Mozambique

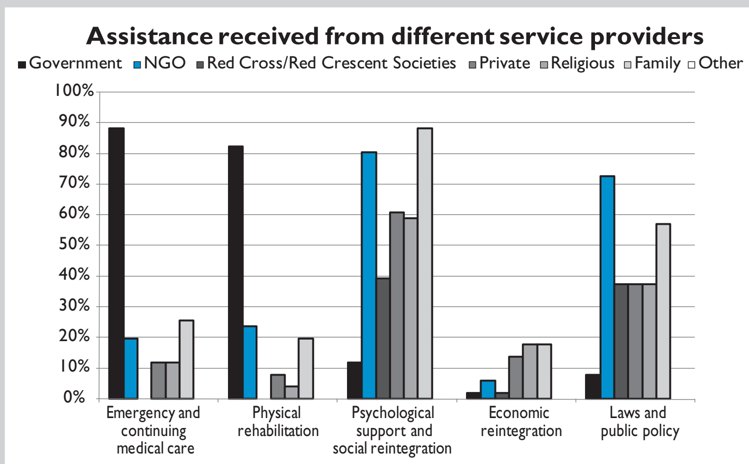
Country indicators

- *Conflict period and mine/ERW use:* Contamination in Mozambique has resulted from the 1964-1974 War of Independence during which both the Portuguese army and the Mozambique Liberation Front used mines, and from the 1977-1992 Civil War.[1]
- *Estimated contamination:* As of May 2008, 12.1 km^2 of suspected mined areas remained in six provinces and there is additional ERW contamination; the number of people affected is unknown.[2]
- *Human development index:* 172nd of 179 countries, low human development (compared to 171st of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$370 – 199th of 210 countries/areas (compared to US$269 in 2004).[4]
- *Unemployment rate:* 21% (1997 estimate, latest available).[5]
- *External resources for healthcare as percentage of total expenditure:* 56.8% (compared to 50.2% in 2004).[6]
- *Number of healthcare professionals:* Less than four per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention 30 March 2007, had not signed the Optional Protocol as of 30 June 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Mozambique is one of the world's poorest countries, having been devastated by nearly 30 years of violent conflict that ended in 1992. The majority of people live below the poverty line and life expectancy is just under 43 years. Mozambique remains dependent upon foreign assistance for much of its annual budget.[9]

VA country summary

Total mine/ERW casualties since 1964: Unknown			
Year	Total	Killed	Injured
2004	30	3	27
2005	57	23	34
2006	30	14	16
2007	47	22	25
2008	9	3	6
Grand total	**173**	**65**	**108**

- *Estimated number of mine/ERW survivors:* Unknown.
- *VA coordinating body/focal point:* The National Institute for Demining (IND) is the coordinating body, but it cannot fulfill its mandate because it cannot direct ministries. The Ministry of Women and Social Welfare (MoWSW) and the Ministry of Health (MoH) share responsibility for the implementation of disability services, but neither felt VA was part of their mandate.
- *VA plan:* None; but in 2009, the IND requested the inclusion of VA into the National Disability Plan 2006-2010; however, it lacks sufficient resources to be implemented.
- *VA profile:* Since 2004, Mozambique has identified VA as the weakest component of its mine action program and has said there is a need for a stronger commitment. Between 2005 and 2009, VA was not a priority for the government of Mozambique, with the IND saying VA had not been assigned to any government body and that the ministries feel "no responsibility for the Mine Ban Treaty and have no special concern for mine victims."[10] No significant international funding has been spent on VA or the disability sector. In 2008, some progress was noted in services for persons with disabilities in general. Even though in 2005-2009, there was some improvement in bringing healthcare to rural areas, the sector remains weak and heavily dependent on international aid. Specialized services are rare and the entire medical system suffers from staff and infrastructure shortages. Some 30% of the population still does not have access to healthcare and most survivors also face transport and accommodation difficulties. In January 2009, the MoH took over responsibility for the one NGO physical rehabilitation center near mine/ERW affected areas. Since 1999, it had been managing nine other physical rehabilitation centers in regional capitals with substantial international support. During 2005-2009 four centers were upgraded, again with external assistance (two had been previously renovated). However, waiting lists are long because of a lack of trained staff, which also affects quality. In 2009, as in 2005, the vast majority of survivors received no psychological support or economic reintegration, which left



them unemployed and dependent on family support networks. Services remain operated mostly by NGOs with limited resources and reaching a small number of survivors. The MoWSW also operated some projects and was in principle responsible for the community-based rehabilitation (CBR) network. Awareness of survivors' rights and available services has increased, but less progress has been made in enforcing existing legislation, and there has been no funding to implement the disability strategy. Casualty data collection and data on survivors' needs remains insufficient to inform planning or to set specific targets for assisting survivors.[11]

