People with disabilities in the suburban areas of Maputo and Matola

Social representation of disability
Socio-economic situation
Access to health and social services
Local stakeholders system

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Maputo, April 2010

The cities of Maputo and Matola have experienced an unprecedented period of demographic and spatial growth over the last thirty years. This rapid urban expansion, combined with an increase in social inequalities in a liberalized society, has led to the **marginalization of neighbourhoods on the outskirts of the metropolitan area.** The impoverishment of the most vulnerable sections of the population in these neighbourhoods, which are located far from centres of economic activity and lack adequate health and social services, is a cause for concern. These populations include **people with disabilities who experience considerable difficulties in adequately addressing their most basic health and social needs.**

This report outlines the **analyses and recommendations arising from the local assessment of the situation facing people with disabilities in nine of the capital's suburban areas,** performed by RAVIM and Handicap International between April 2009 and April 2010, as part of the ''City and Disability'' project. This assessment aimed to provide more information about the social representation of disability in the area, the socio-economic situation experienced by people with disabilities, the conditions for accessing health and social services, and lastly the operation of the local stakeholders system. An estimated 5% of the area's inhabitants are disabled, representing around 10,000 people in the nine neighbourhoods under study and nearly 90,000 people if this estimate is applied to the Maputo/Matola metropolitan area as a whole.

The first part of the report contains a social and anthropological analysis of the social representation of disability in the area. According to this analysis, communities regard disability as primarily a medical problem, with a scientific, divine or mystical origin. Underlying the social inclusion problems faced by people with disabilities is the prejudice they face within their own communities. The people with disabilities who took part in this study spoke of how they were treated with contempt and scorn and even rejected by their fellow citizens in their local neighbourhoods, in stores, on public transport, in schools and businesses, and in the marketplace.

The second chapter reveals the particularly worrying socio-economic situation faced by people with disabilities with regards to the rest of the population. Generally older and more likely to be female, the disabled population living in this area is subject to an accumulation of factors that potentially lead to social exclusion and fuel a vicious cycle of poverty - poor standards of literacy and education, job insecurity, a low level of involvement in disabled people's organisations, etc.

The third section analyses the conditions for accessing health and social services and reveals how people with disabilities still find it difficult to meet certain mainstream and specific needs with regards to health, education, professional training and employment, social programmes, and even sport and culture. Among the many obstacles to accessing these services are economic factors, the poor physical accessibility of buildings, a lack of information and the absence of training for service professionals.

The functioning of the local stakeholders system is explored in the fourth part of this report, which highlights the problems but also the potential of each of the stakeholders in three key groups - disabled people's organisations, service providers and public authorities. The capacity of disabled people's organisations, despite their considerable strengths, is by itself too limited to solve the problems affecting people with disabilities. Service providers are too saturated and centralised in Maputo to be able to meet the constantly increasing social demands made on them in outlying neighbourhoods. People with disabilities are largely excluded from these services due to a lack of professional training, poor access to buildings and a shortage of information. Local public authorities, including devolved government services and local authorities, despite their best intentions, are unable to generate an effective inclusive development dynamic to benefit people with disabilities in the area, in the sometimes confused context of decentralisation.

Lastly, the final part of this report provides a series of recommendations for local, national and international stakeholders, who are called on to take collective action to enhance the social participation of people with disabilities in the area, and consequently their well-being. In addition to raising the public's awareness of the worrying situation facing people with disabilities in the outlying areas of Maputo and Matola, we aim to foster the emergence of a more concerted and inclusive local development dynamic.

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Discussion

"It is particularly hard for people with disabilities to access health and social services due to a number of factors, including physical and environmental obstacles, the inadequacy of the existing legal framework, the absence of specialised services in the country in general and in the cities of Maputo and Matola in particular. These different obstacles considerably heighten the vulnerability and dependence of people with disabilities with regards to their social and family networks.

Although disabled people's organisations have been active in Mozambique for almost 20 years, people with disabilities still face numerous difficulties in accessing basic health, education, transport, employment and social security services.

To tangibly improve access to services, we need to start by changing the attitudes and practices of service providers, more than policies and laws.

The City and disability project, implemented by the RAVIM association, in partnership with Handicap International, aims to improve access to health and social services for people with disabilities and to help them play a full role in local development initiatives. FAMOD is very grateful to everyone who has made this initiative possible. It represents a major step forward in ensuring respect for the rights of people with disabilities in this country."

Ricardo Moresse

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Chair of FAMOD
(Forum of Disabled People's Organisations in Mozambique)

ADEMO *Associação dos Deficiêntes de Moçambique* / Association of Disabled People in Mozambique

AL *Autárquia Local* / Local authority

DPO Disabled People's Organisation

SNA Social Networks Analysis

FAMOD *Forum das Associações Moçambicanas de Deficientes* / Forum of Disabled People's Organisations in Mozambique

FDLP *Federação das Associações de Deficientes dos Países de Língua Portuguesa* / Federation of Portuguese-Speaking Disabled People's Organisations

HI Handicap International

IEC Information, Education & Communication

IFP *Instituto de Formação dos Professores* / Teacher Training Institute

INAS *Instituto Nacional de Assistência Social* / National Institute for Social Assistance

INE *Instituto Nacional de Estadisticas* / National Institute of Statistics

INEFP *Instituto Nacional de Emprego e de Formação Profissionnal* / National Institute of Employment and Occupational Training

MMAS *Ministério da Mulher e da Acção Social* / Ministry for Women and Social Action

NGO Non-Governmental Organisation

OLE *Orgão Local do Estado* / Decentralised Government Service

PWD Person with Disabilities

SP Service Provider

PEN *Plano Estratégico Nacional de Combate ao HIV e Sida* / National HIV/AIDS Control Strategic Plan

PNAD *Plano Nacional de Acção da Area da Deficiência* / National Action Plan for Disability

RAVIM *Rede de Assistência ás Vitimas de Minas* / Mines Victims Assistance Network

SINTEF *Foundation for Scientific and Industrial Research* / Foundation for Scientific and Industrial Research

IGSSS Information, Guidance and Social Support Service

HDSP Health, Disabilities and Social Participation

TPM *Transportes Públicos de Moçambique* / Mozambique Public Transport

WG *Washington Group* / Washington Group

Accessibility - accessibility focuses on three areas: the built environment, communication and mobility aids. In terms of construction, accessibility refers to the implementation of measures to adapt and equip an area to facilitate access for people with disabilities to buildings, equipment and services in such a way as to optimise their independence and dignity.

Local community – refers to a person's local environment, including the population and all of the different stakeholders (public and private), in a defined geographic location/area, with a shared sense of belonging faced with the same limitations and benefiting from the same advantages.

Universal design - universal or inclusive design, also known as ''architecture for all'', refers to the design of products and spaces without a specific focus on the needs of people with disabilities alone. Instead, it takes into consideration the many differences between individuals. Universal design considers accessibility from a broader, all-inclusive perspective.

Inclusive local development - is a process in which all marginalized/excluded groups are included in the local development process. Taking an inclusive local development approach to promote access to services means that people with disabilities benefit/should be able to benefit from the same services or activities as other members of society. These services or activities are therefore adapted to needs rather than specialised in nature. They are not designed for but rather to include people with disabilities. For example, a school accessible to both children with disabilities and children without disabilities.

Physical impairment - refers to a physical condition of the body affecting functioning of the lower and/or upper limbs.

Visual impairment - refers to an eye condition affecting a person's visual abilities to varying extents, from partial to total loss of sight.

Hearing impairment - refers to a condition affecting a person's hearing to varying extents, from partial to total loss of hearing. A person with a hearing impairment may also find it difficult or even impossible to speak, although this is not always the case.

Intellectual disability - refers to an alteration in the brain affecting a person's intellectual abilities, linked with some mental disorders (development disorders or pervasive development disorders). People suffering from an intellectual disability may experience learning and/or memorizing difficulties/limitations and/or other disabilities (communication, social autonomy). Some others mental disorders (psychotics, humor, behaviour disorders) may also affect a person's social behaviour or mental stability, without affecting their intellectual abilities. In these cases, we speak about mental disability. Intellectual disability and mental disability are not treated in the same way, but unfortunately it is often difficult to differentiate between them, since they can also be cumulative.

Local governance - comprises a set of institutions, mechanisms and processes through which citizens and their groups can articulate their interests and needs (including groups of discrimination victims, such as people with disabilities, women, minorities and people with HIV/AIDS), mediate their differences, and exercise their rights and obligations at a local level. This involves the effective participation of citizens, a transparent flow of information and operational accountability mechanisms.

Disability - a person has a disability if he/she is subject to personal and/or environmental obstacles that limit his or her ability to carry on out normal day-to-day activities. Disability is a progressive rather than a static situation. This situation may be due to a reduction in impairments (alteration in the body), the development of abilities (reduction in impairments) or the adaptation of the context or environment (obstacles are transformed into facilitators to ensure the effective performance of a person's day-to-day activities). We refer to full social participation if a person is able to fully perform their day-to-day activities.

Local disability action plan - details the actions to perform to improve the living conditions and equal opportunities of people with disabilities. The plan may extend over two years and describe the measures to adopt each year, for example. In an ideal situation, it corresponds to the length of the mandate of the authority in question. This systematic planning gradually enhances respect for the basic rights of people with disabilities in the area.

Mainstream services - these services meet the basic needs of all individuals (education, health, employment, social services and/or social security). They must be entirely accessible to ensure the social participation, dignity and equal opportunities of citizens. People with disabilities have the same basic needs and therefore the same right to access these services as other citizens.

Specialised services - these services are dedicated to a particular section of the disabled population, according to their specific needs (e.g.: specialised education, physical rehabilitation service, etc). These services may be considered as an extension of mainstream services but must remain ''open'' to the outside by establishing a maximum number of gateways to other types of services.

Support services - designed as individual complementary services, they enable each individual, according to their needs and choices, to access mainstream services at the community level, like any other person. A support service helps to ensure the effective mainstreaming of people with disabilities. For example, compensatory equipment, sign language interpreters, adapted transport, etc.

Signage - includes signposts, street signs and numbers, information displays, maps, etc. Signage, both in urban areas and in buildings, must be clear, simple, easy to read and visible to be accessible to everyone. It supplies information and helps people find their way around an area.

Disability in Mozambique

I/ Key data

► Very little data on the number people with disabilities in Mozambique existed until recently. The National Institute of Statistics (INE) estimated the national disability prevalence rate at 1.8% in 1999.

► In 2009, the first nationwide survey, performed by SINTEF, in partnership with FAMOD and the INE, provided a more accurate picture, with the number of people with disabilities estimated at 6%, equivalent to 1.2 million people across the country.

► The living conditions of people with disabilities are generally more precarious than the rest of the population, of the same gender and age, including their level of education, access to the employment market, level of income, access to services, housing, mobility, access to information and social participation.

► They are viewed negatively and suffer from numerous forms of discrimination within their own communities, but also within society as a whole.

► Socio-economic vulnerability and discrimination of all kinds are even worse for women with disabilities, due to an accumulation of factors.

► People with disabilities are particularly vulnerable to HIV/AIDS due to heightened risk factors and major problems in accessing prevention and screening services.

II/ Legal framework and key dates

1989	Founding of ADEMO, the first disabled people's organisation in Mozambique.
1990	Amendment of the *Constitution of the Republic* to include an article guaranteeing equal rights for people with disabilities.
1999	Launch of the *African Decade of Persons with Disabilities* (1999-2009); Mozambique was among the six pilot countries.
	Adoption of the *National Policy in Aid of People with Disabilities* (Resolution 20/99).
2000	Creation of *FAMOD - Forum of Disabled People's Organisations in Mozambique*, consisting of 18 associations.
2006	Adoption of the first PNAD - *National Disability Action Plan* (2006-2010).
2007	Signing of the *United Nations Convention on the Rights of Persons with Disabilities* (ratification likely 2010).
2008	Adoption of the *Construction and Accessibility of Public Buildings for People with Disabilities or Reduced Mobility Regulation* (Decree no.53/2008).
2009	Adoption of the *Strategy for People with Disabilities in Public Service* (2009-2013) (Resolution no.68/2009).
	Foundation of the *National Disability Council* (Decree no.78/2009).
2010	For the first time, the specific vulnerability of people with disabilities to HIV/AIDS was included in the third *National Strategic HIV/AIDS Control Plan*- PEN III (2010-2014).
	Mozambique appointed chair of the *Federation of Portuguese-Speaking Disabled People's Organisations*.
	Setting up of the *National Disability Council*.
	Development of the second PNAD - *National Action Plan for Disability* (2011-2015)

Introduction to the local assessment

I/ The "City and Disability" project

The "City and Disability" project was launched in March 2009 by RAVIM and Handicap International. This four-year project aims to improve the access of people with disabilities to medical and social services and to promote their full participation in development initiatives in nine suburban areas of the municipalities of Maputo and Matola. It is expected to ensure the development of a system of inclusive services in the territory by raising the awareness of service suppliers and providing them with training, the setting up of a consultation forum including key local stakeholders, and the creation of an Information, Guidance and Social Support Service (IGSSS) for people with disabilities.

To more effectively define disability issues in the territory, the first year of the "City and Disability" project was devoted to carrying out a participatory local assessment. This assessment was carried out jointly by RAVIM and Handicap International. Disabled people's organisations were also closely involved in the process, in particular FAMOD, along with local public authorities and service suppliers.

II/ Goals of the local assessment

More specifically, the local assessment aimed to:

► Focus on the social representation of disability
► Assess the socio-economic situation facing people with disabilities
► Determine the level of access to health and social services for people with disabilities and identify existing environmental obstacles
► Analyse the stakeholders system and the decision-making processes between the public authorities, service suppliers and civil society.
► Develop a series of recommendations for the territory's stakeholders

III/ Implementation schedule and key stages

Performed between April 2009 and April 2010, the assessment was carried out in five successive stages:

Stage 1: preparation of the assessment (April/May 2009)
- Development of the methodological framework for the assessment
- Collection of information on the territory and key stakeholders
Stage 2: launch of the assessment (June 2009)
- Setting up of a project management committee
- Presentation of the assessment process to the territory's stakeholders
Stage 3: field surveys (July 2009-January 2010)
- Social representation of disability survey (via a qualitative focus group)
- Health, disabilities and social participation survey (via quantitative questionnaires)
- Health and social services survey (via quantitative/qualitative questionnaires)
- Interviews with stakeholders in the territory (based on in-depth interviews)
Stage 4: data analysis (October 2009 – March 2010)
- Analysis of interview and discussion groups reports
- Statistical analysis of quantitative data gathered (EPI info, NetDraw)
- Participatory writing process
Stage 5: feedback on results (April 2010)
- Publication of a comprehensive report, a summary of the results and a service directory
- Seminar to present the results and recommendations to the stakeholders

Methodology

Using a participatory approach, we set out to consult key social groups and stakeholders in the area studied. They included representatives and public workers from devolved state services and local authorities, technicians working for health and social service providers, managers and members of disabled people's organisations, and members of the local community.

Four surveys were performed in succession, combining four distinct methodological approaches:

I/ Socio-anthropological approach: qualitative survey via focus groups

To gain a better understanding of the social representation of disability in the area, we began by organising a qualitative survey based on focus groups.

The initial series of 12 focus groups included a total of 111 participants. Representative of the local population, they included the parents of people with disabilities, community residents, members of local associations, local government workers, service providers, etc. A final workshop, attended by 51 people with disabilities, enabled us, more specifically, to highlight the various obstacles that limit their access to the area's existing health and social services.

Each of these discussion groups, lasting two hours on average, focused on three main themes:
- ► the origin and causes of disability,
- ► the social acceptance of disability,
- ► the social inclusion of people with disabilities

A facilitator asked the group open questions. This fostered narration and storytelling, encouraging everyone to formulate and share their own experiences. This format also allowed people to express a range of opinions and to speak freely during discussions between participants.

The information collected during this qualitative survey was subsequently analysed using a socio-anthropological interpretation chart to reveal the system of representations, values and beliefs specific to the population under study. This information was also fed back into the final stages of the field survey, particularly when preparing the questionnaires for the HDSP survey. These focus groups also provided a major lever for community and institutional involvement, providing a starting point for a broader, more in-depth analysis of disability issues in the territory as a whole.

II/ Epidemiological approach: questionnaire-based quantitative survey

An epidemiological approach was also used as the basis for a second survey stage (HDSP - Health, Disabilities and Social Participation) to determine the disability prevalence rate among the population surveyed to more effectively define the socio-economic profile of people with disabilities and assess their level of access to health and social services. To this end, a questionnaire-based quantitative survey was performed in the area over a twelve-week period.

a) Sampling
The sampling of people to survey was performed at two levels:

► Firstly, a selection of 50 clusters "assigned" to each of the nine neighbourhoods surveyed, with probability proportional to population size, broken down as follows:

Neighbourhoods	Census population	Number of clusters	Estimated number of houses to cover	Households to survey
J.Dimitrov	40,963	10	800	160
Zimpeto	25,645	6	500	100
Malhazine	8,753	2	170	34
Magoanine A	4,022	1	80	16
Magoanine B	12,065	3	240	48
Magoanine C	12,065	3	240	48
T3	16,636	4	320	64
Khongolote	27,649	7	540	108
Ndlhavela	57,246	14	1,120	224
Total	**205,043**	**50**	**4,000**	**800**

The geographic boundaries of the neighbourhoods surveyed are poorly laid out on the ground and were unfamiliar to those conducting the survey and the population's representatives. Each cluster centre was defined approximately based on aerial mapping to ensure the clusters were divided equally over the neighbourhood, taking into account apparent housing density.

► Households represented the second level of sampling. The people conducting the survey moved along the streets in a spiral pattern from a centre defined for each cluster. The houses on each side of the streets in question were then counted. Each fifth house was included in the sample (5, 10, 15, etc.). The survey for each selected house or household was completed by the person present. All members of the household were recorded, whether they were present at the time of the survey or not, with the person surveyed providing information about them.

Methodology

b) Application of the questionnaire

We used a two-part questionnaire:

► The **first part included several demography-related questions** (gender and age) **and screening questions** to identify people with disabilities. To provide a basis for comparison with other existing studies, we used the Washington Group's six screening questions, generally used to determine the prevalence of disability in a given population:

   - *Do you have difficulty seeing, even when wearing glasses?*
   - *Do you have difficulty hearing, even when using a hearing aid?*
   - *Do you have difficulty walking or climbing steps?*
   - *Do you have difficulty remembering or concentrating?*
   - *Do you have difficulty with self-care such as washing all over or dressing/undressing?*
   - *Do you have difficulty communicating, for example understanding or being understood?*

We added two additional questions to these six questions to determine if the disabilities expressed by the person surveyed effectively limited the person's ability to perform certain activities or not, and whether it had limited their social participation for at least six months:

   - *Do you have a health problem that limits your ability to perform activities around the home/at school/at work?*
   - *Has this problem lasted more than six months?*

► If the person provided at least one positive answer to any of the screening questions, the person carrying out the survey asked them (directly or via the person present) to complete the **second part of the questionnaire** relating to their level of access to health, education, professional training and employment assistance, social programmes and other types of services (culture, sport, transport, etc). Each time someone with a form of disability was screened, a witness of the same age and sex in the immediate vicinity of the household was asked to answer both parts of the questionnaire to provide a control group.

A team of twenty people were selected to perform the survey. They were trained in survey techniques and the methodology for randomly selecting people to include in the survey. Every effort was made to ensure a gender and disability balance from the start. Half of those conducting the survey were women and each team of two consisted of at least one person with a disability. Priority was also given to a community-based approach.

