Disability Thematic Study Mozambique

Produced for UNFPA

Date: December 2021

Version: FINAL

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Acronyms

CNAD	Conselho Nacional para a Área da Deficiência
CNDH	National Commission on Human Rights
CNAM	Conselho Nacional para o Avanço da Mulher .
CNAS	National Council for Social Action
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DC	Disability Certificate
FAMOD	Forum of Mozambican Associations of Persons with Disabilities (FAMOD
ICT	Information and Communication Technologies
ICF	International Classification of Functioning
INE	National Institute of Statistics
IOF	Household Budget Survey
LMIC	Low- and Middle-Income Countries
MGCAS	Ministry for Gender, Children and Social Action
OPDs	Organizations of Persons with Disabilities
PNAD	National Plan for Disability
PHC	Population and Housing Census
SDGs	Sustainable Development Goals
UN	United Nations
WG	Washington Group
WGSS	Washington Group Short Set
WHO	World Health Organization
UNFPA	United Nation Population Fund

Acknowledgements

This Study was produced by Social Development Direct for UNFPA Mozambique. It was written by Boaventura Manuel Cau, Clodoaldo Castiano and Daniel Mont under the overall guidance of Maria Vlahakis (SDDirect) and Alessio Cangiano (UNFPA Mozambique). Replication of analyses with the 10% Census' sample in the full Census dataset was conducted by the National Institute of Statistics [Muemed Nury Cassimo]. The draft Study was submitted for peer review in November 2021. A special thanks goes out to all individuals who contributed their time to review the study and took part in interviews that informed the study and in the peer review. This study was funded by UK aid from the UK government and from UNFPA, however, the views expressed do not necessarily reflect the UK government's and UNFPA official policies.

Executive Summary

The State of Mozambique has repeatedly conveyed high levels of commitment internationally, including taking legal and policy measures, to fulfil the rights of persons with disabilities and reduce their systematic social disadvantage. The ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2012 and the signalled intentions to ratify the Protocol to the African Charter on Human and People Rights on the Rights of Persons with Disabilities in Africa[1] are examples of these commitments. Yet the implementation of these policies remains a significant challenge and scientific evidence may illuminate efforts for such an implementation in a context-adjusted manner.

This study contributes for generating evidence relating to the prevalence of disabilities and characteristics of persons with disabilities at both individual and household levels, based on data from the 2007 and 2017 censuses in Mozambique. Findings in this study may inform current and future policies, and interventions to ensure that persons with disabilities have equal access to education, employment and basic services.

Key Findings

Measures of prevalence of disability

Key Finding 1*: Measures used to identify persons with disabilities in the 2017 and 2007 censuses are known to seriously underestimate the number of persons with disabilities. The 2017 and 2007 censuses show prevalence rates that are in line with other African countries that use a similar medical model of collecting disability data.** According to the 2017 Census, 2.7% of the population in Mozambique had a disability (727,620 individuals); and according to the 2007 Census, about 2.3% of the population had a disability,*** corresponding to 475,011 individuals. This compares to the global prevalence of 15%. Therefore, this study validates long held understanding among persons with disabilities and their representative organizations, as well as international non-Governmental organizations active in the sector, that the official data on disability generated through both 2017 and 2007 Census underestimate the prevalence of persons with disabilities living and working in Mozambique.

In the 2017 Census there were two main ways of characterizing persons who responded yes to the question on whether they had a disability:

- Whether persons responding to the survey also reported having an impairment, that is, being blind; deaf or mute; with an amputated or atrophied arm; with an amputated or atrophied leg; with paralysis; with mental disability. This was also used to identify persons with disabilities in the 2007 Census.
- Those who self-identified as having functional limitations – those who had one or more of the following: (i) difficulty seeing, even when wearing glasses; (ii) difficulty hearing, even when wearing a hearing aid; (iii) difficulty in remembering or concentrating; and (iv) difficulty with mobility (walking). Individuals could also report other disabilities.

The question “Do you have a disability/difficulty?”, which was asked in both censuses, greatly under-identifies persons with disabilities. A person with a disability may answer “no”

because of the stigma associated with disability. Persons with more moderate disabilities might answer “no” because they think the term “disability” only applies to severe conditions. Despite an attempt in the 2017 Census to integrate Washington Group questions, these questions were only after people who first identify as having a disability through the yes/no question. The results in the Key Findings are a presentation only of the results of the Census, not a presentation of the actual prevalence rate of disabilities in Mozambique.

Key Finding 2: The 2017 Census found 1.4% of individuals who self-identified as having an impairment (1.6% men and 1.3% women), and 0.4% of individuals who self-identified as having other disabilities (disabilities not specified). The 2017 Census also found that 1% of individuals self-identified as having a disability by functional domain.

The 2017 Census found that for both men and women, amputated or atrophied leg is the main type of impairment among people reporting they have disability by impairment type (nearly 31% and 30% for men and women, respectively), followed by deaf/mute disability (16% and 18%, respectively). Among people identified as having a disability in the census, the main functional difficulty reported was *difficulty with mobility (walking) (42.8%)*, followed by *difficulty seeing, even when wearing glasses* (30%) and *difficulty hearing, even when wearing a hearing aid* (14.5%). It should be noted, however, that the categories of disability in the Census do not accurately define the population identified. For example, “mental disability” is a very broad category, and it could include persons with psychosocial and learning disabilities. Furthermore, the question adopted in the Census makes it very difficult to identify persons with less visible impairments, such as those with intellectual and psychosocial disabilities.

Key Finding 3: Congenital and disease/illness are the main causes of disabilities in Mozambique, with more than 7 in 10 cases of any impairment and more than 6 in 10 cases of any functional limitation attributed to them. Labour accidents and automobile accidents are important causes of disabilities.

According to the 2017 Census, of those self-reporting disabilities, 1 in 10 cases of amputated or atrophied arm (about 10%), 1 in 10 of amputated or atrophied leg (about 9%), and almost 1 in 10 of *Difficulty with mobility (walking)* (7%) is attributed to automobile accidents.

Key Finding 4: Persons with disabilities are less likely to be married or living together, and more likely to be divorced, separated or widowed compared to persons without disabilities.

According to the 2017 Census, 76% of persons with disabilities and 89.1% of persons without disabilities were married or living together. Among those who have been in a marital union, 7.9% of persons with disabilities were divorced or separated compared to 5.0% for persons without disabilities; and 16.1% of persons with disabilities were widowed compared to 5.9% of persons without disabilities. Older persons with disabilities (aged over 60 years) are more likely to be divorced or separated (26.2% versus 10.6%) and widowed (65.9% against 42.8%) compared to their peers without disabilities. This trend persists even when disaggregating by gender. There are likely to be implications in the degree of loneliness and the level of immediate social support enjoyed by older persons with disabilities.

Key Finding 5: Girls with and without disabilities are more likely to be married or living together before the age of 18 compared to boys with and without disabilities,

suggesting that child marriage in Mozambique continues to be an issue and one that is gendered.

Looking at the 12-14 and 15-19 age groups, girls and young women with disabilities are more likely to be married or living together than boys and young men with disabilities (e.g., among 15-19 years old, young women: 5.4% versus young men: 1.2%), as is the case for girls and young women without disabilities compared to boys and young men without disabilities (e.g., among 15-19 years old, young women: 12.3% versus young men: 2.9%). Whilst it is not clear how many girls with disabilities are married or living together (because data was disaggregated considering the 15-19 age group), the data still shows that child marriage remains an issue in Mozambique, particularly for girls with and without disabilities – this is also likely to be an underestimate given the issues with the Census methodology outlined above.

Key Finding 6: Although births to adolescents aged 15-19 years of age are higher among girls without disabilities in comparison to girls with disabilities, there is still a significant percentage of girls with disabilities giving births at a young age – about 27% in rural areas and 17% in urban areas.

Although accessing quality healthcare is a challenge for all adolescents in Mozambique, adolescent girls with disabilities face additional barriers due to stigma and discrimination about their worth and sexuality, and are at even greater risk of violence, including sexual violence and rape. The implications of early pregnancy and childbearing on the short and long-term health, education and employment outcomes of girls with disabilities, as well as the health of their children, needs to be taken into consideration in designing disability-inclusive policies and programmes for adolescent girls.

Key Finding 7: Persons with disabilities have much lower levels of completed education than persons without disabilities. Gender also adds another layer of disadvantage for women with disabilities in completed level of education.

Among younger cohorts (12-40 years), where the impact of disability on education is most likely to be seen, persons with disabilities are less likely to have completed any level of education (52.0% versus 39.9%), less likely to have completed a primary level of education (33.3% vs 40.0%) and less likely to have completed a secondary level or more of education (11.0% vs 17.0%) than peers without disabilities. In relation to gender, almost 6 in 10 women with disabilities are illiterate (58.4%) compared to 5 in 10 men with disabilities (46.0%); among persons without disabilities, 5 in 10 women are illiterate (45.1%) relative to 3 in 10 men (34.0%). Given the role of education for social mobility, these disadvantages of persons with disabilities in educational outcomes relative to their peers are likely to adversely impact their wellbeing throughout the life course, with women at increased disadvantage.

Key Finding 8: Working age individuals without disabilities are more likely to be employed than those with disabilities. However, working age women with disabilities are less likely to be employed than working age men with disabilities.

The study confirms that persons with disabilities face additional barriers in finding decent paid work. It found that regardless of gender and area of residence, working age individuals without disabilities are more likely to be employed than those with disabilities. For example, 65.3% of men without disabilities are employed in rural areas compared to 59.4% of men with disabilities in the same area. Regardless of disability status, women are less likely to be employed than men. The gap is even higher in urban areas where about 30.6% of women with disabilities are employed relative to about 43.6% of men with disabilities. Individuals

residing in urban areas are less likely to be employed compared to working age individuals living in rural areas, regardless of gender and disability status.