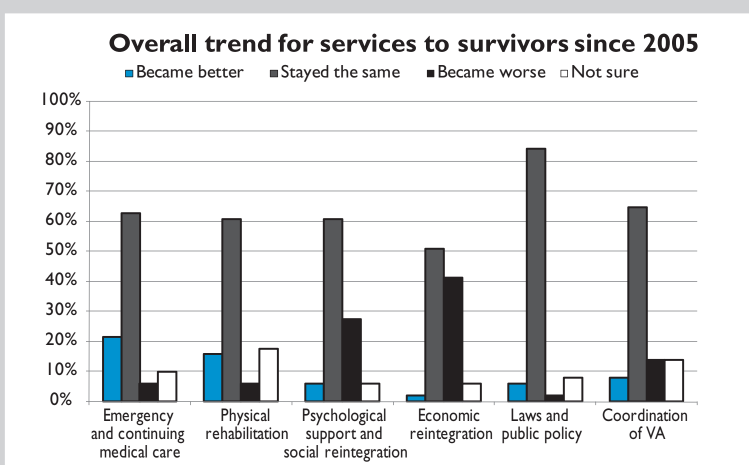
VA progress on the ground

Respondent profile

By July 2009, 51 survivors between 10 and 77 years old responded to a questionnaire about VA progress in Mozambique since 2005: 34 men, 16 women and one boy. Some 63% were heads of households and 66% owned property. Almost half (49%) lived in remote areas without services; another 12% lived in villages with limited services; and 31% lived in the capital or another large city.[12] Just 10% had completed primary school education or higher, while 20% had received no education. Some 16% were unemployed after the incident compared to just 6% before the incident. Of those surveyed, 75% said their income is insufficient. Many were injured prior to 2001. This corresponds to the casualty profile extrapolated from casualty data, indicating that most people became casualties during or shortly after the conflict and that most incidents happened in rural areas.[13] Twelve practitioners from disabled people's organizations (DPO) in the Sofala, Manica and Maputo provinces also responded to a separate practitioner questionnaire.

General findings

Overall, most respondents felt services remained the same over the last five years. In terms of psychosocial support and economic reintegration, a significant number of respondents felt the situation had worsened. Just 25% believed services for female survivors were "equal" to those available to men, and 53% thought they were completely "absent". No one thought they were better, and women responded more negatively than men, with 75% saying services are "absent". Just 10% thought services for child survivors are "sometimes" adapted to their age; 51% were unsure. Practitioner responses corresponded closely to survivor responses.



Some 84% of respondents had been surveyed by government or NGOs three or more times since 2005. Three-quarters felt this had resulted in their receiving more information about services; 65% felt listened to; 63% reported having fewer problems with the bureaucracy; and 49% actually received more services. That same 84% had been given two or more

opportunities to explain their needs to government representatives. These results appear to be more positive than the IND reports, which say casualty and survivor information is under-reported due to difficult terrain, irregular information exchanges, and lack of progress on consolidating data.[14] However, NGOs and DPO networks maintain active ties with their beneficiaries/members and convey their needs to the government. Local authorities and hospitals also maintain this kind of information, but do not systematically report it to the national level.

Emergency and continuing medical care

Nearly two-thirds of respondents (63%) thought that, overall, medical care had stayed unchanged since 2005 and 22% saw improvement. In addition, 24% felt survivors "always" or "mostly" received the healthcare they needed and 33% said "sometimes". However, a significant number of respondents saw progress in just two areas: 41% felt there were more health centers (rising to 57% for those from remote areas) and 37% believed physical access to centers had improved. Just 16% (mostly from urban areas) felt it was easier to get medical care closer to home. This seems to indicate that, although there may be more health centers in rural areas, survivors still feel they are far from their homes. Some 14% or fewer saw improvements in the quality or affordability of healthcare, in better trained staff, or in increased availability of medication, supplies or equipment. Just 4% saw an improvement in the number of first aid workers or the availability of emergency transport. Practitioners responded similarly, with 33% seeing an overall improvement in healthcare and the remainder feeling it had remained the same. Those who saw improvement noted increases in the number of health centers (in rural areas) and better physical access.