Each person conducting the survey was a resident of the neighbourhood surveyed, facilitating their knowledge of the area and their relationship with the local population. A supervisory team of RAVIM members was on hand to guarantee the quality of the data collected, in line with the survey protocol defined in advance.

c) Number of people surveyed

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                    ┌─────────────────────┐
                    │       9,556         │
                    │   people surveyed   │
                    └─────────────────────┘
           ┌──────────────────┼──────────────────┐
  ┌────────────────┐  ┌────────────────┐  ┌────────────────────┐
  │      490       │  │      492       │  │       8,574        │
  │  people with   │  │    control     │  │   people without   │
  │  disabilities  │  │    persons     │  │    disabilities    │
  │                │  │                │  │   (491 entered)    │
  └────────────────┘  └────────────────┘  └────────────────────┘
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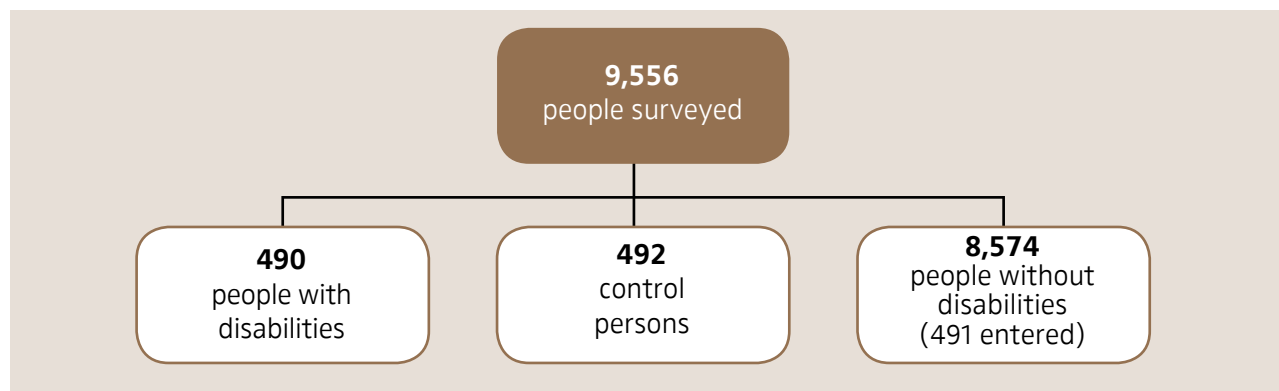
Due to budgetary constraints, we were only able to enter 491 of the 8574 people said to be ''without disabilities'' into the EPI Info processing software, in other words, those who answered ''no'' to all of the screening questions. The analysis sample therefore consists of all ''with disabilities'' and ''control'' questionnaires and one out of 17 ''without disabilities'' questionnaires, which are numerically equivalent to the total number.

d) Checking the representativeness of the samples

The sample population in the field corresponds to all selected households, that is, everyone ''without disabilities'' (8574) and everyone ''with disabilities'' and control persons (982). Since only 491 people ''without disabilities'' were recorded, sample equivalent to 1 in 17 ''cases'' (982/17»58) was selected. The two lists combined (982+58=1040) represent a theoretically representative sample of the source population.

► There is no significant difference in the **sex ratio** between the source population and the sample (p»0.8).

► Nor is there a significant difference between **the age classes** of the source population and the sample population (p=0.7). We only have census data distributed by age for the neighbourhoods in question in Maputo. Representativeness by age has therefore only been checked for this population, not for Matola.

Age	Source	Sample
5 - 9	26.6%	23.6%
10 - 19	24.7%	24.9%
20 - 29	20.5%	23.6%
30 - 39	13.0%	12.2%
40 - 49	8.5%	9.6%
50 - 59	4.0%	2.6%
60 - 69	1.7%	2.6%
70 - 79	0.8%	0.4%
80 +	0.3%	0.4%
Total	**100%**	**100%**

Methodology

▶ As regards the **breakdown of people surveyed by city,** the proportions obtained are also very close to the real weight of each city in terms of the total population of the nine bairros:

City	Source	Sample	Prev.
Maputo	50.5%	50.2%	739
Matola	49.5%	49.8%	734
Total	**100%**	**100%**	**1,473**

▶ Lastly, the **breakdown of people with disabilities by bairros** in our sample is also relatively close to the source population, as revealed below:

City	Source	Sample	Prev.
Zimpeto	12.5%	10.2%	150
Magoanine A		3.5%	52
Magoanine B	13.3%	4.3%	63
Magoanine C		6.9%	101
J.Dimitrov	20.0%	19.9%	294
Malhazine	4.3%	5.4%	79
Ndlavela	27.9%	25.6%	377
T3	8.1%	6.7%	99
Khongolote	13.5%	17.5%	258
Total	**100%**	**100%**	**1,473**

This sample can therefore be considered to be sufficiently representative of the general population for the comparisons made in this study. In addition, most comparisons made in the results (multivariate analyses) take into consideration ''age'' and ''gender'' variables to further reduce the effects of the sampling bias.

III/ Social networks analysis: quantitative survey of services

a) Purpose of the social networks analysis
The social networks analysis (SNA) was integrated into the assessment to specifically highlight existing relationships between the territory's various stakeholders and between service providers in particular. This innovative approach, increasingly widespread in the fields of health and sociology, reveals how the position occupied by an actor in a given network influences their level of access to financial and technical resources and to information circulating within the network. In fact, stakeholders generally establish links with other stakeholders to optimise their access to existing resources and opportunities and to maximise their potential benefits (Clark, 2006). They often unconsciously form groups of stakeholders within which the best informed are often the best positioned, and vice versa. The stakeholders with the broadest access to information very often belong to several groups of stakeholders, providing them with a certain power due to the intermediary role they play in helping less well-positioned stakeholders. As such, the SNA enables us to visualize the organisation and formation of these exchange dynamics at a local level.

b) Modelling the local network

Data was collected from various service providers to analyse the territory's health and social services network. We asked them to describe their links with other local stakeholders who have links with them, including other service providers, devolved government services, local authorities, disabled people's organisations, private sector companies, co-operation agencies, churches and coordination platforms.

Each link was defined according to:

► its nature (technical support, financial support, user referral and information exchange)
► its level (1=low, 2=medium, 3=high)
► its direction (X to Y or Y to X)

The network revealed had a total range of 306 nodes (g=306), of which we analysed, more specifically, the 183 health and social service providers mentioned, including: 48 health service providers; 74 education service providers; 17 providers of professional training or employment support services; 36 providers of social services and programmes; 8 providers of other types of services (sport, leisure, etc).

The information gathered was codified then modelled using the NetDraw software to visualize the existing interactions between the territory's various stakeholders.
These network analyses enabled us to consider various intensification and diversification strategies for inter-stakeholder exchange flows, based on the existing social system, to generate social capital at a local level. The analysis also provided a considerable amount of quantitative data on existing services, including the sector breakdown, setting-up period, sources of financing, physical accessibility conditions, level of staff training, etc.

IV/ Analysis of the stakeholder system - in-depth interviews with the territory's stakeholders

The final qualitative stage was based on individual interviews with **42 key stakeholders involved in the health and social development field in Maputo and Matola** who contribute directly or indirectly to the mainstreaming of people with disabilities in the territory:

► 18 disabled people's organisations;
► 14 devolved government services;
► 6 local authority services in the territory;
► 4 networks and co-ordination systems[1];

These semi-open interviews lasting an average of two hours provided an opportunity to collect data on the actions taken or planned by the different entities and their recommendations for promoting the social participation of people with disabilities at a local level. They also enabled us to analyse in greater depth the **balance of power and dynamics underlying the approaches taken by stakeholders at a local level**.

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[1]The list of different institutions involved in these interviews appears in the attached appendix.

Characteristics of the area studied

I/ A changing urban environment

a) Extremely rapid demographic growth in Maputo and Matola

Sub-Saharan Africa has one of the world's highest rates of urbanization and will become more urban than rural over the next 30 years (Baker, 1997). Mozambique is not immune to this dynamic. Its towns and cities, and especially its capital, have experienced extremely rapid demographic and spatial growth over the last forty years. The former colonial capital Lourenço Marques - renamed Maputo - only had 375,000 inhabitants when Mozambique was granted independence in 1975. The conurbation formed today by the cities of Maputo and Matola has a population of some 1,800,000, according to the last census in 2007 (1,094,315 in Maputo and 672,508 in Matola). This demographic leap is mainly due to the doubling of the population of the city of Matola, once an industrial suburb of the capital, which has gradually "collided" with its neighbour Maputo over the last twenty years. Matola is now considered to be the country's second largest city behind Maputo and the urbanised *continuum* formed by the two cities is home to almost 50% of Mozambique's urban population.

This demographic explosion is due to five key factors (Serra, 2005):

► national independence combined with the nationalisation of private rental properties in 1976, gave Mozambicans once confined to the *city of reeds* access to the *concrete city*;
► the civil war and the consequent massive displacement of the population from the countryside to urban centres;
► the return of refugees following the Rome Peace Accord in 1992, and their resettlement in the country's major metropolitan areas, in particular Maputo;
► the gradual decline in living conditions in the countryside and the resulting rural exodus;
► the slowing of economic migration towards neighbouring countries in the 1990s, and sometimes the repatriation of Mozambican workers.

b) Recent explosion in urban poverty

The city has been considerably transformed, from Lourenço Marques, a spatially and racially segregated city during the colonial period, to modern day Maputo, the showcase for an urban experiment during the country's socialist era. Poverty in Maputo exploded at the country's liberal turning point in the mid-1980s, due in particular to structural adjustment plans that weakened entire areas of the economy and led to the widespread impoverishment of the working classes. This urban poverty was considered to be a new phenomenon. Until then, poverty and its causes were more directly associated with living conditions in rural areas exposed to the vagaries of the weather, war and low labour productivity levels (Lachartre, 2000).

As a direct consequence of the rise in socio-economic inequalities, the ''liberalized'' city rapidly consolidated around two asymmetric centres:

► a relatively uniform city centre, criss-crossed by wide avenues and replete with concrete residences protected by gates, electronic security systems and private gardens, surrounded by hotels, bureaux de change, restaurants, cafés, patisseries, supermarkets and other service centres;

► and an expansive outlying area consisting of multi-form residences, gradually replacing the former ''city of reeds'', with its congested roads, street hawkers, stalls, public rubbish dumps and minibuses, a world of social exclusion and cultural complexity, movement, interaction and the constant mixing of cultures.

c) A context in which social groups are particularly vulnerable

Although the main consequence of the liberalization process initiated in the 1980s was the transition towards a market economy and the transformation of the urban economy (the rise of the informal economy, a female workforce, alterations to the land structure, urban agriculture, etc.), it also gave rise to a series of new social phenomena made possible and accentuated by the city which profoundly altered the nature of its social fabric. Urban anthropology reveals how, for a variety of reasons, these phenomena (Lachartre, 2000) collectively loosened the authority of the state, its local representatives and the family over the individual (Lachartre, 2000). The results of this liberalization take multiple forms, including the splintering of the family unit, an increase in single-parent families, and a rise in the number of street children.

Liberalization leaves the individual to his or her own devices and resources in order to survive and manage their own life. At the same time, the city, seemingly open to everyone, generates exclusion and social decay mechanisms that marginalize vast segments of the disadvantaged population. They include the most vulnerable groups, no longer able to rely on the support of a social framework offering adequate protection in a weakened community - single women, isolated older people, isolated children, the unemployed, and people with disabilities.

d) Interaction between poverty, social exclusion and disability

Although we consider disability to be the result of an interaction between personal and environmental factors in relation to everyday activities (Fougeyrollas, 2006), poverty is still a significant aggravating factor. Poverty can directly or indirectly lead to disability since poor people are less likely to have access to preventive or curative healthcare and more likely to suffer from a poor diet, to be inactive, use a dangerous transport system, etc. In this sense, it can be said that there are more people with disabilities among the poorest segments of the population than the richest (Elwan, 1999).

Conversely, if the disability occurs in later life, it can, in return, lead to the social exclusion and impoverishment of people who were not previously affected by these problems. Due to a poorly adapted environment, a person with disabilities may, for example, lose their ability to perform a professional activity. Their family may suffer a substantial loss of income due to the extra time spent taking care of the disabled person or

Characteristics of the area studied

the additional burden on the family budget (compensatory equipment, medication, other services, etc). In this instance, poverty and disability perpetuate a vicious cycle and become mutually reinforcing.

II/ The nine outlying neighbourhoods studied

a) Neighbourhoods located far from major centres of economic activity in the metropolitan area

Bordered to the east by the Indian Ocean and the south by the Espírito Santo estuary, there are no natural obstacles to the expansion of the metropolitan area to the north and west. These outlying neighbourhoods, originally designed to relieve the pressure on the *concrete city*, are where most new arrivals, very often from the countryside, settle in search of a better life. Located to the north of district 5 of the municipality of Maputo (Zimpeto, Jorge Dimitrov, Malhazine and Magoanine A, B and C) and to the east of the municipality of Matola (Khongolote, Ndlavela and T3), the nine neighbourhoods surveyed have a total of 205,043 inhabitants, representing 11.6% of the total population of the metropolitan area. They constitute a buffer zone between Maputo and Matola, crossed by a Green Area of fertile peri-urban agricultural land and the No.1 national highway linking Maputo to the north of the country. They were both affected by the violent explosion of the military arsenal in Maputo in March 2007, which left 83 people dead, 350 injured and caused extensive material damage.

These outlying areas are mainly home to people from the country's various provinces, giving rise to a mixing of cultures and identities, midway between the rural and the urban. The expanding city also generates a permanent exchange between the old and the new, creating profoundly allotropical operating methods and value systems (Serra, 2005). These suburban residents may visit a traditional healer as well as a local hospital or health centre, appeal to alternative judicial authorities and visit the police station, etc. The sociological profile of the population living in these neighbourhoods is therefore relatively distinct from that of people living in the city centre.

b) Inadequate and saturated basic facilities

Without urban regulatory mechanisms, the speed with which this expansion is taking place, and the pressure on property resources resulting from it, has made it difficult to deploy and expand the basic utility networks (water, sanitation and electricity). Aguas de Moçambique - a state-controlled water company - does not serve these peri-urban neighbourhoods. As a result, water is supplied exclusively by small private operators with limited capacities and varying health standards. Rubbish collection is performed by unofficial collectors in a relatively random fashion.

The area also suffers from a lack of health and social service facilities which are unable to meet the population's growing needs. There are only four main health centres (an average of one for every 50,000 inhabitants) and 13 secondary health centres (an average of one for every 15,000 inhabitants). In addition, each of the 33 primary and secondary schools in the area is attended by an average of 2,330 students, representing 85 students per class, particularly in *expanding neighbourhoods* such as Khongolote and Ndlavela. There are no specialised services in the area to meet the specific needs of people with disabilities, including orthopaedic services and suppliers of compensatory equipment. The lack of physical rehabilitation services is particularly striking.

Summary

The cities of Maputo and Matola have experienced an unprecedented period of demographic and spatial growth over the last thirty years. This rapid urban growth, combined with an increase in social inequalities in a liberalized society, has given rise to the **marginalization of neighbourhoods located on the outskirts of the metropolitan area.**

The impoverishment of the most vulnerable sections of the population in these neighbourhoods, which are located far from centres of economic activity and lack adequate health and social services, is a major cause for concern. These populations include **people with disabilities who experience considerable difficulties** in adequately addressing their most basic health and social needs.

Social representation of disability

Social representation of disability

I/ The causes of disability: group beliefs and representations

a) Disability is primarily considered to be an illness

The majority of people interviewed during group discussions associate disability primarily with the impairment's medical dimension. Disability is first and foremost perceived as an illness that is "caught", mainly during childbirth. Hearing, visual and physical impairments are mainly seen as hereditary or congenital deformations resulting from an incestuous relationship between related parents or complications arising during childbirth. Some recognise that disability can also occur later in life in a sudden and traumatic way (accident, war wound, post-operative complications, etc.) or as part of a more gradual, degenerative process (disabling disease, consumption of alcohol or drugs).

When members of the community are invited to express their opinions on the causes of disability, the discourse surrounding the transmission of HIV plays an implicit role in their understanding. Largely aware of HIV's transmittable, irreversible and disabling nature, and the need to protect oneself against a widespread risk, some individuals appear to have gradually internalized the same approaches to disability. There appear to be obvious similarities between the two issues and, subconsciously, disability is often understood as potentially contagious and transmittable from one individual to another, from mother to child, etc. From a hygiene perspective, it would therefore appear more sensible to isolate people "infected" with an impairment to safeguard "healthy" members of the community.

b) Popular beliefs have a profound formative effect on group representations

Above all, however, community beliefs are dominated by a misunderstanding of the causes of impairments, often opening the way to other forms of interpretation rooted in traditional culture, especially in outlying neighbourhoods mainly inhabited by people recently arrived from rural areas. When it comes to examining the causes of disability, social discourse provides explanations far detached from scientific rationalism, such as curses, destiny, ill fate, or simple bad luck. Numerous myths and popular beliefs support group representations in attempting to explain the occurrence of a disability in an individual or a family, based on three particularly formative representational factors:

► Divine intervention to punish the vices or amoral behaviour of parents:
  - *"Rich families are punished for their greed and that's why they give birth to disabled children."*
  - *"If the firstborn of a rich family is born with an impairment, it is considered to be the supplier of riches, a voluntary sacrifice agreed by the father of the family with the curandeiro (witch doctor) to ensure the family's future prosperity."*
  - *"A child is born with an impairment to punish the mother's infidelity".*

► A disagreement between enemies settled through black magic:
  - *"Some say that it's the result of a disagreement between neighbours, the result of revenge between members of the community."*
  - *"The impairment is often invoked by a curandeiro when someone wants to take revenge on an enemy. He doesn't ask him to kill him, but to give him a disability to cause him harm, by paralysing one arm, for example."*

► A curse of mystical origin:
  - *"Someone who looks at an albino person and swallows their saliva at the same time will give birth to a disabled child"*
  - *"When a child gets too close to the peneira (a place where millet is heaped) he will become deaf."*
  - *"When a pre-pubescent child walks around a house without capulana (a traditional material), it is said that they will have disabled children when they get married."*

- *"It is often said that an amputee loses part of their spirit because part of their body is already in the afterlife."*
- *"A soldier who does not visit his wife during leave will get a bullet in his leg when he returns to the battle field."*
- *"It is said that when an albino person dies, their body disappears forever from the face of the earth."*

These beliefs and myths play a socially-regulating role: women need to look after their children, children should not mock people with disabilities, men should be faithful, neighbours should remain on friendly terms, etc. Disability is therefore a threat to which you expose yourself if you deviate from certain standards and moral behaviour. Although they are given more credit among the more disadvantaged social classes, these popular beliefs are obviously deeply rooted in the collective imagination and go beyond social class.

c) The appearance of disability experienced as a fatality

After the birth of a disabled child in a family, the wife is frequently simply abandoned by her husband. She is generally held responsible for the newborn's impairment (due to inappropriate behaviour during pregnancy, supposed infidelity or a less "pure" family lineage than her husband's). If the impairment appears later in life, it generally also gives rise to rejection or exclusion by the family unit itself. The husband who suffers an amputation is, for example, perceived as a lesser individual, potentially unable to provide for the needs of his family.

Families very often react by consulting a curandeiro in the days immediately following the appearance of the impairment (after birth or an accident, etc.) in an attempt to mitigate or remove it via a "purification" ritual and a specially-prepared remedy (macumba). If a father commits incest with his daughter, people resort to the curandeiro even before the birth of the child to avoid the risk of a congenital deformity caused by consanguinity. The treatment of impairments represents a particularly lucrative source of income for curandeiros (as are HIV/AIDS treatments), a service mainly provided to distressed families with no alternative but to put themselves in the hands of witch doctors and traditional healers, in the absence of a sufficiently accessible and effective conventional medical service.

Social representation of disability

II/ Acceptance of people with disabilities in society

a) People with disabilities are sometimes hidden away by their own families

Faced with a sense of shame, some families even go so far as to hide their disabled child, brother or parent and keep them from the community's gaze. ''I know families who don't bring their disabled relatives to church because of what the other worshippers might think of them.''

Some openly oppose the marriage of a family member to avoid tarnishing their family's reputation or because they are not considered sufficiently capable of ensuring the material welfare of a household.

However, it is mainly the lack of appropriate case-management solutions (day-care centres, schools, training centres, adapted workstations, etc.) that leads families to keep the disabled person at home, especially when the impairment leads to a high level of dependence. If they are unable to socialise with the outside world, it is difficult for them to be included in society or to perform activities involving other people.

b) An environment that often fosters discrimination

Implicit in the social mainstreaming problems experienced by people with disabilities (holding down a stable job, studying, founding a family, finding sanitary accommodation, etc.) is the fact that, first and foremost, they are victims of prejudice within their own communities. The disabled persons interviewed frequently mentioned the scorn, contempt and even rejection they suffer at the hands of their fellow citizens in their neighbourhoods, in stores, on public transport, in schools, businesses and in the marketplace (when they are able to travel there). For children, this may include exclusion from games in the playground or in the street. One mother told us how, when she took her son to play in the street with the other children, their mothers rushed to warn them to keep away so that they ''didn't become mad too.''