***Key Finding 9*: Persons with disabilities are significantly less likely than persons without disabilities to access information and communication technologies. Women with disabilities are least likely to own a cellphone and have access to ICTs, highlighting the gender and disability-related barriers they face.**

This study found that access to critical information and communication technologies (ICTs), including cellphones, the internet and computers, is lower among persons with disabilities compared to persons without disabilities. About 26.5% of women aged 18-60 years with disabilities have a cell phone compared to 38.4% of women without disabilities; among males, about 42.0% of men with disabilities have a cell phone against 56.5% for those without disabilities. With respect to access to the internet and computers, women and men aged 18-60 years with disabilities are two times less likely to have access to each of these ICTs compared to women and men aged 18-60 years without disabilities. There is also a clear gender divide whereby women without disabilities are less likely to access a cell phone, the internet and a computer than men without disabilities, as are women with disabilities compared to men with disabilities. Of all the categories, women with disabilities are least likely to own a cell phone and have access to a computer and the internet across all age ranges.

***Key Finding 10*: Persons with disabilities and their representative organizations faced additional barriers to participating in and influencing the 2017 Census process.**

OPDs who took part in this study repeatedly pointed to technical capacity limitations among the Census staff in collecting disability data. Stigmatized behaviours among enumerators were also repeatedly mentioned, particularly against women with disabilities. OPDs also indicated that they have not been meaningfully engaged in key stages of the Census processes.

Conclusions and policy implications

This study found that in Mozambique the medical model of disabilities still informs disability policies and data collection efforts on disability in the country, resulting in an underestimation of the prevalence of persons with disabilities. Congenital, disease and illness were the main causes of disabilities in Mozambique with labour accidents and automobile accidents holding a prominent place. Evidence in this study also revealed disadvantages among persons with disabilities relative to their peers without disabilities on key social characteristics important for their wellbeing and equal access to participation in society, including education, employment and access to ICTs. Persons with disabilities are also less likely to be married and disproportionally more likely to be divorced or separated and widow relative to their peers without disabilities with higher percentages among older people and women. There are likely to be implications in the degree of loneliness and the level of immediate social support enjoyed by older persons with disabilities. Overall, analysis of the Census data revealed that women with disabilities are facing even greater barriers and are more disadvantaged in key outcome areas. More attention is needed in addressing barriers and disadvantages that persons with disabilities face to advance age and gender sensitive improvements for persons with disabilities in Mozambique

Drawing on the findings of this study, a number of policy considerations have been identified. Further engagement with persons with disabilities and OPDs on the findings will help ensure their priorities and recommendations are included.

1. Improve the quality of data and evidence on disability in Mozambique, including through the full integration of the Washington Group approach for all data collection (including the 2027 Census) and ensuring more active consultation with persons with disabilities and their representative organizations.
2. Conduct more detailed studies (disability surveys, survey modules on general surveys, qualitative studies) on the extent and characteristics of disadvantages observed on basis of census data (e.g., on education and employment), on the one hand, to know better the extent of the environmental challenges facing persons with disabilities and, on the other hand, to identify interventions that are more likely to meet the interests and needs of persons with disabilities.
3. Meaningfully involve and engage with persons with disabilities and OPDs in the development and design of new policies, in addition to the design of the next Census process, from the inception stage up to the administration of the questionnaire.
4. Conduct specific studies to unpack characteristics of congenital conditions and illnesses implicated in the context of Mozambique. Such a study may help for discovering points for preventative interventions.
5. Improve labour and road safety to reduce the risk of labour accidents and automobile accidents being a leading cause of disability in Mozambique.
6. Adopt adequate policies to address the growing number of older persons with disabilities and adapt interventions in line with the disability prevalence figures by province, regional and rural/urban criteria.
7. Improve the design of disability-inclusive policies and programs for adolescent girls and address the structural and attitudinal barriers that adolescent girls with disabilities face in accessing sexual and reproductive health services.
8. Mainstream disability inclusion in child marriage interventions to improve data on violence and harmful practices against girls with disabilities in Mozambique.
9. Increase support for children with disabilities to access and stay in the education system and benefit from a learning experience at the same standard as children without disabilities.
10. Develop and fund a strategy to address disability employment gaps to identify and address the key barriers to employment facing persons with disabilities.
11. Support OPDs led formal and informal employment initiatives throughout the country in terms of preferential access to markets, access to services' opportunities and provision of training for upgrading or upscaling their activities.
12. Address the barriers that persons with disabilities face in accessing ICTs, particularly in relation to mobile technology, and adopt ICT accessibility policy measures to fill the existing gap in line with CRPD obligations, to reduce barriers related to disability and ensure that mainstream information technology institutions prioritize persons with disabilities, especially women with disabilities, in their programs.

1. Introduction

In different parts of the world, data has been showing that persons with disabilities in low- and middle-income countries are 'poorer than their nondisabled peers in terms of access to education, access to healthcare, employment, income, social support and civic involvement.'[2] For example, a study using internationally comparable data from fifteen developing countries found that in most countries, disability is 'significantly associated with higher multidimensional poverty as well as lower educational attainment, lower employment rates, and higher medical expenditures'.[3]

Meanwhile, rapid population ageing combined with the higher risk of disability in older people, together with a global rise in chronic non-communicable health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders, is resulting in an increasing prevalence of persons with disabilities.[4] Wars and conflicts in many parts of the world have contributed to higher levels of disability through physical and mental trauma. Due to policy, physical and attitudinal barriers in society, many of those living with a disability cannot access health services, education or employment opportunities. Their needs, in terms of disability-related services, are unmet and, as a result, an exclusion from everyday life activities is experienced by many.[5] Women and girls with disabilities are often doubly or more disadvantaged due to the intersecting nature of gender, disability and other identities (indigenous, race, sexuality, among others). This includes higher rates of violence and sexual abuse.[6] COVID-19 has further exacerbated discrimination and exclusion of persons with disabilities, who have been disproportionately affected by primary and secondary impacts of the pandemic.[7]

To counter the systematic and generalized exclusion in society, organizations of persons with disabilities have introduced a new disability discourse based on the social model. This has led to a transition in the perception of disability from an individual problem to a structural, social model of disability, where disability is not seen purely as a health problem, but rather as an interplay between a person's physical and mental condition and their social environment. As such, interventions require a balanced approach addressing the various aspects of disability, where both the problems arising from their health condition and contextual barriers should be addressed.[8]

International and regional disability rights agendas have also been put in place to guide countries to a turning point in their efforts to restore the rights of persons with disabilities and address development challenges of this population. The Convention on the Rights of Persons with Disabilities (CRPD), adopted at the United Nations (UN) in 2006, has played a crucial role in reinforcing the understanding of disability as a human right issue, and development priority and providing a legislative framework to planners and decision-makers to positively influence the situation of persons with disabilities.[9] More recently, in 2018, the African Union adopted the Protocol to the African Charter on Human and People Rights on the Rights of Persons with Disabilities in Africa (African Disability Protocol). Building on the human rights model of the CRPD, the African Disability Protocol goes further, addressing the African contextual specific barriers faced by persons with disabilities. Mozambique, through The Parliament, ratified the CRPD in 2012 and signed the African Disability Protocol in November 2021, pending the deposition of the instrument of ratification in the African Union.

However, fulfilment of obligations emanating from the CRPD, the African Disability Protocol and other frameworks aimed at improving the lives of persons with disabilities requires reliable statistics on disability prevalence and the living conditions of persons with disabilities. This is stated both in the African Disability Protocol (article 32), and CRPD (article 31) indicating that "States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention."

In Mozambique, questions on disability were integrated into the 2017 Census and the previous Census conducted in 2007. In 2007, 2.3% of the Mozambican population were found to have a disability. In 2017, 2.7% of the population were found to have a disability. With 15% of the global population estimated to have a disability and with 80% of persons with disabilities estimated to live in low- and middle-income countries, the estimated prevalence rate in Mozambique is low. As will be shown in this study, this is unlikely to be an accurate reflection of the prevalence rate but is likely to be due to the methodology used to arrive at the estimate. The Census data and other surveys should aim at providing an internationally comparable and locally contextualized picture of disability in the country. However, the 2007 and 2017 Census in Mozambique have adopted approaches that considerably limit the international comparability of prevalence of disability data and predominantly capture only the most severe forms of disability. Nevertheless, they remain the main source of disability data in Mozambique providing an informative picture of prevalence and causes of disability and the main socio-economic outcomes of persons with disabilities as compared to the rest of the population, including at subnational level.

The purpose of this Disability Thematic Study, supported by the Census Trust Fund in Mozambique, is to better understand trends and differences between the last two censuses and pave the way for improving and mainstreaming data collection on disability in Mozambique. It is based on a review and analysis of disability data collected from the 2007 and 2017 Census, comparing the results to overall Census counts. This has helped generate evidence on the prevalence, characteristics, causes and socio-economic implications of disability in Mozambique. In particular, the study aimed to examine the Census data to better understand the causes for the low prevalence rate. The study has involved close collaboration with the National Institute of Statistics (INE) and UNFPA and is part of the 2017 thematic studies series.

The thematic study presents: a background on the conceptualization of disability and the different models of disability (section 2); the methodology used and a background to the 2017 Census, as well as to disability data collection in censuses in Mozambique (section 3). an overview of disability prevalence comparing global and sub-Saharan level data on disability prevalence to the data produced in the 2007 and 2017 Census, other relevant sources of disability data in Mozambique, and an analysis of the current disability legal and policy framework as well as the perceptions of OPDs representatives on disability data and the overall situation of persons with disabilities in Mozambique (section 4);the results of the analysis of the Census data (section 5)l and a conclusion and a set of policy implications (section 6). Detailed tables with additional information are provided as annexes to the study.

