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Mozambique: The Ministry of Health advocating for People with Disabilities

Abstract

The government of Mozambique has signed the United Nations Convention on the Rights of Persons with Disability (CRPD), but it has not yet been ratified. However, some of its neighbours have already ratified it. Namibia, for example, has the highest Gini coefficient of income inequality, and its legal framework is much less developed than Mozambique's, nevertheless it has ratified the convention. This will help Namibia to raise people with disability (PWD) out of poverty. This is something that Mozambique needs to do.

Therefore, the aim of this essay is to discuss why Mozambique should ratify the CRPD, and why and how the Ministry of Health should lobby the government to ratify it. The Ministry of Health has a specific role to spur the ratification of the Convention, which will also assist in achieving the Millennium Development Goals (MDG). We will identify possible key partners to be involved in the process. Consequently, we will speak about some practical ways the Ministry of Health should follow to implement the CRPD in the maternal and child health sector, and how to develop capacity building. The final scope is to understand the importance of ratifying such convention, and how Mozambique can improve the health care for PWD.

Keywords: *People with Disability, Disability, Convention on the Rights of Persons with Disability, Mozambique, Health, Medical and Social Model, Community-Based Rehabilitation*

Introduction

The government of Mozambique has signed the United Nations Convention on the Rights of Persons with Disability (CRPD), but it has not yet been ratified. However, some of its neighbours have already ratified it. Namibia, for example, has the highest Gini coefficient of income inequality, and its legal framework is much less developed than Mozambique's, nevertheless it has ratified the convention. This will help Namibia to raise people with disability (PWD) out of poverty. This is something that Mozambique needs to do.

Therefore, the aim of this essay is to discuss why Mozambique should ratify the CRPD, and why and how the Ministry of Health should lobby the government to ratify it. Please, bear in mind that helping and including PWD is not an action of charity, but it is a human right, a right to be part of the society. Impairment cannot be a cause of exclusion. Thus, the Ministry of Health has a specific role to spur the ratification of the Convention, which will also assist in achieving the Millennium Development Goals (MDG). This essay will also help to identify possible key partners to be involved in the process. Consequently, it will show some practical ways the Ministry of Health should follow to implement the CRPD in the maternal and child health sector, and how to develop capacity building.

The final scope is to understand the importance of ratifying such a convention, and how the Mozambican government can improve the health care for PWD.

People With Disabilities in Mozambique

Data shows that Mozambique has around 1.6 million disabled people, which means 8% of the total population (22 million), this figure includes 77% of people with a physical impairment and 16% of people with a mental impairment. The highest percentage is due to the consequences of decades of civil war. The number is definitely a striking one, and accordingly the role of the Ministry of Health is crucial in dealing with their inclusion¹.

If someone thinks that excluding PWD is the solution, then he/she is completely wrong. Governments often do not take into consideration the costs of not including PWD. For example, when in a family of four people, the mother has a movement disability, in a not-inclusive community, she does not work, and another member of the family must take care of her. The husband, eventually, would need to withdraw from his job, and try to spend more time at home to help the wife. Now, within this family three people are affected by the consequence of the mother's impairment. Therefore, the burden in terms of economic cost for the nation is not only for the PWD, but also for two other family members. Therefore, inclusion is essential.

In terms of Mental Health, Mozambique does not have a national policy as Namibia. People with a mental disability have been considered very rarely in the government's policies. Generally speaking, although physical disability has been considered as shameful, it has not been regarded as disturbing as

¹ *Disability and HIV/AIDS in Mozambique: a Research Report by Disability and Development Partners. London: Disability and Development Partners [Internet], 2008 Apr., pp. 5-6, available from: <http://www.ddpuk.org/full-report.pdf>*

intellectual disability². Therefore, the 16% of the population with a mental disability is considered at the bottom of a hierarchy of stigma, and those affected by both a physical and a mental disability (ex. cerebral palsy and epilepsy) are even more stigmatized. Such stigma can be combated only by implementing a rights-based approach to disability within the public health system.

