occurring to the south. The northern province of Niassa is less affected only because settlement is sparse and transportation poor. Separating the central disease pattern from the southern makes it easier to see that the central provinces of Tete, Manica, Sofala, and Nampula, Zambézia, and possibly Cabo Delgado have epidemics nearly as severe as those found in neighbouring countries. These provinces are heavily populated, with 65% of the country's people, and poorly served by formal infrastructure. It is as though Mozambique has within its boundaries several Malawis or Swazilands in terms of seroprevalence levels, with the same pending severity and impact.

There are many reasons to believe that the epidemic will spread very rapidly in Mozambique unless the government takes rapid action:

1. Mozambique is at a "take off" point in the infection cycle given the pockets of high infection rates distributed around the country;
2. The epidemic has multiple cores of infection such as those found in Tete, Manica, Sofala – and potentially, in Cabo Delgado, and Zambézia Provinces – making it much harder to contain;
3. High rates of sexually transmitted diseases and tuberculosis;
4. Behavioural factors that will promote rapid spread of the epidemic are many:
   - High rates of multiple partners for both men and women;
   - Little sexual behaviour change;
   - High rates of sexual activity among young people, with a mean age of first intercourse of 15.9 for women;
   - By age 19, two thirds of Mozambican women have begun childbearing and most are in regular unions, many with a partner who has unprotected sex with other partners;
   - Low condom use, especially among rural populations;

In Mozambique, the epidemic could worsen rapidly because…

- Mozambique has pockets with high HIV infection rates
- There are multiple foci of high infection rates in at least 3 and probably 6 provinces
- Rates of STDs and tuberculosis are high
- Behavioral factors haven't changed:
- Multiple partners high for women and men;
- Little sexual behavior change;
- High rates of sexual activity among young people;
- Early childbearing;
- Low condom use, especially among rural populations;
- Low literacy and inadequate spread of IEC messages,
- Lack of power in sexual and social relations for women.

Mise en forme : Puces et numéros

______Low literacy and inadequate spread of IEC messages,
______Lack of power in sexual and social relations for women.

Implications of Projections for Planning in Mozambique

- More than 1,200,000 Mozambicans adults and 54,000 children are living with HIV/AIDS
- At least 24,000 Mozambican infants are born HIV positive each year
- HIV seroprevalence unlikely to peak before 2002
- **Infection levels will remain high through 2010**
- AIDS deaths between 83,000 and 120,000 per year between 2000 and 2015
- **Deaths will not level until 2020**
- The proportion of children orphaned will be high through 2030 or longer
- **Most severe social and economic impact between 2004 and 2014**

A potential for rapid increase in seroprevalence in the population, unmatched by allocation of budgetary resources and the proliferation of prevention and care services according to a sound national strategy, could worsen the impact of these projections. Governments in neighbouring countries have reached similar conclusions concerning the impact of HIV/AIDS and the need for intensified prevention and care programmes.

The impact of the epidemic, according to recent models in Zambia, will be more long term than thought before. **Even if the epidemic were to be contained in the very near future, and no new infections occurred after 2000, infection levels will remain high through at least 2010, deaths will not level until after 2020, and the proportion of children orphaned will remain disproportionately high through at least 2030**.

B. Contribution to Adult and Child Mortality and Morbidity

The social and economic costs of the epidemic are already high in Mozambique, although they have not been estimated by a quantitative multisectoral study. UNAIDS estimates that there were 83,000 deaths due to HIV/AIDS in the country in 1997 alone, and that there were 1,200,000 infected individuals living with HIV/AIDS. At the end of 1997, there were an estimated 150,000 children who had lost their mother or both parents to the epidemic, projected to increase to 400,000 by 2000. *Some 40% of hospital beds in some provinces are now devoted to HIV positive patients.*

Impact on child and adult mortality and morbidity over the next 20 years will be very high. New projections completed by the Department of Economic and Social Affairs of the UN Secretariat's Population Division in November 1998 of the impact of the epidemic on population growth, infant and adult mortality and life expectancy and death rates include Mozambique among the 34 most affected countries in the world, 29 of which are in Africa. The Population Division worked with UNAIDS, which provided the seroprevalence data and projections using EPIMODEL, and the U.S. Census Bureau, which has the largest repository of AIDS information in the world, to develop infection curves.

Projections for Mozambique were made using the 1996 seroprevalence estimate of 11.92%, which

increases until approximately 2005 and then stabilises. It is assumed that the number of new HIV infections in each country will stabilise at 50% of its peak level and then stay constant through 2050.

Contribution to Infant and Child Mortality. According to these projections, infant mortality in Mozambique will increase between 1995 and 2000 by 9% due to AIDS. Through 2015, HIV/AIDS is expected to increase infant mortality levels 20 to 22% over what they could have been without AIDS. In countries like Namibia, Botswana and Zimbabwe, where significant reductions in infant mortality had been achieved prior to the AIDS epidemic, reversals will be greater than in countries that had higher baseline rates. If infant and under-5 mortality increase by at least 20%, they will be to 162 and 240 respectively by 2010. These rates could potentially go higher if seroprevalence rates to reach 20 to 25%.

The increases in infant and child mortality may be even greater in areas where localised infection rates are approaching the rates seen in Zimbabwe and Zambia, areas where health care facilities are already experiencing the demands from increased HIV/AIDS related mortality. The increase in infant and under-5 mortality will be due to the HIV infection of children born to HIV positive mothers, and will occur unless major inroads are made to improve the health and wellbeing of infants and children who are not HIV positive.

Contribution to Maternal Mortality. In 1996, Mozambique's maternal mortality was measured at 1,500 per 100,000. While there is no documentation of the impact of HIV/AIDS on maternal mortality in Mozambique, a study of hospital data in Swaziland suggests that AIDS has already increased maternal mortality by over 20%.

Contribution to Adult Mortality. There is no direct measure as yet of the impact of AIDS on adult mortality in Mozambique, but we know from direct studies in other countries that adult mortality doubles and triples (depending on the base rate) when HIV prevalence in a country reaches 10%. Since Mozambique's estimated prevalence rate is 14.2%, the impact on mortality in the 15 to 49 year age group is already becoming profound.

Demographic Impact of the Epidemic on Mozambique

- 20% increase in infant and child mortality to 162 and 240 respectively
- Increase of maternal mortality by at least 20%
- At the minimum, doubling of adult mortality
- Increase child and adult morbidity (illness) Tuberculosis
- Lower fertility
- Reduction in population growth
- Change in population structure resulting in severe increases in dependency ratios (loss of productive adults, more children, more older persons)

Contribution to Morbidity. HIV and AIDS have extremely negative impacts on adult and child health. For example, it is estimated that 30 to 40% of HIV positive children die within their first year of life. Surviving children often experience many more illnesses and developmental difficulties than HIV negative children, which means an additional burden for their care-givers. At current infection levels, at least 24,000 Mozambican infants contract HIV each year.

Tuberculosis in neighbouring countries (Zambia, Botswana, Zimbabwe, Malawi), has quadrupled over pre-epidemic levels. Tuberculosis in HIV- children has also been shown to increase in children living with an HIV+/TB+ adult. The economic cost of AIDS-related illnesses suffered by adults is high, often with a more severe economic cost on employers than their eventual deaths. Studies have also shown that HIV/AIDS reduces female fertility at the individual and population

levels.

C. Population Impact

Population Size and Structure. Currently, Mozambique's official population projections do not include calculations of the impact of HIV/AIDS on population growth and structure, both of which will be considerable. *Preliminary estimates of the population growth rate from 1997 Inquérito Demográfico e de Saúde (IDS) is 2.9% per year for the 1991-1997 period, up slightly from 2.6% per year during the1980s*. In depth data from the 1997 Census is due to be published in April by the Instituto Nacional de Estatística (INE), so revised population projections are not yet available. If population projections from the new Census fail to include specific estimates of the impact of HIV/AIDS mortality, Mozambique's estimates of the need for additional resources in all sectors may drive an overstocking of capital and human resources.

The UN Population Division estimates that Mozambique's overall population will be 2% lower than expected by 2000, and 15.2% less by 2015 using a seroprevalence estimate of 11.92%. The number of deaths between 1995 and 2015 is estimated to be 3.4 million greater with AIDS than without AIDS. In addition, the number of children who will be born will also be lower because of deaths of child bearing age women in that period.

In addition, it is well known that HIV/AIDS attacks the most productive age group because they are sexually active. This will increase the ratio of dependent persons (children and the elderly) to economically productive individuals, a ratio that is already high in Mozambique. Published UN estimates do not provide information on changes in the projected population structure in Mozambique, but they are probably available from the Population Division.

D. Sectoral Impact and Preparedness

The new National AIDS Strategic Plan will be created through a multisectoral process lead by the Minstério de Saúde but including representation from all government Ministries, NGOs, religious groups, labour unions, the private sector, political parties and UN agencies to a Steering Committee. Technical personnel will be nominated by the Steering Committee members from each sector.

Given the lack of official projections of population impact, it is difficult for the line Ministries to project impact of the epidemic on demand and need for their services or on their ability to supply essential services. Most are just becoming aware of the trends in increase of the Mozambique epidemic or the implications high seroprevalence had for their sectors. This is a severe handicap to the government's ability to provide leadership in combating the epidemic or being prepared to mitigate its impact.

As a preliminary part of the strategic planning exercise, each Ministry needs to look at impact of the epidemic on loss of skilled personnel, and its impact on reduced client base for their services. In addition, planners need to brainstorm other effects and ways to become better prepared for them (see box). These analyses should be refined by each Ministry using new population data and projections.

Agriculture. As part of its planning process, the *Ministry of Agriculture (MoA)* is developing a vulnerability mapping system with technical support from Save the Children Fund (SCF/UK). This exercise is also being supported by SCF/UK in Zimbabwe, Zambia, and Swaziland to improve drought preparedness and the ability to

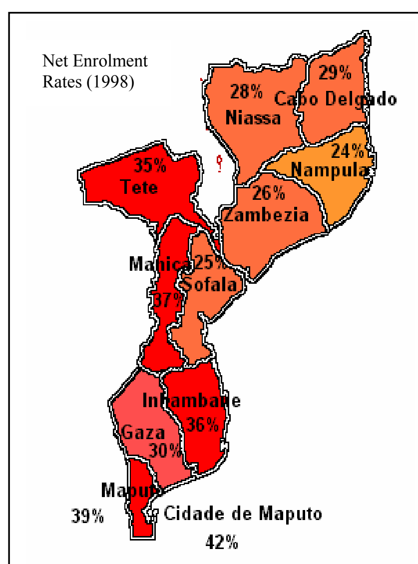
Sectoral Impact and Preparedness

Sector	Impact	Preparedness
Economic Development	Need to review development strategies	New population projections can be prepared
Finance	Reduced savings and investment Decline in economic productivity	Reactions not known
Natural Resources	Land administration and tenure	Protection mechanisms for orphans and widows are in place
Public Works and Housing	Pressure on municipal government from street kids	Developing urban services and land
Labour	Loss of skilled and unskilled labour in all sectors	Projections can be made from revised population projections
Agriculture	Loss of production in subsistence agriculture	Vulnerability Mapping
Education	Loss of teachers # of needy children increasing	Review of informal ed and ECD programme AIDS education in curriculum
Health	Demand for services up, increased AIDS & TB cases; Loss of personnel; Increased hospital costs	PNCS CHWs Syndromic STD managem't, drugs
Social Welfare	Increased demand for child support and counseling	Plan for developing community based care
Gender	Further decline in women's status	CEDAW near adoption
Youth	Increased morbidity, mortality, exploitation, self-sufficiency	Youth Clubs for prevention care, microenterprise fund
Police	Increased demand for child protection	Training programmes
NGOs And Churches	Increased demand for services	NGO Consortium to rationalise programming and increase efficiency
Commercial Private Sector	Data on impact	AIDS prevention/ care programmes

target beneficiaries for relief activities. Mozambique's *MoA* has a preliminary analysis of results that show sources of vulnerability and the locations of most vulnerable households. This can be used by MICAS and the NGO committee on AIDS and the government to strategize development of community based programmes for orphans and target beneficiaries.

Personnel in this Ministry could benefit from having exposure to the many studies of the impact of AIDS on agriculture (subsistence and commercial) which have been supported by FAO in Eastern, Southern and Western African countries. These studies have developed methodologies for evaluating sectoral impact, all of which are premised on the existence of a vulnerability map similar to Mozambique's. FAO also has a programme to support activities to ameliorate impact that might be advantageous to the Ministry.

Education. The Ministry of Education's new development plan is focussed on building facilities and teacher capacity in Mozambique. At present, primary school students may attend schools in three or four sessions a day so that a much larger group of students can be accommodated. The Ministry's 1998 survey showed provincial net enrolment rates ranging between 24 and 42%. The Ministry is also completing development of a new curriculum. Currently, AIDS education is provided in science courses in the secondary schools.



The Ministry is interested in reviewing the efforts of other countries in the region to project the impact of AIDS on teachers and enrolments. Recently, Zambia began complete revision of its policy on access to primary education to accommodate the number of orphans unable to afford school. Zambia's alternative community school system was under increasing pressure to help communities develop more resources, and even to open pre-schools and crèches to care for the youngest orphans.

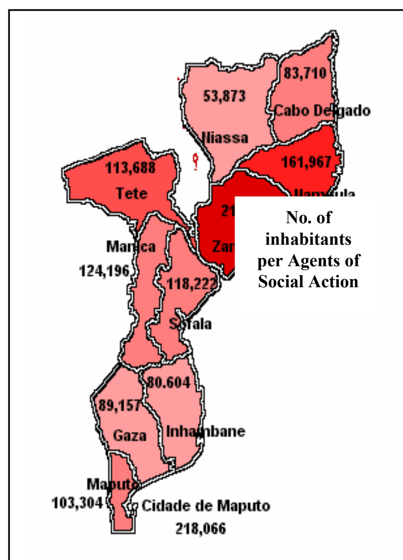
Health. MISAU has not yet prepared projections on the impact of AIDS, but the extensive preliminary projections contained in the 1993 Whiteside/Wood report in neighbouring Swaziland could be helpful as a starting point of analysis. These are available for education and several other sectors as well as health. In the health sector, the projections show increased demand for health care, increased costs and caseloads, and loss of skilled personnel.

The *Programa Nacional de Combate ao DTS/SIDA* within MISAU is thinly staffed. Its director is also responsible for epidemiological analyses for other infectious disease outbreaks in Mozambique, which frequently demand his attention. However, syndromic treatment of sexually transmitted diseases is being introduced in hospitals and clinics, which will contribute greatly to control of the AIDS epidemic. Efforts are underway to make these services more attractive to adolescents and young people. For the time being, the Ministry has concluded that use of AZT to prevent maternal to child transmission of HIV infection is not fiscally possible, and will continue to promote breast-feeding, widespread in Mozambique, because alternatives are unavailable.

MISAU has Provincial AIDS Officers, entrusted with co-ordination of community IEC and behaviour change programmes. Condoms are provided free through health clinics, but there is a sense that they are not widely available or accessible to young people. Informal HIV testing and counselling services are provided through some of the provincial hospitals, and the Ministry has established a counselling and testing and AIDS information centre in Maputo. Despite these efforts, AIDS education, counselling and testing, and condom use must become much more persuasive if epidemic trends are to be reversed.

Home care programmes are not well developed. In Maputo, the Central Hospital has a day centre for AIDS patients who are referred there from the main hospital when they are ambulatory. Services provided include diagnosis and treatment of opportunistic infections, counselling, and home visits where required. This centre is supported by the French Co-operation. There is also a Day Centre in Chimoio, and one is also planned in Tete. MISAU staff receive no training on home based care. Some work has been initiated with AMETRAMO, the organisation of traditional healers, in this area.

