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GUIA TURÍSTICO
TOURISTIC GUIDE
MOÇAMBIQUE

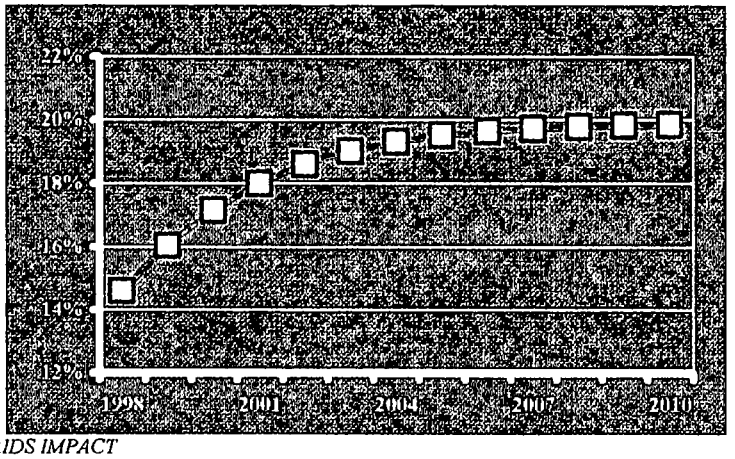
C - Mozambique

Mozambique-Country update

1. Current HIV/AIDS Situation

The first case of AIDS in Mozambique was reported in 1986. Through December 1999 more than 17,224 cumulative cases have been reported to the National AIDS Control Programme (NACP). However, this number is not representative due to the high level of under reporting. Available data indicate that national HIV prevalence in the adult population is 16 %. The epidemic is spreading rapidly, particularly in the Central Provinces.

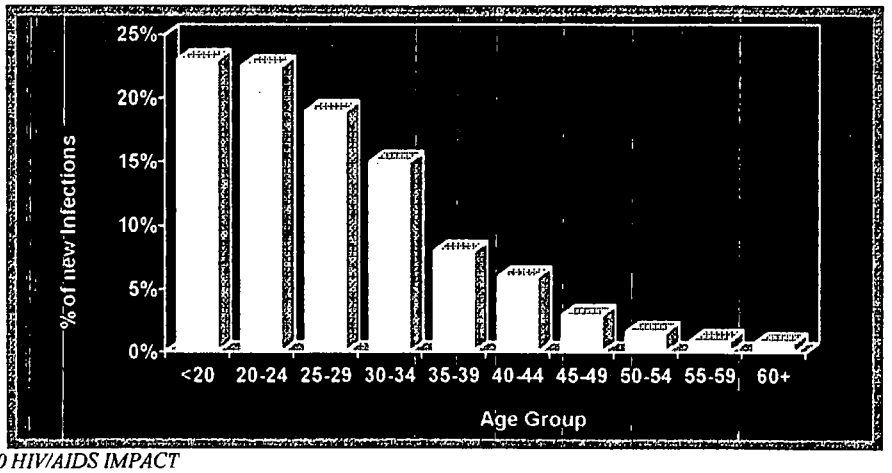
Graphic n. 1 NATIONAL PREVALENCE OF HIV AMONG ADULTS (15-49 y)



Source: NACP/MOH/2000 HIV/AIDS IMPACT

The distribution by age groups of new HIV infections shows that 65% of the cases occur in the age-group 15-29 years, 51% are male while the number of women is growing. 10% of the AIDS cases reported are in children under 5 years of age.

Graphic n. 2 Percentage of new HIV infections distributed by age –groups



Source: NACP/MOH/2000 HIV/AIDS IMPACT

65% of new infections occur in young people less than 30 years old

The estimated cumulative number of orphans in 1999 is 257,000. By the year 2002, it is expected that this number will rise up to 500,000. Data indicate that 700 Mozambicans are newly infected each day.

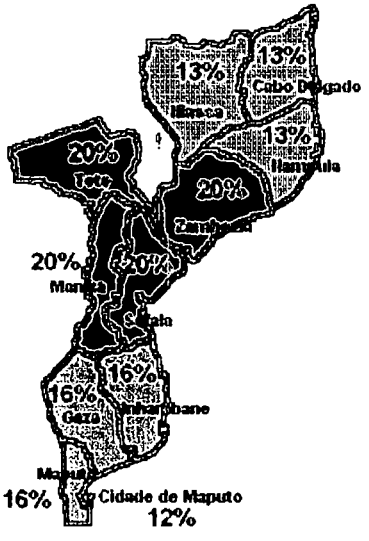
Estimated impact of HIV and AIDS

1999	2002
1,288,000 PLWH/A	1,611,000
257,000 Orphans	500,000
83,600 adult deaths	126,700
13,900 children deaths	16,900

Source: NACP/MOH/2000 HIV/AIDS IMPACT

The most affected provinces, Manica, Tete, Sofala, Zambezia and Nampula, have major transport routes to or borders with the countries of Zimbabwe, Malawi and Zambia.

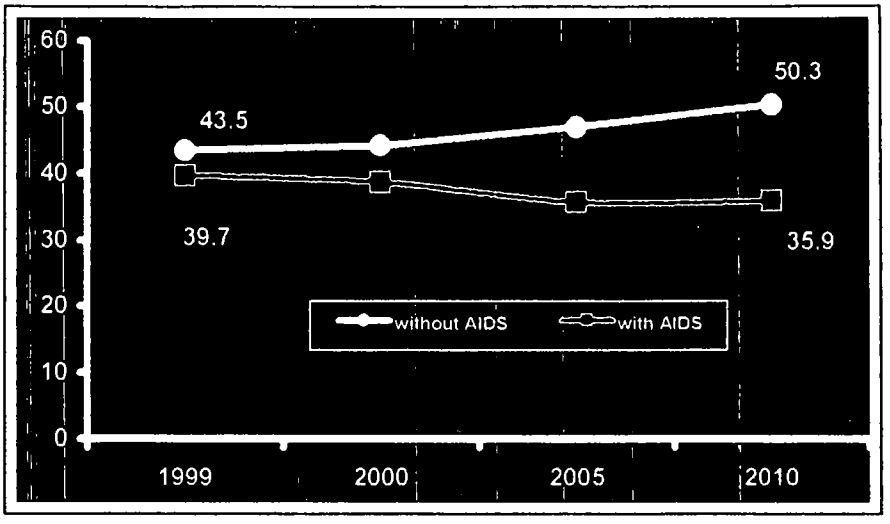
Graphic n. 3 NATIONAL PREVALENCE OF HIV AMONG ADULTS (15-49 y) BY PROVINCES



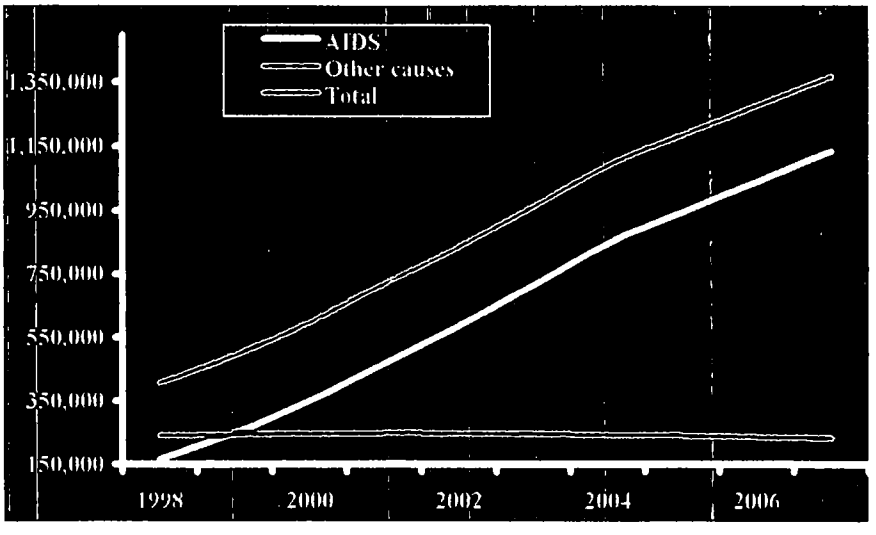
Main determinants of the Epidemic in Mozambique

- High level of STDs among youths and low use of condoms
- Decreased access to prevention and care services among many social groups
- Social and economic inequalities experienced by women
- Difficulty of implementing health education in schools
- Difficulties for formal services to reach vulnerable groups (CSW, prisoners, mobile people, etc)
- Labor migration (mine and agricultural workers) to neighboring countries
- Deterioration of household income
- Low literacy and schooling rate, low coverage of IEC activities/services

Graphic n. 4 LIFE EXPECTANCY WITHOUT AIDS AND WITH AIDS IN MOZAMBIQUE



Graphic n. 5 MATERNAL ORPHANS IN MOZAMBIQUE (1998-2007)



The Flood emergency from February to March 2000 in Mozambique caused a major setback and challenge to Mozambique's National HIV/AIDS Response. Its consequences are being evaluated. The momentum of the impact is just starting to appear. *(The social and economic disruption arising from the floods could fuel HIV transmission as people moved into camps or from their usual environments).*

2. Political commitment

The high-level government commitment appears in the President's declaration of AIDS as a **national emergency**. The National Strategic Plan to combat STDs/HIV/AIDS (2000-2002), completed and endorsed by the Council of Ministers is comprehensive and multisectoral. The MoH has officially launched the 1st association of PLWH/A ("Kindlimuka"), increasing visibility, network and partnership with Government and other stakeholders. Private sector participation is increasing.

Sectoral and provincial plans are being developed for implementation of the strategic plan and new institutional arrangements to increase effectiveness and coordination are being created. Local ownership of the fight against AIDS is very advanced. There are national programmes on STD/HIV/AIDS in every province and activities are extended to district level under the new integrated plan on communicable diseases.

3. Resource mobilisation.

The World Bank and the International Monetary Fund (IMF) have agreed that Mozambique has met the requirements for receiving close to $ 3.7 billion in debt relief from its external creditors under the HIPC Initiative. The total debt relief package is $ 1.7 billion in today's values [2]. The HIPC Initiative debt relief will reduce Mozambique's external public debt by almost two-thirds. It is granted to support the country in its economic and social reforms.

4. National response to HIV/AIDS in partnership

Government capacity to effectively respond to the epidemic is limited by human and financial constraints. There is also a lack of information about the epidemic and its consequences to guide the planning process at local level. Other constraints include: the delay in the disbursement of funds from donors; low involvement of non-health sectors; shortage of HIV tests; low availability of IEC materials in Portuguese and national languages; low condom availability; low coverage and weak counselling activities; the lack of a specific strategy for "vulnerable groups" and the insufficient decentralisation of programme management.

In its annual meeting, the United Nations Theme Group (UNTG) on HIV/AIDS agreed on its assistance to NASP and issued an integrated workplan in order to better co-ordinate the activities of the different agencies according to the country's identified and prioritised programmatic areas and comparative advantages. The main objectives are: supporting the implementation of the NSP through work on institutional development, advocacy and resources mobilisation; enhancing co-ordination and consistency of UN support to NSP; implementation of UN policy on HIV/AIDS at workplace. Areas of focus have been clearly identified.

Bilateral partners (USAID, GTZ, Italian Cooperation, French Cooperation, NORAD, Dutch Cooperation, EU, and others), major international NGOs and national organizations are playing key roles in the implementation of the National Response.

I. BACKGROUND

Although Mozambique's first AIDS case was reported in 1986, until recently, the country's AIDS situation appeared to be less serious than that of neighbors, such as Malawi, Zambia, and Zimbabwe. This was primarily due to the 1977-92 civil war, which so impeded migration and travel that Mozambique was sheltered from the rapid spread of HIV/AIDS that has been devastating its neighbors. Some experts believed as recently as 1997[1] that Mozambique had a small window of opportunity, perhaps two years, in which to intervene to prevent HIV prevalence rates in the general population from rising to the high levels -- over 20% -- found in neighboring countries (Fig. 1). Unfortunately, Mozambique – one of the world's poorest countries, emerging from a long civil war, and implementing fundamental political and economic reforms – was unable to marshal the political, economic, and human resources to mount such an intervention. In the wake of the return of two million refugees from high-prevalence neighbors and the re-initiation of high traffic volumes in the country's transport corridors, AIDS now represents a visible and serious threat to the development of Mozambique.

Fig. 1

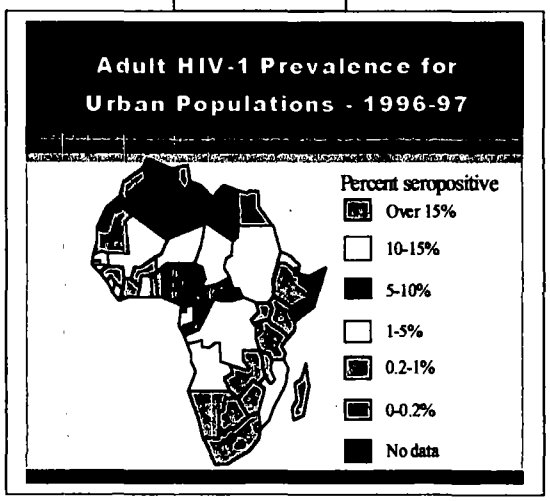
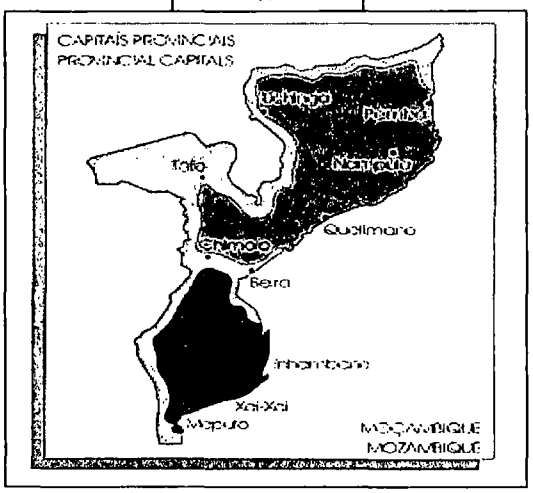


Fig. 2



II. SITUATION ANALYSIS

2.1. Introduction

The available data on AIDS cases and HIV seroprevalence in Mozambique is somewhat sketchy due to the limitations of the national surveillance system. Although there are health facilities equipped to perform HIV testing in all provinces, surveillance efforts have been plagued by problems such as availability of reagents, underreporting, late reporting and poor quality assurance. In addition, surveillance efforts have not consistently covered sentinel populations and have not covered all provinces. Despite these limitations, the available data suggest that HIV prevalence is about 14.5 percent in the adult population.[2] The National Strategic Plan indicates that in 1999, approximately 700 persons a day became infected with HIV.[3] In certain areas of the country HIV seroprevalence is even higher (above 20 percent, Figure 2). High prevalence rates in the central corridor and in districts bordering neighboring countries are of particular concern.

2.2. Number of AIDS cases

National data on the number of AIDS cases per year (Table 1) indicates that the epidemic is at an important transition point: rather than remaining a silent epidemic of HIV infection, the disease is beginning to manifest as

[1] USAID/Mozambique. HIV Strategy. 1997.
[2] National Strategic Plan to Combat STDS/HIV/AIDS, 2000-2002, Government of Mozambique. 1999.
[3] Ibid.

C-M02.

POLICY PROJECT

G/PHNC/POP/P&E
September 1995 - August 2000
New Policy Results Package (NPR): {planned} June 2000 - May 2005

The Futures Group International *in collaboration with*
Research Triangle Institute and CEDPA

STRATEGIC OBJECTIVE:
Improved policy environment for family planning/ reproductive health programs, including HIV/AIDS

****

POLICY/Mozambique

1997-1999: Training

- Local advocacy for FP/RH (with Pathfinder)
- EASEVAL software package for further analysis of DHS data (with CEP/UEM)
- SPECTRUM software package
  - DEMPROJ - demographic projections
  - RAPID - impact of population growth
  - AIM - AIDS Impact Model

1999- 2000: HIV/AIDS
Principal counterpart: National AIDS Control Program/MOH
Partners: UNICEF, UNAIDS

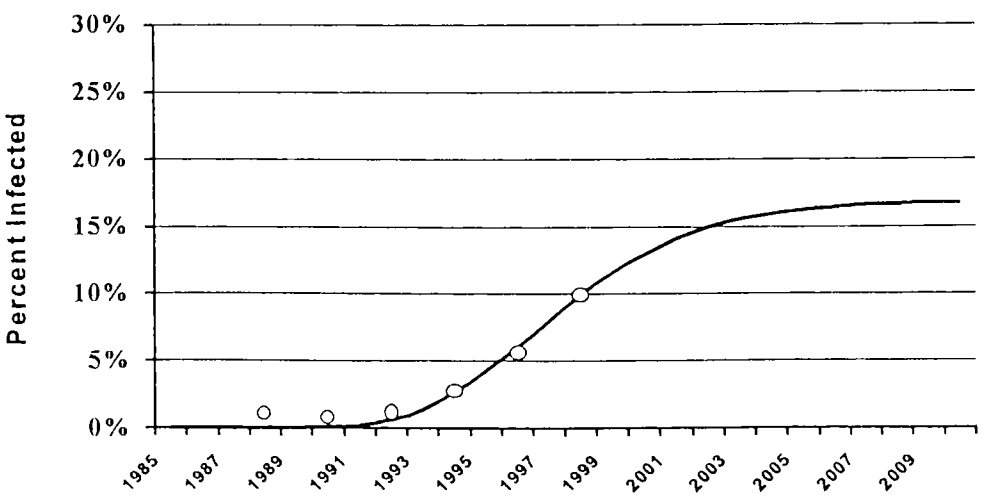
- April 1999: Evolution of HIV/AIDS epidemic in Mozambique
  National Strategic Plan working group
- August 1999: NACP consensus workshop
  Accepted AIDSProj HIV prevalence projections as official
  Recommended formation of multi-sectoral technical group
- October 1999: AIM workshop in USA (financed by UNICEF)
  Technical group coordinated by INE, with MOH, MOPF & CEP
- February 2000: NACP consensus meeting
  Demographic impacts of HIV/AIDS epidemic