2. Background

2.1 The Conceptualization of Disability

To identify persons with disabilities, it is important to have a clear concept of what is meant by the term “disability”. This section briefly reviews prior methodologies, then explains the social model of disability and how it was used in the development of the Washington Group Questions. It ends with a section explaining the difference between data on disability eligibility determination and disability identification using the Washington Group questions in surveys or censuses.

Past methods of identifying disability in censuses, surveys, and administrative records have often been inadequate and generated confusing and inconsistent results.[10] For example, the question “Do you have a disability?” greatly under-identifies persons with disabilities. A person with a disability may answer “no” because of the stigma associated with disability. Persons with more moderate disabilities might answer “no” because they think the term “disability” only applies to severe conditions. This can be true even if those people are facing barriers to participation. Also, many older persons with disabilities believe that because the functional limitations they face are associated with age they do not have a “disability” but simply “old age.”[11] Finally, this type of question makes it very difficult to identify persons with less visible impairments, such as those with intellectual and psychosocial disabilities.

One approach that has been used for identifying persons with disabilities is asking about a list of impairments. However, this is also problematic. First, there are many types of impairments and so any list of possible responses on a survey form will not cover all types of impairments. Second, people may not know the name of their medical condition, especially if they are less educated and have less access to health care. In addition, two persons with the same impairment may have very different experiences. For example, someone with cerebral palsy may have a lot of difficulty speaking and walking or may have very little difficulty. Moreover, their ability to participate will be different if they have different access to assistive technology or support services, if they live in environments with different levels of accessibility, or even because of the way their disability interacts with their age, gender, ethnicity or other characteristics.[12]

Finally, some questions on disability that ask about impairments – or even the difficulties of doing various activities – fail to account for the range of difficulties people may experience. For example, people are sometimes asked if they are “blind.” But people can have significant vision difficulties even if they are not completely blind. Or a question may ask “are you paralyzed” or “Is your leg amputated” to try to get at physical difficulties, but people may have a lot of difficulty walking for many reasons: cardiovascular conditions, a stroke, vertigo, extreme joint pain, etc. So those questions do not capture the full range of persons with disabilities.

Fortunately, recent international efforts have settled on a methodology that is in line with the CRPD and at the same time can create consistent, internationally comparable results. This methodology is informed by the **social model of disability**, which moves away from the old individual model that conceptualizes disability as a medical condition or impairment that is lodged solely in the individual. The focus is not on what condition a person *has*, but the difficulties they have in *doing* things. The next section presents the social model in more detail.

2.2 The Social Model of Disability

According to Article 1 of the CRPD:

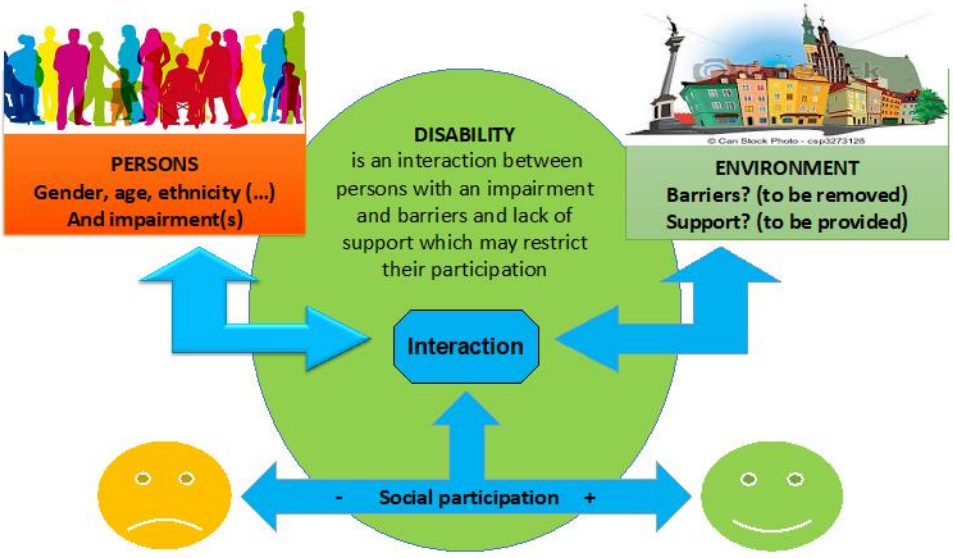
Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[13]

Historically, there have been three main models of approaching disability: the charity model, the medical model and the social model:

- The **charity model** views persons with disabilities as "objects" of charity. Persons with disabilities are seen as "broken" in some way, and society simply has an obligation to provide them with basic needs that they are presumed to be unable to provide themselves, thus relegating them to sit outside the mainstream of society.
- This was followed by the **medical model**, which also regards disability as essentially an individual problem, 'stemming from functional limitation or psychosocial losses' therefore precluding social and contextual factors.[14] As such, medicalization is the dominant way in which disability issues are addressed. Efforts to address the concerns of persons with disabilities go beyond charity to include rehabilitation and vocational programs, but they are conceived to "fix" the person to be able to function in society without recognizing societal values or attitudes as well as the environment that is discriminatory and inaccessible.
- The **social model** understands barriers in society as disabling and regards people living with disabilities as full members of society who have important contributions to make. This model, which the CRPD is based on, leads to policy options that make society more inclusive by eliminating societal barriers and providing support that allow persons with disabilities to enjoy their full human rights equally with others.

A depiction of the social model is shown in Figure 1

Figure 1 Social Model of Disability



People have multiple social characteristics (including, gender, age, race, ethnicity, sexual orientation), and also impairments (for example, paralyzed legs). This alone does not make them disabled. What disables them is the lack of support or the presence of barriers that impede their ability to participate in society, including to go to school, go to work, participate in civic events and public life, and start a family.[15]

Therefore, to better identify people who have disabilities in the social model sense is to have a series of questions that does not ask about impairments but addresses the risk of exclusion faced by people who have difficulties carrying out basic activities that are linked to functional limitations arising from impairments.

2.3 The Washington Group Questions

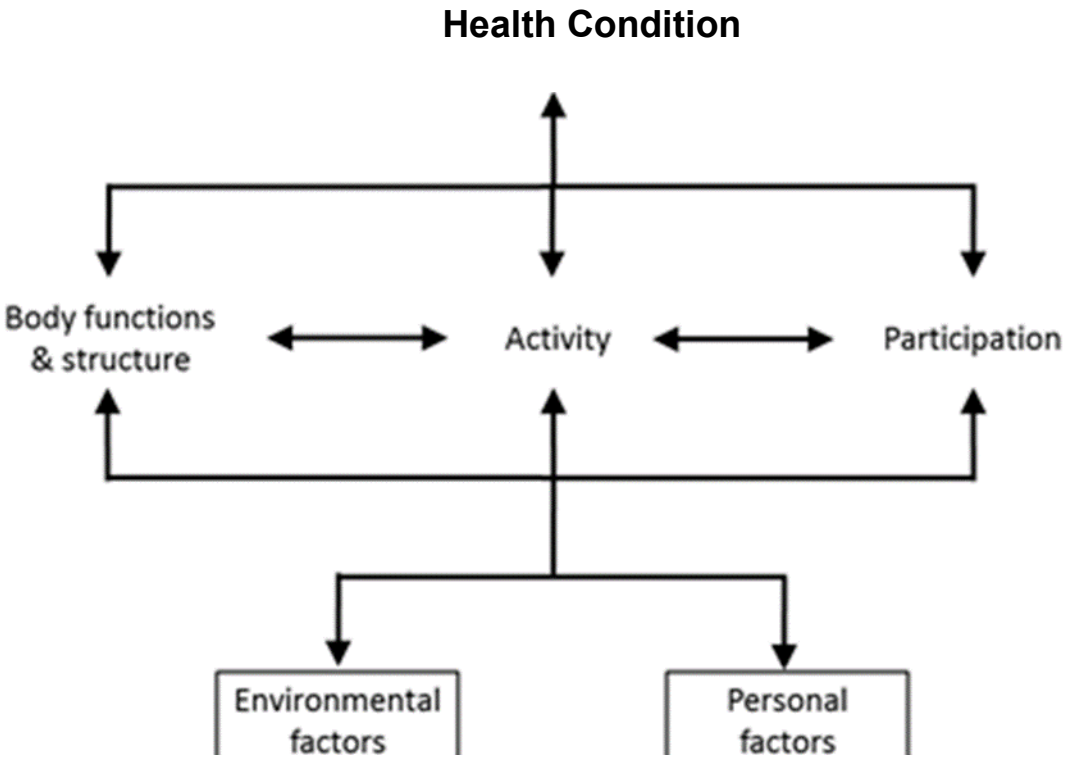
Disability is a complex and evolving experience that presents significant challenges for data collection efforts. One of the challenges has been how best to capture disability experience in a way that can generate credible and realistic data that is comparable across countries. To address this task an international platform has been established under the auspices of the UN Statistical Commission – *The Washington Group on Disability Statistics (WG)*. Since 2001, the WG has developed a set of data collection tools (known as modules) to assist UN member countries to collect data on disability. The primary objective of the WG is, therefore, to 'provide basic necessary information on disability that is comparable throughout the world'**.**[16]

The WG based its approach on the World Health Organisation's (WHO) **International Classification of Functioning (ICF)**, represented below in Figure 2. Within the ICF there are three levels of functioning: body function and structures; activities; and participation. A body function is something like being able to move one's legs. An activity requires the combination of body functions to perform a task, like walking. To walk you must use your legs, your cardiovascular system, your sense of balance, etc. Participation is fulfilling a social role, like going to work. To work you must combine a number of activities like walking, seeing, remembering, communicating, etc. Health conditions, like impairments, can affect these levels of functioning, but the relation between them – for example, how an activity limitation, such as not being able to walk, affects the ability to work – is impacted by personal resources and barriers and facilitators in the general environment.