Social Action. MICAS currently has the smallest government budget, and with roughly one agent of social action post per district, population to social agent availability in the provinces ranges from a range from 53,000:1 to 218,000: 1 (see box). There are four trained social workers in the country. Most skilled staff are in MICAS headquarters.



The responsibilities of the agents of social action are to provide casework services for disabled children, assisting the child and family to cope. They also engage in some community development work, and their other roles depend largely upon the person in the job and their resources, which are few. However, some record the numbers of orphaned children in their community, and monitor their status to some extent. Almost always, their activities are limited to the district capital, as they either have a bicycle or no transport.

Gender. Many attribute the rapid spread of HIV infection in Mozambique to the low status and economic standing of women. Mozambique has ratified the Convention for the Elimination of Discrimination Against Women (CEDAW. There appears to be need to develop new norms and provide training to men who may be pressed into service as care givers, not only for the ill but for children. Fortunately, land laws were changed last year to allow women to own property in Mozambique. This includes rights of ownership to property worked by a woman, whether it is legally deeded or not.

Youth. The Maputo City Health Directorate has a project for the treatment of street children, particularly girls. Other programmes for young people were not determined during this site visit.

Strengths in Mozambique Against AIDS

- ✓ Recognition of need for strategy in all sectors
- ✓ Concern for equity and social justice
- ✓ Commitment to expansion of services
- ✓ Good partnerships between government, NGOs, UN agencies
- ✓ Strong donor commitment
- ✓ Many barriers are due to lack of information rather than traditional biases
- ✓ Willingness to learn on the part of policy makers

Police. Police are receiving training in sensitive handling of abuse cases, and are beginning to work with communities to mobilise their response.

Non-Governmental and Church Organisations. The NGO community in Mozambique is considered a full partner with government in the provision of social services (including health, education, social work) and community development activities. Because of the war and recent refugee resettlement, the government has relied heavily on the services of NGOs resulting neglect of the social welfare services. NGOs have a considerable network of services, described in Section IV below, and are collaborating to produce a co-ordinated, rationalised system of response that will increase equity, access and availability on a geographic basis and improve programme quality.

Commercial Private Sector. Private businesses and employer associations were not interviewed during this visit but it is likely that some have evaluated the impact of HIV/AIDS on their work forces, training needs, and benefit costs.

E. Conclusions and Recommendations

Dangers Implicit in Lack of an Effective AIDS Prevention Strategy

In no sector is the government prepared through planning exercises and scenarios to anticipate or shoulder epidemic-induced changes and increases in demands in the face of lost management capacity and labour productivity. A false sense of security prevails that the MOH is taking care of the problem and that institutional solutions will be sufficient to deal HIV/AIDS. Where Ministries are aware of the problem, they lack the tools and strategies to launch effective interventions. Lastly, a sophisticated strategy across sectors that emphasises rapid and widespread increase in the public's explicit knowledge and use of HIV prevention tools could guide individual Ministry efforts.

Cost of Failure if AIDS is Not Addressed

1. Loss of development gains and potential
   - ✓ Loss of skilled personnel in all sectors
   - ✓ Loss of infrastructure as revenue declines and maintenance becomes more difficult
2. Social unrest from children and youth who are unprotected, underfed, under-schooled, and poorly socialised
3. Loss of human life to AIDS and other diseases as AIDS clogs health care system
4. Retrenchment of diseases, such as TB
5. Diversion of resources to care for HIV/AIDS patients from other sectors is a potential

Mise en forme : Puces et numéros

Fortunately, the government is gearing up for a multisectoral strategic planning exercise in HIV/AIDS. The cost of failure to develop that strategy will be enormous:

Loss of development gains and potential in all sectors, including skilled personnel and

Mise en forme : Puces et numéros

infrastructure that cannot be maintained through long term losses of productivity;
Social unrest from children and youth who are unprotected, underfed, under-schooled, and poorly socialised;
Losses of human life, adult and child, to HIV and other diseases as AIDS destroys the health sector's ability to respond by clogging hospitals and clinics with AIDS-related cases;
Retrenchment of other diseases, such as tuberculosis;
Resources may be diverted from other sectors to meet increased demands for care from HIV/AIDS infected persons for health care.

Disaster, however, is not inevitable. Although public health experts around the world have been humbled by their limited success in controlling the spread of HIV/AIDS, it is not impossible to reverse epidemic trends. Uganda and Thailand countries where increasing infection levels were reversed through deliberate public strategies. Parts of Tanzania, where resources are vastly more limited than Mozambique, have also succeeded in limiting its spread. Finally, in areas where it will be impossible to contain the epidemic, a national HIV/AIDS strategy needs to put in place mechanisms to limit the impact. What is badly needed and will be developed through the strategic planning process is a clear vision and coherent strategy for carrying out activities in prevention and care.

Barriers to Effective AIDS Control in Mozambique

- Most people including policy makers are unaware of the implications of infection levels in Mozambique
- Need for strategic multisectoral plan
- Need for government debate of and investment in prevention and care
- Need for more widespread sentinel surveillance data
- Need for projections of impact on population growth and sectoral impacts
- Need for more skilled personnel in MISAU devoted to AIDS strategy building
- Need for more skilled personnel in MICAS
- Need for strategic planning and coordination and networking between government and NGOs
- Need to communicate potential impact to other Ministries
- Limited health personnel and low access to health care facilities and workers
- Widespread poverty and recent refugee resettlement
- Limited availability of testing
- Need for widespread syndromic management of STDs
- Women's low status and child bearing patterns
- Risk behaviors, such as extensive multiple partners and low condom use and little evidence of behavior change in young people

While the epidemic has hit Mozambique hard and its impact will be felt well into the future, the country has considerable resources for preventing further spread and for intelligent planning to ameliorate the diseases across sectors. Some of Mozambique's considerable strengths for combating the epidemic observed during this assessment are listed in the box above while the box at right lists some of the barriers to programme effectiveness. Details on sectoral preparedness and impacts have been summarised on the preceding two pages.

The first step is for Ministries to undertake technical analyses of sectoral-specific impact and responses. These would include impact on Ministry personnel (losses, projected costs for replacement, key capacities lost) and on delivery of Ministry services. They would also include projections of increased demand for services due to increased AIDS deaths, illnesses, loss of family support services.

Necessary support for these exercises must come from the central Ministries. Population projections revised to reflect the reality of AIDS are essential. Central ministry economic and budgeting personnel who support line or sector functions may benefit from meeting and developing models for projection and analysis that they can then use when working with line Ministry planners.

In preparing these documents, Ministries will begin to understand the widespread and profound impact AIDS will have on their work and their ability to fulfil the development vision of Mozambique.

Strategic and Policy Concerns Related to Orphans

Health
- Delivery of services to households with elderly guardians and child headed households
- Monitoring health status of orphans and non-orphans to ensure equity

Social Welfare
- Develop family and community capacity to support orphaned children
- Provide on-going organisation and psychosocial support to community mechanisms for care
- Social welfare benefits may be needed by the poor so orphans can be maintained within the family and community
- Educating care givers and children to prevent abuse
- Developing community mechanisms to ensure child rights

Education
- Education as protection and socialisation mechanism
- HIV/AIDS education in curriculum
- Alternative schooling in heavily impacted provinces

Women/Gender/Property
- Educating women concerning property and inheritance
- Community education on child rights

2. Costing Alternative Prevention Scenarios and Interventions

From the experience in Uganda and Thailand, we know that there are a variety of effective interventions, including:

Massive, *explicit* public education – the infection levels, behaviours that contract the disease, and ways to avoid infection; compulsory school programmes at the earliest ages; openness about the disease and discouraging stigma, so care and prevention can be linked;

STD diagnosis and treatment – aggressive case identification and syndromic management;

Widespread counselling and testing so that HIV positive people are aware of their status and act to avoid infecting others;

Widespread access to condoms. Limited access and distribution services through the Ministry of Health could be widened.

Each of these strategies has associated costs, infrastructural requirements, and timeframes for implementation. For example, it is likely that public information campaigns concerning the level of the epidemic can be launched immediately. Making AIDS a compulsory school programme will take longer, but will help to protect the next generation of Mozambicans against infection. In all, mass and peer education campaigns are less expensive, fast, and relatively effective with the young. STD and testing alternatives require professional inputs, infrastructure, and are considerably more expensive to implement. Prevention and care scenarios can be linked – must be linked – to be effective.

The Strategic Planning Group needs to develop tools to evaluate alternative strategies along these three dimensions (cost, infrastructure and time), perhaps working with the Ministry of Finance. Once the options are better laid out and costed, Mozambique's central Ministries can better select those that optimise a country's preferences for effectiveness and health.

3. Linking Prevention and Care Alternatives

There are several important reasons why the issue of care, both for persons living with HIV/AIDS and their children, must be featured in the new Mozambican National AIDS Plan and linked clearly with strategies for prevention:

Effective AIDS Prevention and Care Requires Investment

Country	PLWHA	Investment in HIV/AIDS Donors	Government	Total $s/ PLWHA
Uganda	930,000	$12 million	$2.5 million	$15.59
Malawi	710,000	$8.4 million	$1.1 million	$13.38
Mozambique	1,200,000	$3.7 million	$0	$ .27
Zambia	750,000	$5.9 million	$200,000	$ 8.13
Zimbabwe	1,500,000	$13 million	$ 44,000	$ 8.70
Kenya	1,600,000	$6.6 million	$3.5 million	$ 6.31

Draft UNAIDS Data, 1998; last column calculated using columns 2-4

1. From the implementation perspective, Mozambique is well past the period when prevention programmes will be effective unless they are linked to programmes for providing care, especially in the central provinces;

2. Financially and practically, care will be a major development burden to Mozambique. It must be integrated and mainstreamed into many sectors to be affordable and efficient.

3. Simple projections of lost human resources in key sectors will begin to highlight requirements for mitigation of the human suffering caused by the epidemic for policy makers;

4. The national strategic planning process will be tied to donor funding development. The cost of care for PLWHA and orphans must receive a fair share of the AIDS investment in Mozambique or donors will fail to anticipate its long term costs

4. Collection of Additional Serodata to Better Document the Situation in the Provinces and Better Understand Epidemic Development in Mozambique

With the current scheme of sentinel surveillance sites, it is impossible to determine prevalence rates in Zambézia, Cabo Delgado, Inhambane, and Gaza Provinces so a more realistic picture of the epidemic's distribution can be gained. Expanded serosurvey data may be required. Alternatively, an analysis of STD rates might suggest similarities in probable HIV rates. It would also be useful to map comparative data with bordering areas of neighbouring countries, and to display epidemic histories in other countries to show how the epidemic might explode in Mozambique.

While the epidemic has hit Mozambique hard and its impact will be felt well into the future, the country has considerable resources for preventing further spread and for intelligent planning to ameliorate the diseases across sectors. Mozambique has considerable strengths for combating the epidemic (those observed during this assessment are listed on page 33), although the barriers to programme effectiveness are also sizeable (page 34). Sectoral preparedness and impacts is

summarised on pages 30 to 33, but more details are needed from each Ministry, the NGOs and the commercial private sector.

Any effective prevention and care programmes will require considerable investment in a number of sectors, not just health. The box above shows draft data from UNAIDS on government and donor investment, total and per person living with HIV/AIDS, in selected African countries. Government commitment to deal with AIDS, while measured by investment dollars, also signals a willingness to take action across all sectors to stop the disease and ameliorate its consequences.

III. Situation of Orphans and Care Givers in Mozambique

A. Prospects for Children in Mozambique

The prospects of children in Mozambique will worsen drastically because of AIDS in a number of ways:

Infant and child mortality rates will increase by at least 20%;
Many more HIV positive infants will be born;
Orphan rates will be three to four times a higher than normal;
At least one million of all children are living in families where a member is HIV positive, meaning that they are exposed to other infectious diseases in addition to the trauma resulting from caring for ill family members;
As more adults die and children are left without parental and familial protection, significantly more children will be made vulnerable. Rates of abuse and labour exploitation, especially in informal and domestic situations, will increase. More children are likely to live on the street and engage in illegal activities and substance abuse.

Mise en forme : Puces et numéros

1. Estimates of Orphans in Mozambique

Children Affected by HIV/AIDS
Estimates for Mozambique

Existing Orphans, 1997 – IDS/INE
Mother :325,619 (4.3%<15)
Both: 71,685 (0.9%<15)
Father: 505,338 (6.7%)
Total: 901,551 (11.9% <15)

Estimated AIDS Orphans, 2000 -- PNCS
Mother or both: 400,000 (4.9%<15)
(Father: 400,000, 4.9<15)*
(Total: 800,000, 9.8%<15)*

HIV Positive Children, 2000 -- Webb
Number: 247,000
Percent: 3.1% of children <15

Children Living in Families with HIV/AIDS, 2000
Number: 1,144,237
Percent: 14.2% of children <15
Percent: 14.2% of children < 15

The number of children needing care and protection in Mozambique are potentially enormous and will mushroom as AIDS deaths escalate. Data from the 1997 *Inquérito Demográfica e de Saúde* (IDS) show that a large proportion of children are already orphaned in Mozambique before the effects of increased adult mortality from HIV/AIDS are being felt to any substantial degree (box at right). Some 4.3% of children under 15 are missing their mother, 6.7% of children their father, and 0.9% of all children both of their parents, for a total of 11.9%. This is much higher than pre-epidemic DHS data from other Sub Saharan African countries, where only a total of 5% of under-15s are missing one or both parents. In addition, in other countries, these surveys tend to underestimate the proportion of children orphaned by as much as one half because households sampled must include a woman between 15 and 49. As a consequence, orphans who are living with elderly grandparents, fathers or uncles, in child headed households or in temporary arrangements are not included. Full count data, if available from the Census, will provide corrections for any underestimates made in the IDS. Complete IDS data by province is provided in Appendix 5.

Beyond 2010…

If we assume that HIV seroprevalence will peak in Mozambique by 2000 -- unlikely due to lack of significant behaviour change -- orphan populations will peak between 2007 and 2010. **This means that Mozambique will have a high orphan population, as a proportion of children under 15, through at least 2025.**

Estimates made using EPIMODEL by the *Programa Nacional de Combate ao DTS/SIDA* (PNC DTS/SIDA) suggest that approximately 400,000 children will lose their mother to the AIDS epidemic by 2000. Some of these children may be captured in the 1997 IDS survey, which includes children orphaned by all causes of death. In addition to these maternal orphans, whose mothers have died from AIDS, an additional number of children will lose their fathers to the same cause. These children could constitute up to 10% of all children under 15 in the country by 2000 independent of other causes of death, and their numbers will increase rapidly as AIDS-related deaths escalate. Such escalation is common in areas where HIV prevalence climbs towards 20%. Mozambique's central provinces are nearing this level, and it is not unreasonable to assume that orphan populations there could increase rapidly shortly after the turn of the century.

While some of the orphans in the IDS estimates will be older than 15 by that time, many will not. This means the second wave of orphaning – due to AIDS – will compound the effects of the first, threatening to overrun families and communities. Orphaned children whose mother, father or both parents have died are likely to constitute close to one quarter or third of children under 15 years of age by the year 2005. The mushrooming of the orphan population which will occur in the next 10 years due to the epidemic is a typical result of the exponential growth of AIDS infections and death in Mozambique and its neighbours in East and Southern Africa.