Despite significant international assistance since the end of the conflict in 1992, healthcare remained insufficient throughout 2005-2009. Rural centers were unable to provide more than basic assistance, staff and equipment were in short supply, and people had to travel long distances to centers. Only 36% had healthcare available within 30 minutes' travel from their home,[15] and 50% did not have access to adequate assistance. The government acknowledged the lack of staff and infrastructure in May 2009.[16] World Health Organization (WHO) efforts since 2001 to strengthen emergency response seem to have not been very effective.[17]

Physical rehabilitation

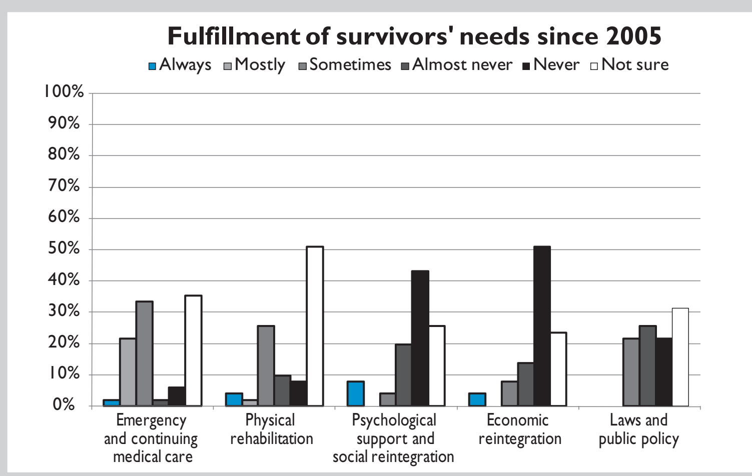
Some 61% of respondents said that, overall, physical rehabilitation services had remained unchanged since 2005; 16% saw an improvement. Half of all respondents (26 people) did not answer or were unsure whether survivors received the physical rehabilitation services they needed. Of the survivors who did respond, 52% felt they only "sometimes" received needed services (25% of total respondents), 36% said this was "never" or "almost never" the case (18% of total respondents); and 12% said services are "always" or "mostly" received (6% of total respondents). Again, the two areas where most survivors saw improvement were an increase in rehabilitation centers (24%) and improved physical access to facilities (41%). Some 22% also found staff better trained and the quality of mobility devices enhanced. Very few respondents (10% or less) felt they could access physical rehabilitation closer to home, that there were more mobile rehabilitation units or more types of mobility devices, or that the waiting lists were shorter. Just 4% thought the government provided more support for physical rehabilitation services. Like the survivors, 16% of practitioners also saw overall improvements to physical rehabilitation services, while 75% felt they had stayed the same.

This perception of more physical rehabilitation centers might be due to the fact that more health centers have started to provide some basic rehabilitation services. The number of centers dedicated to physical rehabilitation has in fact stayed the same since 2000. Renovations to centers possibly also had a positive influence, since by 2009 six (of 10) centers are fully functional. Since just one center is located in a mine-affected area (Gaza) while the others are in regional capitals, survivors would not have felt that services were available closer to home; this center also operates the country's only mobile unit. Throughout 2005-2009 there were shortages of qualified staff, with actual decreases noted in 2006 compared to

previous years,[18] and training targets were unmet for most years, resulting in "long waiting lists that keep getting longer" and patients giving up on receiving services all together.[19] Some short-term training has been given, but a longer-term course, only started in 2008, was not due to finish until 2010. In April 2009, a MoH official noted that few survivors living any distance from orthopedic centers could access services because the MoWSW is no longer able to provide transportation.