Medical Model Vs Social Model

Until recently, most countries have been applying the medical model to disabilities, which argues that PWD are physically unable to carry out social functions because of their impairment. PWD were excluded from social life; governments preferred to give them welfare benefits rather than employment. The general belief was that PWD were not able to produce as people without disabilities. Children were not educated, or when available they were educated in separate schools. Health care has been barely available. However, the social model³ changed the understanding of disability. Providing facilities, health care and welfare benefits, are not the only solutions. As a stark contrast to the medical model, the social model provides the right framework to include PWD into everyday society, making them productive and able to work. In fact, the social model prescribes that disability is a social construction by external factors (ex. stigmas), which determine the limitations of PWD.

² Longmore P. K., Umansky L., eds, *The New Disability History*, New York, New York University Press, 2001, pp. 293-295.

³ Its origins lie in the 1970s, when powerful international mechanisms were established: the *Declaration on the Rights of Mentally Retarded Persons* (1971) and the *Declaration on the Rights of Disabled Persons* (1975).

The social model, thus, provides that it is the society which must change, and not PWD. The CRPD is a tool established on the social model, which also prompted the Community-Based Rehabilitation (CBR) guidelines set by the World Health Organization.

The Convention on the Rights of Persons with Disability

The CRPD and its optional protocol were adopted by the UN on 13 December 2006, and they entered into force internationally on 3 May 2008⁴. “The Convention is necessary in order to have a clear reaffirmation that the rights of persons with disabilities are human rights and to strengthen respect for these rights. [...]”⁵. Mozambique signed the convention on 30 March 2007, however, it has already developed a legal framework for PWD’s rights. By the end of the civil war and with the introduction of the Mozambican Constitution (1990), PWD have been considered as depositary of the same human rights of the civil society. The Constitution guarantees the rights to people who became disabled because of wars or conflict, or as a consequence of their public work or for humanitarian work, and states that all Mozambican have the same rights and duties. Art.37 of the Constitution specifically addresses disability. The article is very striking as it recalls many relevant points of the CRPD. It states that PWD should enjoy the whole rights preserved by the Constitution, and it recognizes the importance of associations for disabled people, which today are known as

⁴ Healey J., ed, *Disability Rights and Awareness*, Balmain NSW, “Issue in Society”, 2010, 316: 23.

⁵ Webber J., Seminar 5: UNCRPD. POPH90088: *Disability in Developing Countries*, The University of Melbourne, lecture given 2012 Sep. 18, cited in: <http://www.ohchr.org>.

Disabled People's Organizations (DPOs). It is with DPOs that the Ministry of Health have to start to implement the CRPD.

Mozambique also passed an Anti-Discrimination Disability Act (1990), nevertheless, not much has been done to improve their life, health and education, and when it came to ratifying the convention, the government did not take a clear stance. Mozambique has signed several agreements that protect human rights⁶, nonetheless, the commitment of the government to implement the rights of PWD has been limited in scope.

A rights-based approach to disability is needed. The six key elements to address are: participation, accountability, non-discrimination, empowerment, legal framework, and sustainability. The rights-based approach considers the whole array of people's rights: civil, cultural, economic, political and social⁷. Hence, a guarantee that PWD have their rights to good health, education, shelter, rule of law, social protection, political participation, and rights to protest.

Art.25 of the CRPD specifically targets the rights to health for PWD, and it is the main article that concerns the Ministry of Health. It states that PWD "have the rights to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability"⁸. It also clarifies that State Parties must take serious steps to ensure that PWD have access to health, and must provide them with the same array, value and

⁶ The *International Covenant of Civil and Political Rights* (1976), the *Convention of the Rights of the Child* (1990), the *Convention for the Elimination of all Forms of Discrimination against Women* (1976), the *Mine Ban Treaty* (1997), the UNCRPD.

⁷ Stubbs D., *Closing the Gap: Making the Rights-Based Approach Real for PWDs in the ASEAN Region*, Utrecht, International Council on Social Welfare, 2008, p. 8.

⁸ Article 25, CRPD.

standard of free or affordable health care. Rural areas, which usually lack health facilities, must be provided with such facilities. Furthermore, the article clearly rejects any form of discriminatory denial of health care or health services of foods and fluids on the basis of disability.