Not only is the problem looming close on the horizon, but it is likely to be long term. When seroprevalence rates increase to 20%, they remain high for it is clear that orphan populations will be disproportionately high through at least 2030, given the lack of significant sexual behaviour change among sexually active groups to slow the spread of the virus. As a proportion of children under 15, orphan populations will continue to grow in Mozambique through at least 2010 if seroprevalence ceases to increase in the country within the next two years. This assumption is not realistic, because sexual behaviour has changed little in Mozambique.

Growth in the number of orphans of the epidemic will not level until AIDS deaths stabilise. If we assume that seroprevalence will not stabilise in 2000 -- likely given the lack of sexual behaviour change in young and old alike in Mozambique -- **the number of orphans will probably continue to grow through the year 2015 or 2020 before the rate levels. This means that Mozambique could experience unusual numbers of orphaned children through at least the year 2030.**

The interaction of tuberculosis and HIV infections has resulted in a quadrupling of TB cases in Mozambique over the last 10 years. HIV is progressively eroding the gains made by tuberculosis control programmes in all Sub Saharan African countries prior to the AIDS epidemic, not just in Mozambique. TB now clusters around the sexually active age group because of its association with HIV infection. The tuberculosis epidemic is increases treatment costs and makes disease control efforts much more difficult. As a result of this interaction, HIV-related deaths in adults may be even higher than that projected for AIDS alone, with obvious implications for orphan rates in Mozambique.

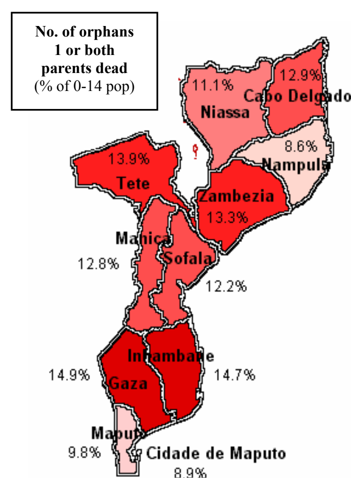
Estimates of children who are paternal orphans, children who have lost their father to AIDS, have not been made for Mozambique. It can be expected that this number will at least twice the number of maternal orphans (children who have lost their mothers). The ratio may be higher in earlier years of the epidemic because men tend to contract the disease first and transmit it to their female partners. The proportion of children who are double orphans will grow as the epidemic deepens and more female partners die.

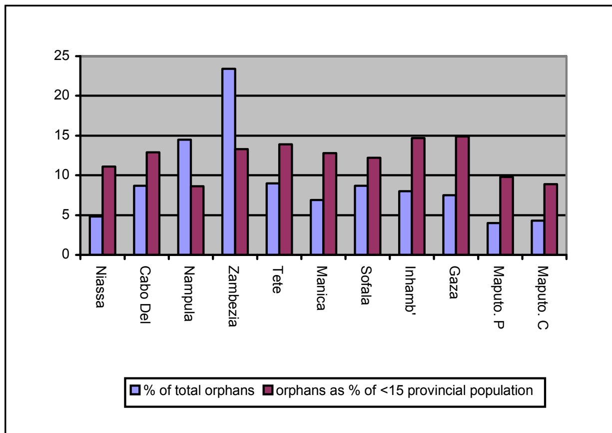
> **Why Paternal Orphans – Children Whose Father Has Died – Are Vulnerable**
>
> -- In patrilineal groups in Mozambique, as in most countries in the region, **when a child's father dies, the child is in fact a double orphan** because the mother is not living with the father, is sent away or leaves to remarry elsewhere.
>
> --Often, both parents are infected, which means that **the child will eventually become a double orphan**, that is, with both parents dead
>
> --Children **over the age of 5 need the cash support** most often provided by fathers for education and health care
>
> --The **vulnerability of families and communities is related to the overall number of adults and children living**, so that a community with large numbers of single or double orphans may have reduced productive capacity

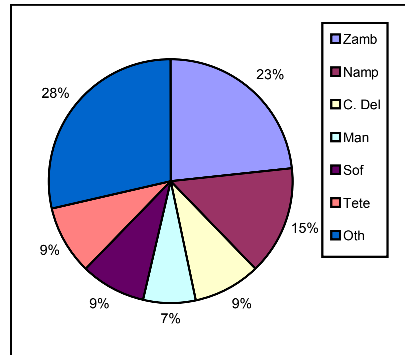
Although demographers generally prefer to estimate maternal and double orphans for methodological reasons, the number of children who are paternal orphans is also important. Paternal orphans may be *de facto* double orphans (missing father and mother both) due to the high proportion of female headed households in the country (30%). In understanding the orphan data, it is important to separate the estimates of children who are in single parent households from those who are orphaned, whose parents are dead. Orphan estimates do not include parents who are absent from the household but are not dead although non-resident parents may not provide support to the households.

2. Geographic Distribution. Given what is known about epidemic patterns in Mozambique, it is likely that the proportion of children orphaned will increase most rapidly in the provinces of Tete, Manica, and Sofala, followed by Zambézia, Nampula and Cabo Delgado. Gaza, as mentioned above, may also have high seroprevalence and see early increases in orphaning given its social and economic history. Levels are likely to reach 25 to 33% of the under 15 population of these provinces in the near future. The first three provinces contain 23% of Mozambican children under 15, and the second three are home to 49%, so a total of nearly three-quarters of children under 15 in Mozambique reside in the 6 provinces likely to be most heavily infected.

As a proportion of the total, over a third of all Mozambican orphans are in only two provinces, Zambézia and Nampula. However, when the number of orphans is expressed as a percent of the provincial population, it can be seen that in Nampula, only 9% of children under 15 are orphaned, compared to 15% in Inhambane and Gaza.







3. HIV Positive Children in Mozambique

According to a recent situation analysis of HIV/AIDS and children in Mozambique (Webb, 1997), approximately 24,000 infants will contract HIV from their mothers during pregnancy or delivery or from breast feeding each year using the current 14.2% infection rate. This number could reach 50,000 per year by 2002 if infection levels approach 25%. This study also estimated that there would be 247,000 HIV positive children in Mozambique by 2000, or 3.1% of children under 15. The estimates of orphans in Mozambique shown above do not include children born HIV positive if one or both parents have died. However, a certain number of these children will be living with HIV+ parents, and are not included in the orphan estimates.

HIV positive children will number in the tens of thousands and represent a substantial burden of care for families, communities, health facilities and health and social workers. In addition, these infant and child deaths will contribute to the anticipated decline in Mozambican life expectancy to 36 by 2005. Reductions in life expectancy does not mean, of course, that HIV negative adults will live shorter lives, but on the average, when additional child and adult deaths from AIDS are included, that life expectancy for Mozambique as a whole is reduced.

4. Children Living in Families with HIV/AIDS in Mozambique

If we assume that children are distributed relatively evenly among Mozambican households with HIV positive adult members, then 14.2% of children under 15 in the country, or 1,144,237, are living in families affected by HIV/AIDS. These children will help care for sick adults, may contract tuberculosis (a particular concern, given the low level of immunisations), and many girl children will be forced to drop out of school to provide care or replace the labour of sick and dying adults. In addition to these deprivations, these children will suffer the psychological trauma of watching a parent die a difficult and protracted death, which typically results in continued behaviour problems through adolescence.

5. Other Vulnerable Children in Mozambique

It is widely accepted that children orphaned by AIDS and other causes do not constitute the only group of vulnerable children in Mozambique, and that through their life cycle, children may move in and out of various categories of vulnerability as their life circumstances change. In order to understand the magnitude of the population of vulnerable children in Mozambique, it would be useful to have estimates of the following:

Street Children. According to Webb's 1997 analysis, the number of children living on the street in Maputo does not seem to have risen dramatically over recent years. This may be due to two factors: relatively low seroprevalence in the city (5.8% of antenatal clinic attendees), and the existing ability of families to absorb orphans in other places. Webb feels Maputo, where half of Mozambique's urban population resides, will see a rise in orphans and street children between 2005 and 2010. Other urban areas may see increases between 2002 and 2005.

Child Labourers. In 1995, it was estimated that there were 1,038,794 working children in Mozambique, 279,398 of whom were under 13. This group is large because of the extent of poverty in the country, and it will increase as AIDS-related mortality grows, and the proportion of children entering the formal work force increases due to losses of adult labour.

Children Who Are Sexually Exploited and Neglected. Formal estimates of this group of children are not available but the overlap with other vulnerable populations is probably high, and may grow as the number of orphans increases and adult supervision declines.

Handicapped Children. It is estimated that for every 100,000 people in Mozambique, there are 152 handicapped boys (under-18) and 175 handicapped girls – over 55,000 handicapped children overall. High compared to other countries because of the long years of war and use of landmines.

Civil Unrest. This last cause of childhood vulnerability is currently not an issue in Mozambique.

Characteristic Vulnerabilities of Children and Care Givers in Heavily Infected Provinces

Children
- Underlying levels of orphaning high
- Low immunisation
- High malnutrition
- High infant and child mortality
- Low school attendance

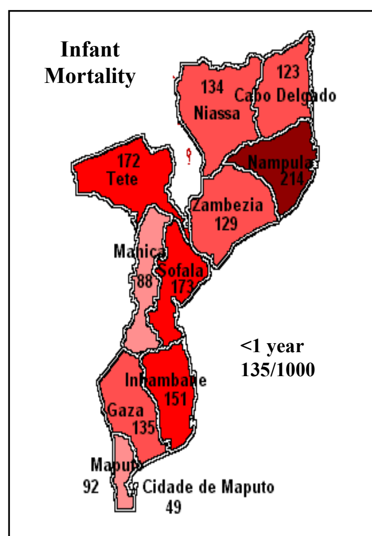
Caregivers
- High maternal mortality
- Low literacy
- Poverty
- Early childbearing
- Large family size

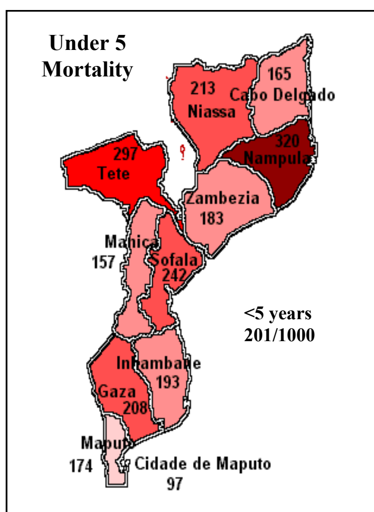
Services
- Use of birth attendants low
- Other health services in short supply
- Educational attendance low
- Social welfare: population ratio low
- NGO services thinner

6. Underlying Vulnerabilities

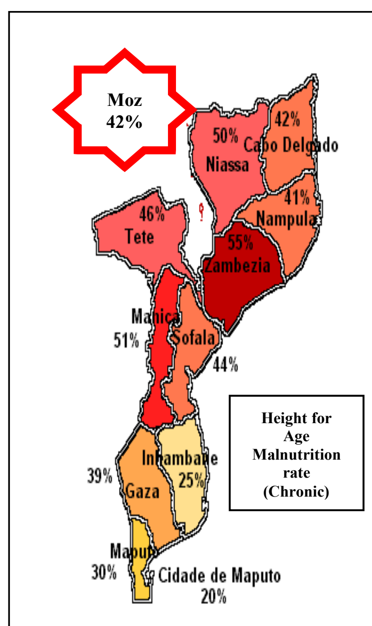
The epidemic's concentration in the central provinces unfortunately coincides with many other vulnerabilities, some shared in common with other provinces, but some of which are greater.

Underlying levels of orphaning are already very high compared to pre-AIDS epidemic levels in neighbouring countries. While some of these children will mature before the next generation of orphans is created by the epidemic, many will still be vulnerable.

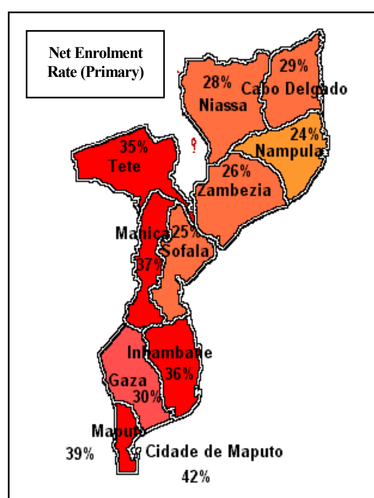




Unlike other provinces, however, children in these provinces suffer poorer health and nutrition status than in other areas of the country. At 214/1000, 173/1000, and 172/1000, infant mortality rates in Nampula, Tete and Sofala are the highest in the country. These three provinces also have the highest under 5 mortality rates in Mozambique. Of the central provinces, only Manica has lower infant and under 5 mortality rates, in fact, the lowest in the country.



Malnutrition rates, including both stunting (shown in the box at right) and wasting, are also higher in all of the northern provinces, including Manica. When chronic malnutrition, or stunting, reaches these levels, children succumb to other childhood illnesses much more easily. These rates are particularly alarming because research studies have shown that orphans suffer higher rates of malnutrition than biological children in the same households, even when their adoptive families are economic stable.



Primary school enrolment rates are also lower in all the northern provinces with the exception of Manica, which has an enrolment rate more similar to those in the southern provinces.

7. Registrations of Orphans and Vulnerable Children

Several groups in Mozambique, primarily church-related volunteers, are collecting baseline data on orphans in the country. While local registrations may be a good exercise for local development or health committees or volunteers, centrally directed enumeration exercises have several drawbacks. The numbers they produce are biased by the point of view of the personnel who collect them. For example, health workers may not see the wider range of vulnerable children seen by social workers. And numbers will expand or contract given economic conditions, so that difficult circumstances may encourage families to identify more children as orphans. Lastly, registrations can stimulate family expectations of assistance if they are not properly handled.

In 1994, Malawi's National Orphans Task Force (NOTF) undertook a comprehensive national registration of orphans which they later called "disastrous". The registration was expensive, it produced unreliable numbers, and raised expectations of assistance. The country still has no vital registration system, so it was also cumbersome to maintain. After evaluating this experience, NOTF recommended that registration be done on a small area basis as a prelude to assistance programmes.

> **Why Malawi and Uganda's National Orphan Registrations Were Abandoned**
>
> -- Registrations were too costly
> -- They raised false expectations of assistance
> -- The numbers produced were unreliable
> -- Registrations could not be maintained or updated once community members learned they were not going to receive assistance
>
> **What Is Now Recommended**
>
> -- Small area, pilot registrations for specific programmes
> -- District registrations by Village Orphan Committees which will be maintained and co-ordinated with local assistance programmes

In Malawi, the Ministry of Women, Youth and Community Services (MOWYCS) now encourages District Social Welfare Officers (DSWO) to work with their District Development Committees and the District AIDS Control Committees to encourage local enumeration of orphaned children by Village Orphan Committees. Results are now being compiled, but it will be better not to draw any inferences from them until they are compared with Malawi's 1991 Census data. These counts can vary widely, depending on the quality of training and breadth of responsibility of the local committees. Orphan enumerations in one district revealed that 6% of children under 15 were orphaned, while in the neighbouring district, with a similar number of AIDS deaths, orphans were estimated at 50% of children under 15.

In 1989, Uganda's Ministry of Labour and Social Affairs worked with local authorities to enumerate orphans in four Ugandan districts (Rakai, Masaka, Luwero and Hoima). This exercise determined that in some areas of Rakai, up to 25% of children under 18 were missing one or both of their parents, many due to AIDS. In 1991, the Ministry and NGOs working with vulnerable children decided to enumerate orphans in other districts, and received funding through the UNICEF Country Programme in 1995 to complete the exercise in 10 districts. Attempts were made to institute Orphan Registration Systems in the 10 districts and update them periodically with an Orphan Migration and Mortality Register.