ESTIMATING ADULT (15+) HIV PREVALENCE

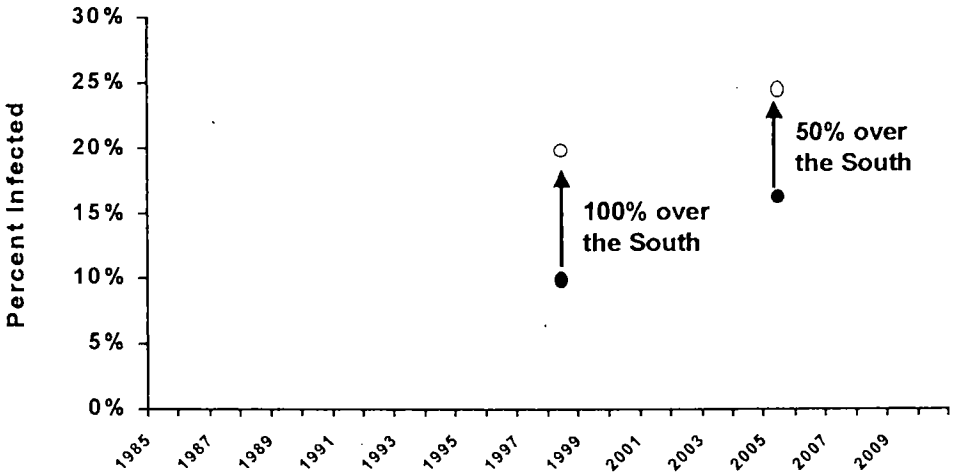
HIV Prevalence Detected in Ante-Natal Clinics

	1988	1990	1992	1994	1996	1998
Maputo	1.0%	0.8%	1.2%	2.7%	5.6%	9.9%
Tete				18.1%	23.2%	17.0%
Chimoio				10.7%	19.2%	17.0%
Beira					16.5%	18.3%

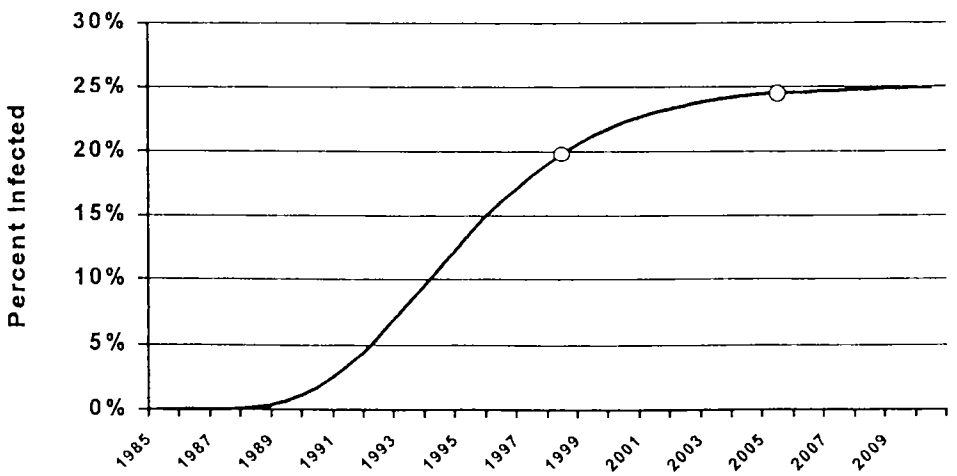
Projected Prenatal HIV Prevalence: South Region



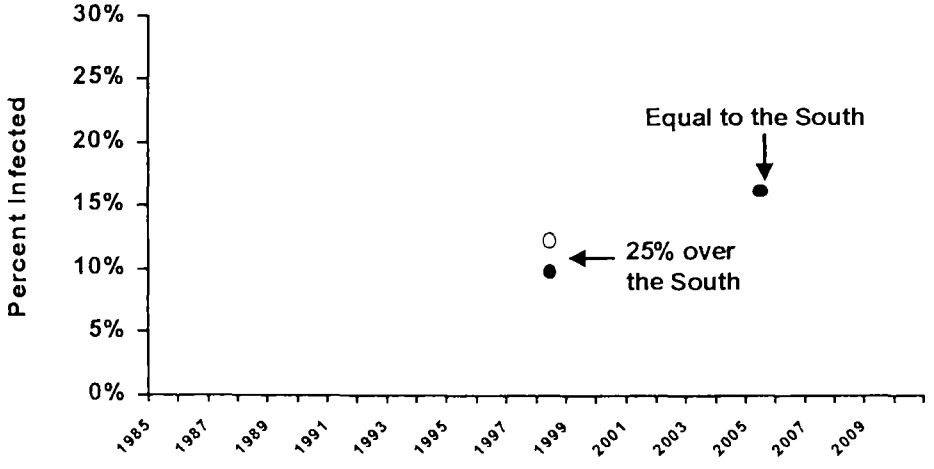
Prevalence Assumptions: Center Region



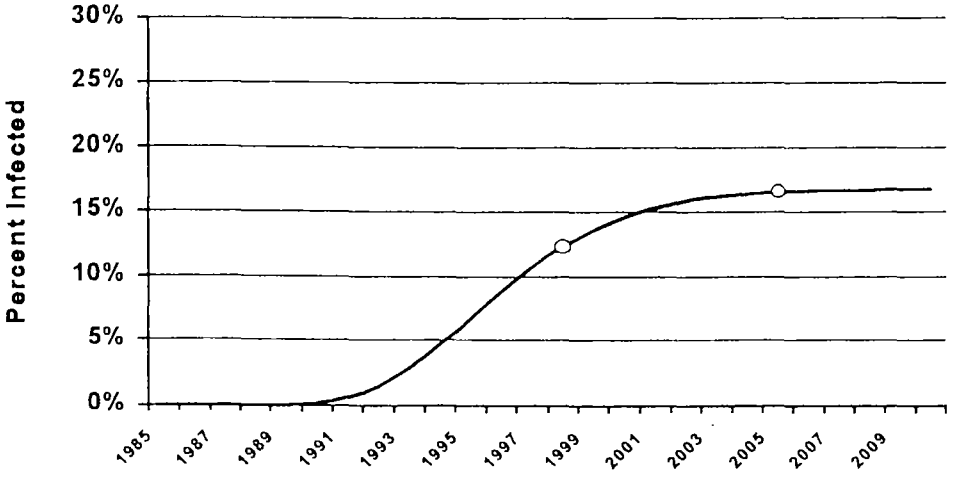
Projected Prenatal HIV Prevalence: Center Region



Prevalence Assumptions: North Region

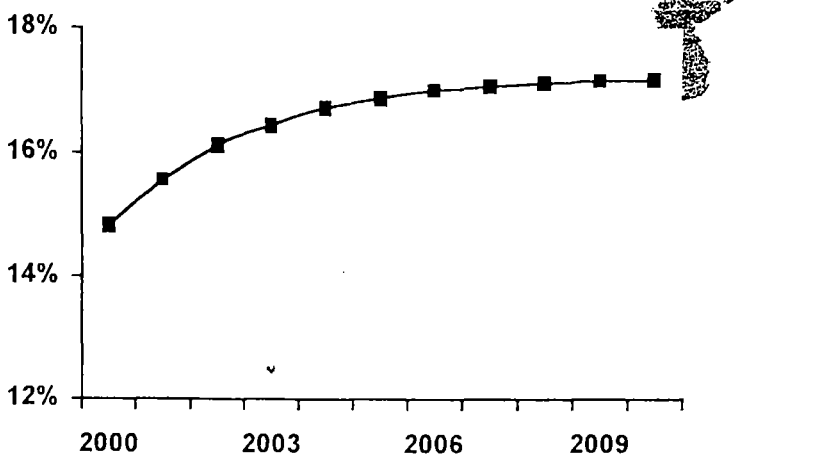


Projected Prenatal HIV Prevalence: North Region

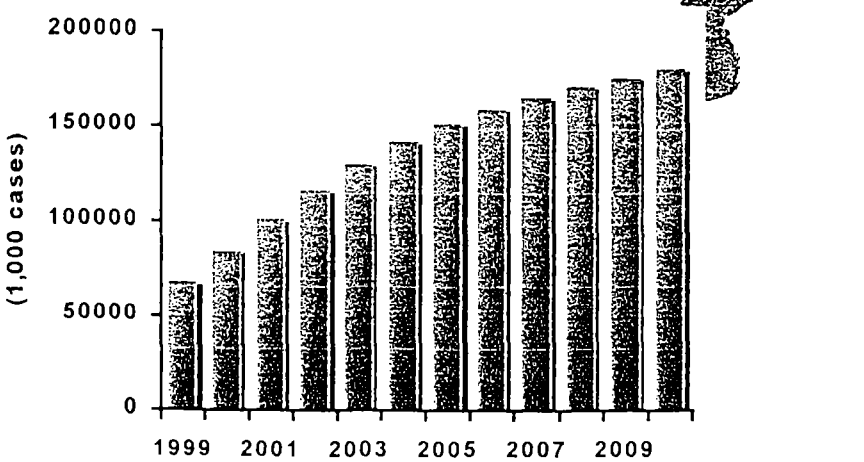


CONSENSUS MEETING: FEBRUARY 2000
Demographic impacts of HIV - Results of AIDS Impact Model

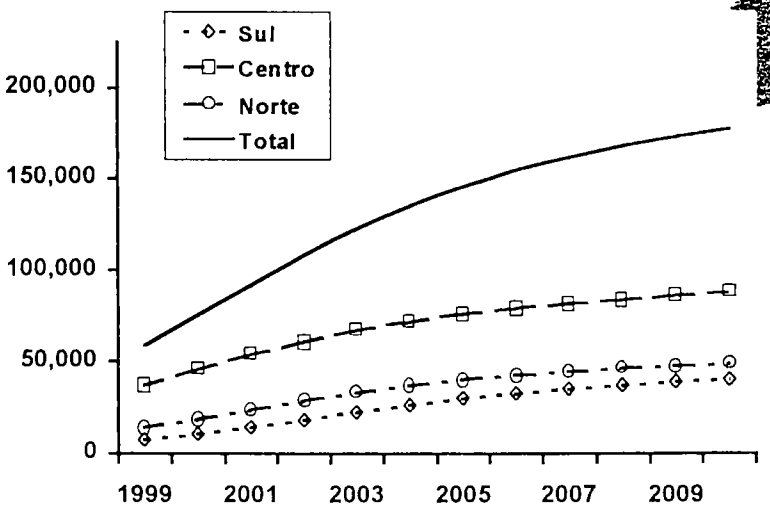
National Projected HIV Prevalence
Adults (15-49 years)



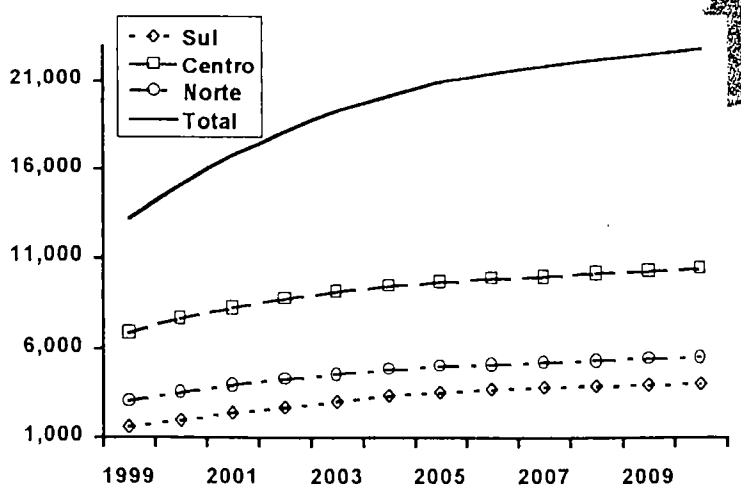
Annual New AIDS Cases
1999-2010



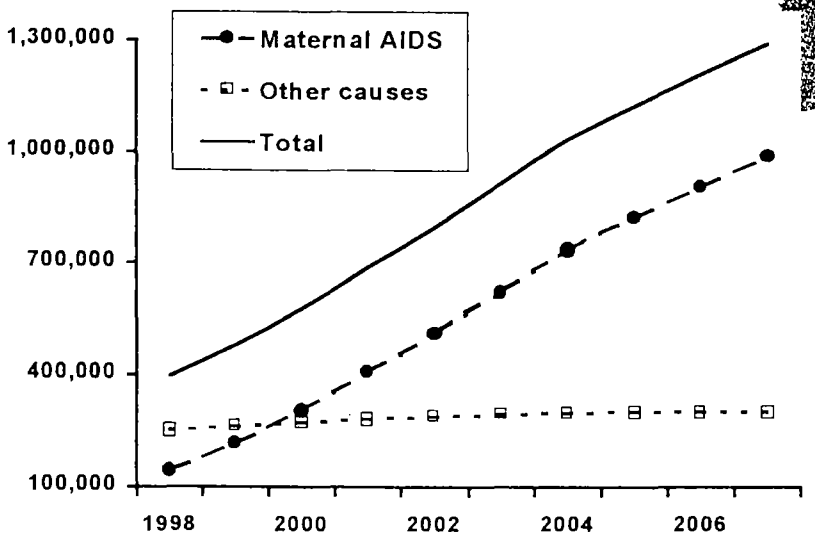
Annual AIDS Deaths among Adults, 1998-2010



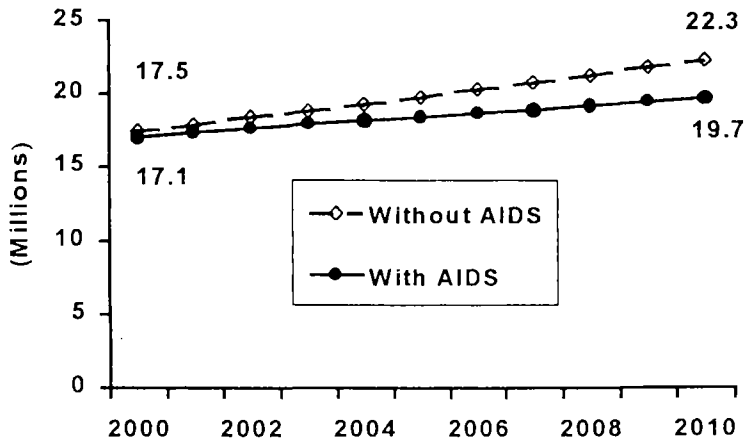
Annual Deaths - Children Born HIV+ 1998-2010



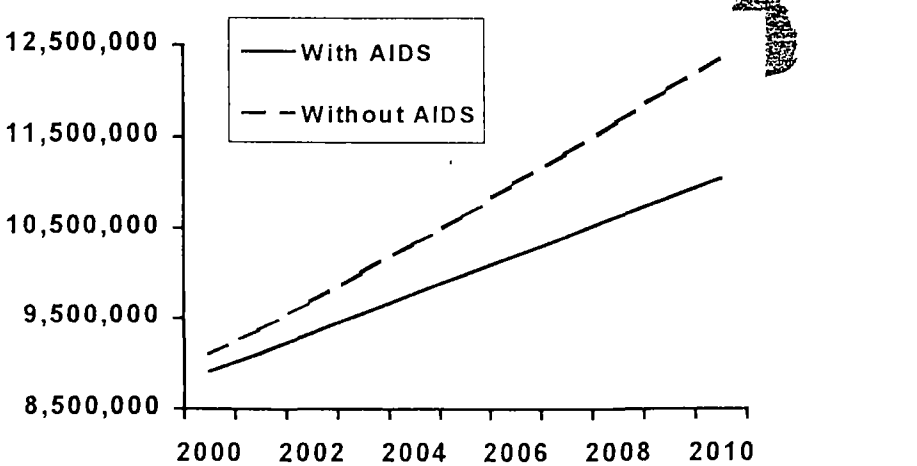
Projected Maternal Orphans (0-14) 1998-2007



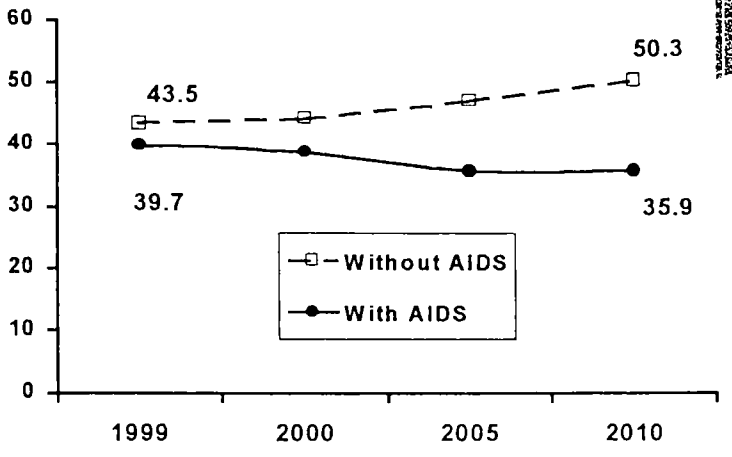
Projected Population Growth 2000-2010



Projected Population 15-64 2000-2010

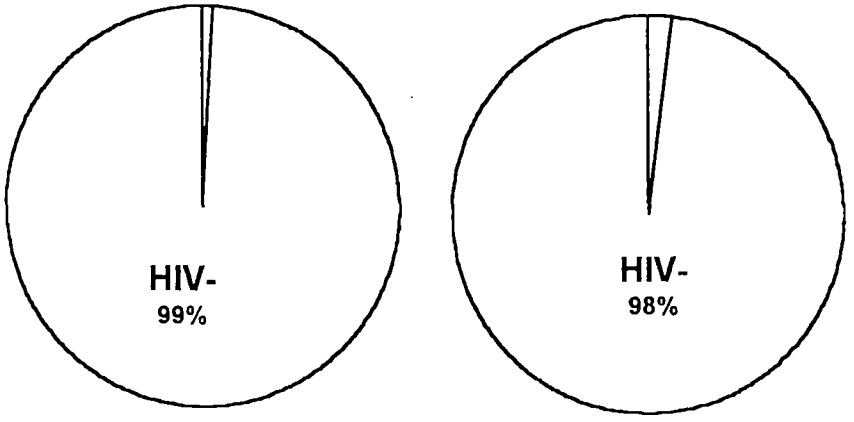


Projected Life Expectancy at Birth
1999 - 2010



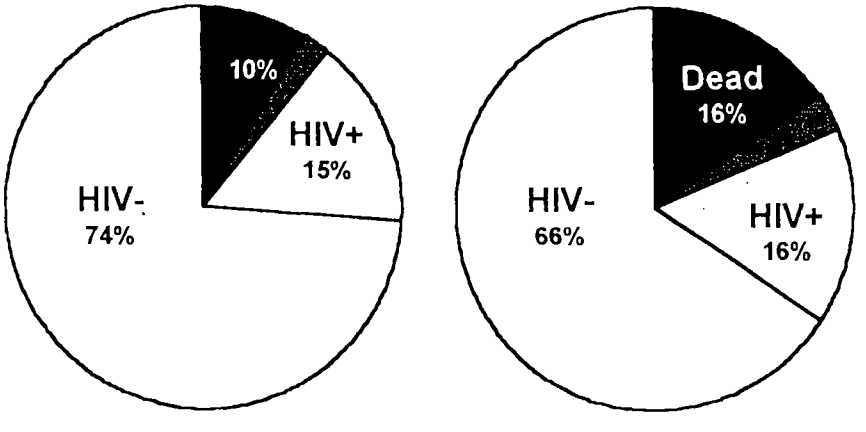
Prospects for Today's Youth at Current Rates of HIV Infection