Barriers in the environment may be physical – for example, limited or no ramps, accessible toilets, or accessible public transportation. They may be informational – for example, limited or no sign language interpreters, closed captioning, Braille, or easy to read versions of signs and documents. They may be attitudinal, including stigma and low expectations. Finally, they can be institutional, for example laws that explicitly restrict persons with disabilities.

These disability-related barriers to participation can interact with other barriers, including those associated with gender, race, ethnicity or other social characteristics. For example, because of a disability the costs of getting to school may be higher (e.g., transportation costs). This may limit school attendance for all children with disabilities, however, if girls' education is valued less, then the extra costs of getting to school may be even more likely to preclude the school attendance of girls with disabilities compared to boys with disabilities. In this case, gender-related barriers combine with disability-related barriers to further marginalise and disadvantage girls with disabilities.

Figure 2 International Classification of Functioning, Disability and Health



This model focuses on activity limitations. It is persons with activity limitations who are *at risk* of not being able to participate in an environment because of barriers. By disaggregating data by disability defined in this manner, it is possible to see the extent to which barriers may be restricting a person's participation. If persons with disabilities are half as likely to be working (controlling for other factors, such as age and gender) than persons without disabilities, that is evidence that there are barriers in the environment that is restricting their opportunities and right to work.

Conceptually, those with activity limitations are the people of most concern to policymakers wanting to remove barriers to participation and to fulfil the goals of the CRPD. They are the people most at risk of facing barriers to participation.

The ICF, however, is very extensive, trying to capture the vast range of human functioning, and so cannot be directly translated into a survey instrument. Therefore, the WG developed a short set of six questions on functioning for use on national censuses and surveys to identify the majority of persons with disabilities in an internationally comparable manner. The **Washington Group Short Set (WG-SS)** can be found below in Box 1.

The advantages of the WG questions are that:

- They identify the large majority of persons with disabilities in an internationally comparable manner
- There are only six questions, and can therefore be added to existing data instruments at low cost, and then used to disaggregate all indicators generated by that survey
- They are functional measures, which means they can easily fit into an analysis framework consistent with the social model of disability.[17]

Box 1: WG Short Set Questions

1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

Response categories: *No – no difficulty, Yes – some difficulty, Yes – a lot of difficulty, Cannot do at all*

A person is identified as having a disability if he or she answers Yes- a lot of difficulty or Cannot do at all to at least one question. For more information see: https://www.washingtongroup-disability.com/

However, there are limitations to the WG-SS. First, WG-SS do not adequately identify children with developmental disabilities.[18] Second, they do not capture a significant percentage of persons with psychosocial disabilities. To address the first problem, the WG worked with UNICEF to create a **Child Functioning Module (CFM)**.[19] The second issue is addressed in the **Washington Group Extended Set (WGES) of questions** that includes questions on anxiety and depression that are shown in Box 2.[20]

The CFM includes functional domains that are specific to children, including: playing; behaviour; and staying on task. In addition, the wording is a bit different because parents are being asked about children. For example, they are asked to provide levels of difficulty compared to children of the same age. In addition, there are two modules, one for 2–4-year-olds and a different one for 5–17-year-olds. Two modules were needed because the expectations of what children can do varies with age. For example, it does not make sense to ask a 2-year-old about self-care.

The WGES extends the WG-SS in two ways. First, it adds functional domains by asking questions on anxiety, depression, pain, fatigue, and upper body mobility. Second, it adds additional questions to the functional domains in the WG-SS. For example, instead of just asking about difficulty walking, it asks about walking shorter and longer distances.

Adding the CFM and the anxiety and depression questions from the WGES to household surveys could make up for the limitations of the WG-SS, but due to the added length of those questions, national statistics offices are generally reluctant to do so. They are considered to be too long to be added to censuses, where space is very expensive.

Box 2: Washington Group Extended Set questions on anxiety and depression

How often [do/does] [you/he/she] feel worried, nervous or anxious? Would you say…

- Every day
- A few times a week
- A few times a month
- A few times a year
- Never

Thinking about the last time [you/he/she] felt worried, nervous or anxious, how would [you/he/she] describe the level of these feelings? Would [you/he/she] say…

A little
Somewhere in between a little and a lot
A lot

How often [do/does] [you/he/she] feel depressed? Would [you/he/she] say…
[*Read response categories*]
Every day
A few times a week
A few times a month
A few times a year
Never

Thinking about the last time [you/he/she] felt depressed, how depressed did [you/he/she] feel? Would you say… [*Read response categories*]
A little
Somewhere in between a little and a lot
A lot

A person is considered to have a disability if they feel a lot of anxiety or depression on a daily basis. For more information see https://www.washingtongroup-disability.com/

Crucially, the validity of all these question sets strongly depends on how they are implemented. The WG-SS can miss its purpose when the questions are not asked correctly. One example is when a question like "do you have a disability" is used first, and then only people responding "yes" get asked the WG-SS. This is not the WG approach, because in effect it is using the "do you have a disability" question to identify persons with disabilities, which greatly under-identifies persons with disabilities, as mentioned above, largely due to disability-related stigma and discrimination. Second, sometimes surveys have an introduction to the WG-SS questions like "We are now going to ask you some questions about disability", and then the questions are asked. This changes the mindset of the respondent and undermines the validity of the questions. Third, some countries substitute "yes/no" responses for the scaled responses, instead of the four response categories, which fails to capture the complexity and dynamics of disability. This also undermines the validity of the questions.

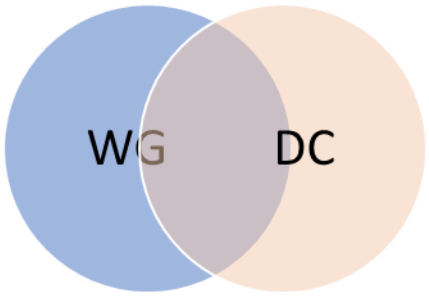
2.4 Disability Certification and the Washington Group Questions

It is true that the use of WG group questions in census tends to increase the disability prevalence rate compared to other methodologies. Governments are often concerned when they see the often-cited statistic that 15% of the global population has a disability. Their concern is that providing benefits to that number of people will be exceedingly expensive and beyond their fiscal capacity. This however confuses the population the WG-SS is attempting to identify with the population eligible for a program. The latter group is usually defined through a disability certification which assesses the individual's specific situation of disability compared to the existing criteria to access social programs.

For example, a disability benefits program may be designed to address only those persons with very high support needs, or those of working age who are considered "unable to work." That is only a subset of people who are at risk of facing various types and degrees of exclusion. Therefore, there can be people identified by the WG questions as having a disability who are not considered eligible for disability benefits, as they are designed.

However, all persons with disabilities do tend to face extra costs of living and additional barriers to access to services and participation, and are at increased risk of discrimination and violence. They are also further disadvantaged at time of crisis and emergency, as evidenced in the recent COVID-19 pandemic.[21] Therefore, governments may design disability certification[22] to be intended for all people at risk of exclusion and facing these costs. In that case there will be closer alignment between WG identification and disability certification. Therefore, the structure and purpose of the programs requiring disability certification will determine its eligibility criteria, and these will be determined by policy priorities and budgets. The structure of social protection programs goes beyond the purpose of this document, but it is important to point out why people having a disability certificate may or may not be identified by the WG questions and vice versa.

Figure 3. Overlap between those identified by Washington Group (WG) Questions and those with a Disability Certificate (DC)



People might be in the disability certificate (DC) circle but not the WG circle (Figure 3) because of conditions that can be missed by the WG questions, such as:

a. Psychosocial conditions when the WG-SS is used
b. Conditions (including chronic medical conditions or short stature) that may be missed by the WG questions
c. Having some difficulty in many domains that makes them eligible for a DC even though they don't have a lot of difficulty (or are unable to do) in one domain.

People might be identified by the WG questions but do not have a DC for reasons such as:

1. They did not have knowledge of or access to the DC procedure
2. They did not want to go through the DC procedure because they did not self-identify as having a disability, were concerned about stigma, or some other reason
3. They are older and were receiving old age benefits that were at least as good as the disability benefits they could receive and so did not try to get a certificate
4. They do not qualify as having a disability under DC procedures

Of course, as with all survey questions, there may be response errors both for WG and DC status. Examining who falls within each of these circles – and who falls within both of them – can give insight into the nature of the disability certificate program and whom it is reaching.

3. Data and Methodology

3.1 Background to Mozambique's 2017 Census

The 2017 General Population and Housing Census of Mozambique was the 4th Census to be carried out in the country in post-colonial Mozambique. The 2017 Census took place across Mozambique from August 1st to August 15th, 2017.[23] Its main goal was "to establish, as exhaustive as possible, quantitative and qualitative statistical knowledge, of the Mozambican people and other residents and presents in the Mozambican territory, as well as the housing infra-structure".[24] The methodology of the 2017 Census data collection was based on a paper-based questionnaire. Data was collected by several enumerators across Mozambique with a supervision from the National Institute of Statistics. The Census collected data about all Mozambicans and all residents in the Mozambican territory as well as about those temporally absent. Persons with residence in Mozambique were classified as the resident population. Persons who were in Mozambique at the time of Census were considered as the present population. Persons temporally absent for a period less than 6 months were also enumerated and considered as the resident population. The Census was at the same time de jure and de facto Census as persons were enumerated where they spent the reference night. The 2017 Census found a total resident population in Mozambique by August 1st 2017 consisting of 26,899,105 individuals. The enumerated population consisting of the resident population and non-resident population was 27,122 222 persons. The Census omission rate was estimated at 3.7%. And the total population adjusted to the Census omission rate consisted of 27,909,798 individuals.[25] The Census questionnaire coverage a vast array of topics at individual and household level. At the individual level, topics covered included age; sex; place of residence; marital status; whether or not a person has disability/difficulty; language, education and employment status. At the household level, topics covered included relationship to the head of the household; housing characteristics of the household; the household's possession of goods and materials and the household's agrarian possessions.[26]

3.2 Disability data collection in Mozambique's censuses

Disability data collection through census is common around the world. The census typically collects data about all the population in a given country, covering the whole territory of a country. Given that the number of persons with disabilities in a small geographical area may be small, the census is best placed for generating data on persons with disabilities throughout a country at a small territorial scale (e.g. at a locality or district level). Although surveys are also used to generate data on disability, these are prone to sampling errors and with a limited representativeness at a sub-national level. As such, census data are uniquely placed to inform the planning and monitoring of disability service outreach at local level. It is also the main source of data that can be generated for some Sustainable Development Goals (SDGs) indicators disaggregated by disability status. The census can also be used to develop the sampling frame for specialized surveys on disability (e.g. oversampling households with persons with disabilities to maximise representativeness). Despite limited territorial coverage, surveys may also provide detailed information about persons with disabilities. Therefore, census and other specialised studies have complementary roles (i.e. breath vs depth).