A 1997 assessment of the Orphan Registration System in Uganda determined that most areas within the 10 target districts had only completed the enumeration once, and that it was fraught with errors. Also, guardians did not update the data by reporting migrations or deaths because they did not

receive any assistance as a result of the initial enumeration. The assessment recommended that enumeration only be done if project assistance was going to be provided because it raised false expectations and was relatively expensive and time consuming to complete.

Key Determinants of Variation in Orphan Needs

- ✔ Age and Sex of Child
- ✔ Age of Guardian
- ✔ Relationship of Guardian to Child
- - ✔ Number of Parents Dead
- ✔ Proportion of Children Orphaned in the Geographic Area
- ✔ Inclusion/Exclusion of Orphaned Children in Family and Community Life
- ✔ Amount of AIDS-related Stigma and Discrimination
- ✔ Access to Health Education, and Social Services and Safety Nets

B. Studies of Children's Needs

Although there is no systematic study of orphans in Mozambique, limited data indicate that they are still being absorbed by the extended family, and their care-givers are predominantly women, many of whom are elderly and poor. Their care-givers are poor and suffer from low literacy. Children and care-givers both experience lower access to resources in health, education, and social welfare.

Studies from other countries show that the needs of orphans, just like other children, vary by their age and sex. Children who have been orphaned by AIDS have the same needs as children orphaned by other causes, although they may suffer additional discrimination and stigma. The needs of orphans are the same as other children in poverty: for basic needs, for food, clothing, shelter, schooling. However, orphans and neglected children often need psychosocial counselling and assistance to deal with the grief they feel over their parents' deaths and the mistreatment they may suffer at the hands of guardians.

Prior research studies in other countries have demonstrated that orphans' needs can vary by the type of orphan, that is, the needs of a child missing its mother are quite different from the needs of children missing their father or both parents. Death of the mother is more critical for children below the age of 5, while death of the father has a greater effect on the develop opportunities of older children. A child missing both parents is generally the most vulnerable of all types of orphans.

Common Problems of Orphans and Their Families Found in Malawi and Uganda Surveys and Studies

--Large Numbers of Orphans Per Family
--Increased Poverty
--Lower Nutritional Status in Fostering Households with Large Numbers of Children.
--Increased Labour Demands on Children
--Reduced Access to Education
--Harsh Treatment and Abuse from Step/Foster Parents
--Less Attention to Sickness in Orphans
--Segregation and Isolation of Orphans at Meal Times
--Loss of Property and Inheritance
--Forced Early Marriage of Female Orphans
--Higher Child Mortality
--Abandonment
--Lack of Love, Attention, Affection
--Grief for Parents, Separated Siblings

The mix by type changes as the epidemic grows in a country. In most Sub-Saharan African countries, men are dying first, followed by their infected wives and partners. This means that over time, more children become double orphans. However, many single orphans, with only one parent missing, are in fact double orphans long before the other parent dies because of cultural practices. In Mozambique, where such a large proportion of women are supporting children on their own, the proportion of children who are "de facto" double orphans is likely to be higher than in other countries in the region. Even when a child's father is not dead, he often fails to

provide support.

Parental death status will also be a predictor of which family member will be the child's guardian, or if the child has any guardian at all. Children staying with their grandparents, especially an elderly grandmother, are often very vulnerable. Stepchildren are characteristically treated more harshly than biological children. Children who are taking care of children are even more vulnerable, and child headed households become more common as a greater number of potential guardians succumb to AIDS or other causes of death.

A 1999 summary of case descriptions on AIDS orphans from Hhohho region of Swaziland (JTK Associates) highlights the following lessons learned and trends emerging in child protection due to the HIV/AIDS epidemic:

Findings on Orphans and Care Givers In Swaziland, 1999

- ✓ Siblings should be kept together
- ✓ Children need to stay in their own homes and communities for continuity and security
- ✓ Many children are responsible for survival
- ✓ Many children are forced to drop out of school
- ✓ Care-givers are often elderly women
- ✓ Income generating projects are needed
- ✓ Psychosocial counseling should be continuous
- ✓ Dying parents should know their status to prepare their families for death
- ✓ No systematic data
- ✓ No monitoring system to prevent abuse
- ✓ Work through traditional structures
- ✓ NGOs and churches provide most of the aid
- ✓ Support to families is self-identified
- ✓ Support to families is urban biased
- ✓ Coordination and cooperation of support systems is not strong
- ✓ Leadership and policy is urgently needed
- ✓ Situation is disastrous because support systems are fragile
- ✓ Research is needed on the children, their care givers and systems of community support

Mise en forme : Puces et numéros

It is important to keep orphaned children from the same family together;

It is equally important to keep orphaned children in their home, family and community, and to ensure that they stay at school with the same friends and teachers;

In many cases, children are left in circumstances where they become responsible for the daily struggle to survive, and provide themselves sufficient food, shelter. They are forced to drop out of school. Their care givers, who tend to be elderly women, are often unable to cope;

It is important to provide income generating projects to these care givers so they can help themselves;

Continuous psychosocial counselling is needed, both for children and their care givers;

It is important to break the silence about the AIDS epidemic in Mozambique so that dying parents can help their children and families prepare for their deaths;

There is no systematic data on these children or systematic monitoring of their welfare or that of their guardians because Social Welfare is helpful but understaffed;

It is important to work through existing structures, especially for rural cases. It is expected that traditional authorities will provide leadership to register and refer cases to Social Welfare;

NGOs, churches, and community volunteers are playing an important role in assisting orphans and their guardians;

Support to these families is not consistent because both government and NGOs are under-resourced;

Support is biased toward urban communities. Rural families are not systematically reached by government or NGOs so they much rely on their own resources;

By and large, children and families identify their own support system;

Co-ordination and co-operation among those providing care to children is not strong.

Leadership from government or NGOs in developing policies is urgently needed;

Policy is needed. "If the SNAP figures are valid, the problem of AIDS orphans is assuming crisis proportions, ad appropriate policies and their co-ordinated implementation are needed and should be widely promoted."

Detailed research is needed, through the social welfare system, schools, and churches to establish the size of the problem and identify which local coping strategies can be replicated."

C. Health and Social Status Indicators

Many studies of HIV/AIDS in Sub-Saharan Africa have noted that increasing numbers of orphaned children and mother to child transmission of HIV may contribute to reductions in gains made in infant and child health in Africa over the last two decades. Specific studies of the health of orphans have shown that these children are disadvantaged in terms of access to health care, immunisation, and nutrition, even after they reach the age of 5. A longitudinal study in Kagera Region, Tanzania showed increased nutritional deficits in both orphans and non-orphans who were HIV-negative because families were unable to successfully support larger families resulting from increased fostering and adoption.

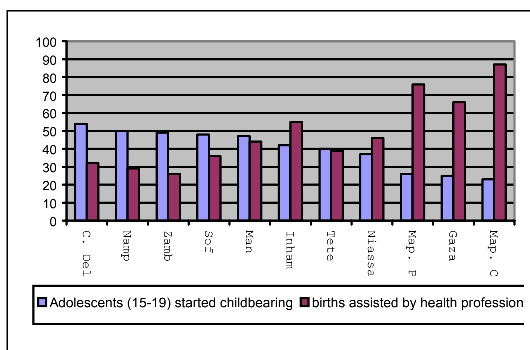
Declines in child health indicators would be especially challenging in Mozambique, which has not achieved the same reductions in these measures as neighbouring countries. Mozambique's pre-AIDS infant (135/1000) and under-5 (201/1000) mortality rates are higher than any neighbouring countries. Maternal mortality is estimated at 1500/100,000. Much of the high maternal mortality rates is attributed to high fertility rates, and early commencement of child bearing, although lack of access to health services also plays a role. All three of these indicators are likely to go up given the impact of HIV/AIDS.

Mozambique's Progress on Child Survival Development and Protection

Indicator	Value
Life Expectancy, 1996	46
Infant Mortality Rate	135/1000
Under 5 Mortality Rate	201/1000
Moderate/severe stunting	42% of < 5's
Moderate/severe wasting	7% of < 5's
Moderate/severe underweight	24% of < 5's
Use of oral rehydration salts	42%
Children <2 years fully vaccinated	47%
Access to a health facility < 5 km	40%
Safe water	20%
Safe sanitation	3%
Maternal mortality	1500/100000
Net Primary enrollment rate	29/100
Adult literacy (male/female)	40%
Percent urban	24%
GDP per capita	$112
Percent below poverty line	69%

High mortality rates correlated with other health indicators in Mozambique. Malnutrition is high, access to health facilities, safe water and sanitation, and schools is low, and 69% of the population falls below the poverty level of 5,433 meticais per day (half a dollar). Immunisation rates are also low. It will be essential to eliminate all institutional barriers to immunisations so that children affected by HIV/AIDS will have all the health protection the system can possibly give them. Health professionals may need information on vaccination protocols for HIV+ children, and programmes that ensure that children lacking parents or primary care givers also receive the full round of immunisations.

D. Situation of Care-Givers in Mozambique



The situation of care-givers and households in the city (some 24% of Mozambicans) is substantially different than in rural areas (76% of the population). Households are smaller, wealthier and have better access to services in urban areas. Since the bulk in growth of the orphan population will occur outside urban areas, we will focus on them in this preliminary analysis. Any research, however, should compile data on both types of households: not only their organisational features, but on their coping strategies as well.

1. Families in Mozambique

While there is no systematic data on orphan care givers – their number, characteristics, and the size of their burden – the 1997 IDS survey provides a good deal of information on type of household by province. Households in Mozambique average 4.2 members according to IDS97, but size varies considerably by province. For example, the average household in Cabo Delgado has only 3.7 members, while in Sofala, average size is 5.0. Some 70% of household heads are men. Roughly 12% of all children under 15 do not live with their parents.

Only 6.5% of Mozambican households have electricity (25% of houses in urban areas and 2% in rural areas). Only 20% of all households have potable water (70% in urban areas, 8%in rural). Only 3% of all households have acceptable sanitation.

Fertility rates vary widely by province. Manica and Tete, with 7.6 and 7.0 children per woman, have the highest rates. Maputo, with a fertility rate of 5.27 per woman, is the lowest in the country. Urban and rural rates countrywide are similar. With such high fertility rates, the burden on women as care givers and on women's health can be seen to be quite high. The high maternal rate, related to these patterns, suggest the proportion of children orphaned in Mozambique would continue to be high even without AIDS.

Childbearing begins early, especially in the provinces with higher HIV prevalence. These figures correlate inversely with the availability of health services, however. It may be important to consider increasing the number of birth attendants as quickly as possible, not to mention increasing availability of modern methods of birth control as a strategy to reduce orphaning in these heavily affected areas. Knowledge and use of modern birth control methods is currently very low.

2. Poverty and Care Givers in Mozambique

INE's 1997 National Household Inquiry into Living Conditions, 1996-97 and the Planning and Finance Ministry's 1998 "Poverty in Mozambique: Profile, Determinants and Policy Implications" combine to paint a staggering picture of poverty in the country. Some 60% of the population is below poverty line of $15 per month. Compared to neighbouring countries, income distributions in Mozambique are not very skewed, and there was a decline in poverty in the provincial capitals from

72.6% to 65.2% in the 1990's.

While poor and non-poor households have the same number of productive adults, poor households have about two times as many dependent members, mostly children. The poor not only have more children, but they begin child bearing earlier. Most women who started child bearing below 16 years of age are in poor households, possibly married off earlier by poor parents to reduce the household burden. Poor women in the 1996-97 survey tended to have two children who had already died. The poor have one-third less land than the rich, but both have little (.4 hectares compared to .6 hectares). Maize is the most common cultivar in all households.

In short, poverty status in Mozambique is affected by sex, age, educational level, and by economic and marital status of the household head. Women, households with older and less educated heads, and lacking wage employment are more likely to be among the poor. The causes of poverty also include death or disability of the breadwinner, large families, teen pregnancy, and breakdown of the traditional social security system whereby productive adults support ageing parents. These findings suggest that poverty will increase as AIDS deaths grow and households try to accommodate more orphaned children.

3. Support for Community Based Care Givers

Given the economic situation of Mozambique now and in the near future, support for family care-givers in crisis will come largely, if not totally from their communities. Conversations with NGOs and government workers seemed to indicate that constraints on the supportive capacity of communities are two: lack of organisation and skills, and lack of income or surplus to share. NGOs working with community volunteers in Mozambique indicated that they were eager to volunteer if they received training, assistance with organisation, contact, and recognition. The record of World Relief indicates that consistent development inputs into volunteer cadres could yield real and measurable improvements in community infrastructure and health status.

Rural communities' lack of commitment to co-operative projects in health, education and social welfare and their failure to participate was thought to be conditioned more by a lack of resources than a lack of will. Recent national surveys in South Africa, Zambia and Malawi indicate that families are willing to accept and care for children if their resources are sufficient. Anecdotal evidence suggests that this feeling is shared in Mozambique. Cost estimates also indicate that it is far cheaper to support care in the home than to incur either the cost of constructing institutions or curbing social problems brought on by children dislocated by loss of parents and guardians.

Findings of recent surveys in Malawi, conducted by Chancellor College's Centre for Social Research and Department of Psychology in Zomba, have found that many families were stressed by the addition of foster children. In many communities, family members were unwilling to absorb any additional children because of economic and psychological stress. However, once the villagers met their needs for psychosocial counselling and support in the development of income generating projects and increased agricultural productivity, they reassumed their traditional responsibility of caring for orphaned children within the extended family.

Innovation in Community Organisation in Malawi in Response to the Orphan Crisis

- ✔ Community Organisation Flexible and Responsive
- ✔ Community Assumes Responsibility for ***All*** Vulnerable Children
- ✔ Community Committees Intervene to Counsel Guardians and Children
- ✔ Community Targets Most Vulnerable Children and Families
- ✔ Community Articulates Children's Rights to Protection
- ✔ Children Have New Forums to Voice Their Problems and Developmental Needs
- ✔ Children and Youth Participating on Village Committees and Contributing to Planning
- ✔ Youth Spontaneously Assisting Vulnerable Children
- ✔ Provision of Minor Support Sustains Community Responses

Development Implications

- ✔ Community Power Structure is Changing
- ✔ Community Asking for Organisational Innovations
- ✔ Civil Society is Becoming More Open

This research suggests that introduction of community and family support programs – psychosocial, organisational and economic – can determine how great a social problem Mozambique will face in the coming years in managing the growing numbers of orphans in the country. To date, the number of street children is relatively small compared to neighbouring countries, suggesting that families are coping.

However, families will exhaust their capacity to absorb additional children with their current range of technologies and resources. Accelerated introduction of support programmes through a variety of agencies may be the key to determining the long run success of family and community response in Mozambique. Through these programmes, the skills and productivity of the community can be expanded so that diminishing numbers of adults can support greater numbers of children, a finding with substantial development implications for the country.

E. Conclusions and Recommendations

Conclusions concerning the situation of orphans and other vulnerable children in Mozambique and their care-givers are as follows:

1. Additional Analysis of Existing Orphan Data

The situation of orphans and other vulnerable children in Mozambique will rapidly become critical within the next 4 years as AIDS-related mortality escalates within the central provinces. Current data and reliable projections of the number of children by province needing assistance would facilitate realistic planning and strategy development for protection and care.

Fortunately, baseline data on the numbers of orphaned children in each Province are available from the *Inquérito Demográfica e de Saúde* (IDS/INE). Their findings are summarised in Section III. Additional analysis of this data showing the conditions of orphans, their living arrangements, care-

givers, schooling, education and health status can be obtained from a special tabulation of the IDS results. It is not yet known if more extensive, full count, data are available from the 1997 Census.