The role of the Ministry of Health is primary because without good health, it is very unlikely that children with disabilities will be able to go to school, to acquire skills or to get a job. Also for adults with a disability a good health service is essential. Moreover three of the MDG face health issues, Goal4 (reduce child mortality), Goal5 (improve maternal health), Goal6 (Combat HIV/AIDS, Malaria and other diseases). These goals are far from being achieved by 2015, and in terms of maternal mortality, although there have been some improvements, the situation remains alarming⁹. Dr. Rahman, director of the Bangladeshi National Forum of Organizations Working with the Disabled (NFOWD), pointed out that in order to achieve these goals countries need political commitment by their governments, funding and the inclusion of PWD in the development processes. Any form of exclusion will undermine the development processes, and this is how the MDG look today. He concluded by suggesting that the acronym MDG, should be restructured by meaning, inclusive development and goals¹⁰. Only, if we include the most vulnerable people within the society, hence PWD, can we really achieve these goals. Though the MDG do not explicitly mention PWD, it is understandable also to the neophytes of disability studies, that

⁹ *The Millennium Development Goals Report 2012*, New York, United Nations, 2012, p. 5.

¹⁰ Rahman N., *The Millenium Development Goals – Are They Really Achievable?*, Bangladesh, National Forum of Organizations Working with the Disabled (NFOWD), pp. 12-13.

by fully implementing Art.25, and therefore, by providing good health service facilities for PWD, we would also address the three abovementioned goals. Art.20 (accessibility) and Art.26 (Habilitation and rehabilitation) together with Art.25 make the framework to establish the rights of PWD.

With such legal structure, a full understanding of the need for the ratification of the CRPD is indispensable. A huge amount of funds of the Ministry of Health are spent each year to create better conditions for PWD, nevertheless, such efforts are not backed by target policies of the national government. From a governmental point of view, the burden of taking care of PWD is only and exclusively a competence of the Ministry of Health. This clearly undermines the effectiveness of its projects. Furthermore, in the long run without a national binding policy towards disability, any time that a new government will take over, the financial plan scheduled from a previous government will possibly be redirected towards different sectors. This would have serious consequences for the effectiveness of any long term inclusive project. Hence, there is a strong need for an advocacy role of the Ministry of Health. As conventions are binding once ratified¹¹, the government will then be obliged to comply with disability rights, improving the public sector, infrastructures, and policies. These policies will advance and support the Ministry of Health to perform its role more efficiently. In order to lobby the government to ratify the convention, the Ministry must raise awareness of the economic costs of not including PWD, of not investing in improving maternal and child health and of not engaging with DPOs. Impairments do not totally

¹¹ Kayess R., *The Convention on the Rights of Persons with Disabilities: a Methodology for Collaboration in Capacity Building and Research*, in Thomas P., ed., *Implementing Disability-inclusive Development in the Pacific and Asia*, "Development Bulletin", 2011 Jun, 74: 25-26.

impede people to work, but an effective strategy is needed, focusing definitely on health and rights. Unfortunately, the government lacks focused policies for maternal and child health. Improving health facilities is essential for creating an inclusive society that takes care of PWD, and prevents those negative habits that may cause impairments.

By having this convention ratified the government of Mozambique will have to adopt legislation and administrative measures to implement PWD's rights; abolish discrimination; stop practices that breach the rights of PWD; consult with DPOs. This will lead to mainstream "disability into a range of program areas and sectors"¹². With such a new framework, improvements to maternal and child healthcare will be easier and more effective for the Ministry of Health.

Successful strategy: identify and involve partners

The best approach to implement the rights of PWD would be to identify key stakeholders. Firstly, inclusion of DPOs. There is no possibility to plan a project for PWD, without formally including them. "A voice of our own", this is the motto of Disabled Peoples' International. In other words, as Ed Roberts a disabled American said "...when others speak for you, you lose"¹³. Therefore, as social and health workers we cannot expect to organize a successful project if we do not listen to DPOs; PWD know their needs. The role of DPOs is to identify needs, express views on priorities, evaluate services and

¹² CBM Australia, *Inclusion Made Easy: A quick Program Guide to Disability in Development*, CBM Australia, 2012, p. 1.