At age 15



Men Women

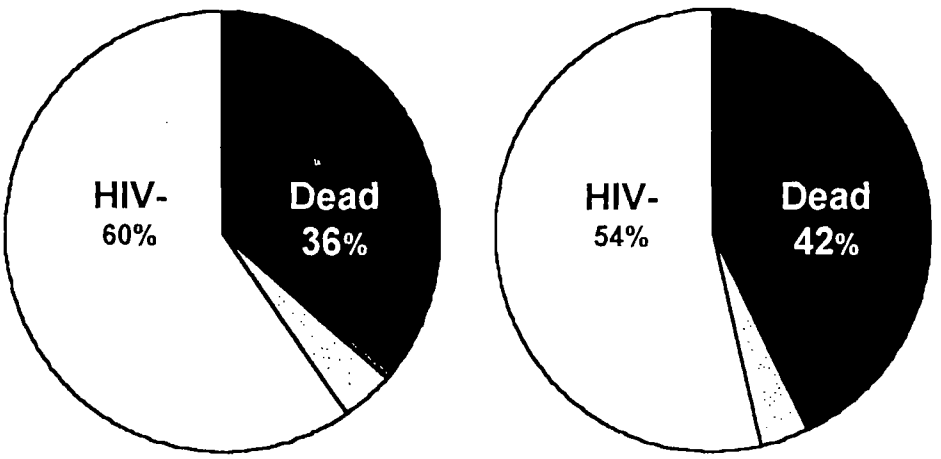
At age 30



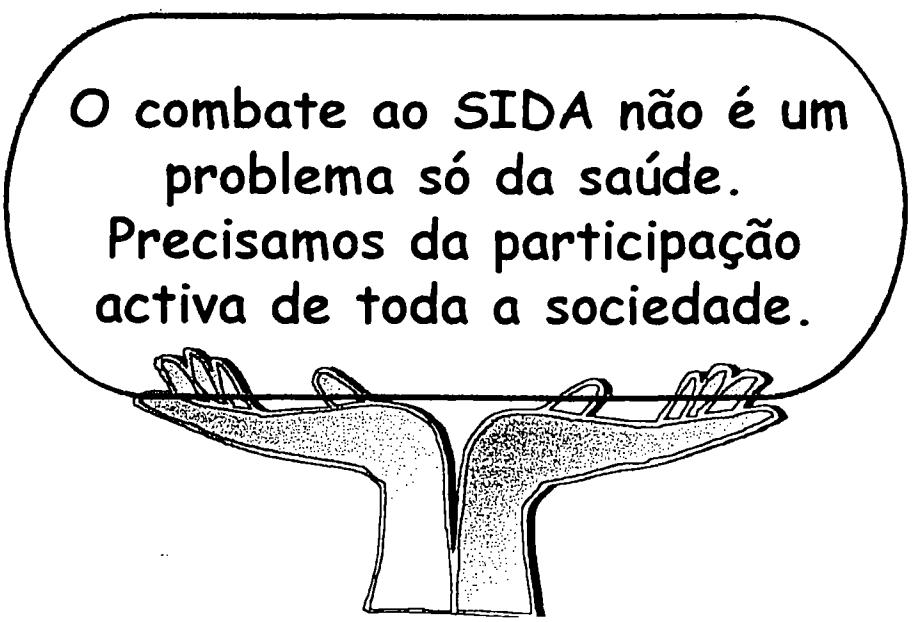
Men Women

Prospects for Today's Youth at Current Rates of HIV Infection

At age 49



Men Women



MOZAMBIQUE AND HIV/AIDS

Country Profile

Mozambique is one of the world's poorest countries, and all of the country's social indicators are well below sub-Saharan African averages.

Mozambique's ten-year civil war reversed post-independence improvements in basic services and had a major impact on mortality and morbidity, especially among children. Thirty to 40 percent of Mozambique's children are chronically malnourished. Roughly 60 percent of the population still lack access to health services. The Mozambican government now allocates 8 percent of its current budget—about US$2 per person per year—to the health sector.

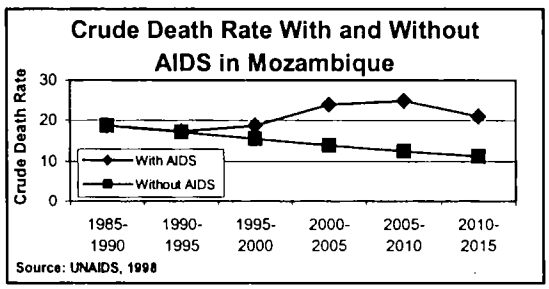
HIV/AIDS in Mozambique

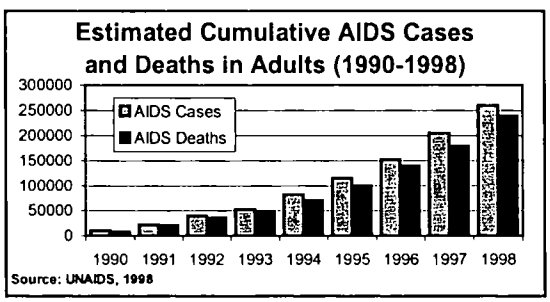
The first AIDS case was reported in Mozambique in 1986. The country's HIV prevalence rate is lower than the rates of neighboring Zimbabwe, Zambia and Malawi, largely due to the isolating effects of the civil war.

Nevertheless, the Joint United Nations Programme on AIDS (UNAIDS) reports that Mozambique is one of nine African countries hardest hit by the epidemic. The virus is spreading rapidly in the central provinces.

- HIV prevalence rates of adults (15 and older) range from 10 percent, as reported by the Ministry of Health, to 14 percent, as reported by UNAIDS. These higher rates are found along transport corridors and in areas in which mine workers from South Africa are recruited.
- An estimated 1.2 million Mozambicans are living with HIV—290,000 of them with AIDS.
- More than three-quarters of those living with HIV/AIDS are ages 20 to 49.

From 1990 to 2010, AIDS will increase the crude death rate in Mozambique by 98 percent.





- 83,000 people died of AIDS-related diseases in 1997.
- Life expectancy will drop 27 percent during the 1990s as a result of HIV/AIDS. By 2010 average life expectancy will be 37 years.

Women and HIV/AIDS

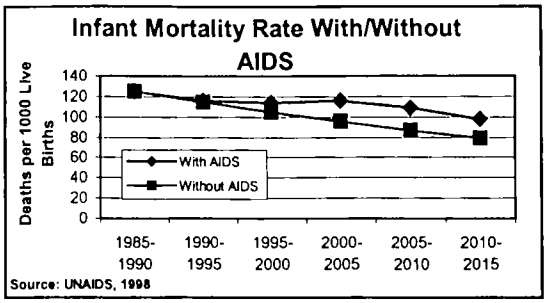
The number of women living with HIV/AIDS is growing in Mozambique. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability.

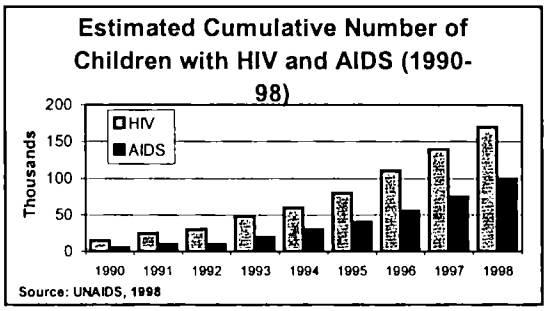
- Women experience socioeconomic inequalities and discrimination, particularly in inheritance and land tenure issues, that put them at increased risk of HIV.

Children and HIV/AIDS

Forty-six percent of the Mozambican population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

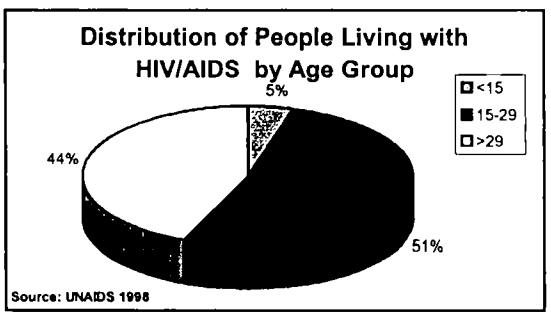
- About 18,000 newborns (50 per day) will acquire HIV in 1999.
- In 1998 pediatric cases represented 15 percent of all AIDS cases.
- By 2015 the infant mortality rate is expected to be at least 25 percent higher than it would have been in the absence of AIDS.
- 77,000 children have died from AIDS-related illnesses since the beginning of the epidemic.
- To date, an estimated 198,000 children have been orphaned by HIV/AIDS. By the year 2000 there will be about 596,000 AIDS orphans.





Youth and HIV/AIDS

Youth and young adults account for a large percentage of all HIV/AIDS cases in Mozambique.

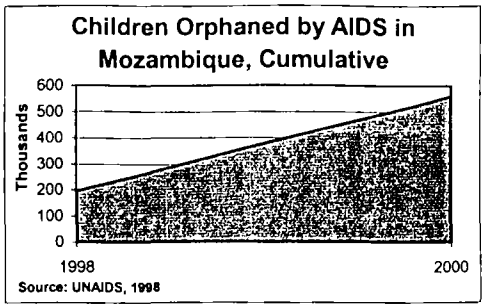


- Half of those living with HIV/AIDS are ages 15 to 29.
- More than one-quarter of reported cases of sexually transmitted infection (STI) occur in teenagers.
- Despite high rates of HIV risk behavior and infection among young people, basic health education has not been effectively implemented in the school system.

Socioeconomic Effects of AIDS

Years of civil war have left Mozambicans—especially returning refugees—particularly vulnerable to HIV. Unemployment rates are high, resulting in greater poverty, wider economic and social imbalances between men and women, and increases in both legal and illegal migration. Poverty and diminishing access to health care and education have also led to the breakup of families, increased the number of children living on the street, and forced many girls and young women into sex work.

HIV/AIDS threatens Mozambique's reconstruction as well as the health of its people. The direct costs alone of caring for millions of people living with HIV/AIDS are expected to overburden the country's inadequate health system. Community-based care in Mozambique is particularly ill-prepared for the influx of people living with



HIV/AIDS (PLWHA). Preliminary data suggest that 20 percent of rural hospital beds are already occupied by AIDS patients.

HIV/AIDS is also beginning to take its toll on businesses in Mozambique, and is expected to reduce annual profits in the coming years. Productivity falls and business costs rise—even in low wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. Despite the fact that some large businesses have responded to the epidemic, the diminished labor pool continues to affect economic prosperity, foreign investment, and sustainable development.

Interventions

National Response

The national response has passed through several stages. Initially there was low acceptance of HIV/AIDS as a problem. Following this period of denial, the National Control Programme against STD/AIDS (NACP) was created in 1988, and the first Medium Term Plan (MPT1) was developed.

The NACP has a central body, located in the Ministry of Health, and regional offices in 11 provinces. The main responsibilities of the NACP include planning, coordinating, monitoring, and assessing provincial plans, and providing technical assistance to government sectors involved in the program. The NACP also develops short- and medium-term plans and establishes cooperation protocols for Mozambican and international NGOs, donors, and social, religious, and mass media associations. A second Medium Term Plan (MPTII) was developed in 1994. The National Strategy to combat STI/AIDS includes prevention, counseling, epidemiological surveillance, and blood testing. Specific components of the national program include management, information, education and communication (IEC), epidemiological surveillance, laboratory support, care of PLWHAs and counseling, and condom social marketing.

On December 1, 1998, President Joaquim A. Chissano addressed the nation on World AIDS Day—the first communication about HIV/AIDS issued from the President's office.

The Mozambican government is currently designing a national strategic plan, with the support of the Mozambican UNAIDS theme group on HIV/AIDS and UNAIDS-Geneva, which will be presented to the Council of Ministers in August 1999. The multisectoral Interministerial Commission and the provincial governors are also involved. The NACP is also collecting data to create an AIDS Impact Model for Mozambique, and is currently developing a national counseling strategy.

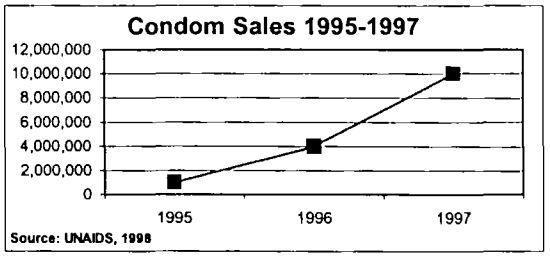
Donors

Multilateral and bilateral donors are actively engaged in Mozambique. According to a UNAIDS/Harvard study, each bilateral organization contributed the following amounts in 1996-1998:

Organization	Amount US$ 1996-97	Amount US$ 1998-99
USAID	4,648,000	7,500,000 *(USAID/Dutch cooperation)*
EU	3,125,000	3,000,000
Finland	1,100,000 (1995-97)	
France	1,059,734	300,000
Total	**9,932,734**	**10,800,000**

Bilateral donor support 1996-1998

USAID's HIV/AIDS funding for FY 1998 was $3.2 million. The mission pursued a nationwide HIV/AIDS prevention strategy with two focus areas: condom social marketing and integration of AIDS and STI control into child survival programs. The social marketing program includes behavior change communication (BCC), using mass media, theater groups, and community agents to promote safer sex.



In 1999 USAID will support cooperating agencies to:

- Expand the reach of behavior change messages through community-based peer education.
- Improve the quality and reach of BCC, focusing on youth.
- Increase activities to improve STI prevention and treatment.
- Increase HIV counseling and testing.

Following a USAID-supported pilot project, the percentage of the population in the four provinces who could state three ways to prevent HIV transmission increased from 17 percent in 1996 to 68 percent in 1998.

USAID is also working with the MOH to expand family planning services into all basic health programs. Efforts are underway to ensure national blood safety and build provincial capacity to implement STI and HIV/AIDS prevention campaigns aimed at changing sexual behavior. USAID will continue to support social marketing activities to increase condom demand and access, and is designing an aggressive HIV intervention strategy targeted at the four major transport corridors in Mozambique—Maputo, Beira, Nacala, and Tete. USAID is also exploring regional issues, including the identification of a regional HIV/AIDS advisory group, mechanisms for information sharing on program activities and prevalence/incidence reporting, and a multicountry study on HIV.

UNAIDS has a coordinating theme group based in Mozambique. The group, chaired by WHO, consists of representatives from UNDP, UNFPA, UNESCO, The World Bank, WHO, and UNICEF. In addition, major bilateral donors who provide the bulk of AIDS financing in Mozambique are active leaders of the group.

Support from the UNAIDS cosponsors in 1996-1998 included the following:

Donors	Amount US$ 1996-97	Amount US$ 1998-99
World Bank (general support for health and drugs)	2,000,000	3,000,000
UNAIDS	492,000	310,000
UNICEF	155,000	450,000
UNDP	120,000	650,000
WHO	72,000	104,000
UNFPA		2,000,000
Total	**2,839,000**	**6,514,000**

UNAIDS cosponsor support 1996-1998

In 1999 UNAIDS will:

- Raise public and political awareness of HIV and the responses needed.
- Support the development of a national, comprehensive, and multisectoral plan.
- Build capacity at all sectoral levels to implement and evaluate an effective response to HIV/AIDS. Promote and enhance partnerships with NGOs, the private sector, and civil society.
- Enhance coordination among government, donors, and the United Nations.
- Provide technical assistance and support in implementing the national HIV/AIDS prevention plan.
- Assist in delivering services to prevent HIV infection and strengthen household and community capacity to cope with HIV/AIDS.

The World Bank supports HIV prevention as part of a road construction project.

WHO is carrying out joint activities in the areas of epidemiological surveillance, STI and HIV/AIDS counseling, prevention interventions for vulnerable groups, and blood safety. WHO also provides some direct support to NGOs.

UNDP is implementing a comprehensive national AIDS project.

UNFPA will support improved integration of STI and HIV/AIDS services into existing reproductive health services in its country program from 1998 to the year 2000.

Finland's Ministry for Foreign Affairs, Department of International Development Cooperation, supported a $1.1 million community development project from 1995 to 1997. The project, implemented by The Red Cross of Mozambique, provided information about HIV/AIDS, nutrition, maternal health care, and hygiene, as well as blood transfusion services.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities in Mozambique, funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include The Futures Group, and Population Services International. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

According to UNAIDS, a relatively small number of NGOs are working on HIV/AIDS prevention and they are concentrated primarily in Maputo and other urban areas. The majority of NGOs receive their funding from external sources and work at a micro level, with limited impact on the epidemic at the national level.

The formation of the Network of AIDS Organizations in Mozambique (MONASO) brought together a variety of organizations working on HIV/AIDS activities throughout the country. MONASO recently prepared an organizational strategic plan to provide more effective coordination and assistance to local NGOs.

With increased disclosure of HIV-positive status, a network of PLWHA has also been formed, and partnerships have been created between the network, other NGOs, and the government.

Challenges

Major constraints to HIV/AIDS control in Mozambique include:

- Other emergencies that make it difficult to make HIV/AIDS a priority.
- Lack of information about the epidemic and its consequences.
- Lack of financial resources for drugs, HIV and syphilis tests, and educational materials.
- Increasing unemployment, deterioration of household income, and rising cost of living.
- The increasing social and economic inequalities experienced by women.
- No specific strategies for at-risk groups.
- A low literacy rate, which makes it more difficult to mount effective education campaigns.
- Poor access to health and education programs.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Mozambique:

- More involvement of PLWHA in the governmental and nongovernmental response to the epidemic.
- Decentralization of management of HIV/AIDS programs in different provinces.
- Legislation and enforcement to protect the human rights of people living with HIV/AIDS.
- Targeted interventions for at-risk groups.
- Targeted interventions along the major transport corridors.
- Diversified funding sources for NGOs and community-based initiatives.
- Drug management protocols at the national and provincial levels.
- An implementation plan to fulfill the national AIDS strategy.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Mozambique. The government of Mozambique has initiated a multisectoral, comprehensive National AIDS Strategic Plan. Now it is up to the country's leaders to ensure that this plan will be carried out to slow the spread of the rapidly growing HIV/AIDS epidemic.