Moreover, it appears to be common practice for people with disabilities to be labelled with particularly humiliating nicknames by people in the street or their neighbourhoods, often in reference to their type of impairment: *cocho, chimbunia, chigono, chikhurumba,* etc. Minibus drivers often ask people wishing to board with a wheelchair to pay double the fare, unless they simply leave them stranded on the roadside to avoid losing time. Some people go so far as to ask for money in the street in exchange for performing the most minor service, such as crossing the street, carrying a grocery bag or reading a sign.

c) The temptation of self-exclusion

Faced with the multiple forms of discrimination of which they are victims in the outside world, some of those surveyed have resigned themselves to their situation and chosen to exclude themselves from society. Because of a lack of self-esteem or the difficulty of accepting their impairment, they prefer to isolate themselves from the rest of the community rather than to enter into contact with the outside world, including their neighbourhood, social and community structures, services, etc. This stigmatization gives rise to numerous psychological disorders in the marginalized individual, often leading to the development of an inferiority complex, a lack of confidence in their own abilities, and a sense of resignation. ''Very often, people with disabilities exclude themselves from the community. I know someone who stays locked in his room because he is ashamed to leave.'' Many consider that they need to accept themselves first before they can turn to others.

d) Certain personal factors appear to increase or mitigate social discrimination

► The type and degree of impairment

Some impairments appear to be more stigmatizing than others. Intellectual or mental impairments or even albinism are considered as the most stigmatizing in the territory surveyed. In the same way, the more severe the disability, the more the person is excluded from their environment.

► Age

Age is also considered to be a determining factor. Families appear to help and stimulate disabled children to wash themselves, go to the toilet or walk around the home more spontaneously than disabled adults, who are sometimes gradually marginalized and no longer take part in the family's everyday activities. Disabilities increase with age. The older a person with disabilities gets, the more dependent they become, increasing their exclusion.

► Gender

Women with disabilities mostly suffer from a double discrimination at the hands of their family network and society as a whole in accessing education, employment and leisure services. Moreover, they are particularly at risk from sexual abuse. ''I know men who abuse women with disabilities to satisfy their sexual desires.'' Rape situations, which some women spoke about during our survey, are evidence of their extreme vulnerability to the risk of unwanted pregnancies or infection with sexually transmitted infections.

► The socio-economic situation of disabled people and their families

People with disabilities are more likely to be accepted by their communities if their family has the resources to meet their ordinary and specific needs and ensure their self-reliance with regards to the rest of the community. A rich family can pay a home help to take care of their disabled child while they are at work and buy compensatory equipment to enable them to move around their neighbourhood. Lastly, if the person with disabilities works or studies, it will be easier for them to consider themselves as ''normal'' and to be regarded as such.

III/ Community resources to promote social mainstreaming

a) Mutual assistance and charity mechanisms within the community

The primarily medical view of disability and the widely held belief that people with disabilities are passive individuals, bound by fate and deprived of their capacity to achieve self-reliance, leaves the field open to essentially assistance-based actions. This charitable approach, often driven by the message of compassion relayed by religious movements present in many of these working class neighbourhoods, reinforces the mechanisms by which people with disabilities remain dependent on their families and communities. Several associations and churches provide direct material assistance, including clothing, medication and food to people with disabilities, outside the framework of a social support strategy.

Although harmful to the personal development of the disabled person, who should be encouraged to realize their own potential, these mutual assistance mechanisms are nonetheless essential to ensuring local solidarity and social cohesion. For some, it would be less difficult to live with a disability in the outlying neighbourhoods than in the city centre. Although basic services are less easy to access, mutual assistance is more spontaneous than in the *concrete city*, where it is constrained by anonymity and individualism.

b) Family perceived as the principal means of mainstreaming people with disabilities

For all of the groups surveyed, the family is unanimously regarded as the main means of socializing and including people with disabilities within the community. The family is the first to take responsibility for a disabled person, taking care of them on a daily basis and assisting them in their environment. Social inclusion must therefore be examined and developed first and foremost within the family unit.

However, due to the socio-economic weakness of some family units, the government, local authorities, associations and churches are called upon to create the necessary conditions to enable them to meet the needs of their disabled family member (services, social welfare systems, compensatory equipment, etc.)

''For me, people with disabilities should be cared for by their family, first and foremost. But our means are limited and we need outside support services to help us. We should be able to rely on other stakeholders, like the government or civil society.''

Socio-economic situation

Socio-economic situation

To highlight the difficulties faced by people with disabilities in the territory, we set out to define their socio-economic profile and to compare it with the rest of the population. The key data collected during our quantitative surveys are detailed below, complete with a number of analyses.

I/ Prevalence of disability and types of disabilities

a) How many people with disabilities live in the territory?

The definition of disability varies so much between one institution and another and depends so heavily on the methodology used that it is always difficult to answer this question. We used six Washington Group questions to help us compare our research with other existing studies. These questions are generally used to determine the disability prevalence rate in a given population. Based on the data collected, several indicators revealing the disability situation in the peri-urban neighbourhoods of Maputo and Matola have been selected for our purposes:

► The percentage of people aged 5 and over meeting the Washington Group criteria[2] :

- **5%** [4.5–5.5%] **of the population has at least one disability**, representing between 9,200 and 11,300 people in the nine neighbourhoods surveyed (see the blue circle in the graph).

- The extrapolation of this figure to the metropolitan area as a whole enables us to estimate **the number of people with disabilities living in Maputo and Matola at between 79,500 and 97,200**.

► The percentage of people aged 5 and over who answered two additional questions relating to an activity limitation:

- **3.5%** [3.1–3.9%] **of the population has had an activity limitation for at least six months** (see groups 2 and 2' on the graph).

► The percentage of people aged 5 and over meeting the Mozambique national survey (SINTEF 2007) criteria:

- **3.8%** [3.4–4.2%] **of the population had at least one intermediate level disability ("a lot") or two minor disabilities ("a little")**

► The percentage of people aged 5 and over with an amputation and who had experienced difficulties:

- **0.12%** [0.06–0.22%] had an **upper-limb amputation**, around 250 people in the nine neighbourhoods surveyed.

- **0.29%** [0.19–0.44%] had a **lower-limb amputation**, around 600 people in the nine neighbourhoods surveyed.

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[2] According to the WG methodology, if a person gave at least one affirmative answer to the screening questions they are considered to have a disability.

[3] SINTEF standard.

In accordance with the diagram below, we will now consider two distinct subsets of people with disabilities in the following analyses:

► **Group 1** consists of people with disabilities defined by the Washington group, without an activity limitation:

- **2.3%** [2–2.6%], representing between 4,000 and 5,200 people in the nine neighbourhoods surveyed.

► **Group 2** consists of people with disabilities defined by the Washington Group with an activity limitation lasting at least six months, to which we have added people from **Group 2'** who have an activity limitation but who do not have a WG disability

- **3.5%** [3.1–3.9%], representing between 6,200 and 7,800 people in the area. This is the most vulnerable group of people with disabilities.

Impairments (WG)
5.0%

Activity limitation,
more than 6 months
3.5%

Amputation
of a lower limb
0.29%

Group 2

Impairments + activity limitation
2.7%

Group 2'

Activity limitations
without impairment
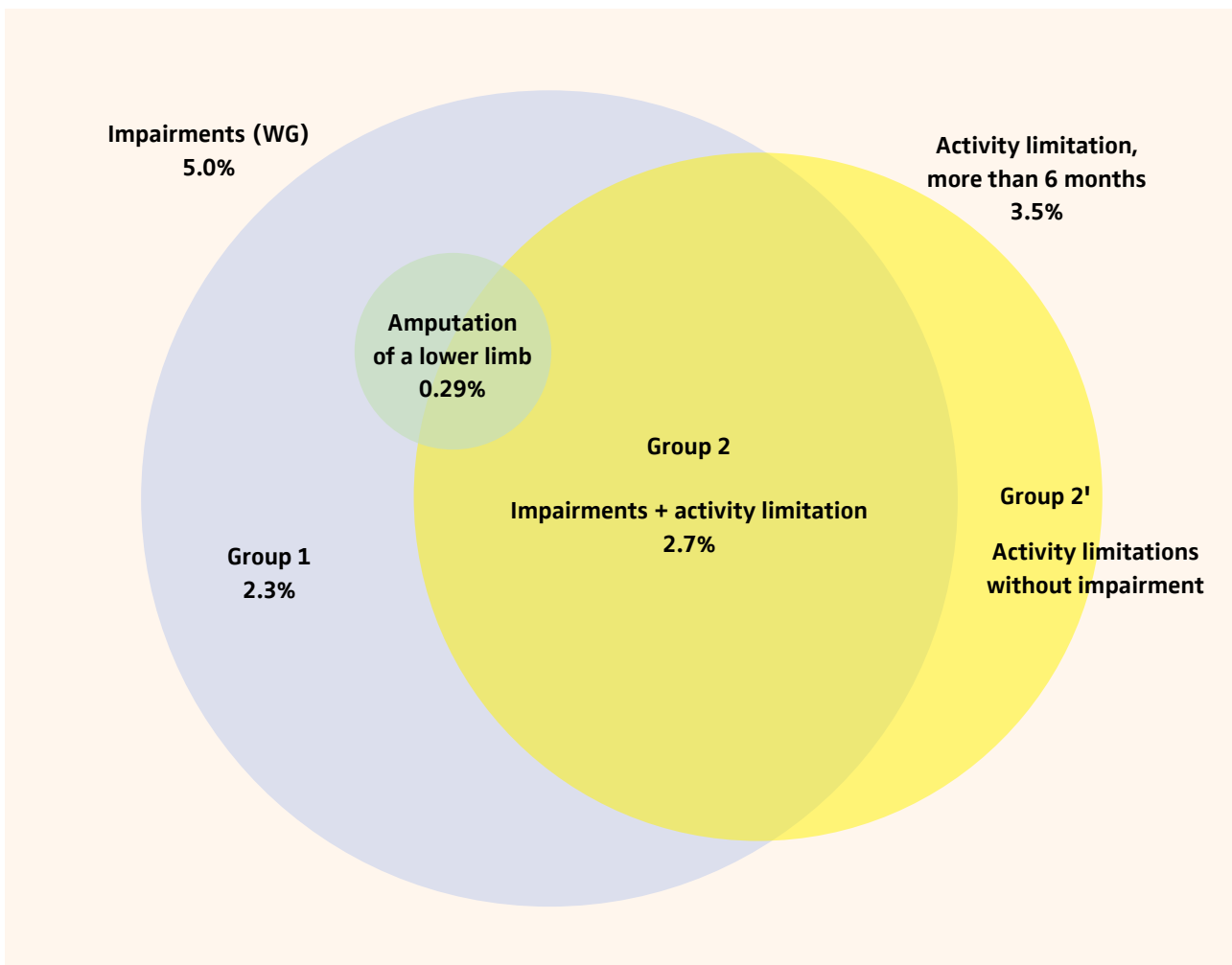
Group 1
2.3%

Socio-economic situation

b) What impairments do people with disabilities have?
To answer this question, we analysed the answers given to the six Washington Group questions by people aged 5 and over.

	No impairment	Slight impairment	Major impairment	Totally disabled	Total
Q1 - Visual impairments	97.4%	1.08%	1.46%	0.10%	100%
Q2 - Hearing impairments	99.1%	0.47%	0.38%	0.06%	100%
Q3 - Mobility impairments	97.8%	0.61%	1.09%	0.48%	100%
Q4 - Memory or concentration problems	98.9%	0.53%	0.57%	0.02%	100%
Q5 - Problems taking a bath or dressing	99.3%	0.29%	0.22%	0.17%	100%
Q6 - Problems understanding or being understood	99.4%	0.29%	0.25%	0.06%	100%

The people screened during our survey primarily had **visual impairments** (2.6%), although total blindness was rare (0.10%). Although most of these impairments can be remedied, they cause major problems in performing day-to-day activities in the absence of ophthalmologic services or sufficiently accessible compensatory equipment.

Mobility impairments are judged to be the most problematic, with 1.57% of people interviewed finding it very difficult or even impossible to move around their immediate environment due to their physical state. These impairments are often linked to paralysis, lower-limb amputation, or the consequences of disabling diseases.

Memory/concentration problems and difficulties understanding or making oneself understood generally associated with an intellectual disability affected 2.1% and 0.6% respectively of the population surveyed and are more frequently observed among older people.

Hearing impairments affected 0.9% of the population, representing approximately 1,900 people in the area.

Lastly, 0.7% of people surveyed expressed **problems taking a bath or dressing themselves alone** and therefore depend on the help of a third person for their daily personal and hygiene requirements, which gives an idea of the problems encountered in terms of dependency.

II/ Gender and age

a) The disabled population is generally older...

The average age of people with disabilities screened during our survey is 36.8 [34.9–38.7] compared with 21.0 years [20.7–21.4] for the rest of the population. The average age difference is therefore considerable between these two groups, which is logical given that a large number of disabilities develop later in life, as the person ages. The older we are, the greater the probability that we will be disabled.

Age pyramid of interviewed people
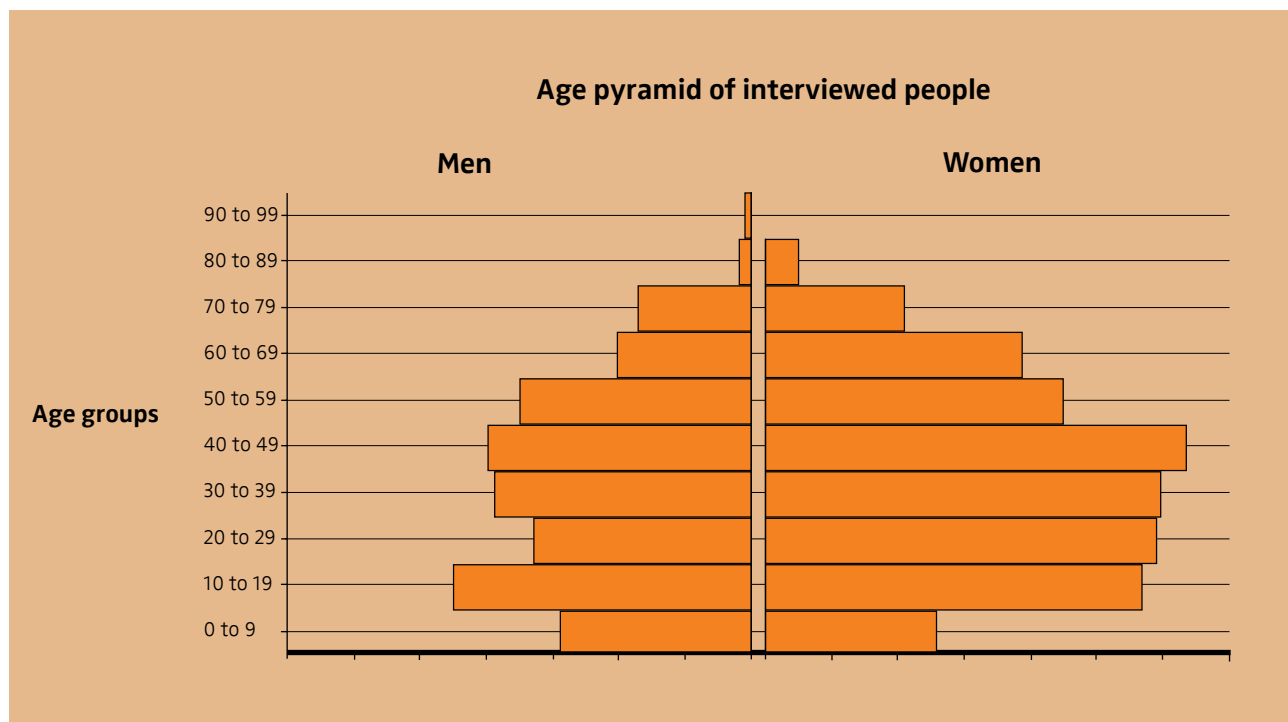
b) ...and more likely to be female than the rest of the population

As well as being older on average, people with disabilities in the area are also generally more likely to be female than the rest of the population. The masculinity ratio is 0.87 for the population surveyed as a whole compared with only 0.75 for people with disabilities and higher for women in all age ranges. For every 100 women with disabilities, there are ''only'' on average of 75 men: women are more often affected by disability than men and disability has a greater impact on them, given the discrimination to which they are subject.

Socio-economic situation

III/ Family situation

a) Civil status

People are less likely to be single as they grow older and men are more likely to be single than women. **Disabled people are twice as likely to be single** as the control group (OR = 1.8 [1.2–2.8]).

As with marriage, people of both sexes are more likely to be in a **marital relationship** as they grow older. In contrast, the rate does vary according to disability: at the same age, people with disabilities are only around half as likely to be in a marital relationship as other people (OR = 0.47 [0.35–0.64]).

Widowhood also increases with age, for both sexes, but is twice as common among people in disability groups as other people at the same age.

Divorce and separation rates increase with age and are ten times higher among women than men at the same age. There is no link between divorce, separation and disability.

b) Household structure

The average **number of children per household** is 6.2 (IC = [6.0–6.4]). This number is significantly higher in households with people from the most serious disability groups (group 2 > group 1 > general population), although to a moderate extent (6.5 children in group 2 compared with 5.9 children in the control group).

For people aged over 15, the likelihood of being the **head of the family** increases with age, with men twice as likely to be the head of the family. Disability does not make a significant difference in this respect.

IV/ Level of education

a) Level of education attained

Based on a comparison between people with disabilities and the rest of the population in the territory, the breakdown of maximum education levels is as follows:

Level of education attained			
	Non-PWD	**PWD**	**Total**
None	11.8%	21.9%	17.7%
Primary	57.1%	59.5%	58.5%
Secondary	27.2%	16.9%	21.2%
Higher	0.0%	0.4%	0.3%
Technical	2.1%	0.8%	1.4%
Special school	1.8%	0.2%	0.9%
Other	0.0%	0.2%	0.1%
Total	**100.0%**	**100.0%**	**100.0%**

Around 22% of people with disabilities have never been to school compared with less than 12% of the rest of the population, highlighting the difficulties involved in finding appropriate educational solutions for almost one in four disabled persons.

For people who have had access to education, the percentage of those attending primary school is more or less identical for people with disabilities and the rest of the population (59.5% compared with 57.1%).

However, there is a considerable rise in the number of people with disabilities disengaging from the system between primary and secondary school. **Although around 78% of them say they attended primary school, only 16.9%** went on to secondary school compared with 27.2% for the rest of the population.

It is particularly rare for people to continue their studies beyond secondary school in these outlying neighbourhoods since only 0.4% and 0.0% respectively of people with disabilities and the rest of the population went on to enjoy a higher education (Baccalaureate, Degree, Masters, Doctorate).

The level of schooling is gradually improving for the youngest generations, even if, at the same age, women and people with disabilities remain acutely disadvantaged.

b) Ability to read and write

Besides differences in educational levels, there are major disparities between people with disabilities and the rest of the population as regards declared ability to read and write.

Able to read and write (15 and above)				
	Men	**Women**	**Together**	**p**
Non-PWD	94.4%	71.3%	81.6%	<0.001
PWD	82.0%	60.0%	69.1%	<0.001

There is a gap of 10 to 12 percentage points, on average, to the disadvantage of people with disabilities of both sexes. There is a gap of 20 percentage points between men and women. **Literacy is therefore less common among women and far less common among women with disabilities, based on a cumulative effect**: only 60% of women with disabilities know how to read and write compared with 94% of men without disabilities.

Socio-economic situation

The following diagrams show that the **interactions between gender and age** have a considerable impact on literacy levels:

► For people without disabilities, there is a gradual reduction in gender-related discrimination over time, due to a spectacular increase in literacy among the youngest women (50% literacy among 50-59 year olds compared with over 90% of women in the 10-19 age group, with an average rise 2% to 5% each year). The rapid rise in education levels among the younger generation is due to the proactive education policies applied in Mozambique over the last 20 years.