Psychological support and social reintegration

More than one-quarter of respondents (27%) thought psychological support and social reintegration services had deteriorated since 2005; 61% felt services remained unchanged. Some 43% believed survivors "never" received the psychosocial support services they needed and an additional 20% found this "almost never" to be the case. Nearly half of all respondents (49%) felt they had become more involved in their communities, while 29% had become involved with psychosocial support activities for other survivors. However, only a few (5% or fewer) saw improvement in the availability of, access to, or quality of services. No respondents said peer support groups had been created or that the government had provided any support for these services, and just 18% thought survivors were considered to be "charity cases" less often. This might explain why only 12% of people felt more empowered. Most practitioners felt psychosocial services had remained the same; 8% saw a decline.



In February 2004, Mozambique recognized the need for "moral support between victims" and called on international donors to support activities in this area.[20] In principle, the MoWSW includes psychosocial support in its CBR program, but no staff has ever received formal training and activities have mostly been left to NGOs with limited means to carry out these activities. One major peer support provider left Mozambique in 2006 because it was no longer cost-effective to work as a stand-alone organization (without local partners) on the issue. Also in 2006 it was reported that there were only 13 psychologists in the entire country, eight of whom were based in Maputo.[21] Since 2004, the government has not mentioned any activities undertaken in the area of psychosocial support. Most respondents were contacted through the DPO network, which might explain why they felt more involved in their communities; many others continued to feel isolated.[22]

Economic reintegration

Some 41% of respondents said opportunities for economic reintegration had worsened since 2005; 51% saw no improvement. Also, 51% felt survivors "never" received the economic reintegration assistance they needed and an additional 14% found this "almost never" to be the case. Some 80% felt unemployment was so high that survivors were the last to be chosen for a job (10% did not answer). The only area where a significant number (51%) of survivors saw improvement was a reduction in educational and professional discrimination. Fewer than 5% of respondents saw improvement on any other progress indicators, such as increased employment opportunities, better access to training programs, more awareness among teachers, more job placement services, or increased government support. Among practitioners, 16% felt economic reintegration assistance had gotten worse and 84% felt it had stayed the same since 2005. The director of one DPO explained that very few people with disabilities in Mozambique work in the formal sector. An NGO representative noted

that the generally low education levels of persons with disabilities are a further obstacle to their finding formal employment.

Since 2004, the government has noted that more funding and facilities are needed for economic reintegration. In subsequent years, it has said there are plans to provide food for work, to encourage the public and private sectors to employ persons with disabilities, to create employment quotas, and to give allowances to those who are unable to generate an income.[23] However, apart from limited government and NGO activities, these plans have not materialized. The fact that Mozambique is one of the poorest countries in the world, with high general poverty and unemployment levels, is a further obstacle, or as one NGO representative commented, "the government just has too many priorities." In 2009, the government reiterated that increasing the sustainability of and capacity for economic reintegration activities is among its biggest challenges for the future.[24]

Laws and public policy

Most survivors (84%) believed the protection of their rights had remained the same since 2005; 47% thought their rights were "never" or "almost never" respected. Nevertheless, 65% felt the general public was more aware of the rights of persons with disabilities; 51% said negative terms about persons with disabilities were used less often; and 49% felt they had received more information about their rights. Some 22% felt discrimination had decreased. More importantly, just 2% felt new policies and legislation had been developed; only 4% said policies were better enforced or that the needs of survivors were included in disability policy. Three-quarters of practitioners indicated that the protection of survivors' rights had remained unchanged. They saw the most progress in rights awareness and information.

These responses confirm the fact that numerous laws do exist to promote disability rights, but their enforcement is weak.[25] As of 2009, no progress had been noted on the approval of the revised disability legislation created in cooperation with disability organizations and submitted in 2005. The various DPO networks all have very limited capacity to carry out advocacy work. While there is a willingness to work with DPOs more often,[26] neither the government nor the DPOs have the resources to put this into practice. International NGOs have increasingly started supporting DPO networks and have spread awareness messages, for example through the radio.[27]

When asked to respond to preliminary survey findings, a government official felt that a deeper analysis of why survivors have not seen more overall change is necessary. The representative believed that, despite the limited national capacity, there has been some progress, and survivors should have received some services, referring to healthcare and physical rehabilitation improvements. However, the representative also noted that some "easy-to-reach" survivors might have received multiple services, while others would not have received any support.