Census data collection on disability in Mozambique started with the 1997 Population and Housing Census of Mozambique.[27] The 1997 Census collected data on disability by

impairment type and it did not include a question on causes of disability.[28]Data on disability was also collected in the 2007 Population and Housing Census of Mozambique. The 2007 Census's questionnaire on disability asked *Do you possess the following disabilities?* Answers could be: 1. None; 2. Blind; 3. Amputated/atrophied arm(s); 4. Amputated/atrophied leg(s); 5. Paralysis; 6. Mental; 7. Other. Those who replied yes were then asked the following question: *What were the causes of disability?* Replies could be: 1. At birth; 2. Disease; 3. Land mines/war; 4. Military service; 5. Labour accident; 6. Automobile accident; 7. Other. Data collected on disability was expanded in the 2017 Census. The 2017 Census included questions on disability by functional domain. According to an interview with a representative of INE, that was held to inform this study, the inclusion of additional questions on disability by functional domain resulted from discussions with stakeholders who took part in the process of preparing for the 2017 Census. Interviews with INE representative and OPD leaders also revealed that inclusion of the WG-SS in the Census is also conditioned by budget restrictions.

Disability in the 2017 census

Analysing the form that was used to collect data in the 2017 Census, it is possible to see that persons with disabilities were still asked a medical model 'yes or no question' (Do you have a disability?) followed by a question to specify the type of impairment: None; blind; deaf; amputated arm; amputated leg; paralysis; mental; other. As explained earlier in this study, this approach has consistently been shown to under-identify persons with disabilities as well as overlook less visible disabilities. Therefore, it is not surprising that the Mozambique census produced lower prevalence rates than those generated in other African countries as shown below. The 2017 Census found a disability prevalence rate of 2.7%, considerably low compared to the international average. Interestingly, the definition of disability presented in the Census Report meets the CRPD standards.[29] However, the actual methodology adopted for data collection in the Census is questionable concerning its alignment to CRPD and WG questions.[30]

The form attempted to adopt a dual measuring approach, using both impairment-based questions and the WG set of questions. However, it should be emphasized that these questions are only asked of people who first identify as having a "disability." It is that first question that generates the prevalence estimates. Then the impairment and WG questions are used to characterize the individuals who are so identified. Therefore, the disability section in the form presents two introductory topics: you have a disability/difficulty. Below this topic the form lists different impairments (blind, deaf/mute, amputated/atrophied arm, mental) followed by a list of functional difficulties (difficulty hearing, even using a hearing aid; difficulty remembering or concentrating; difficulty with mobility (walking); difficulty to see, even when wearing glasses). Apparently, the rationale behind this arrangement is to enable enumerators to make both sets of questions, one at a time. However, either set only accepts a binary yes or no answer for each disability/difficulty approach.[31]

This arrangement invalidated the tentative use of the WG methodology for many reasons:

- It involves a complexity that might not have been understood by the technical staff, particularly if enumerators were not offered adequate training on the use of the WG questions;
- It does not avoid/reduce stigma and discrimination related with the use of the word "disability" and types of disability; This most likely affected the answers to the WG

questions as well, since they come immediately after the impairment questions. Thus, the mindset of the respondents has been affected by medically based questions, colouring the responses to the WG questions.

- It captures disability as a binary concept and not a continuum with graded thresholds;
- The last question (difficulty with mobility (walking)) excluded "difficulty climbing stairs" limiting the scope of the question.

This is in line with the OPDs leaders' perspectives on the data collection process, as they mentioned that due to stigma enumerators were afraid of asking the disability questions. In fact, they would not ask a disability related question until they saw a person with an apparent disability, missing many persons with hidden disabilities. They also mentioned that in most cases they did not read the full set of questions, instead, they would fill the form trusting on their observation of the members of the household. If persons with disabilities were not present when the head of household was being interviewed (which is often the case given the discrimination and stigma associated with disability) or they did not have a readily apparent disability, they would have been missed.

Therefore, the prevalence data issued by this Census is not internationally comparable and remains in the usual prevalence range of disability data collected through methods exclusively focused on a narrow range of impairments.[32]

3.3 Study Methodology

This study used data from the 2007 and 2017 censuses, complemented by a brief evidence review and interviews with key stakeholders on disability and census data in Mozambique.

Our methodological approach in the study involved four stages.

Stage 1: Situational analysis. The research team started by reviewing the 2007 and 2017 questionnaires and other available documentation to gauge alignment with the WG Questions, the CRPD and best practice on disability data. Subsequently, interviews were held with key census stakeholders including INE, UNFPA, the British High Commission Maputo, and FAMOD to understand the background to disability data collection in the 2017 Census, make a comparison between the 2007 and 2017 Census, and get stakeholders' perceptions on priorities for the thematic study on disability.

***Stage 2: Brief evidence review and limited data collection on disability in Mozambique*.** In the second stage, the research team carried out a brief desk-based evidence review that was used to situate and interpret census findings around disability. This included assessing the prevalence rate in Mozambique in comparison to global estimates, including in conflict and post-conflict settings, and comparing it to other Southern African countries. This stage also involved reviewing available data and evidence on persons with disabilities in Mozambique, drawing on research and evaluations, including qualitative data. In addition, 10 interviews with a diverse range of OPDs, including OPDs representing women's organisations and under-represented groups, were carried out to fill gaps found in the evidence review, understand the disability movement's involvement in the 2007 and 2017 censuses and better understand the barriers for persons with disabilities and their full and meaningful participation in Mozambican society.

Stage 3: Statistical analysis. Analysis of 2007 and 2017 Census data was carried out in two parts. First, the statistical analysis was initially carried out by the research team using a 10% representative sample of the 2017 and 2007 census databases. To avoid any statistical bias associated with sample-based analysis of small population subgroups, the final analysis was replicated by INE utilising the full census database. To expedite this process, our research team provided INE with a full tabulation/analysis plan and the executable 'do files' (STATA syntax files).

To assess trends in the prevalence and patterns of prevalence of disability in Mozambique, a comparison between findings from the 2007 census and the 2017 Census was carried out for selected outcomes. It should be noted that the number of cases in the study varies with the outcome of interest – as not all questions of interest were asked on the total resident population (e.g., the question on marital unions was asked for those aged 12 years or more only). Comparison between findings from the 2007 Census and those from the 2017 Census was done only for disability using the impairment method of identification (common method among the two censuses). With the exception of household dwelling conditions, measures to characterize individuals and their households in the study were directly derived from Census questions. To characterize living conditions in terms of the state of household dwelling, a household dwelling building material index was created. A household dwelling building material index was considered as high if a household possessed walls, roof and floors made of conventional material. Households with at least two parts of dwelling made of conventional materials were considered as having a medium household dwelling index. Households with at least one part of dwelling made of convention material held a low level of the household dwelling building material index.

Stage 4: Draft the preliminary and final disability Thematic Study. After the statistical analysis, the research team triangulated the findings from the Census data with the desk-based research and interview findings to produce a draft preliminary report that was sent for peer review. This final report presents final findings and discussions after taking into consideration comments received from peer review.

3.4 Study limitations

There are some limitations to this study. First, in the 2017 Census, persons were identified as having a disability based on the question *Do you have some disability/difficulty?* Those who answered "yes" were then asked about impairments and about having difficulty doing basic activities, namely seeing, hearing, remembering and concentrating, and walking. These questions constituted four of the recommended six WG questions. People in the Census population who could have been identified by either impairments or the functional approach may have answered "no" to the question about whether they had a disability. Therefore, this study was only able to consider people who are self-identifying as "having a disability", who should not be taken to be representative of all persons with disabilities. Second, although there is strong evidence to suggest that the disability prevalence rate presented in the 2017 Census is an underestimation of the true prevalence of disability in Mozambique, the study was not able to measure the level of that underestimation. Third, although the study explored socioeconomic characteristics of persons with disabilities and their households, the extent of that analysis may have been incomplete given the limitations of census data. Despite the

limitations of census data on disability in Mozambique, they remain the main source of disability data covering the whole country down to a small territorial unit. Therefore, findings from this study are important in considering disability improvements in the country as well as identifying evidence and data gaps for further research.

4. Disability in Mozambique and selected African countries

As mentioned above, for reasons mainly related to methodological approaches, disability prevalence data varies greatly across countries. This is also reflected in the establishment of global prevalence data. This section looks at the various existing global disability prevalence estimates and their methodologies. In addition, this section also looks at disability prevalence data from different sub-Saharan countries, some of which are neighbouring countries to Mozambique, and have undergone very similar development patterns, including civil war experiences.