Literacy rates for people "without disabilities"
according to age and gender

Literacy rate

Source : SIPS survey
RAVIM - Handicap International, Mozambique 2009

Men   Women   Age in years
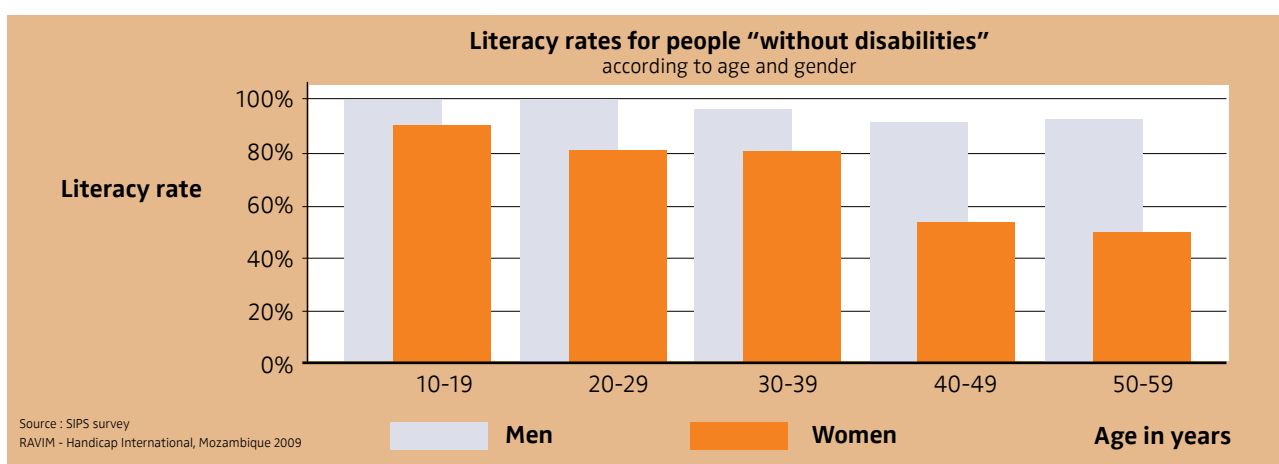
► Literacy levels are significantly lower among disability groups than the rest of the population, for both men and women. There are very few differences between men and women below the age of 40, although little progress has been made from one generation to the next, unlike the population as a whole. It appears that people with disabilities are not benefiting as much as the rest of the population from recent educational advances in Mozambique:

Literacy rates for people "with disabilities"
according to age and gender

Literacy rate

Source : SIPS survey
RAVIM - Handicap International, Mozambique 2009

Men   Women   Age in years
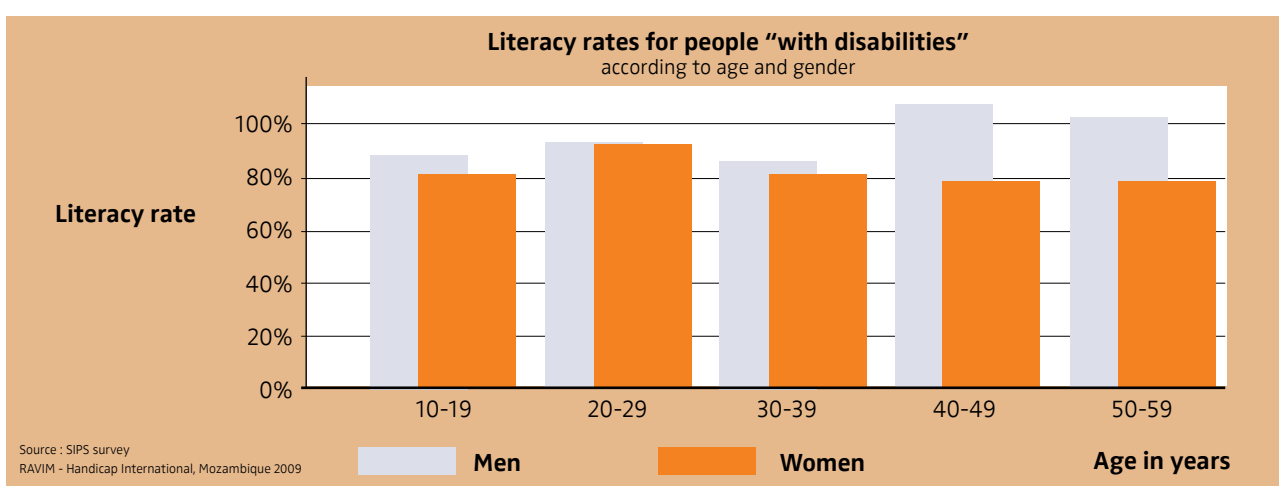
If we compare this data with the previous figures on primary education, which are almost identical for people with disabilities and the rest of the population, we can conclude that people with disabilities and particularly women leave the primary school system, on average, with a lower level of literacy than the rest of the population. This would suggest that their education was less effective, due to their specific educational needs not being taken into account by the current school system or because they leave school at the primary stage without having mastered the basics of reading and writing.

c) Linguistic profile

Fewer people with disabilities (OR = 0.54 [0.35–0.82]), of the same age and gender, **speak Portuguese than the rest of the population.** This difference is probably due to the fact that schools remain the key means of learning Portuguese in Mozambique (in reality, few people speak Portuguese as their mother tongue, especially in these expanding neighbourhoods) and there is a very close correlation between a person's level of education and their ability to speak Portuguese. Since people with disabilities have, as a whole, a lower standard of school education than the rest of the population, it is not surprising that they express themselves less in this language than others, constituting a first obstacle to accessing information.

Speak Portuguese	Yes	No	Total
Non-PWD	88.2%	11.8%	100.0%
PWD	77.1%	22.9%	100.0%
Total	**81.7%**	**18.3%**	**100.0%**

However, although a large proportion of people surveyed say they speak Portuguese (81.7%), **Changana is still the language most people speak at home:** 55% say they speak this language with their family[4]. The pre-eminence of Changana over Portuguese and other regional languages in peri-urban neighbourhoods is explained by the sociology of the population, most of whom recently arrived from rural areas where Portuguese is less present than in the capital and the overall level of education is less high.

Age	Portuguese	Changana	Bitonga	Chope	Other	Total
5-19	48%	43%	1%	3%	5%	100%
20-39	39%	53%	2%	3%	3%	100%
40-59	27%	62%	3%	3%	5%	100%
60-79	15%	65%	5%	8%	7%	100%
80-99	0%	100%	0%	0%	0%	100%
Total	**35%**	**55%**	**3%**	**4%**	**4%**	**100%**

However, **Changana is being gradually replaced by Portuguese among the younger generation**, probably due to an increase in schooling and literacy rates over the last twenty years (a rise of around 10 percentage points from one generation to the next). Because people with disabilities are, on average, older and less well educated than the rest of the population, they remain relatively detached from this dynamic and generally continue to express themselves more in Changana than the rest of the population.

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[4] The opposite is true for the city of Maputo as a whole: 55.2% of inhabitants speak Portuguese at home, compared with 31.4% for Changana (INE data, 2007 census).

Socio-economic situation

V/ Professional profile and activities performed

a) Main activities performed

The following table sets out the main activities performed by respondents. It reveals the professional situation of people with disabilities compared with the rest of the population. Based on the idea that a salaried position offers more benefits and security than self-employment (very often in an informal context) or voluntary work, it provides an indirect insight into the economic situation of people with disabilities.

Main activity (15 years and over)	Non-PWD	PWD
Salaried employment	20%	10%
Self-employed	18%	13%
Unpaid work, voluntary work	2%	2%
Student	14%	9%
Homemaker	36%	37%
Retired	1%	6%
Unemployed (due to ill-health)	1%	17%
Unemployed (for other reasons)	4%	4%
Other	3%	3%
Total	**100%**	**100%**

People with disabilities are only half as likely to be salaried employees (10%) than people without disabilities (20%). There is also a strong gender link, since men are six times more likely to be salaried employees (27.1%) than women (4.4%), whatever their age or disability situation. The following table shows that a combination of two factors (disability+female sex) incrementally puts women with disabilities at a major disadvantage:

Salaried employment (15 years and over)		
	Men	Women
Non-PWD	37%	6%
PWD	19%	3%

Self-employment status is not linked to age or gender. A person's disability group has a smaller impact on self-employment status than salaried employment status, although there is still a ''deficit'' for this status among the two disability groups. There is a significant difference for Group 2 (for the same age and gender):

Self-employment (15 years and over)	
Non-PWD	18%
Group 1	17%
Group 2	10%

Homemaker status is not significantly linked to disability, but heavily influenced by gender. Women (48%) are much more likely than men (9.8%) to perform this activity. Women are 10 times more likely to be homemakers than men of the same age (OR = 9.9; [6.5–14.9]).

Retiree status currently only generally concerns very few people in the population as a whole (3.3% [2.1–4.7%]). However, at the same age and official retirement age, men are fifteen times more likely to be retired than women (OR = 14.7 [3.9–55.2]). The difference between men and women is so high because a lot of women who reach retirement age (55) but who cannot claim a pension probably continue to identify themselves as homemakers or self-employed (both statuses very often include workers in hidden unemployment). Moreover, most of the very small number of people who receive a pension occupied a formal salaried position (and are therefore more likely to be men, as shown above) or were former combatants in the war of liberation or the civil war (mainly men as well). On the other hand, there is no significant difference between disability groups.

Retirement at legal retirement age		
	Men>60 years	Women>55 years
Non-retirees	60.5%	96.1%
Retirees	39.5%	3.9%

Socio-economic situation

b) A much higher unemployment rate than the rest of the population

We can get a much more accurate picture of the actual unemployment rate by counting only those who are presumed to be in the labour force (salaried employees, the self-employed, voluntary workers and students, as defined by the ILO) and those declared to be outside the labour force (all reasons):

People in the labour force with a job and the unemployed (15 years and over)	Non-PWD	PWD	Total
Salaried employment	34%	18%	25%
Self-employment	30%	24%	27%
Unpaid work, voluntary work	4%	4%	4%
Student	23%	16%	19%
Unemployed (all reasons)	9%	39%	26%
Total	**100%**	**100%**	**100%**

As shown, **the calculated gross unemployment rate puts disabled people at a major disadvantage (39% compared with 9%)** and the probability of being unemployed increases with age. This major disparity is mainly due to three reasons:

➤ For persons of the same age and gender, people with disabilities are three times more likely to be unemployed for health reasons than the rest of the population (OR = 3.2 [2.2–4.6]);

➤ Less likely than the average person to have an academic or professional qualification overall, they find it harder to find a decent position in the employment market;

➤ Due to the discrimination they experience from formal and informal employers, they are often sidelined when vacancies arise in a context in which employment opportunities are still few and far between.

VI/ Membership of organisations

Rather surprisingly, **only 6% of people with disabilities are aware of the existence of a disabled people's organisation** (DPO). This figure is identical to that reported by people without disabilities, indicating that people with disabilities are no more likely to be aware of the existence of a DPO than the rest of the population. There is a strong link between DPO awareness and gender, with men twice as likely to be aware of this type of organisation as women (p = 0.02).

In terms of the involvement of people with disabilities in DPOs, **only 2.5% of PWDs are actually members of a DPO**, which raises major doubts about the ability of these organisations to enlist the support of their target public. Membership of a DPO does not appear to be influenced by age or gender, with equivalent figures for men and women across all age groups.

Once again, **membership of an organisation "other than a DPO"** (such as a trade union, sports club or a community organisation) **is higher among disabled people** in Group 1 than the rest of the population, and even higher among people in Group 2 (2.5% compared with 3.9% and 8.1%). Membership is higher among men than women, who are between 2.1 and 2.4 times more likely to be members of an organisation.

People in disability groups are therefore, surprisingly, more likely than other people to be part of an organisation, even though membership is still fairly low. This shows, however, that there is an untapped reserve of support among this population group, particularly for disabled people's organisations, awareness of which is relatively low in these communities.

Access to health and social services

Access to health and social services

To quantitatively assess the access conditions for existing health and social services for people with disabilities, we set out to identify, for each of the five main service categories (health, education, professional training and employment, social services and programmes, and other services),

► **the level of service knowledge, needs and usage:** the difference between the level of knowledge and the level of needs reveals the difficulties involved in obtaining information on available services; the difference between the level of use and the level of needs provides us with information about the effective level of coverage of expressed needs.

► **stated obstacles in accessing these services:** these obstacles enable us to more effectively understand the differences noted between the level of needs and the level of usage of a type of service, whether they are of an economic or environmental nature, or related to mobility or the physical accessibility of buildings.

The results are analysed below. A distinction has been made between people with and without disabilities to measure the relative vulnerability of people with disabilities with regards to the rest of the community, and between women and men to reveal any possible gender gaps.

I/ Access to health services

a) Stated level of service knowledge, needs and usage

► According to **disability**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	PWD	Non-PWD	PWD	Non-PWD	PWD	Non-PWD
Basic health services	98%		88%		89%	
Traditional medicine	45%		12%		6%	
HIV screening and treatment service	41%		27%		11%	
Psychological or psychiatric support service	30%		15%		3%	1%
Physical rehabilitation service	20%		22%	14%	5%	1%
Supplier of compensatory equipment	11%	7%	43%	15%	7%	1%

► According to **gender**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	Women	Men	Women	Men	Women	Men
Basic health services	98%		88%		89%	
Traditional medicine	45%		10%	16%	6%	
HIV screening and treatment service	41%		27%		11%	
Psychological or psychiatric support service	27%	33%	15%		2%	
Physical rehabilitation service	20%		16%	22%	1%	5%
Supplier of compensatory equipment	9%		29%	35%	4%	

Most people (around 90% of the total) use **basic healthcare services**, with no difference between people with and without disabilities. Health posts, health centres, clinics and hospitals are the first services used by households in the event of a health problem.

People use or need other facilities less frequently, according to the survey. Only 6% of people surveyed stated that they visit **medical doctors**, whereas double that number expressed a need to do so. These figures still appear surprisingly low given that there are 126 curandeiros listed by the AMETRAMO in district 5 alone, compared with only 1 to 2 medical doctors on average per public health unit.

11% of people surveyed stated that they used **HIV/AIDS screening and treatment services**, whereas 27% expressed a need to use them. There is therefore a high level of unsatisfied demand for this type of service. More worryingly, only 41% of people surveyed were aware such a service exists in their area. People with an ability limitation lasting more than six months use these services more than others (10% and 14%), which suggests that certain disabilities are directly linked to this disease.

Very few people use **psychological support services**, but there is a difference between people with an ability limitation (4% use them) and the rest (1% use them). However, among those who expressed a need (13%) to use these services, half of people with disabilities and a quarter of others were not aware of the existence of this type of service, which highlights an information access problem. Women in both groups are only half as likely to be aware of a service as men.

Unsurprisingly, the **physical rehabilitation centres** and **suppliers of compensatory equipment** are frequented more by people with disabilities (7%) than the rest of the population (1%). Among those who do not use physical rehabilitation services, a quarter of people with an ability limitation stated a need for them, while 60% were not aware they existed, regardless of disability, which is explained by the fact that such services do not exist in the area under study. Among those who do not use equipment suppliers 40% of people with disabilities and 15% of others stated a need for their services, of which the majority (85%) was not aware of their existence. The need to access equipment suppliers is therefore largely unsatisfied for people with disabilities.

b) Obstacles to accessing health services

A univariate analysis reveals that people from disability groups were affected to a much greater extent (p < 0.001) than the rest of the population by all of the environmental obstacles considered.[5] Cost is clearly seen as the major problem (for 60% to 90% of people with disabilities), far in front of physical accessibility (30%), access to information (29%) and the quality of human relations (around 25%):

Obstacles for:	Non-PWD	PWD	p
Paying for compensatory equipment	70.5%	91.3%	<0.001
Paying for medication	45.0%	68.8%	<0.001
Paying for a medical consultation	35.2%	62.5%	<0.001
Travelling from home to a health service	9.6%	32.4%	<0.001
Accessing and moving around a health centre	6.1%	29.1%	<0.001
Accessing information on health services	14.8%	28.8%	<0.001
Being well-received by health workers	12.6%	24.8%	<0.001

Although care and medication is theoretically free for the most vulnerable people with disabilities[6], the vast majority of the population finds it extremely difficult to pay for their healthcare, generating a **high price elasticity of demand**. In other words, excessively high prices very easily and exponentially discourage users, and as such hinder the deployment of preventive health strategies, which could limit the emergence or development of an impairment in certain people. The area's inhabitants only visit a health centre or hospital as a last resort, when they are very ill or when traditional medicine has reached its limits. The delay is greater when costs need to be met immediately (transport, medication, loss of working time, etc.) while the benefits are only expected in the mid- to long-term (improvement in a person's state of health or mobility, curing of an infection, etc.) (Duflo, 2008).

Travelling to a health facility remains difficult for many people with disabilities due to the lack of health units in the area (and the resulting distance to travel from home), the lack of accessible public and private transport, and the poor state of the roads (mostly untarred and covered with sand). The physical accessibility of buildings is particularly problematic considering that only 24% of health units are easily accessible from the outside and only 3% of toilets are adapted to people with reduced mobility.

Accessing information is visibly more difficult for people with disabilities than others, with the former often excluded from messages relayed by the mass media or community awareness campaigns (in particular people with a visual or hearing impairment). According to the Maputo Health Department, not a single health worker in the city has received training in sign language; there is no training plan to achieve this.

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[5]The following table is based on a univariate analysis comparing people with disabilities and people without disabilities, without taking into account gender and age. The ''p'' column shows the error probability associated with sampling fluctuations; a difference is usually accepted if ''p'' is below 0.05.
[6]In compliance with Decree no.85/2009 governing the basic social welfare system.

These communication problems have a direct impact on the **vulnerability of people with disabilities with regards to HIV/AIDS**, whereas they are more generally exposed than others to the risk of infection (sexual abuse, infusions and drug injections, promiscuity of life in an institution, etc.). They also find it harder to be included in HIV information, screening and treatment initiatives due to the lack of training for health officers, the lack of adapted IEC materials or the unfounded belief that people with disabilities are not sexually active.

II/ Access to education services

a) Stated level of service knowledge, needs and usage

► According to **disability**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	PWD	Non-PWD	PWD	Non-PWD	PWD	Non-PWD
Primary education	84%		25%		24%	
Secondary education	54%	66%	26%	36%	12%	
Higher education	20%		16%	24%	1.5%	
Technical education	21%		18%		1%	
Specialised school	9%		16%	11%	1.5%	0%
Study grant	10%		17%		1%	
Adult literacy programme	27%		22%		1%	4%

► According to **gender**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	Women	Men	Women	Men	Women	Men
Primary education	84%		25%		24%	
Secondary education	56%	63%	30%		12%	
Higher education	17%	25%	19%		1.5%	
Technical education	17%	27%	18%		1%	
Specialised school	9%		14%		1%	
Study grant	8%	13%	17%		1%	
Adult literacy programme	27%		26%	16%	2%	

Overall, people with disabilities experience little discrimination in the use of **primary and secondary schools and higher and technical institutions**, with attendance figures proportionally equivalent to those of other people. However, as stated in the previous chapter, there is a high disengagement rate for people with disabilities from the secondary school level onwards compared with the rest of the population. For the latter two categories, there is a major difference between the level of needs and the level of effective usage, which reveals the difficulties in accessing education beyond primary school.

Higher and technical education and study grants are only accessible to a small number of people (around 1%), regardless of disability.

Only **adult literacy programmes** are used less by people with disabilities than other populations, whereas logically the reverse should be the case (since people with disabilities generally have lower literacy levels, as stated above). **Specialised schools** are, logically, only attended by people with disabilities.

People with disabilities expressed equivalent levels of needs to other people, except, strangely, for secondary and higher education, for which there were fewer expressed needs for people with disabilities than for other people. This would suggest a renunciation of expressed academic ambitions.

b) Obstacles to accessing education services

A univariate analysis reveals that people from disability groups are more acutely aware of all environmental obstacles than other people, to a more or less significant extent. As with health, economic obstacles represent the most serious challenge for people with disabilities wishing to access education (between 65% and 74%), before the absence of family support (40%), the lack of adapted educational methods (40%), the lack of information (between 28% and 36%) and problems travelling to and around educational centres (18% to 23%). Obstacles associated with the attitude or perception of teachers and pupils are mentioned by 13% of respondents:

Obstacles for:	Non-PWD	PWD	p
Meeting educational costs	58.9%	73.1%	0.001
Obtaining educational materials adapted to their needs	43.6%	64.7%	<0.001
Calling on family support	30.5%	39.9%	0.03
Receiving an education adapted to their needs	22.1%	39.9%	<0.001
Obtaining information on existing educational programmes	25.0%	35.9%	0.01
Obtaining information on accessible schools	20.8%	27.5%	0.09
Travelling from home to school	11.2%	22.9%	0.001
Accessing and moving around the school	5.8%	17.8%	<0.001
Being accepted by teachers and pupils	5.5%	13.3%	0.007

The **ability to afford educational expenses** primarily conditions whether a person starts or continues an educational programme, and particularly the move between primary and secondary school. Although state schools are supposed to be free, there are **a certain number of indirect expenses that may discourage families,** including gratuities for carers, transport, uniforms and educational materials.