Important Links and Contacts

1. UNAIDS: Maria Tallarico, Country Programme Adviser UNAIDS, rua Francisco Barreto 322 2nd Floor, Maputo. Tel: (258) 1 49 14 04/ 49 18 84, Fax: (258) 1 49 23 45, e-mail: unaidsmz@virconn.com or unaids@zebra.uem.mz
2. USAID: Okey Nwanyanwu, Chief, Office of Health, Population and Nutrition, USAID/Mozambique, 107 rua Faria de Sousa, Caixa Postal 783, Maputo. Tel: (258) 1 49 07 26, Fax: (258) 1 49 20 98.
3. MONASO
4. NACP

U.S. Agency for International Development

Population, Health and Nutrition Programs
HIV/AIDS Division

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Impact Implementing AIDS Prevention and Care Project

Implementing AIDS Prevention and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

April 1999

Country Brief

MOZAMBIQUE
05.01.00

Socio-Economic Data

Total population (thousands), 1997	17,299	1997 Census-Maputo*
% of population urbanized, 1996	35	UNPOP
Annual population growth rate, 1980-1995	1.9	UNPOP
Infant mortality rate (per 1,000 live births), 1996	134%	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	1500	WHO/UNICEF
Life expectancy, 1996	47	UNPOP
Adult literacy rate, 1995	M 58, F 23	UNESCO
Per capita GNP (US$), 1995	80	World Bank
Human Poverty Index Value (HPI)	50.1	UNDP

* 1997 Mozambique Census Preliminary data published in March 1999

Status of the Epidemic

Prevalence – Year	Trend
14.2 –1997	Stable in some rural areas but still growth in urban sites.

National Response

- The **National AIDS Control Programme (NACP)** located within the Ministry of Health is the national coordinating body of the fight against STD/HIV/AIDS in Mozambique.

National Strategic Planning

- A multisectoral National Strategic Plan to combat STIs/HIV/AIDS (2000-2002) has been developed and was launched by the President in September 1999.

Political Commitment

- President Chissano is very committed to intensifying the response to HIV/AIDS in Mozambique. In December 1999 he participated in the World AIDS Campaign rally, march and cultural activities;
- For the first time in December 1999 Muslim, Catholic and Methodist leaders also participated in activities and spoke out about HIV/AIDS.

Multisectoral Involvement

- Ministry of Health is actively creating partnerships with others Ministries.
- The Government also supports community involvement and the Ministry of Health officially launched the first association of people living with HIV/AIDS ("Kindlimuka"). Non-governmental organizations were heavily involved in the national strategic planning process.

Country Brief

UN Theme Group on HIV/AIDS

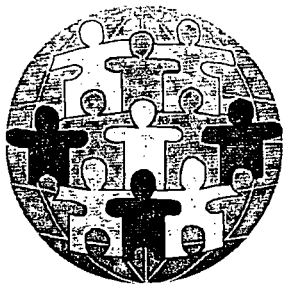
Chair: UNICEF Representative
Deputy Chair: UNFPA Representative
Members: UNDP, UNFPA, UNESCO, WB, WHO, UNICEF, WFP
UNAIDS personnel: Country Programme Adviser (CPA): Maria Tallarico, Junior Professional Officer (JPO): Atieno Odenyo

Support from UN System Agencies for HIV/AIDS activities in 1998-1999

Organization	*Amount US$*
WHO	167,000
UNDP	650,000
UNFPA	339,700
UNESCO	(only 1998-Tete project) 58,000
UNICEF	776,124
World Bank	3,000,000 (IDA credit for Ministry of Health – not specifically for HIV/AIDS)
UNAIDS	514,000
Total	**5,504,824**

Support from bilateral organizations for HIV/AIDS activities in 1998-1999

Organization	*Amount US$*
EU	(1998 – 2000) 3,000,000
USAID	5,212,942
France	833,333
GTZ	(1997 – 1999) 160,000
Total	**10,800,000**



The POLICY Project

The Economic Impact of AIDS in Mozambique

by
John Stover
Lori Bollinger

September 1999

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and Population Activities (CEDPA)

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS				
	Economically Active Labor Force: 1980[a]		Employment by Industry: 1988[b]	
Sector	**'000s**	**%**	**'000s**	**%**
AGRICULTURE				
Agriculture, hunting, forestry and fishing	4,755	85.3	16.9	8.4
INDUSTRY	346.8	6.2		
Mining and quarrying industries			4.9	2.4
Manufacturing industries			17.0	8.4
SERVICES				
Electricity, gas and water			2.9	1.4
Construction	42.1	0.8	21.5	10.7
Trade, restaurants and hotels	112.2	2.0	6.4	3.2
Transport, storage and communications	77.0	1.4	29.3	14.5
Finance, insurance, real estate and business services				
Other services	243.5	4.4	2.7	1.34
TOTAL	**5,576**	**100.0**	**201.6**	**100.0**
Source: a – Europa World Year Book, 1998; b - United Nations, Statistical Yearbook, 1995, table 29				

Mozambique is heavily reliant on agriculture, where the informal, subsistence agriculture segment accounts for over 85% of the labor force. The main subsistence crop is cassava, while the main export products are cotton, cashew nuts, and shrimps and prawns. Food processing was the most important component of the industrial sector.[1] It is believed that over 60% of the population in Mozambique live in extreme poverty, defined as "...the

[1] Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (1998).

income level below which a minimum nutritionally adequate diet is not affordable." Although poverty was pronounced before the civil war, the war certainly exacerbated the poverty.[2]

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Mozambique to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- The Health Ministry has calculated that, through December 1996, there are at least 146,000 orphans due to AIDS in the Mozambique. This number is expected to increase to as many as 400,000 orphans by the year 2000.[3]

- The impact of the movement of troops from west Africa is thought to be part of the cause of the spread of HIV-2 in Mozambique, as military personnel have higher prevalence rates and tend to exhibit risky behavior.[4]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural

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[2] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[3] AIDS Weekly Plus (1997) "HIV/AIDS takes toll in Mozambique," pp. 23-4, June 30, 1997.
[4] AIDSCAP (1995) "Workshop on the Status and Trends of the HIV/AIDS Epidemics in Africa: Final Report," co-sponsored by the Francois-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, December 1995.

labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops.

- A leader of a development project supported by GTZ was asked what the potential impact of HIV/AIDS was on the project. He replied, "We will not be able to increase nor to stabilise agricultural yields..." and that "...it will be necessary to educate and train additional counterparts."[5]

Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

- The perceived effect of HIV/AIDS varies depending on the sector and on the individual; one engineering project in Maputo stated that they had not noticed any impact of HIV/AIDS in their region or in the country, while another development project in Manica felt there had been an impact both in their area and nationwide.[6]

- Legal reforms to protect the rights of people living with HIV/AIDS are being developed currently in Mozambique. New laws protecting the labor rights and social services for civil servants were recently introduced, and efforts are being made to require private firms to have similar policies.[7]

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies

[5] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 28.
[6] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 28
[7] Barreto, A, B de Hulster, A Pinto (1998) "Legal reform in Mozambique, an opportunity to introduce protective laws for PLWHA in Mozambique," Inf Conf AIDS; 12:959 (abstract no. 44106).

can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

    - The health sector in Mozambique is not prepared for the HIV/AIDS epidemic. Mozambique has the lowest number of doctors per capita in Africa, and 46% of the primary health posts were destroyed by 1990 in the civil war.[8] Currently, there are 6 counselling centers in Mozambique, although none offers vluntary testing service.[9]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

    - There are three major ports in Mozambique; selected surveillance data of workers with tuberculosis in these areas have found higher HIV prevalence rates than in the rest of the country, confirming the higher risk these workers are thought to face. Surveillance data from the central corridor road from Beira to Zimbabwe found prevalence rates of 30.3%.[10]

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to

[8] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[9] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS
[10] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.

commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

  - In 1994, there were 44,044 miners employed through The Employment Bureau of Africa, the main miners' organization. They are primarily employed as migrant workers for the mines in South Africa. Most of the miners are primarily young and male, and are housed in single-sex hostels in South Africa, placing them at high risk for HIV-transmission.[11]

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

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[11] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

    - Life expectancy is now projected to be only 46.4 years in the year 2000 in Mozambique because of the impact of AIDS. In the absence of AIDS, life expectancy was 53 years in the year 2000.[12]

    - War delayed the beginning of the epidemic in Mozambique, compared to its neighbors, due to the resulting isolation and restriction of movement both internally and externally to the country. Since the General Peace Accord was signed in 1992, certain regions have seen a sharp increase in HIV prevalence rates. The regions most highly affected are near the international borders and main transport routes. The return of some of the international refugees, who had taken refuge in nearby countries with high HIV prevalence, also contributed to the spread of the virus in Mozambique.[13] It is estimated that over 1.5 million people fled Mozambique during the 1980s because of the civil war, most of which lived in refugee camps. It was estimated that over 2.5 million people were displaced within the country.[14]

    - Providing triple combination antiretroviral therapy to HIV-positive adults in Mozambique would cost 67% of the GDP, according to one recent estimate.[15]

What Can Be Done?

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[12] AIDS Weekly Plus (1997) "HIV/AIDS takes toll in Mozambique," pp. 23-4, June 30, 1997.
[13] Agha, S, A Karlyn, D Meekers. (1999) "The Promotion of Safer Sex Among High Risk Individuals in Mozambique." PSI Research Division Working Paper No. 21, Population Services International, Washington DC.
[14] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[15] Hogg, R, KJ Craib, A Weber, A Anis, MT Schechter, JS Montaner, MV O'Shaughnessy (1998) "One world, one hope: the cost of making antiretroviral therapy available to all nations," Int Conf AIDS. 1998; 12:830 (abstract no. 444/42283).

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

    - The Mozambican Association for the Development of the Family (AMODEFA), an NGO operating in Mozambique, has been leading workshops in schools, workplaces, and neighborhoods throughout Mozambique to increase awareness of HIV and STDs, in order to prevent new infections.[16]

    - Over 75% of the government's budget comes from external donors; these donors have not placed HIV/AIDS prevention programs on their priority list, and thus the government finds it difficult to do so, in spite of having had a national program since 1988.[17]

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

    - The World Bank and MONASO (the AIDS-NGO umbrella organization) are working together to include STD/AIDS prevention activities for the Roads and Coastal Shipping (ROCS) Project.[18]

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[16] "HIV/AIDS ravages southern African nation. Mozambique," (1997) Sex Weekly Plus. 1997 Jun 30:9-10.
[17] Barreto, A, B De Hulsters, L Fransen (1996) "Is a multisectorial approach to the STD/HIV/AIDS epidemic an option in post-war Mozambique?" Int Conf AIDS. 1996 Jul 7-12; 11(2):375 (abstract no. Th.C.4789).
[18] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

    - A project in Zambezia through Save the Children UK is underway to address the needs of AIDS orphans.[19]

    - A hot line for HIV/AIDS "Linha Aberta" was opened by MONASO and provides both information about HIV/AIDS and general support to families with HIV/AIDS patients.[20]

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

[19] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS
[20] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS

MOZAMBIQUE AND HIV/AIDS

Key Talking Points

Although the isolating effects of a ten-year civil war kept the HIV prevalence rate in Mozambique lower than the rates in neighboring countries, it is still one of the nine countries in Africa hardest hit by the epidemic:

- Ten to 14 percent of adults are HIV-positive.
- More than 1.2 million Mozambicans are living with HIV.
- By 2010 AIDS deaths will reduce average life expectancy to 37 years.

Children and HIV Since the beginning of the epidemic, AIDS has claimed the lives of at least 77,000 children and orphaned about 198,000 others.

- In 1998 pediatric AIDS cases represented 15 percent of all AIDS cases.
- About 50 newborns per day will acquire HIV in 1999.
- AIDS will orphan more than half a million children before the year 2000.

HIV in Women Social and economic inequities put women at high risk of HIV infection.

Development and HIV The civil war reversed post-independence improvements in basic services and health, leaving Mozambique ill-prepared to confront a burgeoning HIV/AIDS epidemic. Most of the population still lacks access to health services, and as many as 40 percent of the country's children are chronically malnourished.

More than three-quarters of those living with HIV/AIDS in Mozambique are 20 to 49 years old. Because the illnesses caused by the virus strike people during their most productive years, HIV/AIDS threatens Mozambique's reconstruction and development as well as the health and well-being of its people.

USAID contributed $3.2 million in FY 1998 to improve HIV/AIDS education programs and treatment of the STIs that increase the risk of HIV transmission. The U.S. and Dutch governments are the largest supporters of HIV/AIDS programs in Mozambique.

National Response Mozambique is emerging from an initial period of denial and responding more actively. Despite high rates of HIV risk behavior and infection among young people, family life education is not yet available in schools.

The Mozambican government is developing a national strategic plan with the support of UNAIDS and its theme group in the country. Political leadership and technical and financial resources are needed to ensure that this multisectoral plan is carried out to slow the rapid spread of HIV in Mozambique.

U.S. Agency for International Development

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Implementing AIDS Prevention and Care (IMPACT) Project

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MOZAMBIQUE

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Following a brutal civil war that ended in 1992, Mozambique has made a successful transition to peace. The country is moving forward in a post-transition phase that has included demobilizing opposing armies, resettling almost five million displaced people and refugees, holding successful democratic elections, and installing a new government that is placing economic reform high on its political agenda. Despite these successes, Mozambique has a long road to travel in its development. Mozambique remains among the poorest countries in the world, with chronic malnutrition estimated to affect 30 to 40 percent of Mozambique's children. Roughly 60 percent of the population still lacks access to health services.

USAID Strategy

Both USAID and the Government of Mozambique are relying on community-led initiatives to expand access to adequate health care. USAID's partners are moving from a focus on emergency health services to sustained maternal and child health interventions. The USAID strategy is to improve and expand the low-cost, community-based health service delivery services developed through private voluntary organizations (PVOs) and bring them to newly resettled areas. USAID's family planning and health program is focusing on six North-central provinces that have an estimated population of 9.5 million, but many activities are nationwide in scope, particularly those in policy reform, family planning, and HIV/AIDS prevention. The USAID program is complemented by activities in democracy/governance, economic development, and humanitarian assistance under a food security initiative.

Major Program Areas

Improved Delivery of Essential Maternal and Child Health (MCH) Services. USAID/Mozambique supports improving and expanding public sector preventive services as well as those provided by PVOs and other nongovernmental organizations (NGOs). A very effective transition strategy has been using mobile teams and community health workers who are linked to fixed facilities. USAID is also assisting the Ministry of Health (MOH) and provincial health directorates through special initiatives in malaria treatment and control, integrated management of childhood illness, prenatal care, and micronutrients.

Systems Strengthening and Policy Advocacy. USAID is supporting the development of improved and expanded systems for drug and contraceptive supplies, health care financing, management of decentralized health services, and national and local information systems. Policy reform activities strengthen the ability of decision-makers to analyze and plan for reproductive health and family planning, the importance of cost recovery in the public sector, and the need to liberalize the market for and distribution of imported pharmaceuticals.

HIV/AIDS Prevention. The mission is pursuing a nationwide HIV/AIDS prevention strategy with two major focus areas: the integration of HIV/sexually transmitted infection control into child survival programs and condom social marketing. The latter includes a substantial "behavior change communication" component to promote safer sex through mass media, theater groups, and community agents.

Results

- First-time MCH visits to MOH facilities in USAID's six-province focus area increased from 344,000 in 1994, to 382,000 in 1995, and 432,000 in 1996.
- The number of births assisted by trained personnel, largely through PVO partner efforts, in Manica Province increased from 1,250 to 4,200 over a three-year period.
- Nearly 6,000 community health workers were trained through USAID-supported PVO programs between 1995 and 1997, including nearly 2,500 in 1997 alone.

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- Condom sales grew from 1 million in 1995, to 4 million in 1996, and to 10 million in 1997, using social marketing techniques. Commercial sales outlets for condoms that were established through USAID's program also rose from 1,300 in 1996 to over 1,900 in 1997.

- A heightened awareness of how to prevent HIV/AIDS: In 18 months, the proportion of the population in the four pilot provinces who could state three ways to prevent HIV transmission increased from 17 to 68 percent.

- Increased use of condoms in higher-risk encounters: In areas where USAID supported pilot HIV/AIDS prevention activities, 34 percent of survey respondents reported using a condom with their last nonregular partner, a rate that was twice as high as the rate in nonpilot areas.

Success Stories

In rural Mozambique, where formal health services are still extremely limited, community-based approaches by USAID's PVO partners registered significant improvements in the use of MCH services in target areas. For example, through a World Vision project, a community-based network of "care groups" with over 1,500 volunteers helped achieve the following results:

- Prenatal consultation rates in two districts increased from 30 to 83 percent of pregnant women;
- Tetanus toxoid coverage among pregnant women rose from 37 to 65 percent;
- Among women of reproductive age, the use of modern contraceptive methods grew from 3 to 11 percent; and
- Among mothers with children suffering from diarrhea, the use of oral rehydration therapy rose from 37 to 80 percent.

These successful PVO programs are now being used as models to be replicated and expanded in Mozambique.

For the first time since Mozambique's independence, reliable data are available for health planners and policy makers. With USAID support, Mozambique completed its first national census in 20 years and its first national demographic and health survey (DHS); these are providing updated, reliable national and local social, demographic, and health statistics. With this information, Mozambique can plan programs, set targets, and measure trends, and USAID can set realistic performance targets in consultation with provincial and district health officials.

Continuing Challenges

As Mozambique moves toward sustainable development and the USAID program matures, new emphasis areas have emerged. As health and family planning programs grow, there is an urgent need to assist Mozambique in human capacity development using innovative training programs. Also important are public sector reform initiatives, including decentralization, and the need for sector wide donor, government, and private sector program coordination.

With the 1996 DHS survey data and priority health areas identified, USAID is undertaking new initiatives in malaria prevention and control, prenatal care, and micronutrients, and will continue to promote an integrated approach to MCH care. USAID also plans to increase its promotion of family planning services and reproductive health training. And to keep the HIV/AIDS pandemic from reaching the devastating proportions found in neighboring countries, USAID

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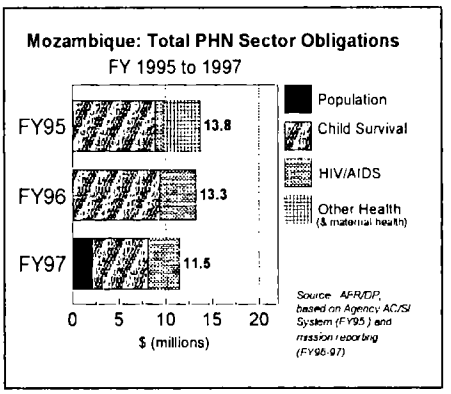
Prepared by Center for International Health Information, Arlington, Virginia 22209, October 1998

USAID Country Program Brief, October 1998
Family Planning and Health Activities in

Mozambique

Population:	12.13 million (1997 census)
Infant mortality rate:	135 deaths per 1,000 births (1997 DHS)
Adequate nutrition (wt.-for-age):	not available
Total fertility rate:	5.2 children per woman (1997 DHS)
Contraceptive prevalence rate:	5.1% (married women/modern methods, 1997 DHS)
Demographic and Health Survey:	1997
Multi-indicator cluster survey:	1995–96 (UNICEF)

USAID's mission in Mozambique is operating under a country strategic plan for 1996–2001 with an overall goal of "broadening participation in political life and economic growth" and a subgoal of "improved health for women and children." Agencywide funding trends for family planning and health activities in Mozambique for 1995–97 are summarized in the figure to the right. The mission's strategic objective in family planning and health, presented below, focuses on six north-central provinces with an estimated population of 9.5 million; but many activities, particularly in family planning and human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention, are designed for national impact. Activities under the second strategic objective are complemented by mission objectives in democracy and governance and economic development as well as substantial humanitarian assistance under a food security initiative.