4.1 Global prevalence of disability

Based on 2010 population estimates and 2004 disability prevalence estimates from the World Health Survey (WHS) and the Global Burden of Disease, there were around 785 (15.6%) to 975 (19.4%) million persons 15 years and older living with disability. Including children, over a billion people (or about 15% of the world's population) were estimated to be living with disability.[33] Also using the WHS, but with some variations on the functional domains and number of countries covered, Mitra and Sambamoorthi (2014) found a prevalence of 14% for all adults.[34] The 2021 Disability Data Report (Mitra and Yap) suggests that only two countries have prevalence rates below 5% among adults 15 and older and the median prevalence of any functional difficulty among adults in the 41 countries stands at 12.6%.[35]

4.2 Prevalence of disability in Africa

In Africa most countries have not used internationally comparable questions based on the WG approach in their last PHC and surveys on disability. Instead, in some cases they remain attached to a medical model type of questions and in others they attempt to deploy functional limitations questions but with some deviations in the design or implementation process affecting the overall results. However, there is a noticeable trend to adopt the WG set of questions which contributes to a rise in the overall disability prevalence data for low- and middle-income countries (LMIC).

4.2.1 Prevalence of disability in sub-Saharan Africa

For the present study, a set of Sub-Saharan countries' disability prevalence data have been analysed, focusing particularly on the impact of the data collection method used. The study also sought to compare the prevalence of women and girls with disabilities. To allow comparability with disability prevalence data in Mozambique, the selected countries have at least one relevant proximity element to Mozambique, either historic (countries that have also been through civil war, considering that wars contribute direct and indirectly to an increase in disability prevalence rates[1]), geographic (neighbouring or fellow southern African countries) or economic (countries within the same GDP index rage). This analysis also took in

[1] Werner, David (2018). Disabled Village Children - A guide for community health workers, rehabilitation workers, and families, Hesperian Health Guides, 2nd edition. < https://en.hesperian.org/hhg/Disabled_Village_Children:Introductory_Material#Copyright_Information>

consideration that the majority of people living with disabilities are developing countries. A summary of this comparative analysis is presented in Table 1.

Table 1. Summary of prevalence by country in sub-Saharan Africa.

Country	Year	Methodology	Prevalence rate
Mozambique	2007	Medical model	2.3
	2017	Medical model	2.7
South Africa	2001	Medical model	6.5
	2005	Medical model	5
	2011	Washington Group	7.5
Malawi	2008	Medical model	4.2
	2018	Washington Group	11.6
Zambia	1990	Medical model	0.9
	2000	Medical model	2.7
	2010	Medical model	2
	2015	Washington Group	13.4
Kenya	2009	Medical model	3.5
	2018	Washington Group	2.2
Angola	2014	Medical Model	2.5
Botswana	2018	Adapted from Washington Group	4.2
Tanzania	2002	Medical model	2
	2012	Washington Group	9.3
Uganda	2002	Medical model	3.5
	2014	Washington Group	12.4
	2018	Washington Group	8.5
Rwanda	2012	Medical model	5.0
Sierra Leone	2015	Medical model	1.3

South Africa

The last HPC in South Africa was conducted in 2011 and the disability prevalence rate was 7.5% for the population 5 years and older[36], which is slightly higher that the rate obtained in 1996 (6.5%) and in 2001 (5%). The South Africa statistics authority is of the understanding that the 2011 Census figures underrate the percentage of persons with disabilities because it does not include statistics on children under the age of five or on persons with psychosocial

and certain neurological disabilities.[2] However, there are important lessons to draw from this process. As part of the preparation process two studies were conducted to assess if the WG set of questions was the best approach to collect data on disability:

- A nationwide qualitative study was undertaken based on representative focus groups and subsequently a further testing of the WG questions using a sample survey to determine whether trends noted in the qualitative study would be replicated for the whole population.[37] Findings from the first study indicated that WG questions were easier to respond to, especially in the mild and moderate categories of difficulty and positive comments were made regarding the use of the term “Difficulty”.[38]
- A follow up survey also yielded similar findings indicating that the WG questions led to much higher disability estimates compared to the traditional questions of 'Do you have any serious disability that prevents your full participation in life activities?' It also confirmed the acceptability of the term 'difficulty' instead of 'disabled' among persons with impairments who did not identify themselves as being disabled. Furthermore, the use of the response options that allow for more nuanced responses rather than 'Yes/No' response allowed persons with mild or moderate difficulties to report these.

Both studies recommended use of the WG questions for Census 2011. However, despite the adoption of the WG questions in 2011, the prevalence rate was not as high as expected. This is partly explained by the common limitations of the WG as mentioned above. In addition, the implementation process conveyed some pitfalls. It has been found that little attention was given to this topic in the training of enumerators, and that this, coupled with interviewers’ perspectives on disability being limited to traditional notions of ‘deaf, blind, crippled or mentally retarded’, led to possible interviewer error in the data.[39]

Malawi

Malawi first collected data on persons with disabilities in the 2008 PHC. However, the methodology adopted for data collection in the census did not meet the WG standards. As a result, the prevalence of disability in Malawi, was reported at only 4.2%.

In 2018, Malawi administered another PHC, and this time the form included the WG-SS of questions. As result, the prevalence increased to 11.6 percent of persons aged 5 years and older identified as having a disability, including those with albinism and epilepsy. To include the later categories, they used an alternative broader definition of disability adding epilepsy and albinism to the WG short set of questions.[3]

Comparing these results to the most recent Mozambique censuses, it is possible to notice that the Malawi 2008 prevalence rate was closer to what was found in Mozambique in the 2007 (2.3) and 2017 (2.7) Mozambique Census Reports. The common trait of these processes is that they did not deploy internationally comparable questions. This reinforces the idea that the prevalence rate in Mozambique is underestimated due to the methodology used, considering the wide gap between most recent results after the introduction of WG Set of questions in Malawi.

[2] Statistics South Africa (2011). Profile of persons with disabilities in South Africa. < http://www.statssa.gov.za/publications/Report-03-01-59/Report-03-01-592011.pdf>

[3] National Statistics Office (2020). 2018 Malawi Population and Housing Census – Disability Report, 6-10.

Zambia

The Zambia 1990 Census used a medical model approach based on a variant of the question 'Do you have a disability?' or 'Are you disabled in any way?' In 2020 a new Census was conducted but the questions used to capture disability were like those of earlier censuses and focused on measuring disability by impairment rather than activity limitations. The 2010 PHC also measured disability using a largely medical definition, with a focus on severe disability, and similar questionnaires for adults and children.

According to published results from the 1990 Zambian Census, the disability prevalence rate in the country was 0.9%, while the derived prevalence rate based on the 2000 Census was 2.7%. The 2010 PHC indicated that 2% of the Zambian population has a disability. These figures are very similar to the ones that have been obtained in Mozambique censuses both in 2007 (2.3%) and in 2017 (2.7%) which were also based on medical model questions.

In 2015, a National Disability Survey was conducted using the WG-SS and the Washington Group/UNICEF Child Module.[40] Prevalence of disability for adults (18+ years) was estimated as being between 13.4% and 17.8%. If the level of inclusion for disability prevalence is "at least some difficulty" in carrying out at least one of the six WG domains, a prevalence rate of 17.8% is achieved; and if a slightly more conservative cut-off was selected at the level of "at least some difficulty" on at least two of the six domains, the resultant national prevalence rate was 13.4%. Both estimates represent a valid estimate of prevalence, and each has its own uses and limitations. These results speak to the flexibility of the screening instrument allowing for a choice of definition based on the purpose of data collection. Among children (2–17 years), the prevalence was estimated to be 4.4 percent.[41]

The prevalence rate for those with the most severe levels of disability (the individual is unable to do at least one of the six domains) was found to be 2.4%. This is in line with the national prevalence rate from the 2000 census of 2.7% – that rate based on a slightly broader impairment-based definition also included the more severe forms of disability.[42] This rate pattern confirms that the medical model questions produce the lowest rates compared to WG questions, because they are more likely to capture mainly the severe disability cases.[43] Furthermore, the similarity with Mozambican census processes also suggests that the low prevalence data currently available corresponds to the most severe levels of disability.

Kenya

Kenya, whilst being an Eastern Africa country which has not registered armed conflict in its modern history, is also another African country that is important to include in this analysis considering the socio-economic proximities (ex., multiple ethnicities and local languages) and that they are amongst the first in the region in conducting the 2020-round census.[4] The challenges of accurately measuring disability demographics have been long recognised in Kenya. The 2009 Census recorded a disability prevalence rate of 3.5%, a figure which OPDs critique as significantly underrepresenting the number of persons with disabilities.[44]

Disability data in the 2019 Census was collected for adults and children above five years of age, following the standard practice of the WG Questions in their analysis of disability

[4] UNFPA (2019). UNFPA Strategy for the 2020 Round of Population & Housing Censuses (2015-2024) < https://www.unfpa.org/publications/unfpa-strategy-2020-round-population-housing-censuses-2015-2024>

prevalence. Despite the use of UN-recommended disability questions and efforts to ensure accurate application of methodology, the 2019 prevalence rate was still low at 2.2%.

There are several possible reasons listed to explain the low prevalence rate in the 2019 Census, however one of the main problems is related to translation. The translation of disability questions into local languages may have caused inaccuracies. While conveying the contents of the census survey into Kenya's local languages, issues of contextualization, cultural nuances and variation of concepts may have arisen. The translated questions may have lacked the purposeful sensitive phrasing of the English version, unintentionally creating a sense of stigma around the questions that could have impacted the accuracy of survey responses.[45]

Translation and capacity of the enumerators are important factors to be considered in countries with many local languages particularly when official translation is not available such as in Mozambique. When the statistics authority (INE in Mozambique) is not able to provide official translations to all languages so enumerators must adapt the questions themselves.

Angola

Like Mozambique, Angola is another Lusophone southern African country which went through a prolonged civil war. Since independence in 1975, Angola has carried out one Population and Housing Census, in 2014. The Angolan 2014 Census asked questions about disability like the ones used in the 2007 Census in Mozambique, which are more likely to capture the most severe cases of disability. The prevalence of disability in Angola was estimated at 2.5%.[46] This is closer to the one reported in Mozambican censuses.