2. Obtaining Better Projections of Need at the Provincial Level

Projections of future numbers of orphans and other vulnerable children are also need to show detailed patterns of distribution and "swells" in these populations by area so protection strategies can be introduced in provinces where children are likely to be most vulnerable. Ideally, these projections would be built using a new round of serodata. Lacking that, it may be possible to develop a set of projection scenarios to guide development of service, policy, and community mobilisation. It would be useful to involve provincial and district authorities in the development of these projections so the results can be well understood and integrated into their thinking, planning, and implementation.

3. Collection of Data on Care-Givers, Families and Communities

In addition, information is needed on their care-givers, and the size, composition and coping strategies of the households and communities where they live. Small sample surveys and focus group discussions conducted by competent researchers that document the condition of these children and their care giving patterns by region are essential for an effective strategy of community development and support.

IV. The Status of the Response

A. Community Response

The perception of family and community willingness and ability to absorb and care for orphaned children in Mozambique varies from observer to observer. Many people feel that the extended family's capacity to care is weakened by extreme poverty and lack of access to services. On the other hand, large numbers of orphans are currently being cared for by families and communities when measured by the relatively small numbers of street children seen in Maputo and other urban areas of the country and the relatively low numbers of orphaned, abandoned, or neglected children in institutional and foster care, or living on their own in urban and rural areas relative to the projected number of orphans already existing in Mozambique. Extended families and community members are still a viable line of support in most of the country, assisted by NGOs, and churches in some areas.

Community Response in Mozambique

Positive Indications of Support

- ✔ Government Commitment to Community Based Programmes
- ✔ Success of ABC and Other Community Based Programmes
- ✔ Active and Expanding NGO and Church Based Activities
- ✔ Community Altruism Reported by NGOs
- ✔ Provision of Minor Support May Encourage and Sustain Community Responses
- ✔ Variation in Settings Has Yet to be Explored

Constraints on Community Support

- ✔ Unemployment
- ✔ Poverty Among Caregivers
- ✔ Illiteracy of Caregivers
- ✔ Poor Health Status of Care Givers
- ✔ Medicalisation and-Unnecessary Professionalisation of Approaches to Family and Community Care
- ✔ Responsibilities of Local Authorities May be Unclear
- ✔ Socialist Tradition May Hamper Individual Self Reliance

Lack of Social Agents/Workers to Help with Community Organisation and Counselling

These patterns are likely to vary a great deal in different parts of Mozambique. For example, care giving and acceptance of non-biological children into families may be substantially different between matrilineal and patrilineal groups in Mozambique. Additionally, care-giver poverty and community organisation to support families will also differ. The lower levels of infant and under 5 mortality seen in Manica may signal better-developed community support mechanisms than seen in other provinces. According to some observers, resettled refugees from Zimbabwe seemed to recover faster in this area, and community cohesiveness is stronger. It will be important to investigate these differences.

Some strengths and constraints on community willingness and capacity to care are noted in the box above. If community support is indeed limited, it can be harnessed in other ways. For example, the formal health care and social welfare systems will need to be expanded considerably over the coming decades. While it may be impractical to expect that volunteer programmes can be successfully substituted for paid services, given high levels of poverty and unemployment in Mozambique, the need for additional personnel could be met by developing lower levels of less skilled but paid personnel in the health and social welfare sectors. This could respond to the need for employment, education and care.

As noted in the previous section, the Chancellor College research in Malawi found that communities can reach the stage of "burn out", when the number of orphans grows so large that it was difficult to absorb additional children without changes in community organisation. The research also demonstrated that community capacity to absorb children could be expanded and sustained through introduction of two key elements, psychosocial counselling and technical assistance to encourage community organisation and continued innovation. Mozambique could make both available through social welfare, health, and community development channels.

Actions Needed to Support Community Care in Extremely Poor Settings

- ✔ Income Support to Poor Households With PLWHA or Orphans
- ✔ Increased Funding for Public Assistance Programmes
- ✔ Tax Credits to Individuals, Households, and Businesses Providing Care
- ✔ Organizational Support and Inputs to Community Based Organizations
- ✔ Training and Paying Semi-Professional Care Givers and Community Workers
- ✔ Involving Men in Prevention and Care Giving Activities

B. Government Response

Social sector spending in health and education has increased, and health spending now represents 6.9% of net government expenditures. Expenditures in social welfare are extremely low, some 0.7% of the total budget. The commitment to social welfare may need reconsideration given the impact of HIV/AIDS on families and communities, and development of a national strategy for orphan care might help the government evaluate its investments in this area. It may be difficult for families and communities to sustain their support to children, particularly under conditions of extreme poverty, unless services like counselling, organisational support, and volunteer development are provided. Additionally, material support, such a bicycles or food for work, may be required to avert sharp increases in infant and under-5 mortality in heavily affected communities.

Many Sub Saharan African countries are re-examining their programming for families and children affected by HIV/AIDS as a part of new strategic planning for HIV/AIDS and extended social policy review. MISAU is in the early stages of the process to develop a new HIV/AIDS strategic plan, where the issue of orphaned children will have high priority. When the second Medium Term Plan (MTPII) was developed, HIV infection rates were at such low levels that the issue of families and children affected by HIV/AIDS was not in mind. It will be important to rectify this and balance concerns for care with prevention in the new plan.

Mozambique is also developing a new Agenda for Action for Mozambican Children that includes an assessment and analysis of the situation of children in Mozambique. Since the HIV/AIDS epidemic will have a major impact on the health, social and economic status of Mozambican children and their families, it is important to document and project the changes that have occurred to date and those anticipated in the next 10 and 20 years. The Agenda for Action for Children is an opportunity to bring AIDS-related issues before the government and communities for discussion, and the process of its development should serve to clarify and motivate additional action in this arena.

The government provides support to children and families affected by HIV/AIDS through the MISAU and MICAS:

a. Health . Health services in Mozambique are thinly spread, and it is doubtful that services related to HIV/AIDS, such as home care – often expanded to help meet the needs of orphans and other vulnerable children – will be expanded sufficiently in the near future to assist the majority of families and children affected by HIV/AIDS. According to Webb (1997), assistance to AIDS patients is provided from the World Bank-funded Poverty Alleviation Fund. Health workers, recruited and trained by NGOs and churches, are struggling to fill some of the gaps in access, but the extent of their distribution has not been mapped.

b. Social Welfare. In 1997, MICAS asked staff to prepared proposals on how the Ministry should respond to persons living with HIV/AIDS and children orphaned by the disease, and key Ministry staff were sent to the CINDI conference on orphans in South Africa in June 1998. In December of the same year, MICAS held a seminar to identify its role and priorities in the national response to HIV/AIDS with UNICEF support. Objectives were to:

1. Identifying the role of MICAS in HIV/AIDS prevention and care;
2. Identifying priority activities for 1999;
3. Organise a working group to guide follow up to the seminar.

The meeting included representatives from MICAS, DPCAS (Zambézia, Manica, Tete, Sofala, Maputo), MINED, MICOA, PNC DTS/SIDA, MONASO, NGOs, UNAIDS, the seropositive association, church groups and UNICEF. Participants agreed that MICAS should not try to implement prevention or care activities, but should:

1. Identify and co-ordinate partners, including NGOs, CBOs, and other government departments
2. Promote and support these groups to provide orphan integration and support services, and counselling/support to the ill and their families.
3. Provide community sensitisation to avert discrimination, and to encourage sense of community responsibility to help those affected by HIV/AIDS.

The Ministry's priorities for 1999 included planning, development of community-based care, training and developing Acção Social workers, monitor the situation; integrate HIV/AIDS into current programmes, co-ordinate with MISAU and NGOs; prepare materials for training and sensitisation. Policies should be universal, but initial activities should be targeted in certain geographical areas. HIV/AIDS issues will be integrated into the Family and ABC programmes.

In 1999, MICAS is creating a working group to develop a strategic plan and intends to begin basic training of MICAS staff. It also hopes to hold multisectoral seminars in priority provinces. The working group, to follow up on workshop recommendations, will include representatives from MICAS, UNICEF, PNC DTS/SIDA, MONASO, Kindlimuka (the Association of PLWHA), Rede de Crianca, and Conselho Cristão da Moçambique (CCM). Results of the seminar were sent to PNCS to inform national strategy development.

According to Webb, MICAS hoped to provide counselling for HIV positive persons, but will need training in counselling if this is to be done. Currently, chronically ill people are referred to MICAS district social agents, who provide money for food. Follow up with the family depends on the agent's assessment of need. There are no guidelines for such assessments. MICAS hopes to develop income generating projects and food for work schemes to assist vulnerable families. Webb

found 27 such projects in Manica project managed by social action agents. MICAS agents have collaborated with PSI on HIV prevention activities in some areas.

Most of MICAS's experience and orientation to orphan issues arises from the war years, when family reunification was the goal of their activities. According to Webb, district social action agents have little knowledge of the numbers of orphans in their districts or their needs. District officers also help to place double orphans with other families, but do not maintain systematic follow up once the child is placed with a new family.

C. Policy Development

There is no specific legislation in Mozambique on HIV/AIDS. MISAU is trying to integrate policy on HIV into other legislation, most recently into the labour law to prevent discrimination against PLWHA in employment and protect their access to benefits. The land law was revised to protect women's property rights, and the penal code will be reviewed for provisions to protect women against violence.

The Mozambique Social Action policy, adopted in 1998, has six broad strategic principles:

Family protection;
Co-ordination of programmes for children;
Complementarity or integration of multidisciplinary interventions for support;
Participation of children;
Use of institutionalisation as a strategy of last resort;
Provision of information to families and communities.

Mise en forme : Puces et numéros

The policy outlines a series of strategies for child protection, including community care and pre-school education. It also outlines strategies for reunification of orphaned and abandoned children, and children living on the street. Most of the responsibility for childcare and protection is placed in the family and community mechanisms.

Mozambique does not have a specific National Orphan Policy as is found in Malawi, nor does it have a single, consolidated Children's Statute, such as that found in Uganda. However, MICAS recognises the need to establish fuller policy provisions in this area.

Malawi was the first country in the region to create a National Task Force on Orphans (NOTF). The body was established in 1991 within the Ministry of Women, Youth and Community Services, and includes national and district government representatives from the MOWYCS; the Ministry of Health through the NACP; key NGOs and Community Based Organisations (CBOs); major religious bodies; and representatives of key UN agencies. Members of the National Task Force, in consultation with advisors from the Ugandan government and NGOs, developed "Policy Guidelines for the Care of Orphans in Malawi and Co-ordination of Assistance for Orphans" in 1992.

Malawi was a pioneer in this regard; few if any other countries have specific orphan programme and co-ordination guidelines, although many are beginning to see the importance of such a policy instrument. The Malawi guidelines are simple and brief, and are often used by the government as programme development guidance for groups interested in developing orphan care programs. In addition, organisations which are not so familiar with the intricacies of orphan programming can understand and follow the principles they put forward.

Elements of Malawi's Orphan Care Policy
1. **Community based approaches** to orphan care are primary. The government will co-ordinate service providers to support and enable communities
2. **Formal foster care** will be expanded as the second source of care.
3. **Institutional care is the last resort**, although temporary care may be needed for children awaiting placement.
4. **Hospitals should record next of kin** so relatives can be traced if children are abandoned.
5. **Birth and death registration should be revitalised** to monitor orphans
6. **Government will protect the property rights of orphans**, and these should be widely publicised.
7. **Self help groups should be developed** to assist families with counselling and other needs.
8. **NGOs are encouraged to set up systems of community based care** in consultation with the government.
9. **The needs of all orphans should be included regardless of cause of death, religion or gender.**
10. **The National Task Force will continuously plan**, monitor and revise programmes and policies
11. **Government will solicit donor support** for resources for capacity building.
12. The **Ministry of Women, Youth and Community Services is the lead government body** on these issues.

Malawi's NOTF is committed to continuing review and update of these policy guidelines along with co-ordinated legal review. It develops joint training programmes, has undertaken joint situation analyses, co-ordinates programme implementation by government and member organisations, is completing a national service inventory, and conducting joint strategic planning to ensure national coverage of the response. The MOWYCS, through the NOTF, is also responsible for administration and review of Acts of Parliament designed to protect the welfare of children, including the Adoption Act, the Children and Young Persons Act, the Affiliation Act, the Maintenance of Married Women Act, and the Wills and Inheritance Act. In addition, it monitors foster care and adoption services, residential institutions for children, and administration of short term assistance and relief.

D. Social Safety Nets/Poverty Reduction

Very little information is yet available on the establishment of formal social safety nets, although discussions of the extent of poverty and means for its alleviation were undertaken in 1997. There are no social safety nets to address the needs of most vulnerable households, although the Ministry of Finance does have a Poverty Alleviation Unit. Instead, NGOs and religious organisations provide support services to households with little collaboration or co-ordination among them or with government.

E. Voluntary and Community Based Responses by NGOs

1. Type of Services

The voluntary sector provides an important contribution to Mozambique's response to HIV/AIDS. Given the human and financial resource limitations of the Government, implementation of the previous mid-term plan of the National STD/AIDS Control Programme was largely dependent on donors and NGOs. The voluntary sector includes agencies that are not part of the government or

commercial private sector such as non-governmental organisations (NGOs) and churches.

However, and in concordance with the national plan, almost all NGO HIV/AIDS activities have concentrated on the prevention of HIV transmission, mainly through community education programmes for young people. This is largely due to the belief that Mozambique, with a lower national prevalence than neighbouring countries, still has an opportunity to avoid a major epidemic though AIDS prevention actions. As we have seen, particularly in the central provinces of the country, this is now unlikely to be the case.

Although MICAS plans to carry out an inventory of child-care services in Mozambique, this has not yet been done. The following account of existing services is therefore not complete, and is mainly based upon those organisations supported by UNICEF. There are several NGOs dealing with women's affairs that might contribute to the protection of women's and children's property rights. Coverage and activities of community based workers, through government, NGO and church based programmes, are not completely known. Discussion with Save the Children UK and US, World Relief, and UNDP reveal a variety of approaches toward developing community health workers. Their connections with agents of social action are not known, but may be limited by transportation and resource constraints.

Institutions. It is the policy of MICAS, and is widely accepted, that institutions should be the last resort for care of isolated children. However, MICAS still receives requests, particularly from religious organisations, for permission (not compulsory) to open more orphanages – some specifically for "AIDS orphans". MICAS has no minimum standards for NGO-run institutions, and has no policy on HIV/AIDS, which is beginning to cause problems. For example, the NGO Terre des Hommes manages two of the government orphanages (in Maputo), and in response to the deaths of two children due to AIDS, wanted to screen all current and incoming children in the centres.

In addition to the eight government-owned orphanages across the country, there are a number of other institutions run by NGOs and religious organisations in particular. Many were opened during or after the war, caring for children orphaned or abandoned, including those abandoned due to disability. A number of these non-governmental institutions and services are supported by UNICEF.

UNICEF supports 14 organisations in Maputo City and Province that provide education, vocational training and/or shelter for orphans, children from poor families and in some cases abandoned disabled children. Three of these organisations are specifically targeting girls. Two centres in Beira (Sofala province) and two in Quelimane in Zambézia province (one targeting girls) are also being supported, and one in Chimoio (Manica). The types of services provided are vocational training, basic education and literacy, and in some cases accommodation, food and basic healthcare.

In Manica UNICEF also supports a catholic women's training centre in Catandica district on the Tete corridor, which has recently also developed a child-care component in response to large numbers of orphans from the war, but increasingly from AIDS. There are currently 42 children living in the centre, more than half thought to be due to AIDS. The centre is managed by the women of the community, who also work with other isolated children in the community, and sustain their work with small income-generating projects.