VA process achievements

Year	Form J with VA	ISC VA statement	MSP VA statement	VA expert	Survivor on delegation
2005	YES	YES	NO	YES	NO
2006	YES	NO	YES	YES	NO
2007	YES	NO	YES	YES	NO
2008	NO	NO	YES	YES	NO
2009	YES	YES	N/A	YES	NO

Between 2005 and 2009, Mozambique does not appear to have made significant progress on VA due to coordination challenges, a lack of national and international resources, and the fact that it has many other priorities. The limited progress made in healthcare and in the sustained ownership of physical rehabilitation has mainly come about through broader development

and post-conflict programs, not so much through disability sector activities. One government representative also blamed the lack of progress on an inadequate response from the international donor community, adding that Mozambique had expected to receive additional international assistance by becoming part of the group of 26 countries with significant numbers of survivors and, therefore, the greatest responsibility as well as the greatest needs and expectations for assistance. As one of the poorest countries in the world, an overall lack of financial resources has clearly been an obstacle, but survivors believed a lack of political will was the bigger challenge, with 82% of survivors responding that political will is lacking.

In 2005, Mozambique presented some of its 2005-2009 VA objectives to further the implementation of the Nairobi Action Plan, but these objectives were not SMART. They were never revised and a plan was never developed, even though it was announced in 2006 that a plan might be ready by the end of 2007. Instead, reference has been made to the National Disability Plan 2006-2010, but the IND only requested the inclusion of VA objectives into this strategy in 2009. This involved revision of the objectives for the new disability plan starting in 2010,[28] (i.e., after the 2005-2009 timeframe). The 2006-2010 plan has remained largely unimplemented due to lack of funds. According to NGO representatives, it also remains unimplemented because the government developed it without sufficient information about the needs of persons with disabilities.

Similarly, under the 2005-2009 objectives, a prerequisite for setting specific targets was determining how many survivors there are, where they are, and what their needs are. As of August 2009, this has not happened. For example, in 2008, Mozambique reported that existing casualty data still did not represent "the real situation of the people surviving accidents with mines/ERW in Mozambique."[29] Overall, objectives were too general to be measurable. Progress was limited to the establishment of an inter-sectoral technical group to coordinate disability activities, signature of the UNCRPD, and internationally-backed improvements in the physical rehabilitation sector. Some small-scale economic reintegration activities were reported as well, but it is unclear who has provided these services. Disability was also included in the 2006-2009 Poverty Reduction Strategy Program, which aimed to assist 400,000 persons with disabilities and included a budget, specific objectives and targets; progress on this program is unknown.

While a disability coordination group has been established, Mozambique still identified coordination as one of its main challenges in May 2009.[30] The IND had developed a draft VA policy as early as 2001[31] and has included VA in all its mine action plans, but its involvement over the years has been constricted. Although the IND is, in principle, the coordinating body for VA, it does not have the mandate to direct the implementing ministries; it has seen its role decreased to data collection and fundraising, with the latter also removed from its latest package of responsibilities outlined in the 2008-2012 mine action plan.[32] Nevertheless, the IND does focus primarily on clearance and has found it difficult to integrate VA into its operations. Coordination between the MoH and MoWSW as main implementers is not adequate and neither feels VA is part of their mandate. All three actors have acknowledged that coordination at government level is a problem, but they have also noted that a lack of coordination between the government and NGOs has resulted in an unequal distribution of services. The VA expert representing Mozambique at international meetings has changed at almost every meeting, which is possibly indicative of this lack of institutional ownership and has prevented continuity.

Survivors' responses concur with those of government representatives. Only 22% of survivors know who is in charge of VA/disability coordination and only 16% have seen more government involvement in VA. Just 8% felt the government had improved coordination with NGOs. A mere 2% felt survivors were included in coordination meetings or felt their needs are taken into account when developing national VA plans. Survivors generally did not feel included in the development of VA plans or their monitoring. The vast majority of practitioners (92%) felt coordination had remained the same since 2005. Some 72% believed the government had maintained its efforts, but 28% felt the government has done "nothing". Mozambique's high dependency on international assistance to provide for its most basic needs and its numerous competing priorities are very real issues and thus obstacles for progress in VA.