A **lack of family support** is also directly mentioned by people with disabilities as an obstacle to education. Many families abandon the idea of sending their children to school because they lack confidence in their abilities to succeed. They are especially discouraged by **the lack of adapted educational solutions** in the area and the expenses incurred by education. For example, the mothers of children attending the ADEMO special school have to accompany their children every morning from their peri-urban neighbourhoods to the district of Malhangalene and wait for them in the schoolyard during the morning, depriving themselves of the possibility of working during this time. Sending a child with disabilities to school under these circumstances represents a substantial financial commitment for these families.

Inclusive education remains difficult to implement with an average of 85 pupils per class in schools in the area. Although it is difficult for teachers to offer support adapted to the educational needs of their students under these circumstances, their lack of training in disability issues also makes it difficult to implement an ambitious mainstreaming policy in schools. Although all new teachers trained at the Teacher Training Institute (IFP) now receive awareness training in including pupils with disabilities in their classes as part of their training programme, it does not go far enough. **In the metropolitan area as a whole, there are only five teachers with a high level of sign language training** (at the Josina Machel school) and none at all in secondary schools or higher education institutes. Under these circumstances, almost half of people with disabilities of school age consider that it is difficult to receive an education adapted to their needs, and almost two out of three find it hard to access educational materials adapted to their educational needs.

Lastly, **physical accessibility** problems were once again highlighted by people with disabilities as a decisive obstacle, since almost 20% of them experienced difficulties travelling to and around educational units. This is unsurprising given that 72% of schools have an inaccessible exterior entrance and 87% of toilets are not adapted to the needs of people with reduced mobility.

III/ Access to occupational training and employment services

a) Stated level of service knowledge, needs and usage

► According to **disability**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	PSH	**Non-PSH**	**PSH**	**Non-PSH**	**PSH**	**Non-PSH**
Occupational training centre	17%	25%	30%		3%	
Occupational training programme	10%		23%		3%	
Employment assistance service	12%		26%		1.5%	3%
Microcredit service	34%		40%		7%	

Access to health and social services

► According to **gender**

Type de service	KNOWLEDGE		NEEDS		USAGE	
	Women	**Men**	**Women**	**Men**	**Women**	**Men**
Occupational training centre	16%	26%	27%	35%	3%	
Occupational training programme	7%	15%	20%	26%	3%	
Employment assistance service	9%	17%	26%		2%	
Microcredit service	30%	39%	37%	44%	7%	

Few people (3%) use **INEFP occupational training centre** services, regardless of disability. However, among those who don't use them, 29% stated a need to use them, most of whom were young men (p=0.01). Out of everyone who expressed a need for these services, 62% say they were unaware of their existence, without disability playing a particular role.

The **occupational training programmes** benefit 2.5% of the population; 22% of those not benefiting from the programmes expressed a need to do so. Three-quarters of them were not aware such programmes existed. None of these results is associated with disability.

Few people with disabilities (2.2%) use an **employment assistance service**, probably because they do not really exist in the area, excluding a few isolated initiatives in the association sector.

There is no difference in **access to microcredit** (7% of the whole) between people with disabilities and the rest of the population, or between men and women. Of those who do not use microcredit services, 37% expressed a need for these services, while 43% were not aware of the existence of a microcredit supplier or service. Men were more likely to express an awareness and need for microcredit than women.

Awareness of the existence of occupational training and employment assistance services is higher among men than women, in all cases, and needs are most often expressed by men than women. In contrast, disability does not appear to be a discriminatory factor in accessing these services, which seem to be in demand from a large proportion of the local population. Access to the employment market appears to be a major concern for everyone, faced with a lack of professional opportunities outside the informal economy.

b) Obstacles to accessing occupational training and employment services

A univariate analysis reveals few differences between people with disabilities and the rest of the population in accessing this type of service. All percentages associated with how obstacles are perceived point in the same direction: the difficulties are always notably greater for people with disabilities than for others, although their significance is insufficient. In other words, people with disabilities and the rest of the population face relatively equal difficulties. Gender is a minor factor, to the disadvantage of women.

In the field of occupational training, cost is the primary deterrent for people with disabilities (78%), before the availability of educational materials (75%), the suitability of training methods in meeting their specific needs (62%) or information on existing training (59%). In terms of employment, the major obstacles mentioned by respondents related to their employability on the employment market (86%), support in setting up a business (81% and 85%), access to information on existing vacancies (77%), the ergonomics of the workplace (62%), childcare services during working hours (44%) and lastly the physical accessibility of the workplace (31%).

Obstacles for:	Non. PWD	PWD	p
Finding a job to match their skills	84.5%	86.1%	0.6
Obtaining microcredit to develop their own business	81.4%	85.5%	0.3
Benefiting from technical support in setting up a business	71.6%	80.9%	0.03
Paying for occupational training	80.8%	78.0%	0.5
Knowledge of job vacancies in their field	72.3%	77.2%	0.2
Finding educational material adapted to needs	68.8%	74.7%	0.2
Benefiting from education adapted to needs (teaching methods, etc.)	53.9%	61.8%	0.2
Enjoying acceptable working conditions	56.2%	61.6%	0.3
Obtaining information on existing training	48.8%	59.2%	0.05
Ensuring trainers adequately cater to their needs	46.3%	49.6%	0.6
Finding a childcare solution during working hours	36.8%	43.8%	0.2
Moving around the workplace without hindrance	25.6%	31.6%	0.2
Travelling to the workplace	23.1%	29.8%	0.2
Being accepted by work colleagues	15.5%	21.7%	0.2

It appears to be particularly difficult for people with disabilities - as for others - to access the INEPF's occupational training centres. This is due, first and foremost, to the fact that there are no training centres of this kind in the area under study. Since it is necessary to travel to Machava (Matola) or even to the Bairro Central and FPLM (Maputo), **transport represents a significant barrier** to taking a training course. Moreover, **the training offered by the INEPF appears to be relatively costly** for people who are not exempt from payment, given that a six-month mechanic's or electrician's course costs, for example, 5000 MT.

In order to compensate for their employability deficit, people with disabilities sometimes take occupational training programmes offered by local associations or churches. However, they appear to be **poorly adapted to the real needs of the employment market and struggle to provide practical employment opportunities.** Many respondents said they take numerous short courses in different fields and often feel restricted to courses related to manual work (sewing, crochet, woodwork, etc.) offering few or poorly paid employment opportunities.

Access to health and social services

The formal sector remains particularly difficult for people with disabilities in the labour force to access (as a reminder, only 18% of disabled people state they are in salaried employment) due to an academic record that often falls short of the qualifications required, but above all the **significant discrimination they face from employees during recruitment** compared with other applicants. Sometimes, it is the company or administration itself that is not accessible or the **workplace that is not adapted to the person's impairment**, which excludes them from certain opportunities.

Women are particularly discriminated against in accessing formal employment - as a reminder, there are six times fewer women in salaried employment than men - and mostly focus their attention on the informal sector when they can. Many of them are also confronted with the **problem of arranging childcare for their children during work hours**. This is even more problematic when they have a disabled child since they have to stay at home to look after him or her due to a lack of adapted solutions within crèches in their area.

Faced with the impossibility of obtaining work in the formal sector, many people with disabilities turn to self-employment, very often in the informal sector (hawking, craftwork, etc.). **The difficulty of accessing credit facilities and support in setting up a business** severely limits their ability to set up income generating projects. People with disabilities, who generally have a less advanced level of training, appear to make more demands than others for specific assistance in setting up these types of businesses.

IV/ Access to social services and programmes

a) Stated level of service knowledge, needs and usage

► According to **disability**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	PWD	Non-PWD	PWD	Non-PWD	PWD	Non-PWD
Crèche and community school	57%	71%	20%		3%	6%
Child reception centre	35%	45%	20%	26%	1%	
Age support centre	33%		29%		1%	
Transit centre	15%		12%		1%	
Open community centre	10%		13%		1%	
Social assistance public programmes (INAS)						
Food Aid Programme (PSA)	21%		70%	60%	3%	
Direct social assistance programme (PASD)	11%		50%	38%	1%	
Social benefit through work programme (PBST)	10%		37%		2%	
Income management programme (PGR)	10%		39%		2%	
Community development programme (PDC)	11%		35%		2%	

► According to **gender**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	Women	**Men**	**Women**	**Men**	**Women**	**Men**
Crèche and community school	63%	71%	20%		5%	
Child reception centre	35%	44%	22%		1%	
Age support centre	33%		29%		1%	
Transit centre	15%		12%		1%	
Open community centre	7%		13%		1%	
Social assistance public programmes (INAS)						
Food Aid Programme (PSA)	21%		65%		3%	
Direct social assistance programme (PASD)	8%	14%	45%		1%	
Social benefit through work programme (PBST)	7%	14%	37%		2%	
Income management programme (PGR)	7%	15%	36%	44%	2%	
Community development programme (PDC)	8%	16%	32%	41%	2%	

Few people (4.5%) use **crèches**, and significantly more non-disabled persons than disabled persons. Among those who don't use them, only 20% expressed the need to use them, of which 65% are already aware of at least one crèche. People with disabilities are much less likely to be aware of this type of service than others (57% compared with 71%).

Very few people (1%) use **Child Reception Centres, Age Support Centres, Transit Centres** and **Open Community Centres** for the simple and good reason that there are very few in the area in question. There is a lot of demand, however, from the most vulnerable groups, in particular elderly persons and children in disadvantaged situations (29% and 23% respectively). There is no significant difference associated with gender.

The various **programmes run by the National Institute for Social Assistance (INAS)** only seem to benefit a very small number of people surveyed in the area (between 1% and 3%) despite the fact that they correspond to an unsatisfied need of a large section of the population (between 35% and 60%). The direct social support programme (PASD) and, above all, the food aid programme (PSA) are the most solicited, significantly more by people with disabilities (58% to 70% of them) than by other people, which clearly illustrates how the great majority of them are facing subsistence issues.

Beyond the very significant differences between the declared level of needs and the stated level of usage, the area's inhabitants have a striking lack of awareness of existing INAS services. Although 20% of people surveyed were aware of the existence of the FAP, regardless of disability, only one in ten people knew of the INAS's four other social programmes, which is relatively low for national programmes, some of which have existed for more than ten years. Moreover, there is a very large difference in awareness between men and women for each of these programmes.

Access to health and social services

b) Obstacles to accessing social services and programmes

A univariate analysis reveals that all items are perceived as moderately more significant obstacles by people with disabilities than by other people. The difficulty of being selected (81%), obtaining information on existing programmes (72%), and being accepted by social workers (60%) are the main problems mentioned, before mobility problems (45%).

Obstacles for:	Non. PWD	PWD	p
Benefiting from social programmes	73.7%	81.0%	0.06
Obtaining information on existing social action programmes	63.8%	72.0%	0.03
Being well received by professionals	45.3%	59.9%	0.01
Travelling from home to the programme	31.9%	44.6%	0.02

Although they are considered to be one of six priority groups for the INAS's social programmes (along with women, the elderly, the sick, children in vulnerable situations, etc.), people with disabilities stated that they experienced numerous **difficulties in being selected for existing social welfare schemes**. According to the official statistics, **they only represent 3.3% of the 17,284 beneficiaries of the INAS nationally in 2009**, that is, only 569 people. According to the INAS in Maputo Cidade, 317 people with disabilities were included in 2009 in the PSA programme and the PASD authorized the distribution of 11 wheelchairs and one pair of crutches in 2009, which is relatively insignificant in relation to the city's total population.

The INAS made the appropriate choice of taking an integrated approach to its various social support programmes, but in reality they **do not benefit people with disabilities in a cross-sectional way**. In the absence of adequate financial resources, and particularly an adapted methodological and organisational framework, they benefit only marginally from recent advances in social welfare policies at a national level.[7]

People with disabilities and the rest of the population (64% and 72%) **experience acute difficulties in accessing information on existing programmes**. This would seem to explain the very significant differences noted between the level of needs for programmes and the level of awareness on the part of the inhabitants surveyed. The INAS appears to have taken this problem into consideration, since it intends to enhance its disclosure mechanisms for existing programmes targeted at local communities as part of its next multi-annual strategy. Particular attention must be paid to people with sensorial disabilities to ensure they are also informed of their social welfare rights.

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[7]Decreto n°85/2009 que aprova o Regulamento do Subsistema de Segurança Social Basica.

V/Access to other types of services: sport, culture, leisure, transport and accessibility

a) Stated level of service knowledge, needs and usage

► According to **disability**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	PWD	Non-PWD	PWD	Non-PWD	PWD	Non-PWD
Cultural and sporting activities	22%		17%	23%	4%	
Leisure activities	14%		17%		8%	
Transport service	54%		60%		49%	

► According to **gender**

Type of service	KNOWLEDGE		NEEDS		USAGE	
	Women	Men	Women	Men	Women	Men
Cultural and sporting activities	16%	29%	16%	25%	3%	6%
Leisure activities	14%		17%		10%	6%
Transport service	54%		60%		49%	

Few people appear to take part in **sporting and cultural activities** in the area, with only 4% of people surveyed stating they regularly take part in events of this type, without any significant difference between people with and without disabilities. On the other hand, women experience a high level of discrimination in accessing cultural and sporting activities, since they are only half as likely to take part as men. 17% of people with disabilities expressed the need to take part in these activities, underlining the difficulties experienced in identifying adapted solutions in this field.

In the same way, only 8% of people were members of an association offering **leisure activities**, regardless of whether they were disabled or non-disabled. Women appear to practice this type of activity more than men. Of those who do not use the services of an association, 11% expressed a need to do so, of whom 38% were unaware of its existence.

49% of people say they use a **transport service**, with no difference between people with disabilities and the rest of the population. Among those who do not use a transport service, 35% expressed the need to do so, of whom 32% were unaware of its existence.

b) Obstacles to accessing other types of services

A univariate analysis reveals that all items are perceived as much more significant obstacles by people with disabilities than by other people, including economic limitations (54% to 77%), lack of available facilities (76%), lack of information (50%) and the lack of physical accessibility in public spaces (25% to 50%) or in the home (14%).

Obstacles for:	Non. PWD	PWD	p
Paying for cultural and sporting activities	62.6%	77.5%	0.001
Finding facilities to practice a sport or cultural activity	63.6%	76.6%	0.004
Paying for public transport	28.0%	54.8%	<0.001
Obtaining information on cultural and sporting events	39.4%	50.0%	0.02
Accessing public transport	27.5%	43.2%	<0.001
Accessing and moving around public service buildings	6.7%	32.5%	<0.001
Moving around public spaces (streets, pathways, etc.)	5.5%	26.7%	<0.001
Travelling from home to the stop	5.0%	24.6%	<0.001
Moving around the home	1.7%	13.5%	<0.001

Cultural and sporting activities are not widely practiced due to a lack of available facilities in these new residential neighbourhoods (football pitches, gyms, cinemas, etc.) and the cost of the events on offer, which is judged to be expensive. Sport can be a valuable and fun way of performing rehabilitation activities and promoting self-development, helping people meet others and make contact with the outside world. Unfortunately, many people with disabilities fail to join in these activities because of a lack of confidence in their abilities or self-esteem. The poor accessibility of these facilities, the high cost of adapting sports equipment (balls with bells, basketball wheelchairs, etc.) and the difficulty of integrating sporting and cultural groups represent major obstacles to the participation of people with disabilities in this field.

Transport is a particularly critical issue for everyone living in the area. Fares are considered to be excessive, vehicles uncomfortable, interchanges difficult and services to the most outlying neighbourhoods sporadic. Added to these problems, people with disabilities are at a greater disadvantage in terms of cost (55% compared with 28%) but especially in terms of the physical accessibility of public transport, which is generally overcrowded and narrow (43% compared with 27%). The disabled person's travel card provided by ADEMO theoretically entitles the bearer to free public transport (TPM). However, these outlying areas are mostly served by individual private transporters - **chapas** and **machibombos** - and they apply their own fares and entry policies, often making people with disabilities accompanied by another person or in a wheelchair pay double the normal rate.

More generally, there is a major difference in the awareness of obstacles to accessibility in everyday life, inside and around the home, and on public transport. **Physical accessibility is five times less satisfactory for people with disabilities than the rest of the population**. Public highways congested with cars and minibuses, pavements crowded with street sellers, and heavily-sanded secondary streets and courtyards are just some of the obstacles to moving around independently in the area for people with reduced mobility.

The local stakeholders system

The local stakeholders system

The operation of health and social services is generally based on the relationships and interaction between three groups of stakeholders (people with disabilities represented in this context by DPOs), service providers and the public authorities. Based on the approach set out in the triangular diagram below, in this final chapter, we will analyse the three main groups of stakeholders who make up the services system in Maputo and Matola.
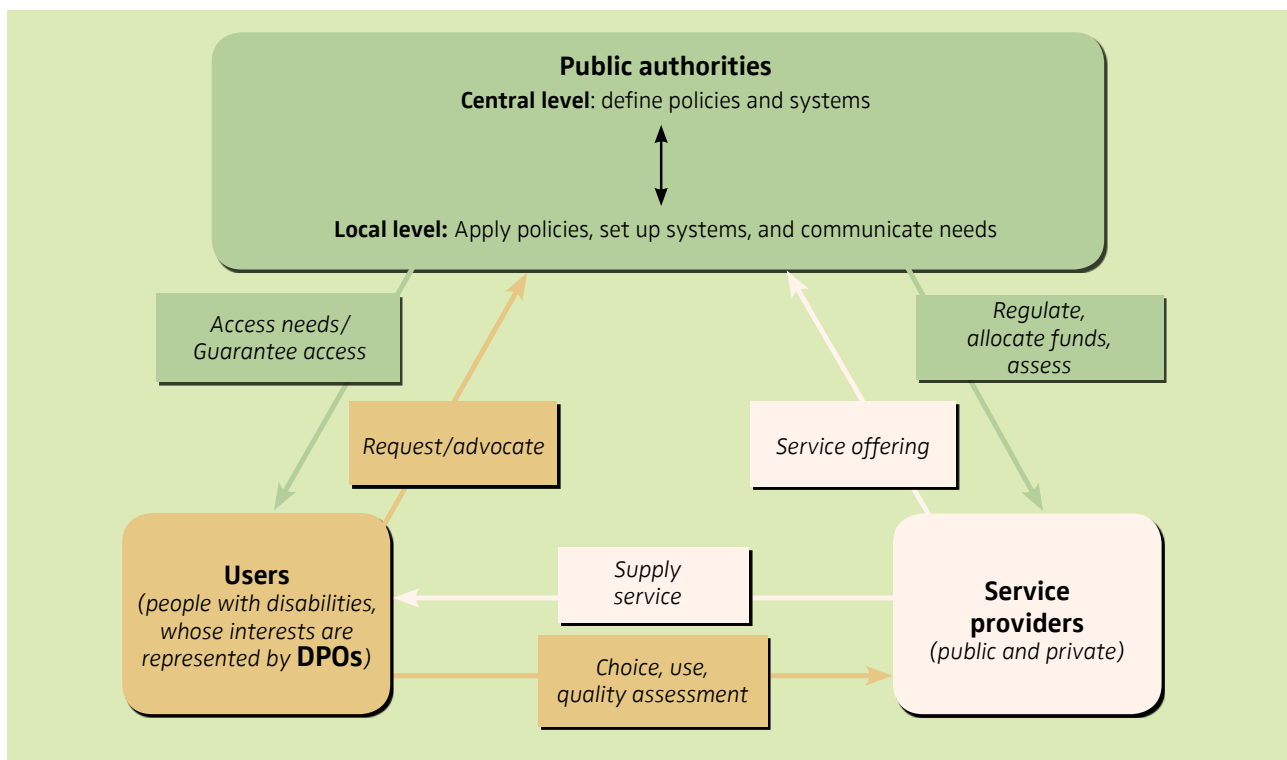
In a balanced set-up, **users are clients and ideally co-developers of the service because they can/must play an active role** in defining priorities and regularly assessing services. This is based on consultation mechanisms, but also advocacy and monitoring actions related to public policies and their application. These actions are generally performed via DPOs. Any improvements in the quality of the services chain is based on stimulating user demand, exerting constant pressure on service providers and local authorities. In fact, a system of controls imposed from above without any demand from below cannot be sustained overtime. (Duflo, 2008).