Strategic Objective 3: Increase the use of essential maternal and child health and family planning services in focus areas.

IR 3.1: Increase access to community-based services.

IR 3.2: Increase demand for community-based services.

IR 3.3: Strengthen policy and management of decentralized, essential services.

Activities in Family Planning and Health

Improved Delivery of Essential Maternal and Child Health Services. USAID/Mozambique supports the improvement and expansion of preventive care services provided through the public sector and private voluntary organizations (PVOs) and other nongovernmental organization (NGO) partners. Projects by World Vision, World Relief, Save the Children Federation, CARE, and Health Alliance International have produced results in expanded immunization coverage, treatment of diarrheal diseases, and improved breastfeeding and weaning, which are being replicated elsewhere. As USAID's partners complete the transition from primarily emergency health services to sustained and focused maternal and child health interventions, one of the most effective strategies has been the use of mobile teams and community health workers linked to fixed facilities. At the national level, the mission and its partners are assisting the Ministry of Health (MOH) and provincial health directorates through initiatives in malaria treatment and control, integrated management of childhood illnesses, prenatal care, and micronutrients (particularly a vitamin A effort by Helen Keller International).

Systems Strengthening and Policy Advocacy. USAID and its partners provide support to improve supply and management of essential drugs and contraceptives, strengthen management of decentralized health services, develop and promote new health care financing options, and improve national and local information systems. The mission facilitates partner forums to promote dialogue about health and population objectives and helped create a reproductive health task force to exchange technical information and coordinate activities. Policy reform activities will enhance Mozambique's capacity to plan and carry out reproductive health advocacy efforts accompanied by an increased capability to plan strategically and utilize information for policy and program development.

HIV/AIDS Prevention. The mission is pursuing a nationwide prevention strategy to integrate HIV and sexually transmitted infection (STI) control into child survival programs; and nationwide social marketing of condoms by Population Services International, whose program includes a substantial behavior change communication component promoting safer sex through mass media, theater groups, and community agents.

Global Bureau and USAID/Mozambique Joint Planning Activities

AIDS Control and Prevention Project has supported training of trainers and community health workers by Save the Children, supervision of a community mobilization activity under a UNICEF-funded, Mozambican Red Cross project; focused HIV prevention initiatives among young men in Maputo; and theater training, translations of radio spots, and communication support for the MOH by Population Services International.

Basic Support for Institutionalizing Child Survival has provided an immunization advisor through funding from the Global Bureau as well as USAID's Africa Bureau, Office for Sustainable Development.

Demographic and Health Surveys conducted a national-level survey in 1997 to develop baseline data for program planning and for monitoring of population and health trends in Mozambique.

Family Planning Logistics Management, through reproductive health programs, will address the weak MOH/FP logistics system and assist the missions and MOH in improving their capability to make rational projections of contraceptive needs.

Family Planning Service Expansion and Technical Support is helping integrate family planning services into PVO child survival programs.

Family Planning Management Development (FPMD) is helping to conduct four health sector finance studies to facilitate a national health sector vision development seminar.

Mothercare is assisting with training for traditional birth attendants (TBAs) [BHR/PVC].

Pathfinder International is strengthening community-based reproductive health services through training of community health workers, TBAs, nurses, NGO staff, and teachers.

POLICY Project is helping to develop advocacy skills in reproductive health and disseminating the RAPID model of population growth, which helped to stimulate the production of a draft population policy at the national level.

Rational Pharmaceutical Management helped design and conduct training of clinicians and pharmacists leading to improved procurement, inventory, and distribution of essential pharmaceuticals, at the central and provincial levels. RPM also helped to develop a national drug formulary and information system.

U.S. Bureau of the Census helped Mozambique's Direccâo Nacional de Estatisticas prepare and implement the 1997 census, the country's first since independence, and continues to assist in analysis and dissemination of survey findings.

Bureau of Humanitarian Response, Office for Private & Voluntary Cooperation
Child Survival Grantees, as of 1998

CARE has a four-year project (through September 2000) focusing on prevention and control of common childhood illnesses, maternal and newborn care, and family planning in Nampula Province.

Health Alliances International received a new child survival grant in 1998.

Save the Children Federation has a four-year project (through September 2000) in Nacala/Velha, Nampula Province for immunization, control of diarrheal diseases, and micronutrients; and maternal and newborn care.

World Resource Corporation has a four-year project (through September 1999) of prevention and control of childhood illnesses, maternal health, and family planning.

This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).

Mozambique

Epidemiological Fact Sheet

on HIV/AIDS and sexually transmitted diseases

UNAIDS
UNICEF • UNDP • UNFPA
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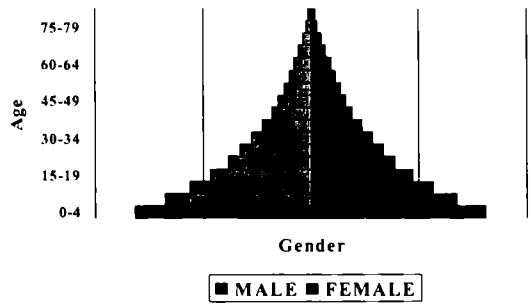
World Health Organization

Country information

Population pyramid, 1997



Indicators	Year	Estimate	Source
Total Population (thousands)	*1997*	18,265	UNPOP
Population Aged 15-49 (thousands)	*1997*	8,178	UNPOP
Annual Population Growth	*1980-1995*	1.9	UNPOP
% of Population Urbanized	*1996*	35	UNPOP
Average Annual Growth Rate of Urban Population	*1980-1996*	9	UNPOP
Net Migration Rate			
GNP Per Capita (US$)	*1995*	80	World Bank
GNP Per Capita Average Annual Growth Rate	*1985-1995*	4	World Bank
Human Development Index Rank (HDI)		166	UNDP
Real GDP Per Capita Rank - HDI Rank		-9	UNDP
Gender Related Development Index Rank		139	UNDP
Gender Empowerment Measure Rank		43	UNDP
Human Poverty Index Value (HPI)		50.1	UNDP
% Population Economic Active		53	ILO
Unemployment Rate			
Total Adult Literacy Rate	*1995*	40.5	UNESCO
Adult Male Literacy Rate	*1995*	58	UNESCO
Adult Female Literacy Rate	*1995*	23	UNESCO
Male Secondary School Enrollment Ratio	*1990-1995*	10	UNESCO
Female Secondary School Enrollment Ratio	*1990-1995*	6	UNESCO
Crude Birth Rate (births per 1,000 pop.)	*1996*	43	UNPOP
Crude Death Rate (deaths per 1,000 pop.)	*1996*	18	UNPOP
Maternal Mortality Rate (per 100,000 live births)	*1990*	1500	WHO/UNICEF
Life Expectancy at Birth	*1996*	47	UNPOP
Total Fertility Rate	*1995*	6.3	UNPOP
Infant Mortality Rate (per 1,000 live births)	*1996*	133	UNICEF/UNPOP
Under Five Mortality Rate (per 1,000 live births)	*1996*	214	UNICEF/UNPOP
% Population Access to Safe Water	*1990-1996*	63	UNICEF
% Population Access to Adequate Sanitation	*1990-1996*	54	UNICEF

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UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance

Global surveillance of HIV/AIDS and sexually transmitted diseases (STDs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, initiated in November 1996, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STDs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are a first output of this close and fruitful collaboration across the globe.

Following a series of consultations, the working group and its partners established a framework standardizing the collection of data deemed important for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV. The data include prevention indicators developed by WHO's Global Programme on AIDS, which aim to measure trends in knowledge of AIDS, relevant behaviours, and a host of other factors influencing the epidemic. Additional indicators – for example, on care and support -- will be included when available.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1997. However, the fact sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact sheets may also be instrumental in identifying potential partners when planning and implementing improved systems.

The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision making and planning.

Estimated number of people living with HIV/AIDS

In 1997 and during the first quarter of 1998, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1994 (WER 1995; 70:353-360) and recent trends in HIV/AIDS surveillance in various populations. Epimodel 2, a microcomputer programme originally developed by the WHO Global Programme on AIDS, was used to calculate the new estimates on prevalence and incidence of AIDS and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV, taking into account age-specific fertility rates. An additional spreadsheet model was used to calculate the number of children whose mothers had died of AIDS.

The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information. This includes information about infection levels in different populations, and behaviours which facilitate or impede infection.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of the term adult to 15-to-49-year-olds has the advantage of making different populations more comparable. This age range was used as the denominator in calculating adult HIV prevalence.

Estimated number of adults and children living with HIV/AIDS, end of 1997

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997

Adults and children	**1200000**		
Adults (15-49)	**1200000**	**Adult rate (%)**	**14.17**
Women (15-49)	**580000**		
Children (0-15)	**54000**		

Estimated number of AIDS cases

Estimated number of AIDS cases in adults and children that have occured since the beginning of the epidemic:

Cumulative no. of AIDS cases	**290000**

Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS since the beginning of the epidemic:

Cumulative deaths	**250000**

Estimated number of adults and children who died of AIDS during 1997:

Deaths in 1997	**83000**

Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under age 15) since the beginning of the epidemic:

Cumulative orphans	**170000**

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1997:

Current living orphans	**150000**

HIV Sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV data base maintained by the United States Bureau of the Census and are a compilation of data from different sources, including national reports, scientific publications and abstracts. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give the reader an overview of the diversity of HIV-prevalence results in a given population within the country.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. This distinction assumes that capital cities in many countries have specific characteristics related to the prevalence of higher risk behaviour and a concentration of HIV infections. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts. Site/study-specific data on which the medians were calculated are printed in an annex at the end of this fact sheet.

HIV prevalence in selected populations in percent

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Major Urban Areas	N_Sites					1		1		1		1		2	
		Minimum					1		0 6		1.2		2.7		19.2	
		Median					1		0.6		1.2		2.7		21.2	
		Maximum					1		0 6		1 2		2.7		23.2	
Pregnant women	Outside Major Urban Areas	N_Sites									1		3		2	
		Minimum									0		10.4		5.8	
		Median									0		10.5		11.2	
		Maximum									0		18.1		16.5	

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Displaced pregnant women	Outside Major Urban Areas	N_Sites										1				
		Minimum										1.5				
		Median										1.5				
		Maximum										1.5				

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Military	Outside Major Urban Areas	N_Sites				1			1							
		Minimum				3 8			3 7							
		Median				3.8			3 7							
		Maximum				3.8			3 7							

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Prisoners	Major Urban Areas	N_Sites								1						
		Minimum								0.5						
		Median								0.5						
		Maximum								0 5						

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Major Urban Areas	N_Sites				1			1	1	1	1		2	1	
		Minimum				2.7			1.6	2.2	2	4.3		7.6	5.7	
		Median				2.7			1.6	2.2	2	4.3		13.35	5.7	
		Maximum				2.7			1.6	2.2	2	4.3		19.1	5.7	
STD patients	Outside Major Urban Areas	N_Sites							1	1	5		3	3	3	
		Minimum							7.1	0.8	1.7		13.1	9	14.3	
		Median							7.1	0.8	2.6		35.6	37.7	23.7	
		Maximum							7.1	0.8	18.1		37.3	44.5	38.7	

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
War displaced people	Outside Major Urban Areas	N_Sites				1	1	1	1		1					
		Minimum				3.4	3.4	4.1	3.7		3.2					
		Median				3.4	3.4	4.1	3.7		3.2					
		Maximum				3.4	3.4	4.1	3.7		3.2					

Assessment of epidemiological situation

Assessment of country epidemiological situation

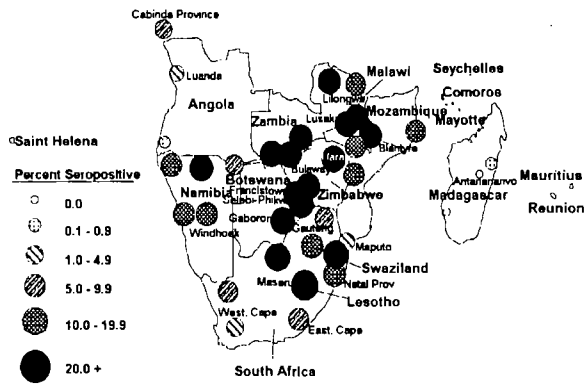
HIV sentinel surveillance of antenatal clinic attendees began in Maputo, the major urban area, in 1988. HIV prevalence increased from 0.4 percent in 1988 to 6 percent in 1996 among antenatal clinic attendees tested. Age detail is available for 1988 and 1990. One percent of antenatal clinic attendees less than 20 years of age tested were HIV positive. HIV prevalence information on antenatal clinic attendees outside of Maputo was available since 1992. At that time, no evidence of HIV infection was found among women tested in Vilanculos. In 1994, a median of 11 percent of antenatal clinic attendees tested in Nacala, Chimoio and Tete were HIV positive. These three areas are near the borders of Zambia and Zimbabwe where high levels of HIV prevalence have been reported. In 1996, HIV prevalence increased in these areas. Among antenatal clinic women tested, 18 percent were HIV positive in Chimoio, 17 percent in Beira, and 23 percent in Tete.

There is no information available on HIV prevalence among sex workers in Mozambique.

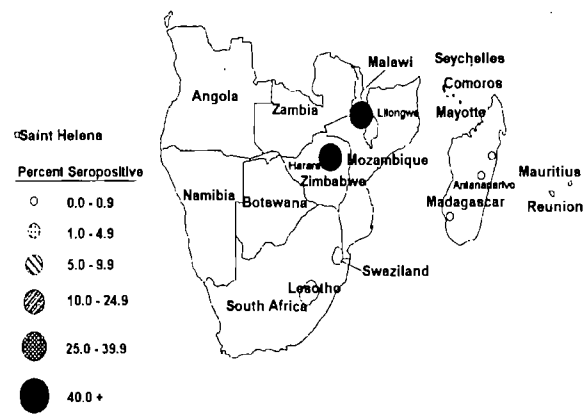
In 1987, three percent of male STD clinic patients tested in Maputo were HIV positive. HIV prevalence among STD patients tested in Maputo increased to six percent by 1996. In 1992, three percent of male STD clinic patients tested in Vilanculos were HIV positive and in Tete and Chimoio 16 to 18 percent of STD patients tested were HIV positive. By 1995, HIV prevalence had reached 40 percent among STD clinic patients tested in Tete and 24 percent in Chimoio.

Regional maps

Seroprevalence of HIV-1 for Pregnant Women Southern Africa



Seroprevalence of HIV-1 for Sex Workers Southern Africa



Reported AIDS cases

AIDS cases by year of reporting

1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total	Unknown
0	0	0	0	0	0	0	1	3	23	37	98	178	322	164	534	1380	2086	1221		6126	79

Date of last report: 10-Jun-1997

AIDS cases officially reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases in a country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries with fewer resources to more than 80% in most industrialized countries (please also compare with the section on estimates). Therefore, distribution by age, sex and modes of transmission may not be representative for all people living with AIDS in a given country.

AIDS cases by mode of transmission

Hetero: Heterosexual contacts.
Homo/Bi: Homosexual contacts between men.
IDU: Injecting drug use. This transmission category also includes cases in which other high-risk behaviours were reported, in addition to injection of drugs.
Blood: Blood and blood products.
Perinatal: Vertical transmission during pregnancy, birth or breastfeeding.
NS Not specified/unknown.

Sex	Trans. group	<94	94/<95	1995	1996	1997	1998	Unkn.	Total	%
All	All								6126	100%
	Hetero								233	4%
	Homo/Bi								0	0%
	IDU								0	0%
	Blood								29	0%
	Perinatal								16	0%
	Other known								0	0%
	Unknown								5848	95%
Male	All									
	Hetero								0	
	IDU								0	
	Blood								0	
	Other known								0	
	Unknown								0	
Female	All									
	Hetero								0	
	IDU								0	
	Blood								0	
	Other known								0	
	Unknown								0	
NS	All								6126	
	Hetero								233	
	IDU								0	
	Blood								29	
	Perinatal								16	
	Other known								0	
	Unknown								5848	

AIDS cases by age and sex

Sex	Age	<1994	94/<95	1995	1996	1997	1998	Unkn.	Total	%
All	All					1221			6126	100%
	0-4								570	9%
	5-14								113	2%
	15-19								268	4%
	20-29								1905	31%
	30-39								2045	33%
	40-49								572	9%
	50-59								157	3%
	60+								68	1%
	NS								428	7%
Male	All					621			3044	100%
	0-4								297	10%
	5-14								64	2%
	15-19								106	4%
	20-29								945	31%
	30-39								1036	34%
	40-49								394	13%
	50-59								95	3%
	60+								26	1%
	NS								81	3%
Female	All					600			2819	100%
	0-4								273	10%
	5-14								49	2%
	15-19								162	6%
	20-29								960	34%
	30-39								1009	36%
	40-49								178	6%
	50-59								62	2%
	60+								42	2%
	NS								84	3%
NS	All					0			263	100%
	0-4								0	0%
	5-14								0	0%
	15-19								0	0%
	20-29								0	0%
	30-39								0	0%
	40-49								0	0%
	50-59								0	0%
	60+								0	0%
	NS					0			263	100%

Curable STDs

Control and prevention of sexually transmitted diseases (STD) have been recognized as a major strategy in the prevention of HIV infection and ultimately AIDS. Consequently, monitoring different components of STD control can also provide information on HIV prevention within a country. One of the cornerstones of STD control is adequate management of patients with symptomatic STDs. This includes diagnosis, treatment, and individual health education and counselling on disease prevention and partner notification.

Estimated incidence and prevalence of curable STDs

	Incidence				Prevalence			
STDs	Year	Male	Female	All	Year	Male	Female	All
Chlamydia trach.								
Gonorrhoea								
Syphilis								
Trichomonas								
Comments	No information available at NAPC							
Source								

STD Incidence, men

Prevention Indicator 9: Proportion of men aged 15-49 years who reported episodes of urethritis in the last 12 months.