Conclusions

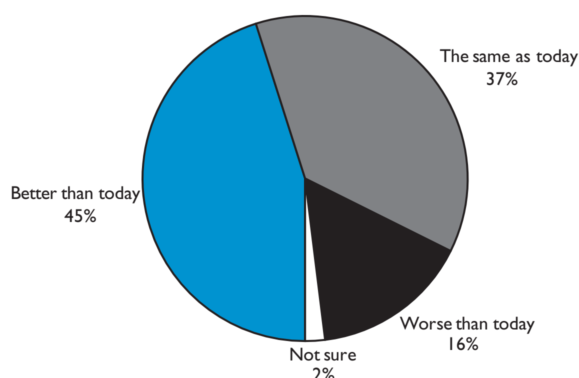
- Access to health and physical rehabilitation services remained difficult for survivors because of a lack of transportation, despite the fact that there were more facilities.
- The vast majority of survivors did not receive either psychosocial or economic reintegration services.
- Survivors did not feel included in VA planning, implementation or monitoring.
- Government and NGO representatives agreed that coordination around VA has not improved since 2005.
- The lack of coordination and national ownership has hampered VA planning and implementation progress, particularly among relevant ministries.
- Insufficient linkages have been made to disability and poverty reduction strategies.
- The competing needs and lack of financial means presented a real obstacle to VA/disability progress.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 45% of respondents felt it would be better than today; 37% felt it would be the same; and 16% felt it would be worse (2% were not sure). To assist in a better future ahead, the following suggestions may be taken into account:

- Urgently develop economic reintegration activities for survivors and other persons with disabilities, strengthen the economic opportunities component of existing development plans, and increase survivors' access to these opportunities.
- Designate a focal point or coordinating body with sufficient authority to raise the profile of VA and ensure its inclusion within a broader disability framework.
- Ensure that responsibility for survivors is internalized in the workings of all relevant government entities.
- Urgently understand the scope of the VA challenge, create a plan as appropriate, and include VA in and strengthen links with existing relevant strategies.
- Reinstate and fund transportation to facilitate much-needed access to services.
- Strengthen DPOs and survivor organizations so they can better negotiate their rights and be more involved in needs-based planning, implementation and monitoring.

What do you think your situation will be like in five years?



Rosa José Njango sits outside her small hut
© Luis Wamusse

In her own words: the life experience of Rosa José Njango

In 1981, Rosa José Njango was just 13 years old when she stepped on a mine in the courtyard of her school in Tenga, a small village in Maputo province. She had to travel some of the way to the district hospital in a cart before a car was available to take her. As a result, she lost a lot of blood and both of her legs had to be amputated. Nevertheless, Rosa has since married and had three children. When her husband died, her relatives took her children away from her, claiming she is unable to care for them because of her disability. She now lives alone in a humble hut.

Rosa has never received any psychological, economic reintegration or financial assistance. However, one survivor association has given her some peer support. She dreams that one day she will be able to get custody of her children. Her message to the international community is: "Enough words, now let's move to concrete actions."

In their own words...

The main priority for VA in the next five years is:

- Raising awareness of survivors' rights.
- Increasing assistance for medical care and medicines.
- Scholarships and support for economic reintegration.
- For the government to recognize the rights of survivors and support them.
- Economic self-sufficiency.
- Reinforcing psychological support.
- Informing us about progress made in implementing the government's plan.
- Strengthening survivors socially.
- Establishing a compensation fund for survivors.
- Strengthening survivors' organizations so they can help us.
- Moving from theory to practice in social and economic support.
- Supporting survivors in doing advocacy.
- Helping all survivors, especially those in rural areas.

In their own words...

If countries really cared about survivors they would:

- Provide high-level support for non-discriminatory access to services.
- Raise awareness of the rights of survivors and persons with disabilities.
- Coordinate VA to provide services to all.
- Provide physical/psychological rehabilitation services and create conditions for economic independence.
- Provide more medical assistance.
- Provide economic reintegration of all survivors and persons with disability.
- Follow through on the commitments made by the government.
- Build national capacity to respond to survivors' needs.
- Provide specialized attention to child survivors.
- Support survivors' dependents.
- Do a survey to find out more about survivors' concrete situations.
- Respect them more.

In their own words...

Survivors described themselves as: having faith in God, frustrated, having a compromised future, happy, abandoned, suffering, confident, good-tempered, "so sick of thinking about my life", angry, disappointed, unhappy, healthy, lonely, desperate, hard-working, persistent, and fighter.