Drop-in shelters and support for street children. UNICEF also supports nine organisations working specifically with street children, eight in Maputo city and one at the South

African border post. The types of services provided are shelter, literacy courses, basic education, vocational training, rehabilitation into community and family life, basic health and hygiene, civic education, and in some cases counselling. One of these organisations, Medecins du Monde, is targeting girls, and includes work to prevent and treat STDs, and to help them to find alternatives to commercial sex work.

Family and Community Based Care. The increasing number of orphans that are likely to result from the AIDS epidemic will soon overload the institutions, even with new ones being built. Family and community based care is an alternative to institutionalising children. This approach of helping a child's extended family to care for them at home is likely to be less traumatic for the individual child, on the one hand, and more logistically and economically possible as a national strategy, on the other. If children have family members who they can live with but are receiving less than adequate care because they are living with a grandparent or have an ill parent who is unable to care for them, family and community-based care may be a more appropriate alternative. This approach would allow the child to remain with their surviving family members while receiving proper attention from a trained care-giver on a regular basis.

However, apart from the institutional-based organisations, it seems that there are currently very few groups working to support families and communities affected by HIV/AIDS. This may be because Mozambique has so far experienced less deaths from AIDS than neighbouring countries. It may be that more groups are developing now, particularly in some of more heavily affected provinces such as Tete. The size of the country and the lack of co-ordination means that activities underway in more remote areas may have low visibility.

Of the organisations providing care for children affected by HIV/AIDS, the PLWHA associations play an important role. There are currently three such groups, in Maputo, Quelimane (Zambézia province) and Chimoio (Manica province), and the Maputo group is encouraging the development of other groups and a national network. All three groups provide support to their members and other PLWHAs, and have some kind of income generating activity. All are concerned about the orphans they are beginning to see in their members' families and communities, and are looking at strategies for providing support.

In Maputo, a group of women called Reincontro is working with the PLWHA association (Kindlimuka) to provide support to orphans and their substitute families. AMODEFA is a national NGO that carries out home health care visits to patients when they leave the Central Hospital.

In Chimoio, a group called Kubatsirana provides home visits to families with AIDS orphans, which are identified by the PLWHA group (Kubetana). Also in Manica province, the women from the training centre in Catandica make home visits to orphaned children, as mentioned above.

Psychosocial Support. Orphaned children, particularly those who may have cared for their parents during illness, will often need some psychological support. This can be important for facilitating the acceptance of children into substitute families, as the child may be prone to behavioural problems. Some organisations provide psychosocial support to children, mostly in response to children traumatised by war. For example, Reconstruindo a Esperança ("rebuilding hope") provides psychosocial assistance to 120 traumatised children in Maputo, and has also trained some educators, community leaders, teachers and NGOs on counselling techniques and psychosocial

assistance.

2. Distribution of Services

Although no inventory of services exists as yet, from the summary above it appears that child care services and organisations are clustered in and around the major cities, particularly Maputo. Outside Maputo, lack of complete information makes it hard to comment on distribution, though it appears that there are more services in the central provinces than in the north and south.

3. Regional Access to Services

According to the DPS data (IDS; 1998), almost half of the orphans (single and double) in Mozambique are in the three northern provinces of Cabo Delgado, Nampula and Zambézia – a total of 455,788 children. These figure correlate with some of the areas most affected by the war. The figures are much lower in the southern provinces, which were generally less severely affected by war.

Despite the large numbers of orphaned children in rural areas, particularly in the north, there is some justification for the clustering of services in urban areas. Families in cities that take in orphans, particularly those whose parents died from AIDS, may be less likely to keep the child due to the financial strain and stigma. In rural areas, where the extended family is generally stronger, stigma is less common and alternatives are not available, families may be more likely to take on another child. However, the more advanced stage of the epidemic in the central and northern provinces will place increasing strains on these families, who will require external support of some kind that is not available to them with the current distribution of services.

F. National Networks Mozambique has several national networks that may provide services and help to build and promote community responses:

MONASO, the **Mozambican Network of AIDS Service Organisations**. A member of the regional network SANASO, this organisation has delegations in almost all of the provinces. Its role is to co-ordinate the activities of its members, and in the past it has also implemented services such as an AIDS hotline. However, it is generally very weak and does not live up to the expectations of its members and others. In 1998 a strategic plan was developed, to strengthen the capacity to co-ordinate activities, and to provide services (training, materials, advocacy) to its members. Most of this proposal is still awaiting funding.

Mise en forme : Puces et numéros

Associação Kindlimuca is the Maputo-based group of PLWHAs, which is encouraging groups to start up in other provinces, with the aim of developing a national network of PLWHAs.

Mise en forme : Puces et numéros

Rede da Crianca is a Maputo-based network of organisations working with children in difficult circumstances. Most of these organisations work with street children. The network is slowly expanding to other provinces, with the aim of developing a national network. They are in the process of compiling a database of child-serving organisations in Mozambique. UNICEF has begun working with this network to test and develop AIDS prevention materials.

Mise en forme : Puces et numéros

Several church networks exist, such as the **Conselho Cristão da Moçambique** (Christian Council).

Mise en forme : Puces et numéros

The **Forum Mulher** is a multisectoral group comprising NGOs, government and donors. Although the network is not national, many of the member organisations have activities in other provinces.

Mise en forme : Puces et numéros

G. UNDF Theme Group

Currently the main activity of the UNAIDS theme group is providing financial and technical support to the national multisectoral Strategic Planning Exercise. It also provides some technical support to MONASO and to the PLWHA association, Kindlimuca.

H. Conclusions and Recommendations

1. Research on Community Development Approaches in Mozambique. Preliminary work will soon be completed on a brief study identifying alternative approaches to community development in Mozambique. This can be expanded to fill out the picture of approaches and range of alternatives for supporting community capacity building.

2. NGO/MICAS Committee for Planning. Although government capacity for support to communities will develop over time, at present NGOs are clearly a major partner for community capacity building. A strategic plan for building family and community support for orphans unfolds, it will be critical to involve as many creative voices as can be found. A combined MICAS/NGO committee could be formed to review research, data, and build models and project direction and strategy from these inputs. Development of national network to support family and community response would improve dissemination of policy, stimulation of equitable distribution of services, and quality of services delivered.

3. Develop a Strategic Plan for Increasing MICAS Capacity. The capacity of MICAS is currently so limited that capacity building for the Ministry must be a central part of any strategic plan. In addition, it may be necessary to provide MICAS additional capacity and technical assistance through the next few years to cope with the demands of planning, sectoral review and policy development.

4. NGO Services Inventory. The preliminary mapping of NGOs providing AIDS-related surveys done as part of this assessment provides only a tiny fraction of the information needed to support strategically driven allocation of NGO resources to communities affected by HIV/AIDS. The NGO/MICAS Committee can work together to expand this map and complete an inventory of services being provided to families and children affected by HIV/AIDS. This can be used to plan for rapid service expansion, partnerships, and co-ordination mechanisms. Review of the distribution of services, which at present is skewed toward urban areas and certain regions of the country:

Urban	Rural
Social Welfare Agents	Some Community Health Workers
Access to Social Welfare Benefits	Some NGOs
Child Care Institutions	Some Churches
Programmes for Neglected/ Displaced Children	

5. Site Visits to Neighbouring Countries. Mozambique's neighbours, Malawi and Zimbabwe, have developed comprehensive government-NGO-community partnerships and policies for supporting families and communities affected by HIV/AIDS. It will be imperative to sponsor site visits by a combined NGO-government team to these two countries to review the development of their systems, diffusion of their models, and the extensive policy review that has taken place. In addition, the team can identify resources in those countries that can assist in strategy building and expansion of the Mozambican effort. Zambia is now revising its entire educational policy to expand access for children as a means of addressing the need for orphan care and socialisation. Education Ministry planners might benefit from a brief visit to Lusaka to discuss the rational and approaches for this plan.

6. Commercial Private Sector Activities. As noted above, it will be important to include the commercial private sector as full partners in the development of systems of prevention and care. This has been done with great success in a number of countries, including Zimbabwe.

7. Planning and Costing Models. Three things are essential to promote more realistic views of future needs:

Estimates for planning. Reliable orphan estimates, discussed above, which clarify the size of the population needing care and support;

Mise en forme : Puces et numéros

Costing of alternative models or scenarios for care. For example, ***if only one third of the current number of orphans (901,551 = 300,517 children) were provided minimal government support (5433 meticais or US$ 0.5 per month), the cost per year would be 19,592,506,330 meticais (US$ 1,580,041) per year. It can be assumed that institutional solutions of any type will be more costly***

The cost of not caring. Additionally, scenarios that estimate the future social costs of not caring in terms of delinquency, correction or remand facilities, social unrest and the like might help build social commitment for mobilising and strengthening local resources.

8. More deliberate inclusion and acknowledgement of people living with HIV/AIDS will stimulate diffusion of their considerable knowledge of positive living to HIV positive people in Mozambique.

V. Requirements for Programme Expansion

A. Requirements for Programme Expansion

Comparison of the numbers of orphans and other children left vulnerable by the epidemic, the availability and distribution of services, and the lack of explicit strategies for support to family and community based responses suggests that programme expansion is required along several dimensions:

- Increased capacity for strategy development and modelling;
- Increase in the volume of services available to families and communities;
- Review of sectoral policies and strategies.

Mise en forme : Puces et numéros

Specific recommendations on each are noted above.

B. Planning Considerations

As the planning process develops in Mozambique, certain key facts about the orphan situation, listed in the box at right, should be considered. Most importantly, the strategic orientation of any programme should emphasise development, not charity. This will only be possible if sufficient assistance is available to communities before they reach a stage of exhaustion and burn out.

In the short term, a national orphan programme requires investment in a planning and monitoring system, which will be maintained to co-ordinate and guide programme implementation. In the long term, implementing agencies should integrate family and community support programmes into health, education, agriculture, water and sanitation sectors, the key sectors determining Mozambique's progress in meeting the World Summit goals.

Key Planning Considerations for a National Orphan Assistance Strategy

Characteristics of Problem	Programme Response
20 or 30 Year Life	Long Term
Large Numbers of Children	Large Scale Community Based Systematised Infrastructure Integrated Low Cost Sustainable
Extreme Vulnerability of Children	Protection and Care
Number of Orphans Predictable Is Predictable Over Time	Plan Programme Scale and Inputs Over Time
Orphan Needs by Age Group Are Predictable	Predictable Programme Design
Project Impact is Measurable	Determine Success and Adjust Programming

C. Planning Data and Tools

Planning Data and Tools
1. Data - Cost and Quality Data - Investment Data **2. Training Needs** - Training for Districts and Communities - Training for Social Welfare Agents - Training for Health Care Providers - Training for Primary and Secondary School Teachers - Sensitising Children - Training in Other Sectors **3. Community Resource Access** **4. Volunteer Development** **5. Research Needs** - Research Capacity - Models for Evaluating Community Response Over Time - Models for Community Participation in Research - Urban/Peri-Urban/Rural Models - "Grand" or Second Generation Orphans - Child and Community Vulnerability Indicators

Mozambique has some additional data, training, community, volunteer and research requirements for strategic, long term, needs based planning:

1. Data

a. Cost and Quality Data. Costing data is unavailable from most organisations at the present, but would be useful to compare implementation approaches. This could be coupled with the collection of data indicating the quality or effectiveness of support services provided to implementing communities.

b. Investment Data. Data is also unavailable which describes the contribution of various sectors to programme implementation. It would be desirable to know the investments being made by government, donors, and communities are making to ensure the welfare of orphans and other vulnerable children. Cash and in kind contributions need to be evaluated to fairly represent the balance of investments and to evaluate their sustainability.

2. Training Needs. A variety of training programmes are needed to build capacity, all of which will have to be updated and scheduled on a periodic basis as the epidemic and community response evolve:

a. Training for Communities. Communities have already identified psychosocial training and community organisation as two high priorities, and other needs will emerge as the epidemic progresses.

b. Training for Social Welfare Agents. A training programme for Social Welfare Agents could be implemented, and will have to be updated periodically. In addition, the country's lack of training capability for social welfare agents/officers/workers needs to be examined closely. A paraprofessional or certificate level course may need to be introduced. In Uganda, distance learning courses were being prepared with the assistance of SCF/UK for this purpose.

c. Training for Teachers. A training programme for primary and secondary school teachers will help them understand national commitment to equity in education for all students, and can also be used to encourage organisation of students to assist vulnerable children in their midst.

d. Training in Other Sectors. With the encouragement of multisectoral planning and management of implementation, selected training opportunities might be useful to equip officers from other Ministries to participate more fully.

3. Community Resource Access. There may be a need for a systematic way to promote community access to resources in such areas as credit for income generating activities, agricultural technology, and skills in small business development. This information will encourage sustainability and can be integrated into community development modules.

4. Volunteer Development. Implementation organisations employ a variety of volunteers. It may be easier to sustain their interest and commitment with training programmes that build their competency and endow them with semi-professional status. This is likely to improve volunteer retention and increase the availability of semi-skilled personnel over the coming decades.

5. Research Needs. A variety of research needs can be identified:

a. Research Capacity. It may be desirable to cultivate a research capability within Mozambique, which can be called upon to undertake short term, operational research and produce quick, easy-to-understand. Additionally, it may be necessary to orient developing academics to aspects of this problem and to encourage them to pursue the issue in their training.

b. Models for Evaluating Community Response Over Time. The impact of the AIDS epidemic on communities in Mozambique over time has yet to be described or measured. It will be important to track this development, especially in heavily affected areas.

c. Models for Community Participation in Research. Participation of community members in design as well as data collection will encourage communities to satisfy their own research needs and improve long term sustainability.

d. Urban/Rural/Peri-Urban Sector Models. Implementation of community based interventions will vary by community type. These variations might be systematised into urban, rural and peri-urban models by such factors as population density, resource availability. Approaches are being systematised in Zimbabwe along these lines so that implementation is facilitated by type.

e. "Grand Orphans" or Second Generation Orphans. Given the early age at which many women in Mozambique begin childbearing, the birth of children to orphans may create considerable family and community stress. Care taking patterns for these children could be researched.

f. Child and Community Vulnerability Indices. The development of indices or checklists of criteria to assist communities in assessing the vulnerability of their children might be needed. It may be possible to develop indices with universal applicability across communities; however, these will vary considerably by such factors as population density, socio-economic status, and variable access to resources. It may be advisable to research the ways in which communities establish their own criteria for vulnerability and apply them given the community's resources.

6. Programming Planning, Monitoring, and Evaluation

a. Programme Planning. Need for data for national programme planning has been described above. Additional needs are likely for the development of planning and data collection tools for use by NGOs, CBOs, and religious organisations.

b. Programme Monitoring. The need for the systemisation of monitoring tools and for community participation in their development and use could be considered.

c. Programme Evaluation. Consistent development of programme evaluation tools will be important.

A vital need in programme development is in indicator development, where there is little guidance. *Process indicators* are needed in the early stages of programming to measure progress of programme implementation, functioning, and sustainability of community organisations. *Impact* or *outcome indicators*, which measure the success of programmes by their ability to support family and community survival and maintenance of child well being and health, are more useful in later stages of programme development. These measures will be necessary to attract and maintain funding from donor and private sector agencies. It might be useful to begin more serious investigation and development of these measures. Their development is vital to guide programme design, implementation, and evaluation design.