Year	Area	Age	Rate	N=
1997	All	15-49	10.6	

Comments: Number of men (15-49) reporting episodes of urethral discharge in the last 12 months..

Sources: National KAP Survey - PSI/PNC-DTS-SIDA

STD Prevalence, women

Prevention Indicator 8: Proportion of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened with positive serology for syphilis.

Year	Area	Age	Rate	N=
1996	All	15-24	6.3	59488

Comments: 1997 information not yet available.

Sources: NAPC

STD Case management (counselled)

Prevention Indicator 7: Proportion of people presenting with STD or for STD care in health facilities who received basic advice on condoms and on partner notification.

Year	Area	Age	Rate	N=
1997	All	All		

Comments: ?

Sources: NAPC

STD Case management (treatments)

Prevention Indicator 6: Proportion of people presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards).

Year	Area	Age	Rate	N=
1996	ALL	All		131115

Comments: Number is total of reported STDs.

Sources: NAPC

Health service indicators

HIV-prevention strategies depend on the twin efforts of care and support for those living with HIV or AIDS, and targeted prevention for all people at risk or vulnerable to the infection. These efforts may range from reaching out to vulnerable communities through large-scale educational campaigns or interpersonal communication; provision of treatment for STDs; distribution of condoms and needles; creating an enabling environment to reduce risky behaviour; voluntary testing and counselling; home or institutional care for persons with symptomatic HIV infection; and preventing perinatal transmission and transmission through infected needles or blood in health care settings. It is difficult to capture such a large range of activities with one or just a few indicators. However, a set of well-established health care indicators -- such as the percentage of a population with access to health care services; the percentage of women covered by antenatal care; or the percentage of immunized children -- may help to identify general strengths and weaknesses of health systems. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS-related issues.

Access to health care

Indicators	Year	Estimate	Source
% of Pop. with access to health services - total:	*1990-1995*	39	UNICEF
% of Pop. with access to health services - urban:	*1990-1995*	100	UNICEF
% of Pop. with access to health services - rural:	*1990-1995*	30	UNICEF
Contraceptive prevalence rate (%):	*1990-1996*	4	UNPOP
% of births attended by trained health personnel.	*1990-1996*	25	UNICEF
% of pregnant women immunized against tetanus:	*1995-1996*	61	UNICEF
% fully immunized - Tuberculosis:	*1995-1996*	83	UNICEF
% fully immunized - DPT:	*1995-1996*	60	UNICEF
% fully immunized - Polio:	*1995-1996*	60	UNICEF
% fully immunized - Measles:	*1995-1996*	67	UNICEF
Proportion of blood donations tested:			
% of ANC clinics where HIV testing is available:			
HIV/AIDS Hospital Occupancy Rate (Days):			

Latex condoms are the only technology available that can prevent sexual transmission of HIV/STD. Persons needing protection in situations that carry risk should have consistent access to high quality condoms. National AIDS Programmes implement activities to increase both availability of and access to condoms. The two condom availability indicators below are intended to highlight areas of strength and weakness at the beginning and at the end of the distribution system so that programmatic resources can be directed appropriately to problem areas.

Condom availability (central level)

Prevention Indicator 2: Availability of condoms per capita in the country over the last 12 months (central level).

Year	Area	N	Rate
1997	All	22302000	3

Comments: During 1997, USAID delivered: 8.268.000 No Logo for free distribution and 14.034.000 Blue and Gold for social marketing. 10 000.000 condoms sold through 2.000 commercial outlets in 1997.

Sources: PSI, 1997

Condom availability (peripheral level)

Prevention Indicator 3: Proportion of people who can acquire a condom (peripheral level).

Year	Area	N	Rate
1997	All		

Comments: 1 Outlet per 3.500 people (15-49 years). There are over 2000 sales outlets nationwide focussing primarily on Urban and peri-Urban areas.

Sources: PSI, 1997

Knowledge and behaviour

Information on knowledge and behaviour related to HIV/AIDS is essential in identifying populations at risk for HIV infection. It is also critical in assessing changes over time as a result of prevention efforts. Guidelines and recommendations have been published in the publication: "Evaluation of a National AIDS Programme: A methods package. 1. Prevention of HIV infection. WHO/GPA/TCO/SEF/94.1 Geneva, 1994".

Knowledge of HIV-related preventive practices

Prevention Indicator 1: Proportion of people citing at least two acceptable ways of protection from HIV infection.

Year	Area	Age group	Male	Female	All
1997	All	15-19	88	80	84
1997	All	20-24	94	87	90
1997	All	25-49	88	79	83
1997	All	15-49	89	81	85

Comments: Sample size for total sample: 5153. Data may be altered slightly due to re-weighting.

Sources: National KAP Survey - PSI/PNC-DTS-SIDA

Reported non-regular sexual partnerships

Prevention Indicator 4: Proportion of sexually active people having at least one sex partner other than a regular partner in the last 12 months.

Year	Area	Age group	Male	Female	All
1997	All	15-19	33	18	26
1997	All	20-24	46	22	34
1997	All	25-49	36	10	22
1997	All	15-49	37	14	26

Comments: Sample size for total sample. 5153. Data may be altered slightly due to re-weighting.

Sources: National KAP Survey - PSI/PNC-DTS-SIDA, 1997

Reported condom use in risk sex (gen pop)

Prevention Indicator 5: Proportion of people reporting the use of a condom during the most recent intercourse of risk.

Year	Area	Age group	Male	Female	All
1997	All	15-19	41	18	
1997	All	20-24	69	23	
1997	All	25-49	29	17	
1997	All	15-49	59	19	

Comments: Sample size for total sample: 1250. Data may be altered slightly due to re-weighting.

Sources: National KAP Survey - PSI/PNC-DTS-SIDA, 1997

Knowledge and behaviour

Ever use of condom

Percentage of people who ever used a condom.

Year	Area	Age group	Male	Female	All
n/a		15-19			
n/a		15-49			
n/a		20-24			
n/a		25-49			

Comments:
Sources:

Median age at first sexual intercourse

Median age of people at which they first had sexual intercourse.

Year	Area	Age group	Male	Female	All
1996	All	15-19	15	15	
1996	All	15-49	16	16	
1996	All	20-24	16	16	
1996	All	25-49	17	17	

Comments: Unweighted values.
Sources: National KAP Survey - PSI/PNC-DTS-SIDA, 1996

Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

Year	Area	Age group	Rate	N
n/a		15		
n/a		15-17		
n/a		16		
n/a		17		
n/a		18		
n/a		18-19		
n/a		19		

Comments:
Sources:

Reported condom use in risk sex (MSM)

Year	Area	Age group	Male	All
n/a		15-49		

Comments: Not measured.
Sources:

Sources

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Annex: HIV Surveillance data by site

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Outside Major Urban Areas	Chimoio, Manica Province										10.7		19.2	
		Nacala										10.5			
		Tete, Tete Province										18.1		23.2	
		Vilanculos, Inhambane Provin								0					
	Major Urban Areas	Beira, Sofala Province												16.5	
		Maputo				0.4		0.6		1.2		2.7		5.8	

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas														

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Displaced Pregnant Women	Outside Major Urban Areas	Zambezia Province									1.5				

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Injecting drug users	Major Urban Areas														

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Military	Outside Major Urban Areas	Pemba						3.7							
		Tete, Tete Province			3.8										

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Prisoners	Major Urban Areas	Maputo							0.5						

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Outside Major Urban Areas	Cabo Delgado Province								2			9	14.3	
		Chimoio, Manica Province								16.1		35.6	37.7	23.7	
		Tete, Tete Province								18.1		37.3	44.5	38.7	
		Vilanculos, Inhambane Provin								2.6					
		Zambézia Province						7.1	0.8	1.7		13.1			
	Major Urban Areas	Beira, Sofala Province											19.1		
		Maputo			2.7			1.6	2.2	2	4.3	3.8	7.6	5.7	

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
War displaced people	Outside Major Urban Areas	Boane					4.1								
		Dondo								3.2					
		Inhaca Island						3.7							
		Moatize			3.4										
		Tete province				3.4									

Notes:

MOZAMBIQUE AND HIV/AIDS

Country Profile

Mozambique is one of the world's poorest countries, and all of the country's social indicators are well below sub-Saharan African averages.

Mozambique's ten-year civil war reversed post-independence improvements in basic services and had a major impact on mortality and morbidity, especially among children. Thirty to 40 percent of Mozambique's children are chronically malnourished. Roughly 60 percent of the population still lack access to health services. The Mozambican government now allocates 8 percent of its current budget—about US$2 per person per year—to the health sector.

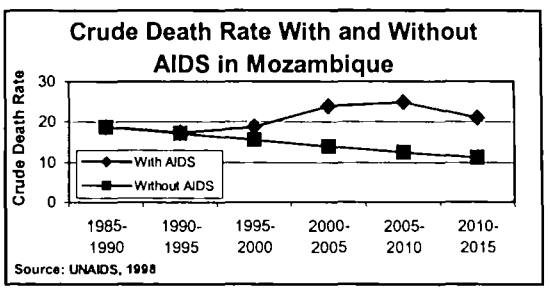
HIV/AIDS in Mozambique

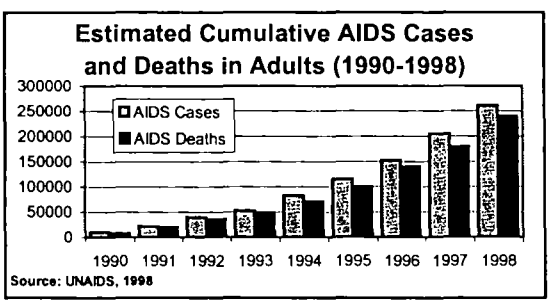
The first AIDS case was reported in Mozambique in 1986. The country's HIV prevalence rate is lower than the rates of neighboring Zimbabwe, Zambia and Malawi, largely due to the isolating effects of the civil war.

Nevertheless, the Joint United Nations Programme on AIDS (UNAIDS) reports that Mozambique is one of nine African countries hardest hit by the epidemic. The virus is spreading rapidly in the central provinces.

- HIV prevalence rates of adults (15 and older) range from 10 percent, as reported by the Ministry of Health, to 14 percent, as reported by UNAIDS. These higher rates are found along transport corridors and in areas in which mine workers from South Africa are recruited.
- An estimated 1.2 million Mozambicans are living with HIV—290,000 of them with AIDS.
- More than three-quarters of those living with HIV/AIDS are ages 20 to 49.

From 1990 to 2010, AIDS will increase the crude death rate in Mozambique by 98 percent.





- 83,000 people died of AIDS-related diseases in 1997.
- Life expectancy will drop 27 percent during the 1990s as a result of HIV/AIDS. By 2010 average life expectancy will be 37 years.

Women and HIV/AIDS

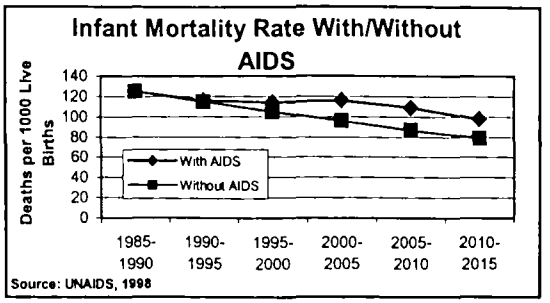
The number of women living with HIV/AIDS is growing in Mozambique. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability.

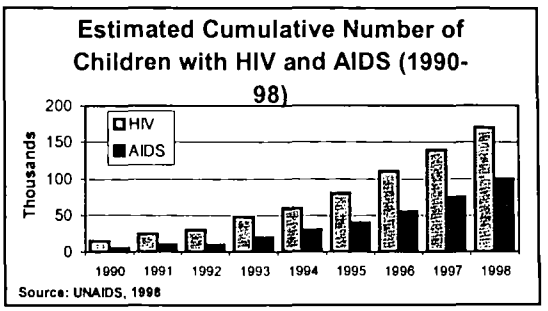
- Women experience socioeconomic inequalities and discrimination, particularly in inheritance and land tenure issues, that put them at increased risk of HIV.

Children and HIV/AIDS

Forty-six percent of the Mozambican population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

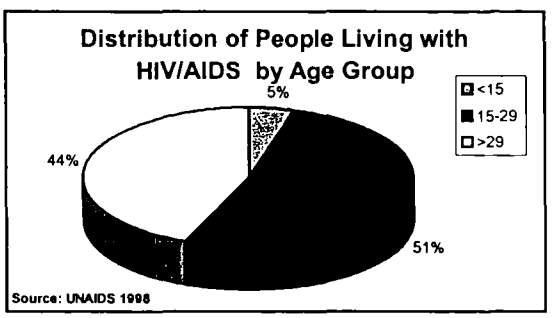
- About 18,000 newborns (50 per day) will acquire HIV in 1999.
- In 1998 pediatric cases represented 15 percent of all AIDS cases.
- By 2015 the infant mortality rate is expected to be at least 25 percent higher than it would have been in the absence of AIDS.
- 77,000 children have died from AIDS-related illnesses since the beginning of the epidemic.
- To date, an estimated 198,000 children have been orphaned by HIV/AIDS. By the year 2000 there will be about 596,000 AIDS orphans.





Youth and HIV/AIDS

Youth and young adults account for a large percentage of all HIV/AIDS cases in Mozambique.

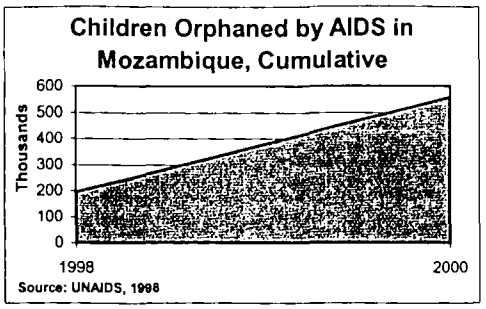


- Half of those living with HIV/AIDS are ages 15 to 29.
- More than one-quarter of reported cases of sexually transmitted infection (STI) occur in teenagers.
- Despite high rates of HIV risk behavior and infection among young people, basic health education has not been effectively implemented in the school system.

Socioeconomic Effects of AIDS

Years of civil war have left Mozambicans—especially returning refugees—particularly vulnerable to HIV. Unemployment rates are high, resulting in greater poverty, wider economic and social imbalances between men and women, and increases in both legal and illegal migration. Poverty and diminishing access to health care and education have also led to the breakup of families, increased the number of children living on the street, and forced many girls and young women into sex work.

HIV/AIDS threatens Mozambique's reconstruction as well as the health of its people. The direct costs alone of caring for millions of people living with HIV/AIDS are expected to overburden the country's inadequate health system. Community-based care in Mozambique is particularly ill-prepared for the influx of people living with



HIV/AIDS (PLWHA). Preliminary data suggest that 20 percent of rural hospital beds are already occupied by AIDS patients.

HIV/AIDS is also beginning to take its toll on businesses in Mozambique, and is expected to reduce annual profits in the coming years. Productivity falls and business costs rise—even in low wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. Despite the fact that some large businesses have responded to the epidemic, the diminished labor pool continues to affect economic prosperity, foreign investment, and sustainable development.

Interventions

National Response

The national response has passed through several stages. Initially there was low acceptance of HIV/AIDS as a problem. Following this period of denial, the National Control Programme against STD/AIDS (NACP) was created in 1988, and the first Medium Term Plan (MPT1) was developed.

The NACP has a central body, located in the Ministry of Health, and regional offices in 11 provinces. The main responsibilities of the NACP include planning, coordinating, monitoring, and assessing provincial plans, and providing technical assistance to government sectors involved in the program. The NACP also develops short- and medium-term plans and establishes cooperation protocols for Mozambican and international NGOs, donors, and social, religious, and mass media associations. A second Medium Term Plan (MPTII) was developed in 1994. The National Strategy to combat STI/AIDS includes prevention, counseling, epidemiological surveillance, and blood testing. Specific components of the national program include management, information, education and communication (IEC), epidemiological surveillance, laboratory support, care of PLWHAs and counseling, and condom social marketing.

On December 1, 1998, President Joaquim A. Chissano addressed the nation on World AIDS Day—the first communication about HIV/AIDS issued from the President's office.

The Mozambican government is currently designing a national strategic plan, with the support of the Mozambican UNAIDS theme group on HIV/AIDS and UNAIDS-Geneva, which will be presented to the Council of Ministers in August 1999. The multisectoral Interministerial Commission and the provincial governors are also involved. The NACP is also collecting data to create an AIDS Impact Model for Mozambique, and is currently developing a national counseling strategy.

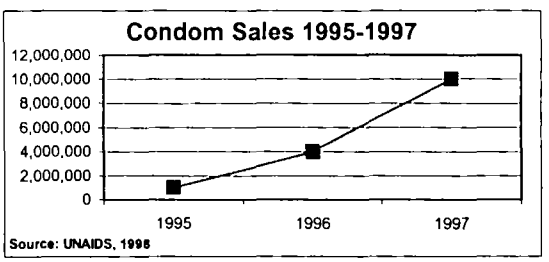
Donors

Multilateral and bilateral donors are actively engaged in Mozambique. According to a UNAIDS/Harvard study, each bilateral organization contributed the following amounts in 1996-1998:

Organization	Amount US$ 1996-97	Amount US$ 1998-99
USAID	4,648,000	7,500,000 *(USAID/Dutch cooperation)*
EU	3,125,000	3,000,000
Finland	1,100,000 (1995-97)	
France	1,059,734	300,000
Total	**9,932,734**	**10,800,000**

Bilateral donor support 1996-1998

USAID's HIV/AIDS funding for FY 1998 was $3.2 million. The mission pursued a nationwide HIV/AIDS prevention strategy with two focus areas: condom social marketing and integration of AIDS and STI control into child survival programs. The social marketing program includes behavior change communication (BCC), using mass media, theater groups, and community agents to promote safer sex.



In 1999 USAID will support cooperating agencies to:

- Expand the reach of behavior change messages through community-based peer education.
- Improve the quality and reach of BCC, focusing on youth.
- Increase activities to improve STI prevention and treatment.
- Increase HIV counseling and testing.

Following a USAID-supported pilot project, the percentage of the population in the four provinces who could state three ways to prevent HIV transmission increased from 17 percent in 1996 to 68 percent in 1998.

USAID is also working with the MOH to expand family planning services into all basic health programs. Efforts are underway to ensure national blood safety and build provincial capacity to implement STI and HIV/AIDS prevention campaigns aimed at changing sexual behavior. USAID will continue to support social marketing activities to increase condom demand and access, and is designing an aggressive HIV intervention strategy targeted at the four major transport corridors in Mozambique—Maputo, Beira, Nacala, and Tete. USAID is also exploring regional issues, including the identification of a regional HIV/AIDS advisory group, mechanisms for information sharing on program activities and prevalence/incidence reporting, and a multicountry study on HIV.