Botswana

In 2018 the prevalence of disability in Botswana was determined through a Demographic Survey which asked questions on disability adapted from the WG questions – including categories of possible answers.[47] Statistics Botswana reports a prevalence of disability of 4.2% in Botswana, with a higher rate among women (4.7%) than men (3.7%).[48]

This rate is lower than the average prevalence rate among African countries that have used the WG-SS. However, the rate is still higher that the prevalence rate in Mozambique.

Tanzania

Using the WG questions on disability, the 2012 Population Census of Tanzania found a prevalence of disability of 9.3 percent among people aged 7 years or more.[49] This is a significant increase from the 2002 Population Census of Tanzania which reported the prevalence of disability of 2% - a medical model approach.[50]

The trend continues here, whereby the lower rate from the previous Census in Tanzania is closer to the latest Mozambique prevalence data and was obtained through the same type of approach.

Uganda

Uganda is a sub-Saharan African country which went through civil war like Mozambique. In 2002 Uganda conducted a National Population and Housing Census which produced a prevalence rate of 3.5%, using a Yes or No question about disability. In 2014 Uganda carried out another Census which reported 12.4% of Ugandan people as living with some form of

disability.[51] The Ugandan Census only included 4 questions from the WG-SS. The 2014 Ugandan Census has been criticized for having included those who replied at least "some difficulty" in one or more functional domains.

More recently, a survey on disability in Uganda carried out in 2019 using the full WG-SS found 8.5% of the population as having at least "a lot of difficulty" in performing at least one functional activity.[52] The pattern on disability prevalence in Uganda also confirms that the lower rates are associated with the use of medical model question in the Census form, suggesting that the same change might occur in Mozambique if the WG methodology is applied. This case also reflects that it might be necessary to conduct a specific disability survey to have accurate data on prevalence.

Rwanda

Rwanda is another African country with a fairly recent history of armed conflict. The Rwandan Census of 2012 measured disability among people aged 5 years or older. The disability prevalence rate in Rwanda was 5%.[53] Rwanda did not use the WG Questions. In Rwanda the disability prevalence rate is slightly higher for men.[54]

Sierra Leone

Sierra Leone went through conflicts. The disability thematic study based on the Sierra Leones 2015 Population and Housing Census reported a prevalence of disability among adult population of 1.3% of the total population. Sierra Leone did not use the WG Questions, so the prevalence data suggested is likely to cover only those who have severe impairments.

4.2.2 Implications for Mozambique

All of the prevalence rates at the global level are considerably higher than the prevalence rate in Mozambique. Data from other African countries, particularly similar contexts in sub-Saharan Africa, has conveyed that countries using the same type of disability questions as Mozambique used in the 2007 and 2017 Census identify a very low number of persons with disabilities. In contrast, countries that have introduced international comparable questions based on the WG models measured higher prevalence rates, particularly compared to their previous census exercises that did not use the WG questions. It has also been noticed that inconsistent implementation of the WG questionnaire might also lead to lower prevalence rates.

4.3 Disability legal and policy framework in Mozambique

4.3.1 Institutional Framework

Figure 4 shows the institutional framework in Mozambique as it relates to disability and statistical data. The Ministry for Gender, Children and Social Action (MGCAS) has the mandate to promote the rights of persons with disabilities in Mozambique. In 2015, the Government of Mozambique established the National Council for Social Action (CNAS), an inter-sectoral consultation body with the objective of coordinating the implementation of government social policies and programs. CNAS emerged from the merging of previous specific population-based mechanisms, namely the *Conselho Nacional para a Área da Deficiência* (CNAD) and the *Conselho Nacional de Acção para a Criança* (CNAC), all based at MGCAS (from these specific based-population mechanisms, only the Women's Council - Conselho *Nacional para o Avanço da Mulher* (CNAM) - remained untouched). The

establishment of CNAS was strongly opposed by OPDs in Mozambique, who consider the mechanisms as ineffective.[55] Instead, OPDs advocated for the creation of a specific Disability Council, with involvement of persons with disabilities, with autonomy and a fully funded secretariat tasked to coordinate and advise the Government on disability issues.[56] To date, CNAS has yet to be fully operational.

The National Commission on Human Rights (CNDH) is tasked with promoting and monitoring human rights in Mozambique. However, it has yet to be designated as human rights monitoring institution under the CRPD article 33 (2).[57] Despite the expressed will of its leadership, the CNDH lacks the technical competence to carry out its mandate when it comes to the rights of persons with disabilities. Efforts are under way through partnership with the Forum of Mozambican Associations of Persons with Disabilities (FAMOD) to establish specific disability unity within the Commission, and to advocate for the designation of the CNDH as a mechanism under the CRPD article 33.2. Another important body is the *Provedor de Justiça* (the Ombudsman), established by the 2004 Constitution with the mandate to guarantee the rights of citizens, defend legality and justice in the actions of the Public Administration. The Ombudsman reports to the Parliament. Judging by the content of the Ombudsman reports to the Parliament, it can be argued that this body has held little engagement with OPDs and with disability rights issues.[58]

The *Instituto Nacional de Estatística* (INE) is the Government entity tasked with recording, collecting, coordinating, and disseminating statistical data. INE's tutelage is under the Council of Ministry who appoints a member (a Minister) to oversee its operation including the decision of statistical data to be gathered, in line with Government priorities.[59] INE has been involved in data collection on disability having contributed significantly to the 2009 SINTEF survey on Living Condition Among Persons with disabilities in Mozambique. However, efforts to improve data collection methodologies in INE's own statistical initiatives have been constrained by limited expertise and financial resources (see section 5 about the census in Mozambique).

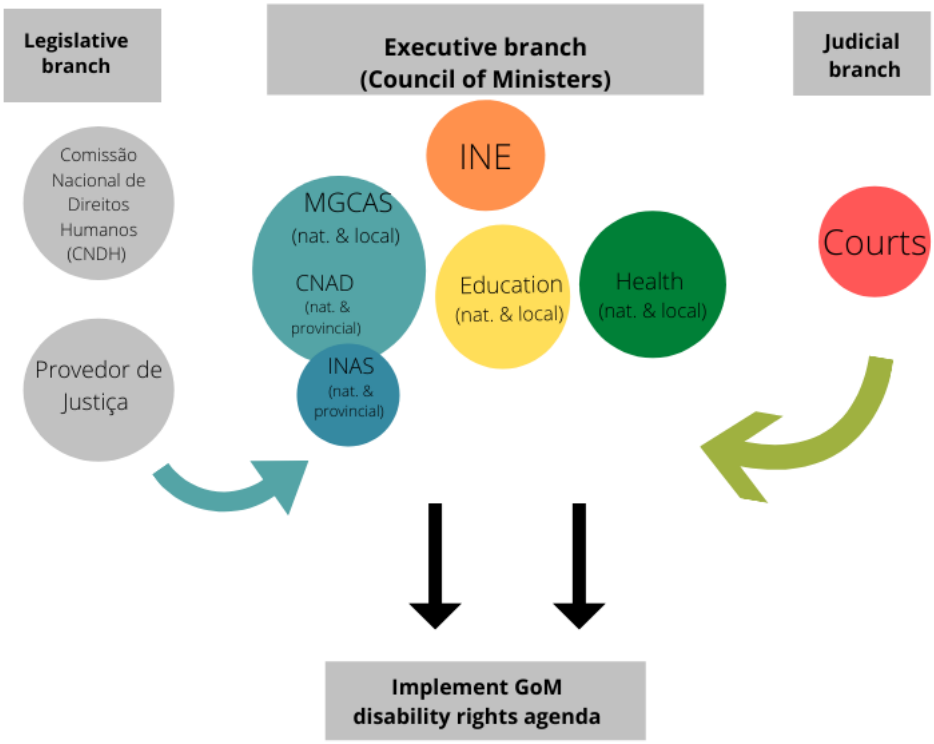


Figure 4. Institutional framework as it relates to disability and statistical data.

4.3.2 Legal and Policy Frameworks

In Mozambique, the rights of persons with disabilities are enshrined in the Constitution in articles 37 and 125 which recognize special protection from the family, society, and state and enshrines a set of rights to be protected and realized by the State. Article 125 (4) of the Constitution establishes a set of rights in accordance with the constitutional principle of non-discrimination, including: a) right to independent life; c) right to rehabilitation and means of compensation; g) right to access to social services, public places and transport (public and private) as well as to reserved places; h) right to influence, individually or via representative organizations in decisions that impact their life; and i) right to information. The Constitution further mandates that the State shall:

> *Promote, in cooperation with associations of disabled and with private entities, a policy that will guarantee the rehabilitation and integration of the disabled; the creation of appropriate conditions to prevent them from becoming socially isolated and marginalized; priority treatment of disabled citizens by public and private services; and easy access to public places*.[60]

The *Politica para Pessoa Portadora de Deficiência* (Policy for Persons with Disabilities), was approved in 1999. In it, disability is defined as "…any reduction or loss of capacity considered normal for a human being as result of an impediment."[61] In general, this has been the definition that has informed Government actions on disability, including when it comes to statistical data on disability, and helps explain the discrepancies between CRPD compliant definitions used in the census and the methodology (see section 5 about census in Mozambique).