Service suppliers respond directly to the needs of users and must provide quality services, based on a customized approach. Government, non-government, voluntary, profit-making and not-profit-making organisations must act within the framework defined by the local/national authorities and comply with the quality standards and principles defined.

Lastly, **the public authorities, at a local and central level, are responsible for defining public policies and mechanisms related to the regulation of health and social services.** As such, they define the major strategies and supply or organise the financial resources necessary to ensure service availability. Policy and system development should be based on the regular assessment of the needs of people with disabilities and on the basic rights defined under national and international law. These policies and systems must, in particular, ensure the accessibility and quality of services.

I/ Disabled people's organisations (DPOs)

There are currently 18 disabled people's organisations active in the territories of Maputo and Matola (see list in Appendix 1). Often national organisations, they have emerged over the last twenty years in three successive waves:

► The first wave (1989-1995) was a direct consequence of the political liberalization process that began in Mozambique in the early 1990s (greater public freedoms, particularly the right of association).

► The following two waves (1995-2003 and 2003-2008) resulted rather from the gradual splitting up of existing associations, due to differences or funding opportunities provided by funding bodies (calls for proposals, initiative support funds, etc.).

a) Limited operational capacities

The DPOs operating in Maputo and Matola primarily focus their activities on the promotion and protection of the rights of people with disabilities (33%), health (18%), training (15%), sport (11%) and education (11%), as shown in the diagram below:
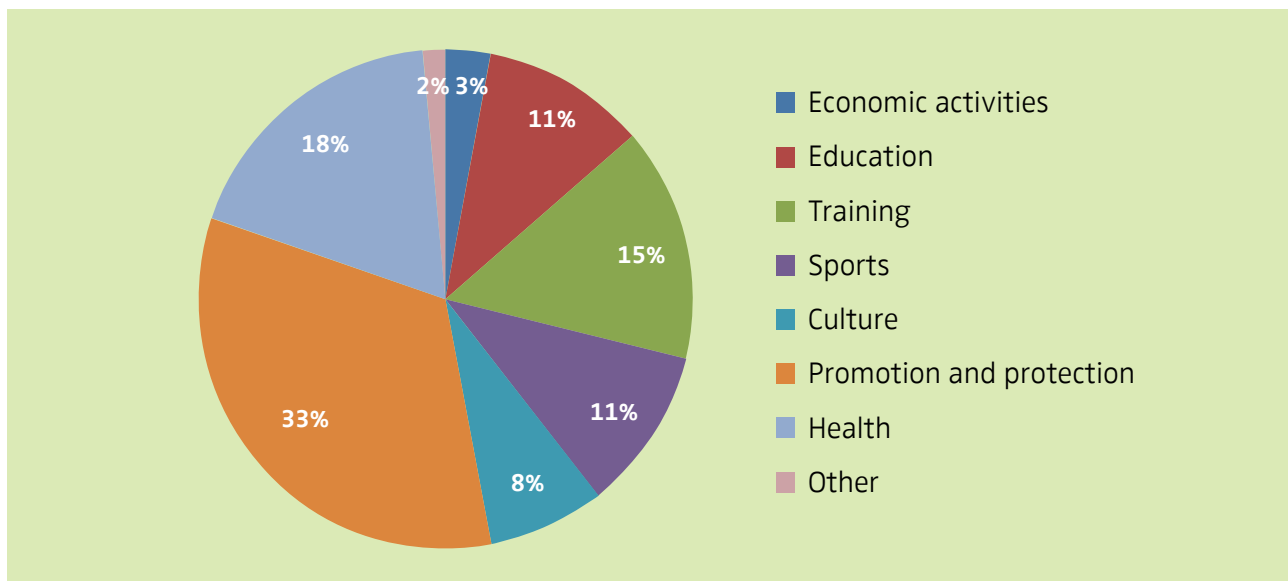
Most of the organisations interviewed as part of our survey stated that they faced major difficulties in performing their activities due to a lack of material resources, as well as sporadic and unstable financing. This phenomenon is exacerbated by the presence of several organisations operating in similar ''niches'' and activities, giving rise to stiff competition for available funds, either locally or via international cooperation agencies.

These organisations also appear to suffer from a lack of qualified human resources, particularly in relation to strategic planning, project development, fundraising and project cycle management. The low level of training received by the organisations' members, particularly middle managers, places major limits on the movement's capacity to perform advocacy activities nationally in relation to public opinion, local authorities or service providers.

b) Lack of support and representativeness

Fifteen of these organisations consist of people with disabilities, while three others are organisations for people with disabilities. All types of disability are represented within the DPO movement, although physical disability takes precedence over hearing, visual and intellectual disability, as shown in the following diagram:
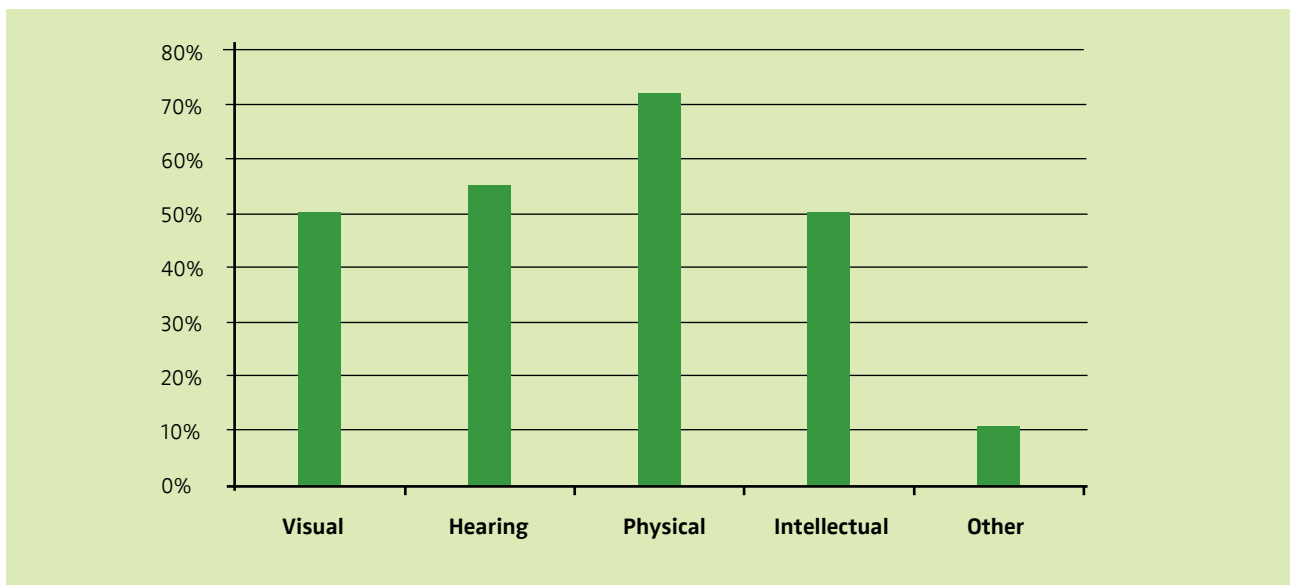
The total national membership of these 18 organisations is around 30,000, concentrated mainly in their historic base - the Maputo region. This is a relatively approximate figure, since most DPOs do not keep up-to-date membership lists, while members are often in arrears with their subscriptions (subscription payment rates are often below 25%). Moreover, two organisations (ADEMO and ADEMIMO) purportedly account for two thirds of disabled subscribers nationally. Lastly, due to limited human and material resources (vehicles and communication materials), **DPOs have major problems in reaching people with disabilities living in the most remote areas of the metropolitan area**.

Our survey reveals that these organisations **are far from representative**, with only a minority of people with disabilities (6%) aware of the existence of a DPO and only 2.5% are members. Women with disabilities are also largely under-represented in these organisations - as a reminder, men are between 2.1 and 2.4 times more likely to be members of a DPO than women - and on management boards, where only 31% of positions are occupied by women. This is particularly surprising given that there are more disabled women than men.

c) Poor turnover of managers and internal governance

Despite apparently having thousands of members nationwide and more specifically in the Maputo/Matola metropolitan area, the same individuals always represent the DPO movement at the centre. Although there are officially 150 managers, mostly voluntary workers, the dynamic of these organisations is based primarily on the leadership of several charismatic figures present in various locally organised seminars, meetings and training sessions. The turnover of managers poses a particular problem, and it is not rare to see the founders of an organisation retain management positions for over fifteen years after the founding of the organisation, in the absence of governance practices to ensure a change in leadership.

d) Sluggish coordination dynamic

Seventeen of these organisations are members of FAMOD, a national coordination umbrella organisation for the disability movement, which is charged with promoting the rights of people with disabilities nationwide. Also confronted with a lack of financial, material and human resources, it is difficult for **FAMOD to effectively put the movement's advocacy and representation role into practice on the national and local stage.**

Due to the lack of a sufficiently unifying system, **inter-organisation coordination dynamics remain relatively weak**, as shown in our modelled DPO network map.
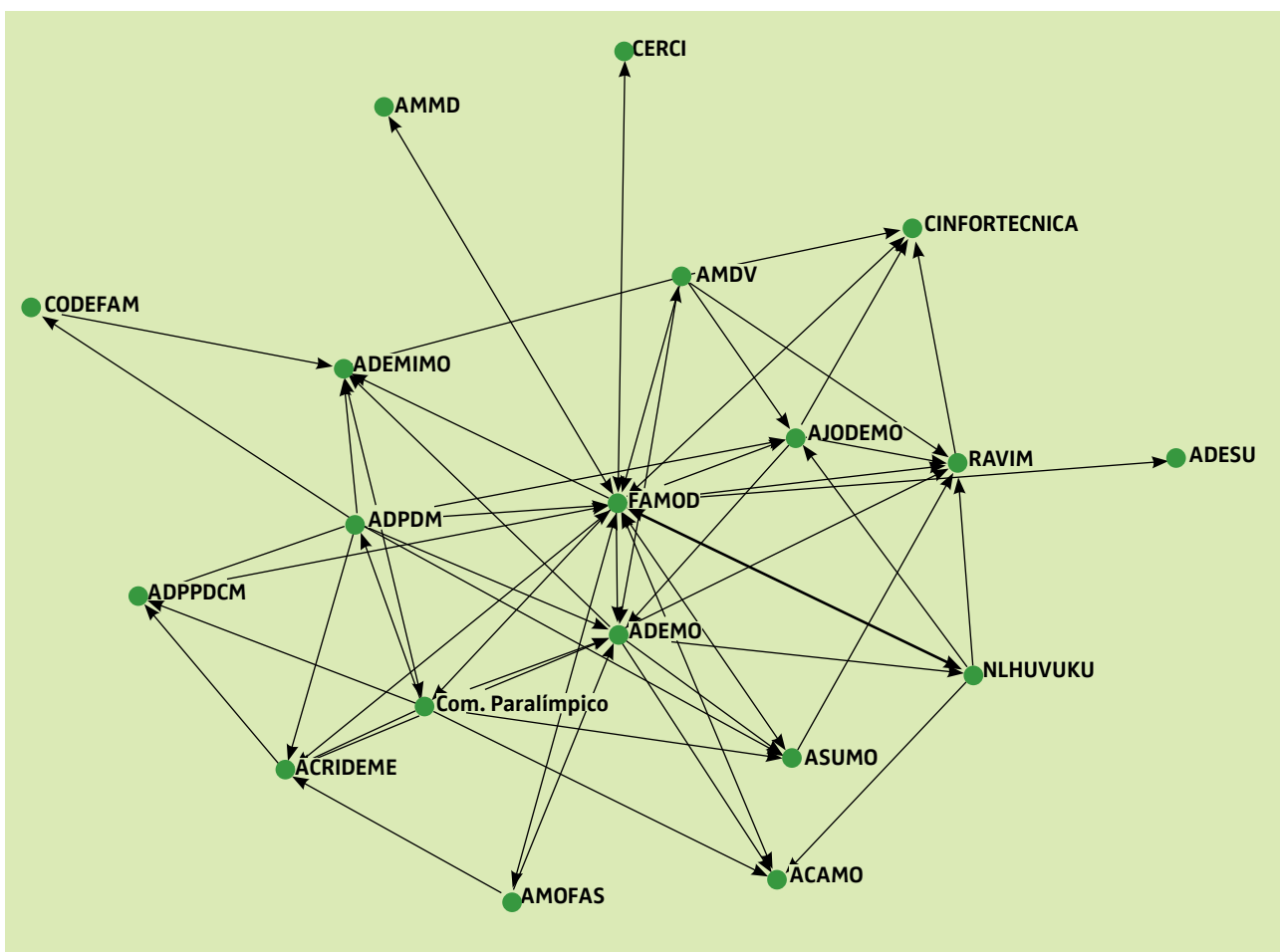
Despite the presence of 5 to 6 associations acting as ''intermediary nodes'', existing links between DPOs are particularly loose and often unidirectional, suggesting a sparse network lacking any real momentum. **There are very different levels of integration between the DPOs, with some organisations in more or less frequent contact with other organisations, while others are particularly isolated with no link with the rest of the movement outside the mediation performed by FAMOD** (these organisations are on the fringe of the network). It is not surprising that the movement's capacity to make its voice heard nationally and locally is poor. With the exception of key commemorative dates (such as 3 December, International Day of Disabled Persons), co-ordination spaces, and especially co-productions between organisations, remain relatively rare.

The local stakeholders system

The DPO network's interactions with the outside world are also relatively sparse, including with service providers, but above all with local authorities (autárquias locais), which are almost never asked to support the various activities performed. DPOs often confine themselves to playing an intermediary role between people with disabilities and government services, without seeking to build new bridges with local third party stakeholders.

e) Potential and existing strengths

Disabled people's organisations still enjoy considerable **potential for supporting local development dynamics**. Well-established in the Maputo metropolitan area, they benefit from an extensive knowledge of the area. Active within civil society for many years, the representatives of the DPOs have an equally thorough understanding of the operation of local institutions, especially government services.

Their legitimacy was recently confirmed by the nomination of Mozambique to the head of the FDLP and the setting up of the National Disability Council, based on a close partnership between the public authorities and civil society. The council should enable DPOs to play a greater role in developing and monitoring national public policies in aid of people with disabilities. **Within this framework, the members of the organisations will provide practical expertise to the area's other stakeholders**. Very often disabled themselves, they enjoy an excellent knowledge of the issues affecting them personally. They are therefore in a position to propose adapted solutions.

II/ Health and social service providers

Our survey identified a total of 143 health and social services in the area under study, broken down as follows:

Sporting activities
Cultural and artistic activities

Sport and Culture **9%**

Health **23%**

Primary health care
Traditional medicine
Pharmacies
HIV/AIDS screening and treatment
Mental health
Physical medicine and rehabilitation
Suppliers of technical aids

Crèches and day centres
Vulnerable children reception centre
Transit centres
Support programmes for people living with HIV/AIDS

Social services and programmes **19%**

Training and employment **17%**

Education **32%**

Professional training
Apprenticeship programmes
Microcredit
Income generating activities
Employment support

Primary education
Secondary education
Specialised education
Adult literacy

A total of 2,564 people work within these different services, including salaried staff and voluntary workers, including:

► 1,714 technicians (teachers, nurses, doctors, educators, project co-ordinators, etc.)
► 850 support staff (carers, maintenance staff, drivers, etc.).

a) A saturated service offering centralised in Maputo

Most health and social services identified during the local assessment are located in the city of Maputo (73% compared with only 27% in Matola). This difference reveals the major disparities in basic infrastructure equipment between the two neighbouring municipalities. These differences have a major impact on the conditions in which the services are used **since they are globally much more saturated in the neighbourhoods of Matola than Maputo** (particularly schools and health centres). This saturation is exacerbated by a lack of available professionals and qualified staff in particular (one to two doctors only on average per health unit, for example), which increases the number of tasks to perform and reduces work productivity and user reception quality.

Moreover, **the available services in the nine neighbourhoods in which the project was implemented are exclusively mainstream services**. All specialised services are located outside the area, mainly in the centre of Maputo, requiring people with disabilities to travel long distances when they need to consult an ophthalmologist, undergo a physical rehabilitation session, take their children to a special school or a mainstream class, etc. **This poses a number of problems, given the challenges involved in travelling from the outlying areas to the city centre. Each journey lasts at least 90 minutes**.

The local stakeholders system

b) Services often recently-established, gradual trend towards privatisation

However, there is a resolve to make up for lost time and to expand mainstream services in these neighbourhoods where **two thirds of existing services were set up between 2000 and 2010**. These new services are mainly health centres, primary and secondary schools, pharmacies and crèches (in line with the explosion in female labour in the city). Many other services are expected to be set up over the coming years **in response to the massive growth of the metropolitan area, in particular in expanding neighbourhoods such as Khongolote, Ndlavela and Zimpeto**.

In parallel with the upgrading of the system, there is a **gradual trend towards the privatisation of new health and social services set up** over the last decade. Although only 38% of services were private in 2000, the situation has been completely reversed over the last decade, with private services representing 62% of all services compared with 38% public services. The changeover from a public to a private system, including both profit-making and not-for-profit ventures, **inevitably risks financially excluding the users of these services, particularly the most vulnerable groups such as people with disabilities**. This transfer must therefore include the setting up of a parallel support mechanism to guarantee access to these services for the most disadvantaged groups.

c) Inadequately inclusive system

Although most services visited (90%) stated that they sometimes received people with disabilities or would not be inconvenienced by such a visit, the services in the area are generally perceived to be inadequately inclusive by people with disabilities questioned as part of our survey.

As shown above, **the physical accessibility of services** is perceived to be a key problem for many people with disabilities. Although around a third of service providers consider their premises to be physically accessible to people with reduced mobility, far fewer are accessible in reality, as the table below shows:

| Services	Total staff	Accessible exterior access	Free movement inside premises	Accessible toilets	Accessible information	Staff trained in PWD case-management
Health	33	24%	42%	3%	3%	36%
Education	46	28%	33%	13%	7%	26%
Occupational training and employment	24	33%	58%	8%	13%	25%
Social services and programmes	27	15%	44%	15%	0%	22%
Sport and Culture	13	0%	8%	23%	0%	0%
TOTAL	**143**	**23%**	**39%**	**11%**	**5%**	**25%**

Staff also receive little training in case-managing the specific needs of people with disabilities, with only a quarter of facilities surveyed stating they had staff with adequate awareness and skills to provide a suitable service for people with disabilities. There are no health workers and only a handful of teachers trained in sign language in the whole of the city of Maputo. However, 86% of service managers interviewed would like their staff to benefit from training to improve their case-management of people with disabilities and to make their services more inclusive.