UNAIDS has a coordinating theme group based in Mozambique. The group, chaired by WHO, consists of representatives from UNDP, UNFPA, UNESCO, The World Bank, WHO, and UNICEF. In addition, major bilateral donors who provide the bulk of AIDS financing in Mozambique are active leaders of the group.

Support from the UNAIDS cosponsors in 1996-1998 included the following:

Donors	Amount US$ 1996-97	Amount US$ 1998-99
World Bank (general support for health and drugs)	2,000,000	3,000,000
UNAIDS	492,000	310,000
UNICEF	155,000	450,000
UNDP	120,000	650,000
WHO	72,000	104,000
UNFPA		2,000,000
Total	**2,839,000**	**6,514,000**

UNAIDS cosponsor support 1996-1998

In 1999 UNAIDS will:

- Raise public and political awareness of HIV and the responses needed.
- Support the development of a national, comprehensive, and multisectoral plan.
- Build capacity at all sectoral levels to implement and evaluate an effective response to HIV/AIDS. Promote and enhance partnerships with NGOs, the private sector, and civil society.
- Enhance coordination among government, donors, and the United Nations.
- Provide technical assistance and support in implementing the national HIV/AIDS prevention plan.
- Assist in delivering services to prevent HIV infection and strengthen household and community capacity to cope with HIV/AIDS.

The World Bank supports HIV prevention as part of a road construction project.

WHO is carrying out joint activities in the areas of epidemiological surveillance, STI and HIV/AIDS counseling, prevention interventions for vulnerable groups, and blood safety. WHO also provides some direct support to NGOs.

UNDP is implementing a comprehensive national AIDS project.

UNFPA will support improved integration of STI and HIV/AIDS services into existing reproductive health services in its country program from 1998 to the year 2000.

Finland's Ministry for Foreign Affairs, Department of International Development Cooperation, supported a $1.1 million community development project from 1995 to 1997. The project, implemented by The Red Cross of Mozambique, provided information about HIV/AIDS, nutrition, maternal health care, and hygiene, as well as blood transfusion services.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities in Mozambique, funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include The Futures Group, and Population Services International. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

According to UNAIDS, a relatively small number of NGOs are working on HIV/AIDS prevention and they are concentrated primarily in Maputo and other urban areas. The majority of NGOs receive their funding from external sources and work at a micro level, with limited impact on the epidemic at the national level.

The formation of the Network of AIDS Organizations in Mozambique (MONASO) brought together a variety of organizations working on HIV/AIDS activities throughout the country. MONASO recently prepared an organizational strategic plan to provide more effective coordination and assistance to local NGOs.

With increased disclosure of HIV-positive status, a network of PLWHA has also been formed, and partnerships have been created between the network, other NGOs, and the government.

Challenges

Major constraints to HIV/AIDS control in Mozambique include:

- Other emergencies that make it difficult to make HIV/AIDS a priority.
- Lack of information about the epidemic and its consequences.
- Lack of financial resources for drugs, HIV and syphilis tests, and educational materials.
- Increasing unemployment, deterioration of household income, and rising cost of living.
- The increasing social and economic inequalities experienced by women.
- No specific strategies for at-risk groups.
- A low literacy rate, which makes it more difficult to mount effective education campaigns.
- Poor access to health and education programs.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Mozambique:

- More involvement of PLWHA in the governmental and nongovernmental response to the epidemic.
- Decentralization of management of HIV/AIDS programs in different provinces.
- Legislation and enforcement to protect the human rights of people living with HIV/AIDS.
- Targeted interventions for at-risk groups.
- Targeted interventions along the major transport corridors.
- Diversified funding sources for NGOs and community-based initiatives.
- Drug management protocols at the national and provincial levels.
- An implementation plan to fulfill the national AIDS strategy.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Mozambique. The government of Mozambique has initiated a multisectoral, comprehensive National AIDS Strategic Plan. Now it is up to the country's leaders to ensure that this plan will be carried out to slow the spread of the rapidly growing HIV/AIDS epidemic.

Important Links and Contacts

1. UNAIDS: Maria Tallarico, Country Programme Adviser UNAIDS, rua Francisco Barreto 322 2nd Floor, Maputo. Tel: (258) 1 49 14 04/ 49 18 84, Fax: (258) 1 49 23 45, e-mail: unaidsmz@virconn.com or unaids@zebra.uem.mz
2. USAID: Okey Nwanyanwu, Chief, Office of Health, Population and Nutrition, USAID/Mozambique, 107 rua Faria de Sousa, Caixa Postal 783, Maputo. Tel: (258) 1 49 07 26, Fax: (258) 1 49 20 98.
3. MONASO
4. NACP

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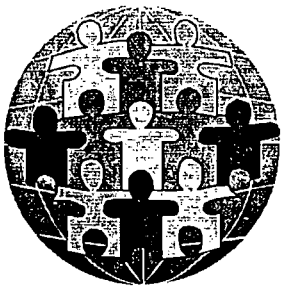

The POLICY Project

The Economic Impact of AIDS in Mozambique

by
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September 1999

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and Population Activities (CEDPA)

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AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS				
	Economically Active Labor Force: 1980[a]		Employment by Industry: 1988[b]	
Sector	'000s	%	'000s	%
AGRICULTURE				
Agriculture, hunting, forestry and fishing	4,755	85.3	16.9	8.4
INDUSTRY	346.8	6.2		
Mining and quarrying industries			4.9	2.4
Manufacturing industries			17.0	8.4
SERVICES				
Electricity, gas and water			2.9	1.4
Construction	42.1	0.8	21.5	10.7
Trade, restaurants and hotels	112.2	2.0	6.4	3.2
Transport, storage and communications	77.0	1.4	29.3	14.5
Finance, insurance, real estate and business services				
Other services	243.5	4.4	2.7	1.34
TOTAL	**5,576**	**100.0**	**201.6**	**100.0**
Source: a – Europa World Year Book, 1998; b - United Nations, Statistical Yearbook, 1995, table 29				

Mozambique is heavily reliant on agriculture, where the informal, subsistence agriculture segment accounts for over 85% of the labor force. The main subsistence crop is cassava, while the main export products are cotton, cashew nuts, and shrimps and prawns. Food processing was the most important component of the industrial sector.[1] It is believed that over 60% of the population in Mozambique live in extreme poverty, defined as "...the

[1] Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (1998).

income level below which a minimum nutritionally adequate diet is not affordable." Although poverty was pronounced before the civil war, the war certainly exacerbated the poverty.[2]

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Mozambique to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- The Health Ministry has calculated that, through December 1996, there are at least 146,000 orphans due to AIDS in the Mozambique. This number is expected to increase to as many as 400,000 orphans by the year 2000.[3]

- The impact of the movement of troops from west Africa is thought to be part of the cause of the spread of HIV-2 in Mozambique, as military personnel have higher prevalence rates and tend to exhibit risky behavior.[4]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural

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[2] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[3] AIDS Weekly Plus (1997) "HIV/AIDS takes toll in Mozambique," pp. 23-4, June 30, 1997.
[4] AIDSCAP (1995) "Workshop on the Status and Trends of the HIV/AIDS Epidemics in Africa: Final Report," co-sponsored by the Francois-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, December 1995.

labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops.

- A leader of a development project supported by GTZ was asked what the potential impact of HIV/AIDS was on the project. He replied, "We will not be able to increase nor to stabilise agricultural yields..." and that "...it will be necessary to educate and train additional counterparts."[5]

Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

- The perceived effect of HIV/AIDS varies depending on the sector and on the individual; one engineering project in Maputo stated that they had not noticed any impact of HIV/AIDS in their region or in the country, while another development project in Manica felt there had been an impact both in their area and nationwide.[6]

- Legal reforms to protect the rights of people living with HIV/AIDS are being developed currently in Mozambique. New laws protecting the labor rights and social services for civil servants were recently introduced, and efforts are being made to require private firms to have similar policies.[7]

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies

[5] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 28.
[6] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 28
[7] Barreto, A, B de Hulster, A Pinto (1998) "Legal reform in Mozambique, an opportunity to introduce protective laws for PLWHA in Mozambique," Inf Conf AIDS; 12:959 (abstract no. 44106).

can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

    - The health sector in Mozambique is not prepared for the HIV/AIDS epidemic. Mozambique has the lowest number of doctors per capita in Africa, and 46% of the primary health posts were destroyed by 1990 in the civil war.[8] Currently, there are 6 counselling centers in Mozambique, although none offers vluntary testing service.[9]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

    - There are three major ports in Mozambique; selected surveillance data of workers with tuberculosis in these areas have found higher HIV prevalence rates than in the rest of the country, confirming the higher risk these workers are thought to face. Surveillance data from the central corridor road from Beira to Zimbabwe found prevalence rates of 30.3%.[10]

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to

[8] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[9] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS
[10] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.

commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

- In 1994, there were 44,044 miners employed through The Employment Bureau of Africa, the main miners' organization. They are primarily employed as migrant workers for the mines in South Africa. Most of the miners are primarily young and male, and are housed in single-sex hostels in South Africa, placing them at high risk for HIV-transmission.[11]

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

[11] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

    - Life expectancy is now projected to be only 46.4 years in the year 2000 in Mozambique because of the impact of AIDS. In the absence of AIDS, life expectancy was 53 years in the year 2000.[12]

    - War delayed the beginning of the epidemic in Mozambique, compared to its neighbors, due to the resulting isolation and restriction of movement both internally and externally to the country. Since the General Peace Accord was signed in 1992, certain regions have seen a sharp increase in HIV prevalence rates. The regions most highly affected are near the international borders and main transport routes. The return of some of the international refugees, who had taken refuge in nearby countries with high HIV prevalence, also contributed to the spread of the virus in Mozambique.[13] It is estimated that over 1.5 million people fled Mozambique during the 1980s because of the civil war, most of which lived in refugee camps. It was estimated that over 2.5 million people were displaced within the country.[14]

    - Providing triple combination antiretroviral therapy to HIV-positive adults in Mozambique would cost 67% of the GDP, according to one recent estimate.[15]

What Can Be Done?

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[12] AIDS Weekly Plus (1997) "HIV/AIDS takes toll in Mozambique," pp. 23-4, June 30, 1997.
[13] Agha, S, A Karlyn, D Meekers. (1999) "The Promotion of Safer Sex Among High Risk Individuals in Mozambique." PSI Research Division Working Paper No. 21, Population Services International, Washington DC.
[14] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[15] Hogg, R, KJ Craib, A Weber, A Anis, MT Schechter, JS Montaner, MV O'Shaughnessy (1998) "One world, one hope: the cost of making antiretroviral therapy available to all nations," Int Conf AIDS. 1998; 12:830 (abstract no. 444/42283).

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

    - The Mozambican Association for the Development of the Family (AMODEFA), an NGO operating in Mozambique, has been leading workshops in schools, workplaces, and neighborhoods throughout Mozambique to increase awareness of HIV and STDs, in order to prevent new infections.[16]

    - Over 75% of the government's budget comes from external donors; these donors have not placed HIV/AIDS prevention programs on their priority list, and thus the government finds it difficult to do so, in spite of having had a national program since 1988.[17]

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

    - The World Bank and MONASO (the AIDS-NGO umbrella organization) are working together to include STD/AIDS prevention activities for the Roads and Coastal Shipping (ROCS) Project.[18]

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[16] "HIV/AIDS ravages southern African nation. Mozambique," (1997) Sex Weekly Plus. 1997 Jun 30:9-10.
[17] Barreto, A, B De Hulsters, L Fransen (1996) "Is a multisectorial approach to the STD/HIV/AIDS epidemic an option in post-war Mozambique?" Int Conf AIDS. 1996 Jul 7-12; 11(2):375 (abstract no. Th.C.4789).
[18] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

    - A project in Zambezia through Save the Children UK is underway to address the needs of AIDS orphans.[19]

    - A hot line for HIV/AIDS "Linha Aberta" was opened by MONASO and provides both information about HIV/AIDS and general support to families with HIV/AIDS patients.[20]

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

[19] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS
[20] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS

c - Mozambique

Chiefs of State and Cabinet Members of Foreign Governments

Last Updated: 3/10/2000

MOZAMBIQUE, REPUBLIC OF

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Prime Minister	**Mocumbi,** Pascoal Manuel
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Chiefs of State Home

MOZAMBIQUE AND HIV/AIDS

Key Talking Points

Although the isolating effects of a ten-year civil war kept the HIV prevalence rate in Mozambique lower than the rates in neighboring countries, it is still one of the nine countries in Africa hardest hit by the epidemic:

- Ten to 14 percent of adults are HIV-positive.
- More than 1.2 million Mozambicans are living with HIV.
- By 2010 AIDS deaths will reduce average life expectancy to 37 years.

Children and HIV Since the beginning of the epidemic, AIDS has claimed the lives of at least 77,000 children and orphaned about 198,000 others.

- In 1998 pediatric AIDS cases represented 15 percent of all AIDS cases.
- About 50 newborns per day will acquire HIV in 1999.
- AIDS will orphan more than half a million children before the year 2000.

HIV in Women Social and economic inequities put women at high risk of HIV infection.

Development and HIV The civil war reversed post-independence improvements in basic services and health, leaving Mozambique ill-prepared to confront a burgeoning HIV/AIDS epidemic. Most of the population still lacks access to health services, and as many as 40 percent of the country's children are chronically malnourished.

More than three-quarters of those living with HIV/AIDS in Mozambique are 20 to 49 years old. Because the illnesses caused by the virus strike people during their most productive years, HIV/AIDS threatens Mozambique's reconstruction and development as well as the health and well-being of its people.

USAID contributed $3.2 million in FY 1998 to improve HIV/AIDS education programs and treatment of the STIs that increase the risk of HIV transmission. The U.S. and Dutch governments are the largest supporters of HIV/AIDS programs in Mozambique.

National Response Mozambique is emerging from an initial period of denial and responding more actively. Despite high rates of HIV risk behavior and infection among young people, family life education is not yet available in schools.

The Mozambican government is developing a national strategic plan with the support of UNAIDS and its theme group in the country. Political leadership and technical and financial resources are needed to ensure that this multisectoral plan is carried out to slow the rapid spread of HIV in Mozambique.

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MOZAMBIQUE AND HIV/AIDS

Country Profile

Mozambique is one of the world's poorest countries, and all of the country's social indicators are well below sub-Saharan African averages.

Mozambique's ten-year civil war reversed post-independence improvements in basic services and had a major impact on mortality and morbidity, especially among children. Thirty to 40 percent of Mozambique's children are chronically malnourished. Roughly 60 percent of the population still lack access to health services. The Mozambican government now allocates 8 percent of its current budget—about US$2 per person per year—to the health sector.

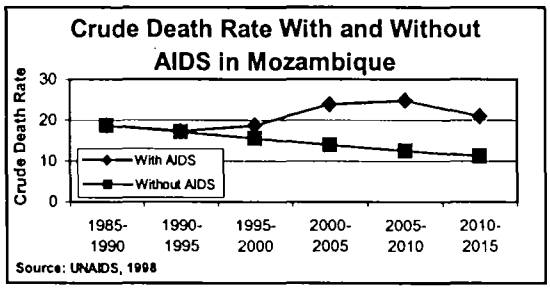
HIV/AIDS in Mozambique

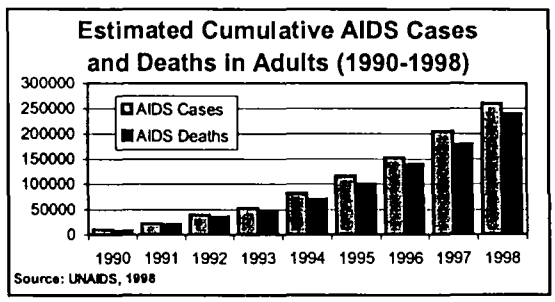
The first AIDS case was reported in Mozambique in 1986. The country's HIV prevalence rate is lower than the rates of neighboring Zimbabwe, Zambia and Malawi, largely due to the isolating effects of the civil war.

Nevertheless, the Joint United Nations Programme on AIDS (UNAIDS) reports that Mozambique is one of nine African countries hardest hit by the epidemic. The virus is spreading rapidly in the central provinces.

- HIV prevalence rates of adults (15 and older) range from 10 percent, as reported by the Ministry of Health, to 14 percent, as reported by UNAIDS. These higher rates are found along transport corridors and in areas in which mine workers from South Africa are recruited.
- An estimated 1.2 million Mozambicans are living with HIV—290,000 of them with AIDS.
- More than three-quarters of those living with HIV/AIDS are ages 20 to 49.

From 1990 to 2010, AIDS will increase the crude death rate in Mozambique by 98 percent.





- 83,000 people died of AIDS-related diseases in 1997.
- Life expectancy will drop 27 percent during the 1990s as a result of HIV/AIDS. By 2010 average life expectancy will be 37 years.

Women and HIV/AIDS

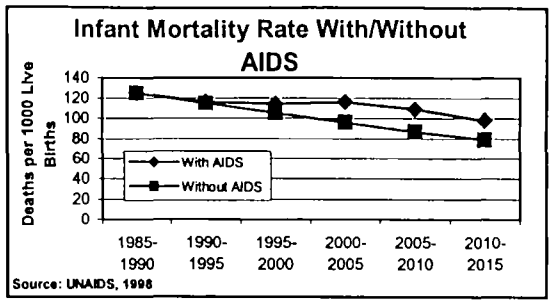
The number of women living with HIV/AIDS is growing in Mozambique. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability.

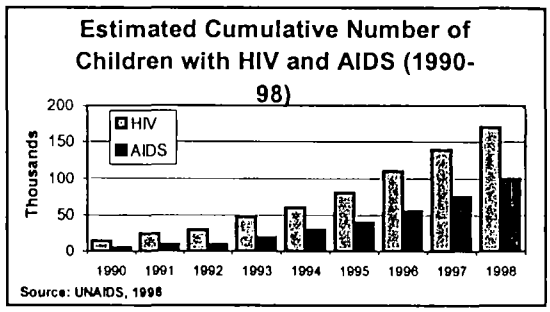
- Women experience socioeconomic inequalities and discrimination, particularly in inheritance and land tenure issues, that put them at increased risk of HIV.