¹³ Cited in: Enns H., *The Role of Organizations of Disable People: A Disabled Peoples' International Discussion Paper*, in *Independent Living* [Internet], available from:

<http://www.independentliving.org/docs5/RoleofOrgDisPeople.html>

advocate change and public awareness. In Mozambique, DPOs are represented by the Forum for Mozambican Association of Disabled People, established in 1998. It had 14 local representatives; unfortunately, today there are only 10 left. The Forum tried to lobby the government to adopt a rights-based approach to disability. Unfortunately, it did not have the hoped outcome. Another national DPO, established in 1989, just after the end of the civil war, is the ADEMO. It has more than 80.000 members, and has also promoted the birth of other local DPOs supporting war veterans, students, and women¹⁴. Clearly, the Ministry of Health needs to enter into dialogue with DPOs. They can help the Ministry to understand the problems and to find solutions. What we know about the current situation of PWD is that Mozambique had a civil war that left people mutilated, HIV/AIDS is endemic, maternal and child mortality is still very high, and we know that more likely the MDG will not be achieved by 2015.

Other key stakeholders would be Power International and Handicap International, which have already worked extensively in advocating for PWD. On a national scale it would be important to include the Washington-based institutions: the IMF and the World Bank.

Practical Solutions and Capacity building: Community-Based Rehabilitation

It is widely proved that poverty is one of the causes of impairments, as people live in unhealthy circumstances. In Mozambique, people injured by landmines during the civil war cannot afford proper health care. In many rural areas, health services and rehabilitation mechanisms are basically inexistent.

¹⁴ “Disability and Development Partners”, 2008 Apr., pp. 5-9.

Child mortality is very high; facilities for pregnant women are very basic. These people are prevented from enjoying their rights to health as established in the CRPD. The Ministry of Health needs to address such situations.

An effective strategy is the application of the CBR concept, which would assist in the implementation of the CRPD and to develop the necessary capacity to face the needs of PWD. A definition of CBR looks like this: “CBR is a focused community development program in the field of disability prevention and rehabilitation”¹⁵. “The role of CBR is to identify health promotion activities at a local, regional and/or national level and work with stakeholders to ensure access and inclusion for PWD and their family”¹⁶. “CBR is a way of thinking not a specific program, organization or group of people”¹⁷.

CBR concepts need to be applied at a national level, and it consists of 5 elements, of which health is of our concern today. It has 5 subcategories: promotion, prevention, medical care, rehabilitation and assistive devices. Maternal and child health care can be improved through promotion and prevention. A CBR project should promote breastfeeding, good nutrition and persuade “pregnant women to attend antenatal care for iron and folic acid supplements”¹⁸. Prevention through antenatal care and skilled care during the delivery and after the birth of the child reduce the risk of mothers and babies developing impairments.

¹⁵ *Finding out about CBR: Training Materials for Community Based Rehabilitation Workers*, Indonesia, CBR Development & Training Center [Internet], p. 5, available from:

http://unipd-centrodirittiumani.it/public/docs/23647_cbr.pdf

¹⁶ *CBR Guidelines, Health component*, WHO, 2010, p. 13.

¹⁷ *Finding Out About CBR: Training Materials for Community Based Rehabilitation Workers*, p. 4.

¹⁸ *CBR Guidelines, Health component*, p. 29.

Primary prevention would also promote mass vaccinations, as well as education for mothers. There are still some kinds of dreadful practices, linked to religious beliefs that actually cause serious disabilities or even the death of many women. It is in the interests of the Ministry of Health to promote education and hygiene to young pregnant women. Projects specifically tackling AIDS and HIV need to be implemented. Women need to be aware of sexually transmissible diseases. The Disability and Development Partners report in 2008 (p.6) said that by having improved healthcare many causes of disabilities could be prevented. The report gives a real example. Many people become disabled because they are bitten by venomous snakes, they could be cured by receiving antivenin in local posts. In addition, sufficient nutrition for children is important; otherwise they will likely develop impairments. Medical support with drugs and surgery is also imperative, as well as rehabilitation for person with mental and physical impairments.