VI. Funding Development

A. Indigenous Sources of Support

Indigenous Sources of Support for Orphan Programmes in Mozambique

--Government of Mozambique
--Communities
--Religious Organisations
--Commercial Private Sector
--Community Fund Raisers
--Small Contributors

Indigenous sources of support for orphan programming may be available from several sources:

1. Government of Mozambique. The Government of Mozambique supports some proportion of the destitute in the country with small income subsidies. As noted in earlier sections of this report, implementation of this programme is hindered and the programme is thought to reach few of the beneficiaries it is intended to target.

2. Communities Themselves. Relative to their asset base, communities may well be required to provide a large share of support for programmes in their areas through in-kind contributions of material and labour. This obligation is not likely to change.

3. Religious Organisations and Hospitals. Both groups are providing organisational skills, staff, and material resources to community based home care and orphan programmes. This contribution might also be included in the analysis of resources available to the national programme.

4. Commercial Private Sector. As the participation of this sector in programming grows, a model for evaluating its contributions and payback can be developed. This would not only provide better estimates of overall national investment, but would also be useful in attracting and sustaining participation by private sector organisations.

5. Community Fundraisers. Community fundraisers can be conducted to raise small amounts of money for support. Organisations might be encouraged to develop credit programmes to ensure sustainability of their support.

6. Small Contributors. Extended philanthropic efforts are also being cultivated, including sponsorship by the local branches of civic improvement organisations, such as Rotary. In addition, these organisations may be able to provide technical assistance to organisations and communities, as noted above.

B. External Sources of Financing and Donor Interest

The international donor community is currently receptive to the problems facing Sub Saharan African communities from HIV/AIDS. UNICEF offices in a number of countries are fielding special programme proposals through headquarters for donor support. The World Bank and WHO through UNAIDS are organising a special African Initiative to respond to the epidemic with enhancements of prevention and care programmes. Once plans are developed by Mozambique's line Ministries, they can be fielded for support to this initiative.

VII. Support for Programme Development

A. The UNAIDS Country Team

Technical experts associated with the UN agencies that are included as sponsors in UNAIDS can provide in-country and international assistance on many of the technical analyses needed in Mozambique. In addition, they are participating in various projects and programmes that will be useful in combating the epidemic.

B. UNICEF Headquarters

As noted in Section I of this report, UNICEF Headquarters is providing technical assistance to country offices, helping to build or expand resource networks, and developing funding streams at the international level for expanding programme development.

C. Existing Regional Networks

Mozambique's Assistant Project Officer in Child Protection is a member of UNICEF/ ESAR's CEDC/Child Protection Network, which includes UNICEF programme and project managers from Eastern and Southern Africa who are working in the area of child protection. The Network has been active in all areas of child protection, and is expanding its treatment of issues related to orphans or children without parents or guardians. ESAR's HIV/AIDS Network has been primarily focused on life skills education, adolescent sexual health and prevention. The Child Protection Network is organising a programme consultation in Nairobi at the end of March, which will focus on technical issues in programme development for families and children affected by HIV/AIDS.

Appendices

Appendix 1: Timetable of Mozambique Site Visit
Appendix 2: Persons Interviewed, Meetings Attended, and Focus Group Discussions
Appendix 3: Essential Documents, Mozambique Orphan Support Programmes
Appendix 4: Mozambican Orphans by Province, 1997
Appendix 5: Partial List of Voluntary Organisations Providing Assistance for Families and Children Affected by HIV/AIDS in Mozambique
Appendix 6: Programming Innovations in Neighbouring Countries

Appendix 1: Timetable of Mozambique Site Visit

Wednesday, 10 February 1999

20:00 – Arrival in Maputo

Thursday, 11 February 1999

8:30 – Briefing with Mark Stirling (Representative), Ian Macleod (CRMP Programme Officer), Jonathan Cauldwell (Consultant) and Sally Griffin (Consultant), UNICEF.

10:00 – Meeting with Ian Macleod & Jonathan Cauldwell, UNICEF

Friday, 12 February 1999

9:00 – Meeting with Orelia Gomez, USAID.

11:00 – Meeting with Salvador Macive, Associação Kindlimuca, and Jorge Aquino, AMODEFA

14:00 – Meeting with Dermot Carty (Water Sanitation & Hygiene Programme Officer), UNICEF.

Monday, 15 February 1999

11:00 – Meeting with Guilhermina Milice, MULEIDE.

12.30 – Meeting with Cooper Dawson (Education Programme Officer), UNICEF.

16:00 – Meeting with Maria Tallarico (Country Programme Advisor), UNAIDS.

Tuesday, 16 February 1999

11:00 – Meeting with Roy Trivedy (Country Director), Save the Children Fund (UK).

14:15 – Meeting with Annie Foster (Country Director), Save the Children Foundation (US).

16:00 – Meeting with Galen Cary (Country Director) & Johnson Nghatsane, World Relief.

Wednesday, 17 February 1999

11:00 – Meeting with Acucena Duarte, Minister for Co-ordination of Social Action.

14:00 – Meeting with Ivone Rizzo (Health Programme Officer), UNICEF.

15:00 – Meeting with Ben Henson (Community Development Project Officer), UNICEF.

16:00 – Meeting with Departments of Planning and Basic Education, Ministry of Education.

Thursday, 18 February 1999

9:30 – De-briefing meeting with UNICEF staff members.

15:00 – Public de-briefing meeting with representatives of government, UN agencies, donors, NGOs, and UNICEF staff.

Friday, 19 February 1999

11:00 – Meeting on research within UNICEF.

Appendix 2: Persons Interviewed and Meetings Attended

Name and Title	Date, Length of Session	Topics
Mark Stirling (Representative), Ian Macleod (CRMP Programme Officer), Sally Griffin (Consultant), UNICEF/Mozambique	February 11, 1999 – 1 hour	- Purpose of consultancy and assessment of programming in Mozambique - development of UNICEF/Mozambique's new country programme - UNICEF's strategy for expanding orphan response; national strategic planning process - UNICEF/Mozambique HIV/AIDS strategy and work to date, particularly with MICAS - possible involvement of other donors such as USAID, DfID, GTZ, CIDA.
Ian Macleod (CRMP Programme Officer), Jonathan Cauldwell (consultant researcher), UNICEF.	February 11, 1999 – 1.5 hours	- Agenda for Action for Mozambican Children – concept, process, development, and status - Situation analysis - Research/information needed in the area of children & HIV/AIDS.
Orelia Gomez (Activities Manager), USAID	February 12, 1999 – 1.5 hours	- New programme structure at USAID - HIV/AIDS activities in last country programme - future plans for expansion of HIV/AIDS programme, including integration of HIV into other programmes - PNC DTS/SIDA attitudes to orphans, home-based care, MTCT - USAID global plans regarding HIV/AIDS & orphans.
Salvador Macive (President), Associaçao Kindlimuca, & Jorge Aquino (IEC Officer), AMODEFA	February 12, 1999 – 1.5 hours	- Activities of Kindlimuka and AMODEFA (Mozambican Association for the Development of the Family) - PLWHA groups in other provinces - levels and types of discrimination faced by PLWHAs here - planned national assembly of PLWHA in Maputo in July - Kindlimuka planned activities (Seminar on advocacy, & setting up VCT centre in new offices) - Kindlimuca's role in lobbying for changing labour laws.
Dermot Carty (Water Sanitation & Hygiene Promotion Programme Officer), UNICEF	February 12, 1999 – 45 mins	- Importance of access to clean water for both HIV prevention (hygiene reduces STD infections) and reducing impacts (care; reducing labour burden on caregivers and on children affected by AIDS, as don't have to spend so much time fetching water); also impact of water on agricultural production (including communal gardens) - possibilities of targeting UNICEF water projects to areas most heavily affected; also UNICEF is supporting multisectoral provincial planning for water, can make sure AIDS in on the agenda; Direcção Nacional das Aguas is very open to discussion about multi-sectoral approaches.

Guilhermina Milice (Health Co-ordinator), MULEIDE	February 15, 1999 – 1.5 hours	- Activities of MULEIDE (Women, Law & Development NGO) - Women's rights to land and property in Mozambique - Recent reforms in the land laws. Problems with informing women and communities to ensure implementation of these land laws. Consideration of some materials developed for this purpose - Possibilities for MUlEIDE to co-operate with other organisations to extend its coverage to provinces - organisations supporting co-operative machambas.
Cooper Dawson (Basic Education Programme Officer), UNICEF	February 15, 1999 – 1 hour	- Current development of strategic education plan by MINED - importance of knowing the current & future impact of AIDS on the education system, and the implications for orphans - community organisation in Mozambique - UNICEF's education programme – Zambézia (incl. material development) & Nampula, in- & out-of-school children.
Maria Tallarico (Country Programme Advisor), UNAIDS	February 15, 1999 – 2 hours	- National strategic planning exercise – process & status - UNAIDS Partnership Initiative for Africa - problem of lack of data to assess status of epidemic, problems with interpreting data, possible other sources - responses of other ministries (apart from health) to AIDS (Education, Social Action, Youth, Agriculture, Labour, Planning & Finance, Foreign Affairs, private sector) - orphan care strategies & consequences of increasing numbers.
Roy Trivedy (Country Director), SCF-UK	February 16, 1999 – 1.5 hours	- Lack of desegregated data to analyse epidemic - national strategic planning exercise - potential of SCF to work at regional level (cross-border exchange of experiences etc.) - characteristics of responses in neighbouring countries - lack of understanding about how communities are organised & function in Mozambique (Renamo/Frelimo/colonial systems/traditional) - SCF's strategy, building capacity at district level - problems of government decentralising responsibility to provinces, but not resources - role of MICAS in response to AIDS, and concept of safety nets - poverty alleviation programmes in Mozambique - levels of altruism in Mozambican society - role (& problems) of activistas, eg in ABC programme.
Annie Foster (Country Director), SCF-US	February 16, 1999 – 1 hour	- Current SCF-US projects (Nampula & Gaza; road construction, nutrition, sustainable agriculture, health, food security, child survival, health) - Idea of implementing Cope Project (from Malawi) in Tete province - role & potential of using volunteers - women's land rights - differences between situation of orphans in matri- & patrilineal societies.

Galen Cary (Country Director), Johnson Nghatsane, World Relief	February 16, 1999 – 1 hour	- World Relief's programme (health, agriculture, community development) - have organised "care groups" of women in villages trained to educate & support families - HIV education through pastors - micro-finance credit scheme, village banking (Xai-Xai & Inhambane) - role of church in care & community support - differences in stigmatisation between urban & rural areas.
Acucena Duarte (Minister), Joaquim Duarte (Deputy Director), MICAS; Mark Stirling (Representative), Ian Macleod (Programme Officer), UNICEF	February 17, 1999 – 1 hour	- AIDS in Mozambique, expectations of response from MICAS - need to build alternatives to institutional response - experiences after the war with Family Reunification Programme, need for different approach now due to numbers and nature of orphans - MICAS priorities of research to determine scale of problem, and capacity-building of families - possibility of expanding ABC programme to include HIV/AIDS - importance of having sufficient numbers of service-providers in the community to support affected families - importance of counselling for families & children - some NGOs already provide this service but coverage unknown - need to study traditional family/community coping capacities - how to incorporate these issues into strategic planning exercise.
Ivone Rizzo (Health Programme Officer), UNICEF	February 17, 1999 – 1 hour	- UNICEF's community-based approach to health services in Mozambique - participation of communities in identifying problems & solutions - establishment of committees, and possibility of extending them to identify/support orphans - strategic planning at district level.
Ben Henson (Community Development Project Officer), UNICEF	February 17, 1999 – 30 mins	- Destructive effect of war on community organisation & cohesion, especially in Zambézia, Sofala, Tete - distribution of NGOs working in provinces.
Sr Logo (Deputy Director of Planning), Sra Graça Praz (Pedagogical Technician, Basic Education Department), MINED; Cooper Dawson (Programme Officer), Marco Teixeira (Consultant), UNICEF	February 17, 1999 – 1.5 hours	- Responses of Education ministries to AIDS in other countries in region - impacts of AIDS on education sector in region - current response of MINED in Mozambique - need for participation of MINED in national strategic planning exercise - curriculum reform, and incorporation of HIV/AIDS - need to take into consideration the impact of HIV/AIDS for Education Strategic Plan, including impact of increasing numbers of orphans - importance of learning from experiences of other countries.
Mark Stirling (Rep.), Laila Ismail-Khan (SPO), Ian Macleod (Programme Officer), Jonathan Cauldwell (consultant), Sally Griffin (consultant), UNICEF/Mozambique	February 18, 1999 – 45 mins	- Findings and outcomes of visit - possible follow-up issues and activities.

Public de-briefing meeting. Participants: Duarte Joaquim (MICAS); Graca Machel (FDC);Victoria Ginga (Min. Plan. Fin.); B. D. Curran (US Ambassador); Mussa Calu & Andrew Krefft (USAID); Emilia Adriana (MONASO); Roy Trivedy (SCF-UK); Annie Foster (SCF-US); Chad MacArthur (Helen Keller Int.); Johnson Nghatsane (World Relief); Stella Pinto (UNDP); Gloria Chungica (WHO); Georges Georgi (UNFPA); Atieno Odenyo (UNAIDS). UNICEF: Mark Stirling, Laila Ismail-Khan, Ian Macleod, Ivone Rizzo, Jonathan Cauldwell, Ben Henson, Gabriel Pereira, Amélia Russo, Joseldo Massango, Marco Teixeira, Sally Griffin);.	February 18, 1999 – 2 hours	- Situation of children affected by HIV/AIDS globally and in the region - Findings and conclusions of the Mozambique visit - characteristics of Mozambican epidemic, and the country's history (eg war) as important determining factor - gaps and areas of need (research, data etc).

Appendix 3: Essential Documents, Mozambique Orphan Assessment

Planning Documents

Cauldwell, J., 1999, “List of NGOs/Donors Working on HIV/AIDS in Mozambique”, UNICEF/Mozambique, Maputo.

Ministério da Saúde, 1992, “Programa Nacional de Combate ao DTS/SIDA”, Maputo.

Ministério da Saúde, 1995, “Draft Programme to Control STD/AIDS in Mozambique, Maputo.

Ministério da Saúde, 1998, “Mozambique Health Sector Profile”, Maputo.

MONASO, 1998, “Workshop para finalização do Plano Estratégico da Monaso”, Maputo.

----, 1998, “Proposal for Learning Without Frontiers”, Maputo.

UNAIDS/Mozambique, 1997-98, Various planning documents and meeting notes, Maputo.

UNAIDS, 1999, “Feedback from the Annapolis Retreat”, Geneva, 1999.

UNAIDS, 1999, “International Partnership Against HIV/AIDS in Africa: Meeting of the UNAIDS Cosponsoring Agencies and Secretariat, Annapolis, Maryland”, Geneva, 1999

UNAIDS/Maputo and UN Theme Group on HIV/AIDS-Mozambique, 1998, “Process to Review the Existing HIV/AIDS Situation and Response in Mozambique and Design National AIDS Strategic Plan”, Maputo.

UNICEF/Mozambique, 1998, “Programme of Co-operation between the Government of the Republic of Mozambique and the United Nation’s Children’s Fund for the Children and Women of Mozambique, 1999-2001”, Maputo.

USAID, 1999, Various programme development and planning documents and notes, Maputo.

Policy Documents

Ministério da Coordenação de Acção Social, 1998, Estratégia da Acção Social Sobre a Criança, Government of Mozambique, Maputo.

HIV/AIDS in Mozambique and Neighbouring Countries

Donahue, J. & Williamson, J., 1998, “Community mobilization to address the impacts of AIDS: A review of the Cope II program in Malawi”, Displaced Children & Orphan Fund, Washington, DC.