Children and HIV/AIDS

Forty-six percent of the Mozambican population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

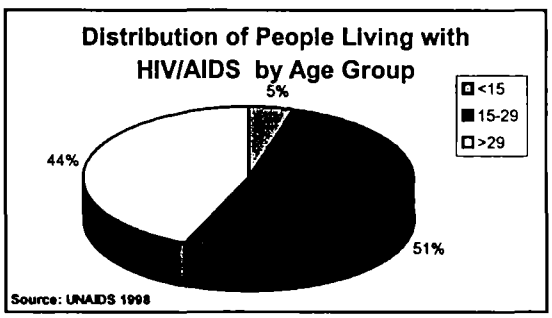
- About 18,000 newborns (50 per day) will acquire HIV in 1999.
- In 1998 pediatric cases represented 15 percent of all AIDS cases.
- By 2015 the infant mortality rate is expected to be at least 25 percent higher than it would have been in the absence of AIDS.
- 77,000 children have died from AIDS-related illnesses since the beginning of the epidemic.
- To date, an estimated 198,000 children have been orphaned by HIV/AIDS. By the year 2000 there will be about 596,000 AIDS orphans.





Youth and HIV/AIDS

Youth and young adults account for a large percentage of all HIV/AIDS cases in Mozambique.

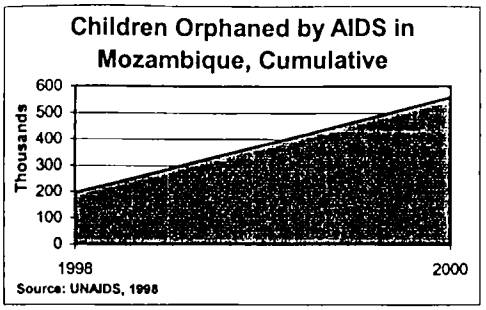


- Half of those living with HIV/AIDS are ages 15 to 29.
- More than one-quarter of reported cases of sexually transmitted infection (STI) occur in teenagers.
- Despite high rates of HIV risk behavior and infection among young people, basic health education has not been effectively implemented in the school system.

Socioeconomic Effects of AIDS

Years of civil war have left Mozambicans—especially returning refugees—particularly vulnerable to HIV. Unemployment rates are high, resulting in greater poverty, wider economic and social imbalances between men and women, and increases in both legal and illegal migration. Poverty and diminishing access to health care and education have also led to the breakup of families, increased the number of children living on the street, and forced many girls and young women into sex work.

HIV/AIDS threatens Mozambique's reconstruction as well as the health of its people. The direct costs alone of caring for millions of people living with HIV/AIDS are expected to overburden the country's inadequate health system. Community-based care in Mozambique is particularly ill-prepared for the influx of people living with



HIV/AIDS (PLWHA). Preliminary data suggest that 20 percent of rural hospital beds are already occupied by AIDS patients.

HIV/AIDS is also beginning to take its toll on businesses in Mozambique, and is expected to reduce annual profits in the coming years. Productivity falls and business costs rise—even in low wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. Despite the fact that some large businesses have responded to the epidemic, the diminished labor pool continues to affect economic prosperity, foreign investment, and sustainable development.

Interventions

National Response

The national response has passed through several stages. Initially there was low acceptance of HIV/AIDS as a problem. Following this period of denial, the National Control Programme against STD/AIDS (NACP) was created in 1988, and the first Medium Term Plan (MPT1) was developed.

The NACP has a central body, located in the Ministry of Health, and regional offices in 11 provinces. The main responsibilities of the NACP include planning, coordinating, monitoring, and assessing provincial plans, and providing technical assistance to government sectors involved in the program. The NACP also develops short- and medium-term plans and establishes cooperation protocols for Mozambican and international NGOs, donors, and social, religious, and mass media associations. A second Medium Term Plan (MPTII) was developed in 1994. The National Strategy to combat STI/AIDS includes prevention, counseling, epidemiological surveillance, and blood testing. Specific components of the national program include management, information, education and communication (IEC), epidemiological surveillance, laboratory support, care of PLWHAs and counseling, and condom social marketing.

On December 1, 1998 President Joaquim A. Chissano addressed the nation on World AIDS Day—the first communication about HIV/AIDS issued from the President's office.

The Mozambican government is currently designing a national strategic plan, with the support of the Mozambican UNAIDS theme group on HIV/AIDS and UNAIDS-Geneva, which will be presented to the Council of Ministers in August 1999. The multisectoral Interministerial Commission and the provincial governors are also involved. The NACP is also collecting data to create an AIDS Impact Model for Mozambique, and is currently developing a national counseling strategy.

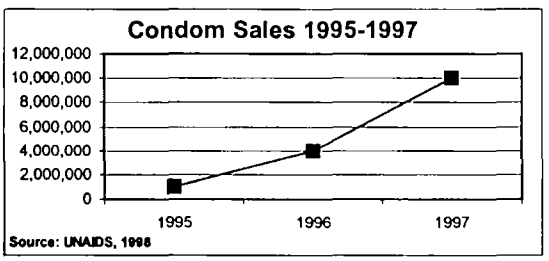
Donors

Multilateral and bilateral donors are actively engaged in Mozambique. According to a UNAIDS/Harvard study, each bilateral organization contributed the following amounts in 1996-1998:

Organization	Amount US$ 1996-97	Amount US$ 1998-99
USAID	4,648,000	7,500,000 *(USAID/Dutch cooperation)*
EU	3,125,000	3,000,000
Finland	1,100,000 (1995-97)	
France	1,059,734	300,000
Total	**9,932,734**	**10,800,000**

Bilateral donor support 1996-1998

USAID's HIV/AIDS funding for FY 1998 was $3.2 million. The mission pursued a nationwide HIV/AIDS prevention strategy with two focus areas: condom social marketing and integration of AIDS and STI control into child survival programs. The social marketing program includes behavior change communication (BCC), using mass media, theater groups, and community agents to promote safer sex.



In 1999 USAID will support cooperating agencies to:

- Expand the reach of behavior change messages through community-based peer education.
- Improve the quality and reach of BCC, focusing on youth.
- Increase activities to improve STI prevention and treatment.
- Increase HIV counseling and testing.

Following a USAID-supported pilot project, the percentage of the population in the four provinces who could state three ways to prevent HIV transmission increased from 17 percent in 1996 to 68 percent in 1998.

USAID is also working with the MOH to expand family planning services into all basic health programs. Efforts are underway to ensure national blood safety and build provincial capacity to implement STI and HIV/AIDS prevention campaigns aimed at changing sexual behavior. USAID will continue to support social marketing activities to increase condom demand and access, and is designing an aggressive HIV intervention strategy targeted at the four major transport corridors in Mozambique—Maputo, Beira, Nacala, and Tete. USAID is also exploring regional issues, including the identification of a regional HIV/AIDS advisory group, mechanisms for information sharing on program activities and prevalence/incidence reporting, and a multicountry study on HIV.

UNAIDS has a coordinating theme group based in Mozambique. The group, chaired by WHO, consists of representatives from UNDP, UNFPA, UNESCO, The World Bank, WHO, and UNICEF. In addition, major bilateral donors who provide the bulk of AIDS financing in Mozambique are active leaders of the group.

Support from the UNAIDS cosponsors in 1996-1998 included the following:

Donors	Amount US$ 1996-97	Amount US$ 1998-99
World Bank (general support for health and drugs)	2,000,000	3,000,000
UNAIDS	492,000	310,000
UNICEF	155,000	450,000
UNDP	120,000	650,000
WHO	72,000	104,000
UNFPA		2,000,000
Total	**2,839,000**	**6,514,000**

UNAIDS cosponsor support 1996-1998

In 1999 UNAIDS will:

- Raise public and political awareness of HIV and the responses needed.
- Support the development of a national, comprehensive, and multisectoral plan.
- Build capacity at all sectoral levels to implement and evaluate an effective response to HIV/AIDS. Promote and enhance partnerships with NGOs, the private sector, and civil society.
- Enhance coordination among government, donors, and the United Nations.
- Provide technical assistance and support in implementing the national HIV/AIDS prevention plan.
- Assist in delivering services to prevent HIV infection and strengthen household and community capacity to cope with HIV/AIDS.

The World Bank supports HIV prevention as part of a road construction project.

WHO is carrying out joint activities in the areas of epidemiological surveillance, STI and HIV/AIDS counseling, prevention interventions for vulnerable groups, and blood safety. WHO also provides some direct support to NGOs.

UNDP is implementing a comprehensive national AIDS project.

UNFPA will support improved integration of STI and HIV/AIDS services into existing reproductive health services in its country program from 1998 to the year 2000.

Finland's Ministry for Foreign Affairs, Department of International Development Cooperation, supported a $1.1 million community development project from 1995 to 1997. The project, implemented by The Red Cross of Mozambique, provided information about HIV/AIDS, nutrition, maternal health care, and hygiene, as well as blood transfusion services.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities in Mozambique, funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include The Futures Group, and Population Services International. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

According to UNAIDS, a relatively small number of NGOs are working on HIV/AIDS prevention and they are concentrated primarily in Maputo and other urban areas. The majority of NGOs receive their funding from external sources and work at a micro level, with limited impact on the epidemic at the national level.

The formation of the Network of AIDS Organizations in Mozambique (MONASO) brought together a variety of organizations working on HIV/AIDS activities throughout the country. MONASO recently prepared an organizational strategic plan to provide more effective coordination and assistance to local NGOs.

With increased disclosure of HIV-positive status, a network of PLWHA has also been formed, and partnerships have been created between the network, other NGOs, and the government.

Challenges

Major constraints to HIV/AIDS control in Mozambique include:

- Other emergencies that make it difficult to make HIV/AIDS a priority.
- Lack of information about the epidemic and its consequences.
- Lack of financial resources for drugs, HIV and syphilis tests, and educational materials.
- Increasing unemployment, deterioration of household income, and rising cost of living.
- The increasing social and economic inequalities experienced by women.
- No specific strategies for at-risk groups.
- A low literacy rate, which makes it more difficult to mount effective education campaigns.
- Poor access to health and education programs.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Mozambique:

- More involvement of PLWHA in the governmental and nongovernmental response to the epidemic.
- Decentralization of management of HIV/AIDS programs in different provinces.
- Legislation and enforcement to protect the human rights of people living with HIV/AIDS.
- Targeted interventions for at-risk groups.
- Targeted interventions along the major transport corridors.
- Diversified funding sources for NGOs and community-based initiatives.
- Drug management protocols at the national and provincial levels.
- An implementation plan to fulfill the national AIDS strategy.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Mozambique. The government of Mozambique has initiated a multisectoral, comprehensive National AIDS Strategic Plan. Now it is up to the country's leaders to ensure that this plan will be carried out to slow the spread of the rapidly growing HIV/AIDS epidemic.

Important Links and Contacts

1. UNAIDS: Maria Tallarico, Country Programme Adviser UNAIDS, rua Francisco Barreto 322 2nd Floor, Maputo. Tel: (258) 1 49 14 04/ 49 18 84, Fax: (258) 1 49 23 45, e-mail: unaidsmz@virconn.com or unaids@zebra.uem.mz
2. USAID: Okey Nwanyanwu, Chief, Office of Health, Population and Nutrition, USAID/Mozambique, 107 rua Faria de Sousa, Caixa Postal 783, Maputo. Tel: (258) 1 49 07 26, Fax: (258) 1 49 20 98.
3. MONASO
4. NACP

U.S. Agency for International Development

Population, Health and Nutrition Programs
HIV/AIDS Division

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Impact Implementing AIDS Prevention and Care Project

Implementing AIDS Prevention and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

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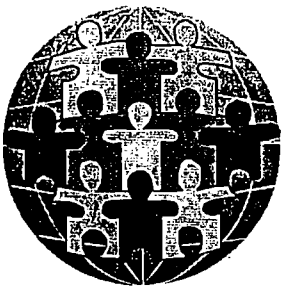

The POLICY Project

The Economic Impact of AIDS in Mozambique

by
John Stover
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September 1999

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and Population Activities (CEDPA)

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS				
	Economically Active Labor Force: 1980[a]		Employment by Industry: 1988[b]	
Sector	'000s	%	'000s	%
AGRICULTURE				
Agriculture, hunting, forestry and fishing	4,755	85.3	16.9	8.4
INDUSTRY	346.8	6.2		
Mining and quarrying industries			4.9	2.4
Manufacturing industries			17.0	8.4
SERVICES				
Electricity, gas and water			2.9	1.4
Construction	42.1	0.8	21.5	10.7
Trade, restaurants and hotels	112.2	2.0	6.4	3.2
Transport, storage and communications	77.0	1.4	29.3	14.5
Finance, insurance, real estate and business services				
Other services	243.5	4.4	2.7	1.34
TOTAL	**5,576**	**100.0**	**201.6**	**100.0**
Source: a – Europa World Year Book, 1998; b - United Nations, Statistical Yearbook, 1995, table 29				

Mozambique is heavily reliant on agriculture, where the informal, subsistence agriculture segment accounts for over 85% of the labor force. The main subsistence crop is cassava, while the main export products are cotton, cashew nuts, and shrimps and prawns. Food processing was the most important component of the industrial sector.[1] It is believed that over 60% of the population in Mozambique live in extreme poverty, defined as "...the

[1] Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (1998).

income level below which a minimum nutritionally adequate diet is not affordable." Although poverty was pronounced before the civil war, the war certainly exacerbated the poverty.[2]

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Mozambique to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- The Health Ministry has calculated that, through December 1996, there are at least 146,000 orphans due to AIDS in the Mozambique. This number is expected to increase to as many as 400,000 orphans by the year 2000.[3]

- The impact of the movement of troops from west Africa is thought to be part of the cause of the spread of HIV-2 in Mozambique, as military personnel have higher prevalence rates and tend to exhibit risky behavior.[4]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural

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[2] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[3] AIDS Weekly Plus (1997) "HIV/AIDS takes toll in Mozambique," pp. 23-4, June 30, 1997.
[4] AIDSCAP (1995) "Workshop on the Status and Trends of the HIV/AIDS Epidemics in Africa: Final Report," co-sponsored by the Francois-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, December 1995.

labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops.

- A leader of a development project supported by GTZ was asked what the potential impact of HIV/AIDS was on the project. He replied, "We will not be able to increase nor to stabilise agricultural yields..." and that "...it will be necessary to educate and train additional counterparts."[5]

Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

- The perceived effect of HIV/AIDS varies depending on the sector and on the individual; one engineering project in Maputo stated that they had not noticed any impact of HIV/AIDS in their region or in the country, while another development project in Manica felt there had been an impact both in their area and nationwide.[6]

- Legal reforms to protect the rights of people living with HIV/AIDS are being developed currently in Mozambique. New laws protecting the labor rights and social services for civil servants were recently introduced, and efforts are being made to require private firms to have similar policies.[7]

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies

[5] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 28.
[6] Hemrich, G and B Schneider (1997) "HIV/AIDS as a cross-sectoral issue for Technical Cooperation," GTZ, Eschborn, Germany, May 1997, p. 28
[7] Barreto, A, B de Hulster, A Pinto (1998) "Legal reform in Mozambique, an opportunity to introduce protective laws for PLWHA in Mozambique," Inf Conf AIDS; 12:959 (abstract no. 44106).

can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

    - The health sector in Mozambique is not prepared for the HIV/AIDS epidemic. Mozambique has the lowest number of doctors per capita in Africa, and 46% of the primary health posts were destroyed by 1990 in the civil war.[8] Currently, there are 6 counselling centers in Mozambique, although none offers vluntary testing service.[9]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

    - There are three major ports in Mozambique; selected surveillance data of workers with tuberculosis in these areas have found higher HIV prevalence rates than in the rest of the country, confirming the higher risk these workers are thought to face. Surveillance data from the central corridor road from Beira to Zimbabwe found prevalence rates of 30.3%.[10]

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to

[8] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[9] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS
[10] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.

commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

- In 1994, there were 44,044 miners employed through The Employment Bureau of Africa, the main miners' organization. They are primarily employed as migrant workers for the mines in South Africa. Most of the miners are primarily young and male, and are housed in single-sex hostels in South Africa, placing them at high risk for HIV-transmission.[11]

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

[11] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

    - Life expectancy is now projected to be only 46.4 years in the year 2000 in Mozambique because of the impact of AIDS. In the absence of AIDS, life expectancy was 53 years in the year 2000.[12]

    - War delayed the beginning of the epidemic in Mozambique, compared to its neighbors, due to the resulting isolation and restriction of movement both internally and externally to the country. Since the General Peace Accord was signed in 1992, certain regions have seen a sharp increase in HIV prevalence rates. The regions most highly affected are near the international borders and main transport routes. The return of some of the international refugees, who had taken refuge in nearby countries with high HIV prevalence, also contributed to the spread of the virus in Mozambique.[13] It is estimated that over 1.5 million people fled Mozambique during the 1980s because of the civil war, most of which lived in refugee camps. It was estimated that over 2.5 million people were displaced within the country.[14]

    - Providing triple combination antiretroviral therapy to HIV-positive adults in Mozambique would cost 67% of the GDP, according to one recent estimate.[15]

What Can Be Done?

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[12] AIDS Weekly Plus (1997) "HIV/AIDS takes toll in Mozambique," pp. 23-4, June 30, 1997.
[13] Agha, S, A Karlyn, D Meekers. (1999) "The Promotion of Safer Sex Among High Risk Individuals in Mozambique." PSI Research Division Working Paper No. 21, Population Services International, Washington DC.
[14] AIDS Analysis Africa (1997) "Country Profile: Mozambique," 7(5): Feb/Mar 1997.
[15] Hogg, R, KJ Craib, A Weber, A Anis, MT Schechter, JS Montaner, MV O'Shaughnessy (1998) "One world, one hope: the cost of making antiretroviral therapy available to all nations," Int Conf AIDS. 1998; 12:830 (abstract no. 444/42283).

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

    - The Mozambican Association for the Development of the Family (AMODEFA), an NGO operating in Mozambique, has been leading workshops in schools, workplaces, and neighborhoods throughout Mozambique to increase awareness of HIV and STDs, in order to prevent new infections.[16]

    - Over 75% of the government's budget comes from external donors; these donors have not placed HIV/AIDS prevention programs on their priority list, and thus the government finds it difficult to do so, in spite of having had a national program since 1988.[17]

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

    - The World Bank and MONASO (the AIDS-NGO umbrella organization) are working together to include STD/AIDS prevention activities for the Roads and Coastal Shipping (ROCS) Project.[18]

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[16] "HIV/AIDS ravages southern African nation. Mozambique," (1997) Sex Weekly Plus. 1997 Jun 30:9-10.
[17] Barreto, A, B De Hulsters, L Fransen (1996) "Is a multisectorial approach to the STD/HIV/AIDS epidemic an option in post-war Mozambique?" Int Conf AIDS. 1996 Jul 7-12; 11(2):375 (abstract no. Th.C.4789).
[18] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

    - A project in Zambezia through Save the Children UK is underway to address the needs of AIDS orphans.[19]

    - A hot line for HIV/AIDS "Linha Aberta" was opened by MONASO and provides both information about HIV/AIDS and general support to families with HIV/AIDS patients.[20]

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

[19] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS
[20] UNAIDS (1998) "1998 Mozambique Country Profile," UNAIDS