One effective example is Tanzania. The government improved neonatal and infant care, ensuring also the screening of children under 5 years, and provided nutrition education and nourishment for children underweight. It reduced HIV and AIDS amongst women and men with disabilities. Provided training to health care workers, and removed any form of barriers to health care for pregnant women and children, eliminating unofficial charges¹⁹. This is something that can be definitely and successfully replicated in Mozambique.

A successful strategy would require the identification of available health services within the community; raise awareness of the health facilities to pregnant women and encourage them

¹⁹ Miller U., Ziegler S., *Making PRSP Inclusive*, Germany, Handicap International Christoffel-Blindenmission, Jan. 2006, pp. 68-69.

to use those facilities. Women with disabilities need to have the same rights to access maternal facilities. Specific counselling is required to answer doubts about current and future pregnancies. Training of birth attendants in the local communities to ensure a prompt and inclusive service that aims at an early recognition of impairments. Promote a registration of children with disabilities with the local authorities at birth²⁰. Other ways to improve maternal and child health would be through the implementation of clean water, sanitation, and proper toilets. They all contribute to improve the health of mothers and sons.

In terms of capacity building, it is imperative to open a dialogue between the Ministry of Health and PWD and their representative organizations, and to set the basis of inclusive projects and to monitor them.

Building capacity to install CBR requires a twin-track approach, which aims at addressing inequalities between disabled and non-disabled persons in health care, and at supporting initiatives to enhance the empowerment of PWD. This will lead to equal rights and opportunities. Inclusion of PWD and their families, as well as the community and the civil society is essential. Partnership and cooperation between national and local stakeholders, CBR workers, and PWDs, their families and carers will definitely augment impact and figures²¹.

A CBR project follows this path: identification of the needs of PWD, through surveys, meeting with community representatives, families, doctors, religious leaders; involving the government; monthly seminars to update the government

²⁰ *CBR Guidelines, Health component*, p. 30.

²¹ Finkenflugel H., *Who is in... and for what? An Analysis of Stakeholders' Influences in CBR.*, "Asia Pacific Disability Rehabilitation Journal", 2006, 17 (1): 12-30.

agencies; community meetings, identification of resources and funds, training of new volunteers for the project²².

Working with PWD is central to capacity building, because it helps to promote a better and wider understanding of the disability experienced²³. Data collection in the post meeting is a must, and we have to rely on cross-sectional and time-series data. The long run monitoring of the projects will be essential in determining the outcomes and to correct possible wrong approaches.

Conclusion

In conclusion, the CRPD, based on the social model, reaffirmed once again the human rights of PWD. The Ministry of Health needs to take an advocacy role in promoting the ratification of the CRPD. It must do so, because its inclusive projects are much more effective if backed by national disability policies. Policies will help to properly allocate funds, and to avoid the corruption and redirection of funds by the government. In order to achieve the ratification, the Ministry of Health needs to make politicians and society aware of the costs of not including PWD. They can be productive and their impairments do not totally impede their ability to work. By not including them, the costs would be much greater, and impact upon the whole community.

By ratifying the CRPD, the inequality gap between PWD and people without disabilities will be much smaller than what we have seen in the past decades. Mozambique has a good legal framework on its own to protect the rights of PWD, but it never

²² *Finding out about CBR: Training Materials for Community Based Rehabilitation Workers*, pp. 20-22.

²³ Kayess R, 2011, p. 26.

really implemented it. For far too long the government believed that PWD must be helped as a means of charity rather than because of their human rights. The wrong belief that disability is of exclusive competence of the Ministry of Health has been dominating the theorists of the medical model, and this is why today the whole world will miss the MDG 2015. Disability is a national matter, and governments need to act now! The social model, in fact, asserts that PWD have their own voice, and that disability is a social construction. Based on the social model, the CBR guidelines were structured which formally help to establish capacity in the stakeholders of inclusive projects. It is through CBR that the Ministry of Health can improve maternal and child healthcare by cooperating with other stakeholders: DPOs, CBR personnel, governments, NGOs.

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