Lastly, although two thirds of services visited are ostensibly free, users must in reality very often provide money to buy uniforms or equipment in schools, provide carers with gratuities, etc. 69% of fee-based services say they nevertheless offer **preferential usage rates for the most vulnerable users** (the elderly, single women, vulnerable children, people with disabilities, etc.): exemption from payment, preferential rates, specific usage conditions, flexible opening times, shorter queues, etc. However, given the difficulty of obtaining proof of poverty or recognition for their disability card in order to benefit from preferential conditions, the most vulnerable users end up paying the required fees… or only using the services as a last resort.

d) Mainly sector-based and vertical relationships

An examination of the service providers network map visually reveals three structurally cohesive subsets of relatively independent ''archipelagos'':

► The first group aggregates health facilities in a particularly dense and uniform cluster *(a)*,

► The second subset almost exclusively contains education facilities, mainly primary and secondary schools *(b)*,

► Lastly, a third cluster hybridizes education and social service facilities, mainly crèches, revealing a certain interconnection between these two sectors *(c)*.
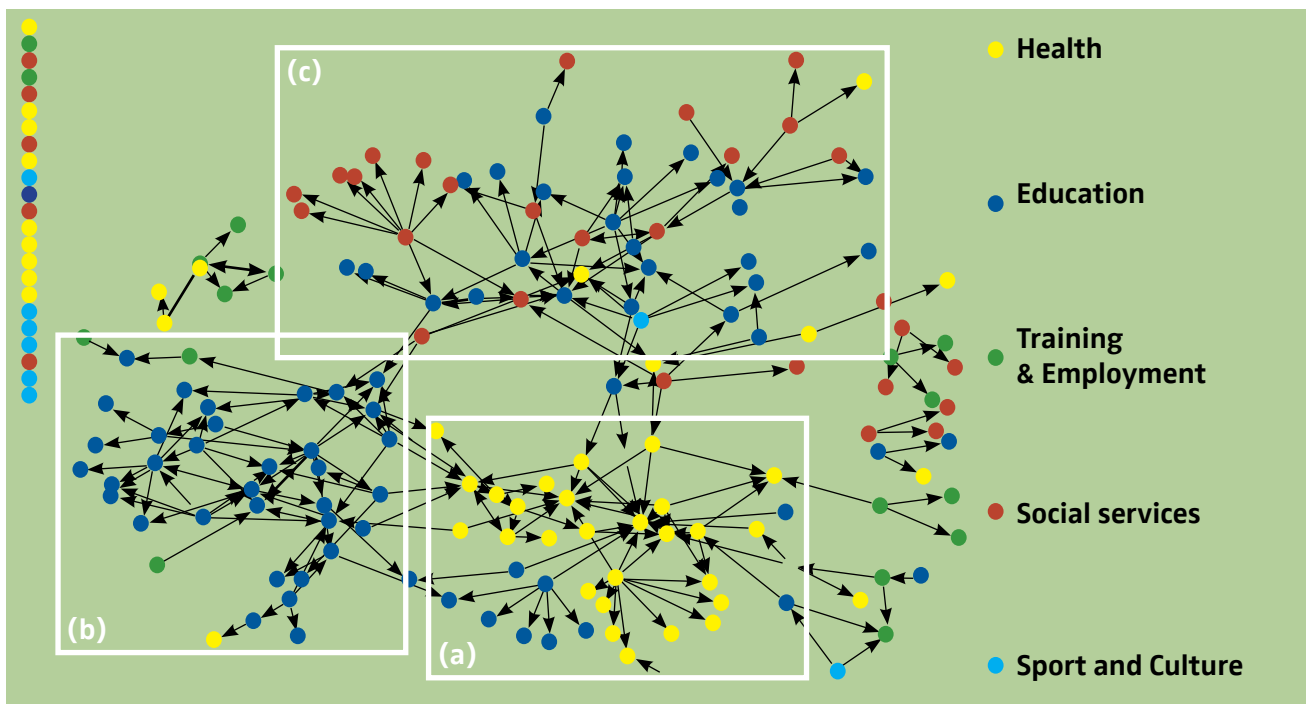
The local stakeholders system

The two other sectors studied during the survey (occupational training and employment, sport and culture) appear to be relatively scattered, revealing a looser cohesion. They fill the gaps in this stakeholder network. Lastly, some service providers remain perfectly isolated. At the time of the survey, they did not maintain any links with other suppliers in the local network (top left of the map).

We can conclude that **the relationships between service providers in the area is organised structurally based on sector-based and vertical approaches:** health facilities interact mainly between themselves in a *top-down* fashion (central hospital to general hospital then local health centre, etc.) for example. There are too few flows between stakeholders from distinct sectors to offer the users of these services effective bridges that would allow them to receive appropriate guidance in line with their overall needs or to benefit from customized solutions in conjunction with other stakeholders in the area. The situation facing disadvantaged or excluded individuals generally results from a deterioration in their sanitary conditions and well-being, without it always being possible to determine if a person's health and social condition deteriorate or improve in tandem. In order break this vicious cycle, it is essential to optimise the interconnection between the different health and social operators in order to increase the network's density.

e) Effective coordination and referral mechanisms
However, despite the high level of segmentation in the service provider network, **pre-eminence is given to referral and coordination links over technical or financial exchanges**. This is particularly true in the field of health, where the referral mechanisms between the different levels of the health structure play a key role in the operation of the care chain. In all likelihood, therefore, this is a sign of a budding culture of co-operation that no doubt calls for further nurturing.

Type of link between the area's service providers	Total staff	Percentage	Average intensity of links (1 to 3)
Technical/training support	45	11.54%	2.29
Financial/material support	19	4.87%	2.53
Referral of patients/customers	136	34.87%	2.21
Information exchange/co-ordination of activities	190	48.72%	2.35
Grand Total	**390**	**100.00%**	**2.34**

Addition to the links existing between them, **local services also rely heavily on the neighbourhood's secretaries to communicate specific information to the community** (start of a vaccination campaign, opening of school registrations, launch of a literacy group, etc). 41% of facilities say they have informed the population about the services they offer through local administration workers compared with only 8% through the network of health and social action professionals, for example. This reveals **the dominance of the neighbourhood's secretariat as a communication interface at a local level, concealing the inadequacies of existing flows between professionals**.

III/ Local public authorities: devolved government services and local authorities

Existing local public authorities in Maputo and Matola fall into two distinct categories of operators, resulting from two decentralisation processes currently underway in Mozambique - devolved government services (*Orgãos locais do Estado - OLE*) and local authorities (*Autárquias locais - AL*).

► **Devolved government services** form part of **an administrative devolution approach**, that is, a process by which the state does not abandon its role but manages local resources in such a way as to strengthen the link between administrative operators and users. This process aims to improve the effectiveness of government action by delegating certain responsibilities from the central administration to local public workers. This category includes the different provincial and district services for women and social action, health, education and culture, responsible for administrating the Maputo and Matola territory in close association with its inhabitants.

► **Local authorities** were created as part of **a territorial decentralisation strategy**, which aims to provide local authorities with their own administrative authority, distinct from that of the state, enabling residents to elect their authorities in order to optimise the balance of power throughout the territory. This territorial decentralisation aims to bring decision-making closer to citizens and promote the emergence of local democracy. This category includes the municipalities of Maputo and Matola as well as their different services, including municipal services for social action, health, education and culture, etc.

The local stakeholders system

MATOLA

	Devolved services	Local authorities	
State	► Ministério da Mulher e da Acção Social ► Direcção Nacional do INAS	► Conselho Municipal da Matola	**Central Level**
Province	► Direcção da Mulher e da Acção Social da Provincia de Maputo ► Delegação do INAS da Provincia de Maputo ► Direcção da Saúde da Provincia de Maputo ► Direcção da Educação e Cultura da Provincia de Maputo ► Direcção da Juventude e Desportos da Provincia de Maputo	► Gabinete do Gênero e Empoderamento da Mulher e Acção Social do Municipio de Matola ► Vereação da Cultura, Juventude e Desportos do Municipio da Matola	**Municipal Service**
District	► Serviço de Saúde, Mulher e Acção Social da Cidade de Matola		
Administrative Post	► Posto Administrativo de Infulene		
Neighbourhood	► Khongolote, T3, Ndlavela		**Neighbourhood**

MAPUTO

	Devolved services	Local authorities	
State	► Ministério da Mulher e da Acção Social ► Direcção Nacional do INAS	► Conselho Municipal da Maputo	**Central Level**
Province	► Direcção da Mulher e da Acção Social da Cidade de Maputo ► Delegação do INAS da Cidade de Maputo ► Direcção da Saúde da Cidade de Maputo ► Direcção da Educação e Cultura da Cidade de Maputo ► Direcção da Juventude e Desportos da Cidade de Maputo	► Gabinete do Gênero e Empoderamento da Mulher e Acção Social do Municipio de Matola ► Vereação da Cultura, Juventude e Desportos do Municipio da Matola	**Municipal Service**
District	► Vereação / Administração do Distrito Municipal n°5 ► Direcção Distrital da Mulher e Acção Social do Distrito Municipal n°5		
Neighbourhood	► Jorge Dimitrov, Malhazine, Zimpeto, Magoanine A, B, C		**Neighbourhood**

a) A sluggish but effective decentralisation process

The first stage of the territorial decentralisation process, which led to the creation of the municipalities of Maputo and Matola, was only begun in Mozambique in 1997.[8] It was followed by an administrative decentralisation stage, establishing the prerogatives of the government's devolved services for the different levels of the administration (province, district, administrative positions, neighbourhood)[9], from 2003 onwards. Although developed concomitantly, these two distinct processes are relatively recent in the territory and incomplete. This transitional situation has given rise to a **certain amount of confusion in the dividing up of responsibilities and prerogatives between the different levels of the administration and territory.**

Moreover, whereas the districts develop their planning resources[10] according to a primarily bottom-up approach, with the district as the cornerstone of local development, financing follows a top-down pattern from the central administration to the local levels, which **creates a certain disconnection between the planning and budgeting of activities.** Without the allocation of corresponding resources, there remains a high level of uncertainty about their ability to effectively implement local action plans.

It is also **difficult to synchronise and coordinate the transfer of responsibilities and financial resources** from central government to the devolved services or to local authorities (responsibilities are sometimes assigned without the allocation of corresponding resources, and vice versa). However, despite these difficulties, **the transfer of the management of certain basic medical and social units is starting to be implemented**[11], at least in Maputo. As such, from 1 January 2010, the whole of the primary education system up to the last year of primary school (104 schools), along with its related resources, were transferred to the Education, Culture and Sports Department of the Municipality of Maputo. 21 out of 28 health centres in the city were also placed under the authority of the municipality on the same date. The role of the Municipalities in health and social matters is therefore gradually increasing in importance, although no objectives in terms of the improvement of the quality of public services have been set.

b) Complex urban government

As shown in the diagram above, **the organic structuring of the municipalities differs significantly between local authorities.** For example, health and social action are managed by the same service in Maputo, and separately by distinct municipal services in Matola. These structural differences make it more complicated to link up contacts from the two municipalities in the field of health and social action.

Nor is the breakdown of responsibilities between OLEs and ALs clear for operators in the field or for the population itself. Without mentioning the fact that certain entities are placed under the double supervision of a devolved state service and the municipality, which does not exactly make it easier to understand the role played by each one (for example, Infulene administrative unit, District 5 administration and neighbourhood secretaries). This institutional confusion encourages local stakeholders to give preference to **individual opportunity strategies over collective consultation approaches,** in the absence of clearly organised and structured relationships between the different decentralised and devolved entities.

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[8] Municipalisation law 2/97.
[9] Law 8/2003, Decree 11/2005 and Decree 6/2006
[10] District economic and social plan (PESOD).
[11] Application of Decree 33/2006

The local stakeholders system

This on-going decentralisation process, added to a divided territorial administrative structure (Cidade/Provincia and Municipio de Maputo/Matola), makes **local urban governance particularly complex**, especially in the field of health and social action. Although the metropolitan area of Maputo and Matola is being transformed into an increasingly homogenous urban whole, with increasingly interpenetrating social and urban dynamics, there appears to be an urgent need to adopt a global approach to resolving the difficulties of people with disabilities.

c) Operational capacities hindered by a lack of resources

Generally, the capacities of OLEs and ALs to nationally enforce existing laws and action plans are relatively limited, due to a **distinct lack of financial and material resources for developing their activities.** Municipal social action services have a staff of no more than a dozen people, for example, to implement programmes for thousands of people in situations of vulnerability. There is only one INAS permanent employee in each of Maputo's 43 neighbourhoods (each neighbourhood has up to 10,000 inhabitants) responsible for the social follow-up of hundreds of people and without logistical resources at their disposal. Under these circumstances, social work ends up being an administrative process involving the transfer of resources without any personalised social support dimension, due to a lack of time and resources.

The **lack of human resources with the necessary technical qualifications** is also, to a large extent, a problem for the public authorities, both in promoting inclusive education and applying mechanisms relating to the physical accessibility of buildings.

d) Drive to enhance social programmes

More positively, **the development and strengthening of existing social action mechanisms are gathering momentum**, both nationally - with a new basic social welfare law - and locally, following the recent setting up of social action services in the Municipalities of Maputo and Matola. Although local authorities currently give priority to a more charity-based approach to social action (food baskets, gifts of material and clothing, etc.) and are, in large part, not related to the actions performed by the INAS services, these initiatives seem to be moving towards greater consideration for the needs of vulnerable populations.

Among these vulnerable populations, people with disabilities are considered as a priority group by most social assistance mechanisms developed by the various entities in question, both in terms of devolved government services and decentralised local authorities. However, because of the difficulty of communicating with their target public, added to limited material and financial resources, these programmes struggle to provide people with disabilities with a satisfactory service.

e) Neighbourhood secretaries: intermediaries between users and services

Neighbourhood secretaries are generally the first resort for the local population in meeting family needs (schooling of a child, caring for a sick parent, social services, etc.). They often **take responsibility for receiving, analysing and channelling the social demands of citizens to existing local services.** In this way, the local administration is a key contact, on which the development of social support strategies for people with disabilities need to be based.

Neighbourhood secretaries also perform a pivotal role as *intermediation nodes* between the different health and social services. On the map below, we have highlighted the nodes that correspond to the neighbourhood secretariats within the network of health and social service providers. **Their presence is highly formative for the local network**. They are essential channels for linking the service chain and inter-sector exchanges, in particular in the field of education and social services.

- ● **Health**
- ● **Education**
- ● **Training & Employment**
- ● **Social services**
- ● **Sport and Culture**
- ● **Neighbourhood secretariats**
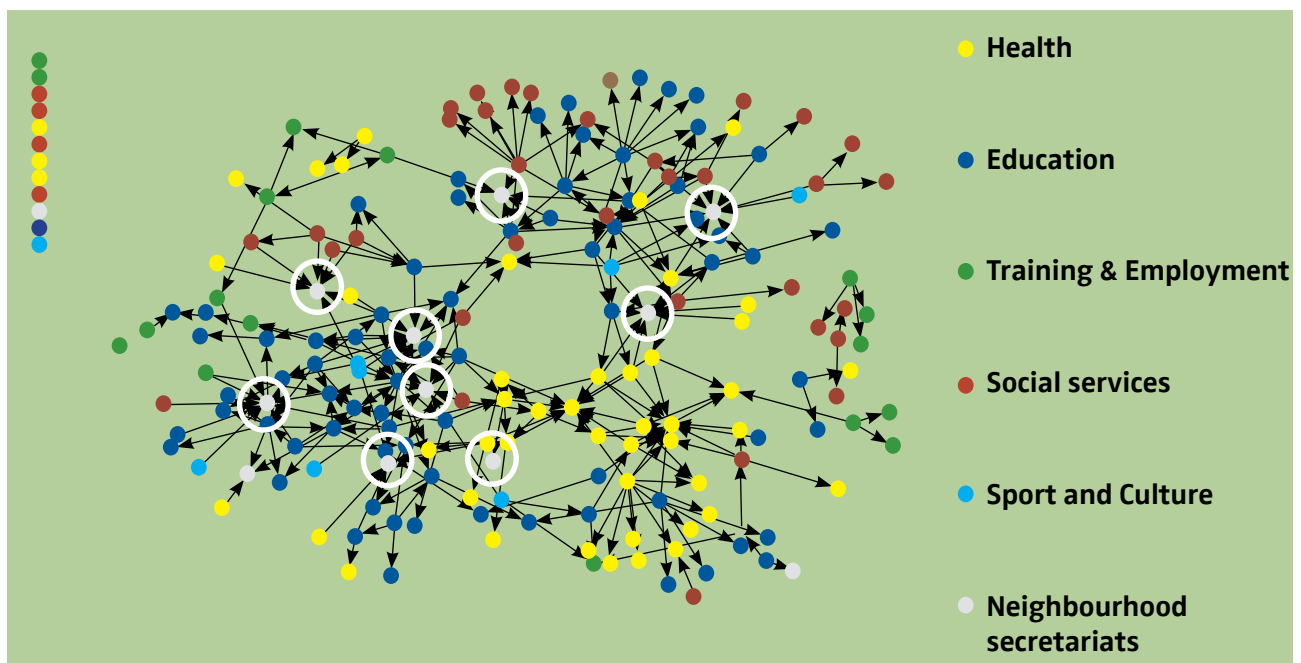
Historically and culturally well-established, although this triangular system linking users and service providers via the intermediary of neighbourhood secretaries is effective, it does have certain limitations:

► The staff of the neighbourhood secretariats are not always well trained in social work techniques and can **experience problems in correctly analysing the requests made to them**, especially when they are complex and specific, as in the case of people with disabilities;

► They very often have **an incomplete vision of the range of services existing in their neighbourhood or in adjoining neighbourhoods due to a lack of information**, which limits their capacity to direct potential users to facilities with the capacity to meet their needs;

► **Their role as gatekeepers at the intersection between social demand and the service offering can lead to the development of a patronage-based relationship** with potential users. In fact, the rarer the resources, the more individuals need to develop patronage-based relationships with the authority locally to ensure their needs are met immediately (Badie, 1992).

Recommendations for improving the social participation of people with disabilities in the territory

Recommendations for improving the social participation of people with disabilities in the territory

Due to the weakness of local consultation mechanisms, the development of proactive strategies in aid of people with disabilities in the metropolitan area of Maputo/Matola now appears to be unavoidable. Excluding public opinion and society in general, all operators in the territory need to perform a major effort in response to this issue:

Based on suggestions from a number of operators interviewed for this assessment, we have outlined a set of recommendations and proposals below to promote the synergy and harmonization of the initiatives performed in this territory:

I/ By intervention area

Area 1 Raising awareness of and providing information on the rights of persons with disabilities

► Informing people with disabilities of their basic rights, particularly access to services, based on the United Nations Convention on the Rights of Persons with Disabilities.

► Raising public awareness to change the way people see disability, supported by the media and DPOs.

► Informing people with disabilities about existing INAS programmes, as well as the new basic social welfare law, through DPOs.

► Informing health and social action professionals about services available in the territory, for example by distributing annual service directories.

► Raising the awareness of parents to the need to send children with disabilities to school, with priority given to mainstream schools.

► Raising the awareness of and training civil engineering technicians to include physical accessibility in the design of new buildings, based on universal design principles.

► Raising the awareness of private sector companies to the need to hire people with disabilities.

► Raising the awareness of private sector companies to the need to improve the accessibility of the workplace and the ergonomics of workstations.

► Sharing and enhancing existing knowledge on disability issues in Mozambique, and more specifically in urban areas, based on the development of studies and reports in close partnership with DPOs, the university sector and the INE.

Area 2 Implementing and improving the existing legislative framework

► Applying existing laws and regulations, in particular those guaranteeing:
  - free medication and healthcare for the most vulnerable people with disabilities in health units and public pharmacies
  - exemption from school fees for children with disabilities from underprivileged families
  - the hiring of people with disabilities in the public sector
► Expanding mainstream schooling for people with disabilities, particularly in secondary and higher institutions

► Speeding up the establishment of the National Disability Council and the development of PNAD II (2011-2015).

► Developing incentives (fiscal advantages) or requirements (minimum quotas) to promote the hiring of people with disabilities in the public and private sectors.

► Applying the existing technical and legislative framework to ensure the accessibility of:

- public buildings (administrative buildings, hospitals, sports facilities, etc.),
- buildings open to the public (banks, stores, museums, etc.),
- public transport (chapas, machibombos, etc.),
- public spaces (streets, pavements, parks, etc).

► Defining the allocation conditions and entitlements for holders of a disability card (free public transport, medication, cultural events, etc.)

► Defining the breakdown of responsibilities between OLE and AL in the current decentralisation process, in particular the health and social development-related sectors.

► Supporting the ratification of the United Nations Convention on the Rights of Persons with Disabilities by the Mozambican government.

Area 3   Mainstreaming the health and social services system

► Training health and social service professionals in accommodating and case-managing people with disabilities (teachers, health workers, sports educators, trainers, etc.)

► Improving the physical accessibility of health and social services based on universal design principles (building of access ramps, adjustment of internal furniture, adapting toilets, etc.) to accommodate disabled users as part of a mainstreaming approach.

► Increasing the accessibility of information for people with disabilities within services (Braille, audio, pictogrammes, multi-language, etc.), adapted to different disabilities and the linguistic abilities of users.

► Promoting the development of support services to form a link between mainstream and specialised services (adapted transport services, sign language interpretation or Braille services, accommodation alteration services) including:

- the setting up of an Information, Guidance and Social Support service in the territory consisting of mixed teams from civil society, the community and social workers from the local administration.
- assistance for support services targeted more specifically at women with disabilities, more likely to be excluded from the health and social services system (literacy courses, day care for children, discussion and mutual assistance groups, etc.)
- Harmonizing the methodologies and tools used to identify and support people with disabilities.

► Providing support for neighbourhood secretariats to deploy an effective local social communication strategy and link up service supply and demand.

► Increasing practical exchanges between mainstream and specialised service professionals.

► Defining a Quality Charter of specialised services in collaboration with users to include them within the common system.

► Stimulating demand from users to ensure improvements in the quality of services offered become a political demand made by citizens.

Area 4   Placing disability at the centre of coordinated local development strategies

► Promoting a cross-sectional approach to systematically including people with disabilities in priority groups for economic and social projects and programmes implemented by various institutions in the territory.

► Building the capacities of social action services provided by the Municipalities of Maputo and Matola, to optimise the mainstreaming of the needs of people with disabilities.