Duffield, J., 1997, “An application to the Joint Funding Scheme of the Department for International Development: HIV Prevention and Care”, Action Aid, Maputo.

Griffin, S., 1998, “HIV/AIDS in Mozambique: Mission Report”, Save the Children/UK, Maputo.

Hunter, S., 1997, Children on the Brink, USAID: Washington, D.C.

Hunter, S., 1998, “Community Based Orphan Assistance in Malawi: Demographic Crisis As Development Opportunity”, Lilongwe.

Hunter, S., 1998, “Orphan Programming in Zambia: Developing a Strategy for Very Young Children in Zambia”, Lusaka.

Hunter, S., 1998, “Community Based Orphan Assistance in Zimbabwe: Developing and Expanding National Models by Building Partnerships with NGOs, CBOs, and the Private Sector”, Harare.

Hunter, S., 1998, “Stimulating Orphan Programming in Swaziland: Government and Community Response in a Multisectoral Context”, Mbabane.

Muchine, C. & Bazima, M., 1998, “Estudo micro-exploratorio sobre sexualidade, familia, educação: DTS/SIDA e planeamento familiar”, SCF (US), Maputo.

PSI, 1998, “Prevenção do HIV/SIDA em Moçambique: Inquérito Populacional sobre Conhecimentos, Atitudes, Comportamentos e Práticas (CAP), Preliminary report”, Maputo.

Taimo, N., 1997, “Estudo CAP e pesquisa qualitativa sobre saúde-reproductiva dos adolescentes de 13 a 18 anos nos distritos de Mocuba e Quelimane, Provincia da Zambézia”, ICS/MISAU/UNFPA, Maputo.

United Nations Population Division, 1998, “Technical Meeting on the Demographic Impact of HIV/AIDS: AIDS, Mortality and Population Change”, UN Secretariat Department of Economic and Social Affairs, New York.

UNAIDS, 1998, “Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Diseases: Mozambique”, Geneva.

UNAIDS/Maputo and NACP, 1998, “UNAIDS Country Profiles: Mozambique”, Geneva.

UNAIDS/Maputo and NACP, 1997, "UNAIDS In-Country Status Assessment: Mozambique", Geneva.

UNAIDS/Maputo and NACP, 1998, "UNAIDS Country Profiles: Mozambique", Geneva.

UNICEF/Zambia, 1998, "The Inclusion of an HIV/AIDS Component in BESSIP (Basic Education Programme", Lusaka.

Webb, D., 1998, "UNICEF's Response to HIV/AIDS and Children in Mozambique 1999-2001: A Strategy Outline, Working Draft", Maputo.

Whiteside, A. and G. Wood, 1993, "Socio-Economic Impact of HIV/AIDS in Swaziland", Mbabane.

The Situation of Children and Women in Mozambique

Bagnol, B., 1997, "Appraisal of Sexual Abuse and Commercial Sexual Exploitation of Children in Maputo and Nampula", Maputo, Royal Dutch Embassy.

Cauldwell, J., 1999, Various maps and comparative charts of the situation of Mozambican woman and children, UNICEF/Mozambique.

Cauldwell, J. 1998, "Situation Analysis of the Rights and Realities of Mozambican Children". UNICEF/Mozambique.

Departamento de Estudos da Mulher e Género, 199-, "Situação Legal da Mulher e o Direito Sucessório", CEA/UEM, Maputo.

Instituto National de Estatistica. 1998. "Estimativas e Projeccoes Anuais da Populacao, Pais, Provincias e Distritos 1990- 2000.

JTK Associates, 1999, "Case Descriptions on AIDS Orphans", UNICEF, Mbabane.

Ministerio de Saude. Inquerito Demografico de Saude. 1997. INE, MoH, Macro International Incorporated. 1997.

UNDP, 1998, Mozambique National Human Development Report, Maputo.

Appendix 4: Mozambican Orphans (0-14 yrs) by Province - 1997

	Total Population (0-14 years)	**Mother dead**	**%**	**Both parents**	**%**	**Mother or both parents**	**%**	**Father dead**	**%**		
0-9 years	5,456,193	162,026	3	18,570	0.3	180,883	3.3	267,384	4.		
10-14 years	2,124,586	163,593	7.7	53,115	2.5	216,708	10.2	237,954	11		
Male	3,687,914	143,829	3.9	44,255	1.2	188,084	5.1	265,530	7.		
Female	3,867,874	181,790	4.7	34,811	0.9	216,601	5.6	239,808	6.		
Urban			4.3		0.9		5.2		(		
Rural			4.3		1		5.3		6.		
Tete	583,239	30,912	5.3	5,832	1	36,744	6.3	44,326	7.		
Manica	489,313	16,147	3.3	4,893	1	21,040	4.3	41,592	8.		
Sofala	643,173	36,018	5.6	10,934	1.7	46,952	7.3	31,515	4.		
Subtotal	**1,715,725**	**83,077**	**4.8**	**21,659**	**1.3**	**104,736**	**6.1**	**117,433**	**6.**		
Cabo Delgado	610,623	47,018	7.7	5,496	0.9	50,071	8.2	26,257	4.		
Nampula	1,520,767	34,978	2.3	10,645	0.7	45,623	3	85,163	5.		
Zambezia	1,584,961	77,663	4.9	14,265	0.9	91,928	5.8	118,872	7.		
Subtotal	**3,716,351**	**159,659**	**4.3**	**30,406**	**0.8**	**187,622**	**5**	**230,292**	**6.**		
Niassa	392,349	25,110	6.4	1,569	0.4	26,680	6.8	16,871	4.		
Inhambane	493,019	29,581	6	5,423	1.1	35,004	7.1	37,469	7.		
Gaza	453,704	15,880	3.5	6,352	1.4	22,231	4.9	45,370	1		
Maputo	371,349	4,085	1.1	4,085	1.1	8,170	2.2	28,223	7.		
Maputo City	438,282	10,957	2.5	2,191	0.5	13,148	3	25,859	5.		
Subtotal	**2,148,703**	**85,613**	**4**	**19,620**	**0.9**	**105,233**	**4.9**	**153,792**	**7.**		
Total (0-14 y)	**7,580,779**	**325,619**	**4.3**	**71,685**	**0.9**	**397,591**	**5.2**	**505,338**	**6.**		

Source: J. Cauldwell-UNICEF, IDS. 1998. and INE 98

Appendix 5: Partial List of Organisations Providing Assistance for Families and Children Affected by HIV/AIDS in Mozambique

Name	Key Responsible	Address
ACÇÃO SIDA (Action AIDS)	Ricardo Barradas	P.O.Box 1253 Maputo Tel: 497252 - 082-304339 Fax: 425255/6 e-mail:medico@zebra.uem.mz
ACCAO PELA VIDA/RM	Teresa Xavier	Tel: 431687/88
ACTION AID	Janet Duffield	Av 24 de Julho, 431 CP 2608 Maputo Tel: 493641; Fax: 493638
ACTIVA	Maria Angélica Salomão	Av. 24 de Julho, 20/21 C.P. 30; Tel/Fax: 423506
ADEMIMO	Cezerino Mone Nando	Av. Mao Tse Tung, 911 Tel: 496297
ADPP	Brigit Holm/Ana Margarida Lemos	Rua Bertha Catadu – Machava Tel: 750832, 750106; Fax: 750107
ADPP - BEIRA	Nicole Ward	Tel: 03-364352 e-mail: esperanca@teledata.mz
AJAIDS (Journalist Association Against AIDS)	Alberto Zandamela	Av. Amilcar Cabral,214 Maputo Tel 422524/428657; Fax: 430951
AMME (Mozambican Association of Women and Education)	Armanda Chuva	Praceta dos Herois de Mocuba, 130/A Tel/Fax 423375 Av. Eduardo Mondlane, 1928, 3 andar
AMODEFA (Mozambican Association of Family Development)	Olinda Mugabe	Rua da Tanzania, 70 Maputo Tel: 405107/405149 Fax 405109
ARO JUVENIL	Policarpo Tamele	Av. 24 de Julho, 1420 Maputo Tel: 428016/308452, Fax: 402910
AMRU - ASSOCIACAO DE DESENVOLVIMENTO DA MULHER RURAL	Amélia Zambeze	Tel: 422809 Fax: 422893 Cell: 082-302645
CASA MILITAR (Military House)	Rafael Ernesto Dinis	Av. General Teixera Botelho, 1643. Tel: 415558/493364; Fax: 416713
CAA (OXFAM AUSTRALIANA)	Judy Walls	Av. Patrice Lumumba, 770 1o. andar Tel: 303094; Fax: 420799
CARITAS DIOCESANA	Inácio André Mucavele	Av. Amilcar Cabral, 777 Tel: 302861
CLUBE SINTAXE – EX-LIGA JUVENIL PARA SEGURANCA JUVENTIL	Inácio José Fernando	Tel: 305295; Fax: 305298 e-mail: nsalgado@rocketmail.com
COMITÉ INTERSECTORAL DE APOIO AO	José Neves Maluleca/ Arão Cumbane	MCJD Av. 25 de Setembro, 916, 7 andar

DESENVOLVIMENTO DO ADOLESCENTE E JOVEM		Tel/Fax: 428650/428167 Fax: 301604
CONSELHO CRISTÃO (Christian Council)	Reverendo Lucas Amosse Secretário: Leonardo Buna	Av. Ahmed Sekou Touré, 1822 Maputo Tel: 422836-425103 Fax: 421968
COOPERAÇÃO FRANCESA (French Cooperation)	Dr. Guillaume Guirand	Clinica Dermatologia, HCM, Maputo Tel/Fax: 420831
CVM (Mozambican Red Cross)	Armando Machiana	Av. Agostinho Neto, 284 Tel: 490943/497721; Fax: 497725
GASD (University Group of Activists on HIV/AIDS)	Cornelio Balane	Av. Paulo Samuel Nkankhomba, 203 2o andar. Tel/Fax: 497014 - 082-306566 e-mail: balane@health.uem.mz
KINDLIMUCA	Salvador Mazive	Rua da Tanzania, 70 Maputo Tel: 405107/8 Fax 405109
KUBATANA	Sr. Pechisso	Tel: 051-22725/22738 Provincia de Manica
KULIMA	Domenico Liuzzi	Avenida Karl Marx, 1452 Maputo Tel: 421622- 430665 Fax: 421510
MEDICINS DU MONDE	Daisy Grindlay	Rua Tenente Valladim, 95 – Centro da Baixa Tel/Fax: 423288
MONASO (Mozambican Network of AIDS Services Organisation)	Ricardo Trindade	Av. Ahmed Sekou Touré, 1425. Maputo Tel: 425260 Fax: 425256
MSF BELGIUM	Luc Van der Veken	Av. Agostinho. Neto, 1007 Maputo Tel: 307946/7 Fax: 425417
MSF SWITZERLAND	Louis Felipe	Av. Agostinho Neto 1007, Maputo Tel: 307976 Fax:420056
MULEIDE (Woman, Law and Development)	Guilhermina Milice	Av. Paulo Samuel Kamkhomba, 2150 Tel: 425580 Fax:425580
NORAD	Ann Helen Azedo	Av. Agostinho Neto, 620 Maputo Tel: 429411/3/5 Fax: 429410 P.O.Box 828
OJM (Youth Organization of Mozambique)	Paulino Lai	Rua Pereira do Lago, 147 3º floor, Tel: 490164/490526
OMS (WHO)	Miguel Aragon	Av. Zimbabwe,1230 Maputo Tel: 492732/490896; Fax: 491990 e-mail:office@who.uem.mz
ORGANIZAÇÃO DA MULHER MOÇAMBICANA (Woman Organisation of Mozambique)	Paulina Mateus	Rua Pereira do Lago,147 E 2º Tel: 491646/492565/491646 Fax: 492581

ORGANIZAÇÃO DOS PROFESSORES (Teacher's Organisation)	Chindele Fafetine Muquingue	Av. Ahmed Sekou Toure, 2150. Maputo Tel: 429751/490400 Fax/Tel: 422113
OTM (Trade Union of Mozambique)	Pedro Mondlane	Rua António Manuel de Sousa, 36 Tel 428300/426477Fax:421671
PSI (Population Services International)	Clayton Davis	Av. Patrice Lumumba, 204 Maputo Tel: 430638/430307,Fax: 430636 P.O.Box 783
RÁDIO MOÇAMBIQUE	Teresa Xavier	Rua da Rádio, 2 Maputo Tel: 431687/8 ext 215; Fax: 429905
RIBANGO COLECTIVO	Domingos Alexandre Simbine	Av. da Zambia, 371, 3o. andar Tel: 405546
SAAT (Southern African AIDS Training)	Balbina Santos	Av. 24 de Julho 661 Maputo Tel/Fax: 302976- 429904 casa
SAVE THE CHILDREN FUND (UK)	Sally Griffin	Av. Armando Tivane, 474; C. P. 1882 Tel: 498762/3, Fax: 498751 e-mail: scf@scfukmoz.uem.mz
SAVE THE CHILDREN (US)	Clara Muchine	Av. Thomas Nduda, 1489 R/C Maputo Tel: 493283, Fax: 493121
TVM	Eugénio Benhe	Tel/ Fax: 308117/9 Ext. 344/345
UNIÃO BIBLICA (Bible Union)	Alice Ripanga	Tel: 430561/428698 Fax: 429473
VISÃO MUNDIAL (World Vision)	Martha Newsome	Av. P. Samuel Kamkhomba, 1170, – P. O. Box 2531 Tel:431279/300640;Fax:300640 e-mail: martha_newsome@wvi.org
VSO – Voluntary Service Overseas	Tome Eduardo	Tel: 431478 Fax: 421661
WORLD RELIEF CORPORATION	Galen "Paulo" Carey Country Director	Rua João Mateus, 274 Tel: 492967/492725, Fax: 492974 P.O.Box 680 – Maputo e-mail: carey@zebra.uem.mz

Appendix 6: Programming Innovations in Neighbouring Countries

Note: Notable innovations appear in bold face type

Country	Planning & Finance	Health	Education	Social Welfare	Agriculture & Land	Non-governmental
Botswana	Multisectoral Population and Economic Impact Study	NACP orphan estimates	Barriers to access for orphans	Welfare benefit scheme; child law review		Private sector partnerships for micro-credit
Malawi		NACP orphan estimates	Implementing free primary education; **voluntary crèches / pre-schools**	Welfare benefit scheme; leading community based care development; **child law review and policy development**		**NGO/Government Co-ordination at National and Local Levels; integrated into formal social welfare system; COPE model**
South Africa	Aggregate costing models of care			Welfare benefit scheme; testing models of care in one province; leading community based care development; child law review		NGO/Government Co-ordination at National and Local Levels; integrated into formal social welfare system
Swaziland	Multisectoral Population and Economic Impact Study	NACP orphan estimates; barriers to health sector access for young children		Welfare benefit scheme (being revised); child law review	Vulnerability mapping and impact assessment	NGO/Government Co-ordination at National and Local Levels

Country	**Planning & Finance**	**Health**	**Education**	**Social Welfare**	**Agriculture & Land**	**Non-governmental**
Uganda	Costing impact for educational changes		Increased access (financial) for orphans; limited free primary education	Leading community based care development; **child law review**	Vulnerability mapping and impact assessment	NGO/Government Co-ordination at National and Local Levels
Zambia		NACP estimates; Leading community based care development with social welfare	**Large alternative schooling system; currently revising national policy to improve access**	Welfare benefit scheme; child law review		NGO/Government Co-ordination at National and Local Levels
Zimbabwe				**Leading community based care development**; child law review		**NGO/Government Co-ordination at National and Local Levels; integrated into formal social welfare system**