► Defining the consultation mechanisms between the social services of the OLE, AL and civil society at an operational level.

► Intensifying and diversifying exchange flows between services, Municipalities and the INAS to locally generate social capital: referral of users, exchange of practices and information, etc.

► Adopting a trans-territorial approach in response to local challenges to reduce the administrative gaps between Maputo and Matola and address the metropolitan area as a whole.

► Creating a Consultation Forum for Maputo and Matola, associating organised civil society, local public authorities and service providers, to establish a permanent dialogue across the territory.

► Developing and implementing a local inclusive disability action plan at the instigation of the Consultation Forum, with specific annual goals by theme, responsible operators and clearly-identified budgets.

► Developing and piloting a metropolitan labelling system for buildings and inclusive services (single pictogram system in public services, hotels, restaurants, parks, buildings open to the public, stations, etc.)

Recommendations for improving the social participation of people with disabilities in the territory

Area 5   Follow-up and assessment

► Building the advocacy capacities of FAMOD and DPOs to monitor the implementation of existing regulations and raising public awareness of the conditions experienced by people with disabilities.

► Developing specific disability follow-up indicators and building the capacities of local stakeholders (Municipalities, INAS, DPOs, etc.) to monitor the social programmes implemented.

► Controlling the application of accessibility standards for all new public buildings or premises open to the public.

► Checking the effective implementation of the Strategy for People with Disabilities in Public Service (2009-2013) adopted in September 2009.

► Enlisting the support of the National Disability Council to monitor and assess national and local public policies for people with disabilities.

► Monitoring the application of measures specifically related to people with disabilities in PEN III (2010-2014).

► Capitalising on best practices and bringing them to the attention of the area's operators.

II/ By intervention sector

Health

- Raising the awareness of people with disabilities to their rights in terms of health, based in particular on article 25 of the Convention and on existing national regulations.
- Improving the physical accessibility of health units.
- Improving the accessibility of information in health units, in particular awareness and prevention messages.
- Training health professionals in receiving and case-managing people with disabilities.
- Improving access to medication and health care for people with disabilities in health units and public pharmacies: free medication and care, priority in health unit queues, home visits for people with reduced mobility, etc.
- Facilitating access to compensatory equipment and spare parts (setting up of a compensatory equipment production and maintenance workshop, for example).
- Developing specific strategies for people with disabilities in the fight against HIV/AIDS.
- Improving disability detection and prevention mechanisms in health units.
- Expanding the local health network to meet demand for care, particularly in expanding neighbourhoods.

Education

- Raising the awareness of people with disabilities to their rights in terms of education, based in particular on article 24 of the Convention and on existing national regulations.
- Raising the awareness of parents to the need to send children with disabilities to school, within the mainstream system if possible.
- Training teachers to cater to the needs of children with disabilities in their classes.
- Improving the physical accessibility of schools and universities to ensure they cater to students with disabilities.
- Producing and making available educational materials adapted to different types of disability.
- Exempting children with disabilities from disadvantaged families from paying school fees.
- Speeding up the deployment of inclusive education, in particular in the secondary and higher education sectors.
- Developing a sign language interpreting service within the Ministry for Education.

Recommendations for improving the social participation of people with disabilities in the territory

Professional training

► Improving the physical accessibility of occupational training centres.

► Adapting training courses and methodologies to the needs of people with disabilities.

► Promoting the access of people with disabilities to the occupational training system and diversifying training opportunities.

► Strengthening the link between the training system and the private sector to promote post-training opportunities, particularly through the development of internship programmes in companies.

Employment

► Raising the awareness of people with disabilities to their rights in terms of work and employment, based in particular on article 27 of the Convention and on existing national regulations.

► Analysing the employment market in Maputo and Matola to study the balance between the needs of businesses and the available workforce of people with disabilities.

► Setting up a local employment grant to promote the interaction between job offers and demand for people with disabilities, in association with the Ministry for Work and the INEFP.

► Developing incentives (fiscal advantages) or requirements (minimum quotas), for example, to promote the hiring of people with disabilities in businesses and the public and private administrative sectors.

► Raising the awareness of the private sector to the need to improve the accessibility and ergonomics of companies.

Social Services and Programmes

► Raising the awareness of people with disabilities to their rights in terms of social welfare, based in particular on article 29 of the Convention and on existing national regulations.

► Underlining the need to take people with disabilities into consideration as a priority group for social services and programmes.

► Informing people with disabilities about existing social welfare mechanisms, particularly the new basic social welfare law, enlisting the support of DPOs.

► Building the capacities of INAS technicians at a local, district and provincial level to optimise the inclusion and support of people with disabilities in social programmes.

► Building the capacities of social action services provided by the Municipalities of Maputo and Matola, to optimise the mainstreaming of the needs of people with disabilities.

► Improving the physical accessibility of existing social units in Maputo and Matola.

Sport and Culture

► Raising the awareness of people with disabilities to their rights in terms of taking part in cultural and recreational/leisure and sporting activities based in particular on article 30 of the Convention and on existing national regulations.

► Promoting the practice of physical activities for people with disabilities and their families.

► Facilitating the loan and purchase of equipment enabling the practice of habilitated sports activities.

► Training sports educators in disability sports.

► Improving the physical accessibility of sporting facilities in both cities (stadiums, gyms, etc.).

► Supporting the formation of disability sports clubs and organisations.

► Raising public awareness of disability sports to change the way people perceive the capacities of people with disabilities.

► Facilitating the production and programming of works involving artists with disabilities.

► Improving the physical accessibility of existing cultural facilities, including cinemas, theatres and cultural centres.

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APPENDIX 1 - List of Disabled people's organisations involved in the assessment

	Disabled people's organisations	Representative
ACAMO	Associação de Cegos e Amblíopes de Moçambique	José Diquissone
ACRIDEME	Associação de pais e amigos de Crianças Deficiêntes Mentais	Berta Biose
ADEMIMO	Associação de Deficiêntes Militares e Paramilitares de Moçambique	Virgilio Evaristo Wanela
ADEMO	Associação dos Deficientes Moçambicanos	Ricardo Moresse
ADESU	Associação dos Deficiêntes do Ensino Superior	Elias José David
ADPPDCM	Associação de Desporto da Pessoa Portadora de Deficiência da Cidade de Maputo	Raimundo Manuel Patrocinio
ADPPDPM	Associação Desportiva para Pessoas com Deficiência da Provincia de Maputo	Alberto Chave Ngoma
AJODEMO	Associação dos Jovens Deficiêntes de Moçambique	Cantol Alexandre Pondja
AMDV	Associação Moçambicana dos Deficientes Visuais	José Alvaro Macou
AMMD	Associação Moçambicana de Mulheres portadoras de Deficiência	Eufemia Amela
AMOFAS	Associação Moçambicana dos Familiares e Amigos dos Surdos	Marilia Filomena Amade
ASUMO	Associação dos Surdos Moçambicanos	Agostinho Foliche
CERCI	Cooperativa para a Educação e a Reabilitação de Cidadões Inadaptados	Nelson Beete
CINFORTECNICA	Associação de Jovens Técnicos Portadores de Deficiencia de Moçambique	Sergio Manuel Simone
CODDEFAM	Comité de Defesa dos Deficiêntes das Forças Armadas de Moçambique	Tomas Chigamane
CPM	Comité Paralimpico de Moçambique	Jorge Miguel Bai Bai
NLHUVUKU	Grupo teatral	João Magaia
RAVIM	Rede para Assistência as Vitimas de Minas	Luis Silvestre Wamusse
FAMOD	Forum das Associações Moçambicanas de Deficientes	Ricardo Moresse

Year founded	Type of impairment of members
1995	Visual
1994	Intellectual
1992	Visual/Hearing/Physical/Intellectual
1989	Visual/Hearing/Physical/Intellectual
1995	Intellectual
2007	Visual/Hearing/Physical/Intellectual
2003	Visual/Hearing/Physical
1995	Physical
2003	Visual/Physical
2007	Physical
1995	Hearing
1999	Hearing
2002	Hearing/Physical/Intellectual
2005	Visual/Hearing/Physical/Intellectual
2002	Visual/Hearing/Physical/Intellectual
2008	Visual/Hearing/Physical/Intellectual
1997	Physical
2005	Physical
1998	National DPO network

APPENDIX 2 - List of government and local authority services involved in the assessment

	State services	Representative	
NATION-WIDE	Ministério da Mulher e da Acção Social	S.Excia Ministra	Iolanda Maria Cintura
	Direcção Nacional do Instituto Nacional de Acção Social	Directora nacional	Lúcia Bernardete Pedro Maivosse
MAPUTO CITY	Direcção da Mulher e da Acção Social da Cidade de Maputo	Directora provincial	Angelina Paulo Lubrino
	Delegação do INAS da Cidade de Maputo	Delegada provincial	Cilda Antonio Cossa
	Direcção de Saúde da Cidade de Maputo	Director provincial	António Paulino Rodrigues
	Direcção da Educação e Cultura da Cidade de Maputo	Director provincial	Gedião João Jamo
	Direcção da Juventude e Desportos da Cidade de Maputo	Director provincial	Antonio Alberto Munguambe
	Direcção Distrital da Mulher e Acção Social do Distrito Municipal n°5	Directora distrital	Ana Eduardo C. Invõa
MAPUTO PROVINCE	Direcção da Mulher e da Acção Social da Provincia de Maputo	Director provincial	Luciano José
	Delegação do INAS da Provincia de Maputo	Delegado provincial	Geraldo Abilio Bazo
	Direcção de Saúde da Provincia de Maputo	Directora provincial	Cremilda Alice da Silva
	Direcção de Educação e Cultura da Provincia de Maputo	Director provincial	Lucas Paulo Fernando
	Direcção da Juventude e Desportos da Provincia de Maputo	Directora provincial	Ana Albertina Wate
	Serviço de Saúde, Mulher e Acção Social da Cidade de Matola	Directora	Celeste Moreira

	Local Authorities	Representative	
MAPUTO MUNICIPALITY	Vereação de Saúde e Acção Social do Municipio de Maputo	Vereador	Alexandre Munguambe
	Vereação de Educação, Cultura e Desporto do Municipio de Maputo	Vereador	Simião Mucavele
	Vereação / Administração do Distrito Municipal n°5	Vereador	Lourenzo Duarte Mabanga
MATOLA MUNICIPALITY	Gabinete do Genero, Empoderamento da Mulher e Acção Social do Municipio	Directora	Florencia Muianga
	Vereação da Cultura, Juventude e Desportos do Municipio da Matola	Vereador	José Bento Coffe
	Posto Administrativo de Infulene	Chefe do posto	Manuel Ouana

ANNEXE 3 - List of health and social service providers involved in the assessment

	Health and social service providers	Status	Neighbourhood
	Associação dos alvanários de Moçambique	Private	25 de Junho
	Direcção Distrital da Mulher e Acção Social do Distrito Municipal n°5	Public	25 de Junho A
	Centro ortopédico - A.F. Abegão Lda	Private	Alto-Maé
	Centro de saúde de Bagamoyo	Public	Bagamoyo
	Centro de saúde de Bagamoyo	Public	Bagamoyo
	Cooperativa para a educação e a reabilitação de cidadões inadaptados	Private	Baixa
	Departamento de medicina fisica e reabilitação do Hospital Central	Public	Central
	Centro ortopédico do Hospital Central	Public	Central
	Serviços de oftamológia do hospital central	Public	Central
	Centro de saúde Licuacuanine	Private	Khongolote
	Centro de saúde de Khongolote	Public	Khongolote
	Centro de saúde de Denise Irmãos	Private	Khongolote
	Farmácia Khongolote	Private	Khongolote
	Farmacia Licuacuanine	Private	Khongolote
	Centro de saúde de Magoanine A	Public	Magoanine A
	Associação dos Medicos Tradicionais de Moçambique	Private	Magoanine A
HEALTH	Centro de saúde Kungaya	Private	Magoanine B
	Posto de saúde Magoanine Tendas	Public	Magoanine C
	Posto de saúde Magoanine Tendas	Public	Magoanine C
	Centro de medicina fisica e reabilitação Vikhela	Private	Malhangalene
	Centro de reabilitação infantil de Malhangalene	Public	Malhangalene
	Centro de saúde Tinashe	Private	Malhazine
	Farmacia de Malhazine	Private	Malhazine
	Farmacia Aloe Vera	Private	Malhazine
	Centro de saúde de Ndlavela	Public	Ndlavela
	Farmâcia Stefane	Private	Ndlavela
	Posto de saúde de T3	Public	T3
	CINFORTECNICA	Private	Urbanização
	Ministerio Arco- Iris	Private	Zimpeto
	Centro de Saúde de Zimpeto	Public	Zimpeto
	Centro de saúde Moyo	Private	Zimpeto
	Farmacia Zabdiel	Private	Zimpeto
	Hospital psiquiatrico de Infulene	Public	Zimpeto

Health and social service providers	Status	Neighbourhood
Escola comunitária 1° de Maio	Private	1° de Maio
Associação de cegos e ambliopes de Moçambique	Private	Alto Maé
Escola primaria completa Infulene Benfica	Public	Bagamoyo
Escola de educação especial nº 1	Public	Bairro Central
Escola primária completa Especial n°2	Public	Bairro Central
CERCI	Private	Baixa
Associação moçambicana dos deficiêntes visuais	Private	Hulene B
Escola primaria completa 1 de Junho	Public	Jorge Dimitrov
Escola primaria completa São Francisco Xavier	Private	Jorge Dimitrov
Escola comunitária Jorge Dimitrov	Public	Jorge Dimitrov
Escola primaria Unidade 29	Public	Jorge Dimitrov
Escola Primária do 2° grau de Mubukwane	Public	Jorge Dimitrov
Escola primaria Unidade 29	Public	Jorge Dimitrov
Escola primaria completa São Francisco Xavier	Private	Jorge Dimitrov
Escola comunitária Missão Yoido	Public	Khongolote
Escola primeira completa de Khongolote	Public	Khongolote
Escola comunitária Missão Yoido	Public	Khongolote
Escola comunitária Hitahlula	Private	Khongolote
Escola primaria 19 de Outubro	Public	Magoanine A
Colégio Ilia	Private	Magoanine A
Centro de alfabetização da Igreja Evangélica da Salvação de Moçambique	Private	Magoanine A
Escola primaria completa de Magoanine A	Public	Magoanine A
Escola secundaria de Magoanine A	Public	Magoanine A
Centro de alfabetização de adultos da Igreja Assembleia de Deus	Private	Magoanine A
Centro de alfabetização e educação de adultos	Public	Magoanine A
Centro de alfabetização da Igreja Evangélica da Salvação de Moçambique	Private	Magoanine A
Escola primaria de Magoanine B	Public	Magoanine B
Escola primaria Artur Hussene Canana	Public	Magoanine C
Escola primária completa 10 de Janeiro	Public	Magoanine C
Centro de recursos de Magoanine C	Private	Magoanine C
Escola comunitária da ADEMO	Private	Malhangalene
Escola primária completa de Malhazine	Public	Malhazine
Escola secundária de Malhazine	Public	Malhazine
Escola primária completa Samora Machel	Public	Ndlavela
Escola primária completa de Ndlavela	Public	Ndlavela
Escola secundária 3 de Maio	Private	Ndlavela
Escola primária completa Unidade T3	Public	T3
Escola primária Nossa Senhora do Livramento	Public	T3
Escola comunitária Nossa Senhora do Livramento	Private	T3
Escola comunitária Nossa Senhora do Livramento	Private	T3
Escola primaria completa de Zimpeto	Public	Zimpeto
Escola primaria completa Ingrid Chawner	Public	Zimpeto
Ministerio Arco- Iris	Private	Zimpeto

The first column of the table is labelled **HEALTH** (spanning all rows).

	Health and social service providers	Status	Neighbourhood
HEALTH	Escola primaria completa Wiryamu	Public	Zimpeto
	Escola secundaria Quisse Mavota	Public	Zimpeto
	Escola primaria completa Wiryamu	Public	Zimpeto
PROFESSIONAL TRAINING	ACAMO	Private	Alto Maé
	Instituto Nacional de Emprego e Formação Profissional (Bairro Central)	Public	Bairro Central
	Instituto Nacional de Emprego e Formação Profissional (Bairro Central)	Public	Bairro Central
	Centro de formação profissional de eletrotecnia do INEFP	Public	FPLM
	Associação comunitária Tintswalo	Private	Jorge Dimitrov
	Caixa Comunitária de Microfinanças de Maputo - Norte	Private	Jorge Dimitrov
	Instituto Nacional do Emprego e Formação Profissional (Machava)	Public	Machava
	Colégio Ilia	Private	Magoanine A
	Associação dos Medicos Tradicionais de Moçambique	Private	Magoanine A
	Centro de alfabetização de adultos da Igreja Assembleia de Deus	Private	Magoanine A
	Associação das Mulheres Jovens Vítimas das Cheias de 2000	Private	Magoanine C
	Centro de recursos de Magoanine C	Private	Magoanine C
	Associação cultural Muhodjo	Private	Magoanine C
	Escola comunitária da ADEMO	Private	Malhangalene
	Associação de crédito Josina Machel	Private	T3
	CINFORTECNICA	Private	Urbanização
	Centro juvenil Ingrid Chawner	Private	Zimpeto
	Associação Reconstruindo a Esperança	Private	Zimpeto
	Ministerio Arco- Iris	Private	Zimpeto
	Escola secundaria Quisse Mavota	Public	Zimpeto
	Associação Reconstruindo a Esperança	Private	Zimpeto
	Associação Nthananu	Private	Zimpeto
	Associação Agro-Pecuária de Golhosa	Private	Zimpeto
	Associação Agro-Pecuária de Golhosa	Private	Zimpeto
SOCIAL SERVICES AND PROGRAMMES	Associação das escolinhas	Private	Jorge Dimitrov
	Escola primaria completa São Francisco Xavier	Private	Jorge Dimitrov
	Centro infantil Sol de Khongolote	Private	Khongolote
	Escola comunitária Missão Yoido	Public	Khongolote
	Colégio Ilia	Private	Magoanine A
	Centro de alfabetização da Igreja Evangélica da Salvação de Moçambique	Private	Magoanine A
	Escolinha Anjo Azul	Private	Magoanine B
	Escolinha Sacrificio da Mãe	Private	Magoanine B
	Escolinha Cantinho da Borboleta	Private	Magoanine B
	Escolinha Magoanine B	Private	Magoanine B
	Escolinha Glim-Glim	Private	Magoanine B
	Centro infantil Casa da Familia	Private	Magoanine C
	Centro de recursos de Magoanine C	Private	Magoanine C
	Associação cultural Muhodjo	Private	Magoanine C

ANNEXE 3 - List of health and social service providers involved in the assessment

	Health and social service providers	Status	Neighbourhood
SOCIAL SERVICES AND PROGRAMMES	Centro de trânsito de Malhangalene	Public	Malhangalene
	Escolinha Santa Baquita	Private	Malhazine
	Associação Yinguisseta	Private	Malhazine
	Associação Yinguisseta	Private	Malhazine
	Escolinha Alegria	Private	Ndlavela
	Escolinha Nova	Private	Ndlavela
	Centro infantil Funda	Private	Ndlavela
	Escola comunitária Arco-Iris	Private	Ndlavela
	Centro infantil Villas	Private	Ndlavela
	Centro infantil Flor da Paz	Public	T3
	Obra Dom Orion	Private	Zimpeto
	Associação de activistas de educação para a sociedade	Private	Zimpeto
	Associação de activistas de educação para a sociedade	Private	Zimpeto
SPORT AND CULTURE	Futebol Clube de Chindjerere	Private	Jorge Dimitrov
	Associação comunitária Tintswalo	Private	Jorge Dimitrov
	Associação comunitária Tintswalo	Private	Jorge Dimitrov
	Futebol clube de Khongolote	Private	Khongolote
	Comissão desportiva	Private	Magoanine C
	Grupo cultural Ngalanga	Private	Magoanine C
	Grupo cultural Muthimba	Private	Magoanine C
	Centro comunitário aberto de Magoanine C	Public	Magoanine C
	Associação cultural Muhodjo	Private	Magoanine C
	Selmas Ballet	Private	Malhangalene
	Selmas Ballet	Private	Malhangalene
	Selmas Ballet	Private	Malhangalene
	Raizes Futebol Clube	Private	Ndlavela

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(Mines Victim Assistance Network)
Av. Milagre Mabote, nº852
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