Mozambique ratified the CRPD in 2012. According to the Constitution, any instrument ratified by the Parliament becomes automatically part of the Mozambican legal framework. To date, the Convention has not led to major reforms resulting in a patchwork of contradictory legislation in terms of approach and content. For instance, while the CRPD adopts the social model definition of persons with disabilities, in practice data collection on disability is still informed by the definition stated in the Politica para Pessoa Portadora de Deficiência which, as mentioned above, is based on the medical model. Moreover, while the CRPD recognizes denial of legal capacity as a form of discrimination against persons with disabilities, laws such as the Civil Code, the Family and Electoral Law, continue to deny those with intellectual and psychosocial disabilities the right to exercise their legal capacity and their rights (for example, to get married and to vote). The situation is exacerbated because international treaties are hardly used in court decisions in Mozambique. Mozambique only submitted its initial State report on the implementation of the CRPD in 2020, and no significant information was provided in relation to CRPD article 31 (Statistics and data collection).[62]

In 2012, the Government also adopted the National Plan for Disability 2012-2019, (hereinafter PNAD II) as a follow up of PNAD I which ran from 2006 to 2010 to coincide with the African Union Decade of Persons with Disabilities. The purpose of the PNAD II is to ensure the effective participation of persons with disabilities in every aspect of contemporary society. PNAD II had the following areas of intervention: i) vocational training, ii) basic education and literacy programs for youth and adults; ii) Access to employment; iv) Social Security; v) HIV/Aids and sexual and reproductive health; vi) rehabilitation services and family support; vii) women with disabilities; viii) Youth, sport and development of children; viii) capacity building; ix) policies, and legislation; and xi) assistance of persons affected by landslides. PNAD II is a programmatic instrument implemented annually through the Economic and Social Plan (ESP). The evaluation found that the implementation of PNAD II was not satisfactory failure due to inadequate budgeting; lack of coordination between the different government departments; non-recognition at the sector level, of PNAD as a key planning document; inadequate data collection, among others.[63]

Apart from the CRPD, Mozambique has adhered to other global and regional treaties relevant to disability rights. These include the UN Convention on the Rights of Child, the UN Convention on the Elimination of All Forms of Discrimination against Women. At regional level, the Government of Mozambique signalled, on June 8th, the ratification of the recently adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa. It is hoped that the Parliament will ratify in the next ordinary session scheduled.

In the framework of the 2018 Global Disability Summit, the Government of Mozambique made several commitments.[64] On data disaggregation, the Government committed by 2020 to adopting the WG tools and ensuring a study is undertaken to understand the situation of persons with disabilities in Mozambique. Another commitment made by the Government was to draft and approve a specific disability law. To date, Mozambique does not have a specific disability law, being one of only a few countries in the region without one. In 2017, the Government approved a Disability Bill, but It was rejected by the movement of persons with disabilities arguing among other aspects that It was framed under a medical model of disability.[65] A revised bill drafting process initiated by OPDs and now led by the Government is underway. Among OPDs' demands is the need to ensure that the new law mandates the

Government to collect statistical, administrative, epidemiological and other relevant data on disability, using international agreed standards.

Given the disproportionate representation of persons with disabilities living in poverty, social protection is critical in addressing the vulnerabilities that they are exposed. The social protection system in Mozambique comprises four main programs, namely i) *Programa de Subsidio Social Básico* (PSSB) - consisting of cash transfers to households living in poverty and without members who can work; ii) *Programa de Apoio Social Direto* (PASD) - consisting of fixed-term social transfers – in-kind or payment for services - designed to cope with shocks that exacerbate the degree of vulnerability of people or households living in poverty; iii) *Programa de Atendimento em Unidades Sociais (PAUS)* - consisting of direct assistance to users of the Social Units namely: Old Age Support Centres, Transit Centres, Open Centres, Reception Centres and Nurseries; and iv) *Programa Ação Social Produtiva (PASP*) which aims to create opportunities for self-support for individuals living in poverty with the capacity to work, through the performance of public works and other activities to support income generation. These programs are implemented by the *Instituto Nacional de Acção Social (INAS),* the Government agency under the tutelage of the Ministry of Gender, Children and Social Action (MGCAS).

However, only a small proportion of those eligible are covered by social protection programs: the PSSB (5.3%), PASD (5%) and overall, between 4-6% of person with disabilities in Mozambique have access to basic social protection programs.[66] There is no consistency in data gathering and reporting on disability across different programs. Some programs report data on disability and others do not.[67]

The legal and policy Framework in Mozambique shows how, on the one hand, the medical model of disability still informs disability policies and data collection efforts on disability in Mozambique. On the other hand, there are areas which can benefit from disability disaggregated data as per the WG methodology standards and, ultimately, would, potentially, lead to more inclusion and participation of persons with disabilities in development efforts.

4.3.3 Brief overview of the situation of persons with disabilities in Mozambique

In Mozambique, data on disability is not systematically collected. The disability prevalence rate provided by the Census (2007 and 2017) is very low (2.3% and 2.7% respectively) and is questioned by the disability rights movement who argue that prevalence is much higher. It appears considerably more questionable when compared to the WHO world estimated of 15%.[68] As explained in Section 6, these census processes have not adequately adopted the WG methodology.

In addition, as part of the Household Budget Survey (IOF 2014/15), INE has collected disability prevalence data.[69] The study suggests a disability prevalence rate of 1.5%, with higher prevalence among men with disabilities (1.7%) compared to women with disabilities (1.3%). However, the study does not explain the methods used to obtain the disability figures.

In 2007, an initiative led by SINTEF, a Norwegian statistics research institute, arrived in Mozambique. In collaboration with INE and FAMOD, a survey on living condition for persons with disabilities was conducted in Mozambique. The study includes: (i) a comparative study of households with and without family member(s) with functional limitation and (ii) a comparative study of individuals with and without functional limitations. The survey applied the Activity and

Participation Matrix drawn from the ICF developed by the WHO in 2001 and produced a prevalence rate of 6%.[70] Overall findings of the survey indicate that individuals with disabilities and their households experience lower levels of living conditions as compared to their non-disabled counterparts or households without disabled members. Indicators such as education, employment, economy, and access to information revealed that there was a difference between the two groups.[71] A systematic difference on gender was found, where women with disabilities scored lower than men with disabilities and women without disabilities on the main indicators on standard of living. There are further demographic differences indicating that individuals with disabilities found it was difficult to establish their own family and be independent of the household they grew up in.[72]

To complement the desk-based review and statistical analysis, this thematic study carried out 10 semi-structured interviews with OPDs to gauge their perspective of data collection on disability in Mozambique and their understanding of the situation and barriers experienced by persons with disabilities. First, OPDs that took part in interviews for this study agreed that the disability prevalence rate does not represent the real spectrum of disability in Mozambique. All OPDs cited methodological issues as the primary reason for the underrating of disability data.[73] In addition, they also mentioned several problems in the preparation and administration of the Census questionnaire, including:

- Stigma and discrimination affecting the extent to which persons with disabilities were engaged in the survey: for example, enumerators did not always ask the questions about disability and families themselves hid their relatives with disabilities;
- Limited capacity within technical staff - for instance enumerators would not ask any question on disability unless they saw a person with an apparent disability; they struggled to classify disabilities, particularly those that are not apparent;
- Limited engagement of disability specialized stakeholders (OPDs and MGCAS).

Reflecting on the living conditions of persons with disabilities in Mozambique, OPDs leaders reported that in many areas persons with disabilities are still facing greater barriers to participation in society, which are considerably aggravated in rural areas and for women with disabilities. Access to employment or other income generating sources, access to education and professional training and access to health services are the areas of most concern. Barriers related to accessibility (physical accessibility, information accessibility, ICT accessibility), stigma and lack of capacity to address disability/impairment specific access and support needs were highlighted as the main challenges faced by persons with disabilities. Moreover, OPD leaders highlighted the need to pay attention to persons with less visible disabilities and those identified as highly disenfranchised. Those include women with disabilities and persons with disabilities with specific impairment types, including persons with communication impairments, persons with psychosocial disabilities and those with albinism. Finally, there is gender dimension that may contribute to deficiencies in data collection. Respondents reported episodes of enumerators refusing to interview women with disabilities as the head of the household. In a context where, due to stigma, mothers of children with disabilities are often abandoned by their partners, these practices may impact negatively on the data generated.

5. Results

This section presents the results of the 2017 Census and selected findings from the 2007 Census. First, the section looks at breakdowns on disability identified using the impairment method of identification and their causes, and then at the functional method of identification and their causes. Then, it looks at socioeconomic characteristics of persons with disabilities and their households, presented with all persons with disabilities combined (unless indicated). The study focuses on presenting key findings from the Census data; detailed tables with additional information are provided as annexes to the study. As set out in Section 3.2, both censuses used a yes/no question about whether the person had a "disability" to identify persons with disabilities, a medical approach to disability measurement that is a method well-known to under-identify persons with disabilities.[74] Therefore, the results in this section should be understood in that context, and are a presentation of the results of the Census only, not a presentation of the actual prevalence rate of disability in Mozambique (Section 5.1 explains this in more detail).

5.1 Prevalence of disability in 2007 and 2017 censuses

5.1.1 How the census measured disability

The 2017 Census identified 727,620 individuals as having disabilities (372,061 men and 355,559 women), corresponding to 2.7% of the population.[75] The previous Census held in 2007 reported 2.3% of the population as having disabilities (475,011 individuals; 249,752 men and 225,259 women).[76]

While the 2007 Census sought to categorize persons with disabilities by impairment type, the 2017 Census integrated questions adapted from the WG methodology to identify disability by functional domain. However, as set out in Section 2.3, the validity of the WG questions depends on how they are implemented and, as set out in Section 3.2, the attempt in the 2017 Census to integrate WG questions was undermined by the "do you have a disability" question which was first asked to identify persons with disabilities. Impairments are based on particular conditions a person has, while the functional approach captures difficulties people have doing basic activities. It is important to note that people who could have been identified by either impairments or the functional approach may very well have answered "no" to the question about whether they had a disability. In fact, based on research in other countries, this is expected. Therefore, **this section of the study only describes those people who are self-identifying as "having a disability" and should not be taken to be representative of all persons with disabilities**. To identify that group, a set of questions, such as the WG approach, would have to be used to make an accurate identification of persons with disabilities.

Key Finding 1: Measures used to identify persons with disabilities in the 2007 and 2017 censuses are known to seriously underestimate the number of persons with disabilities. The 2017 and 2007 censuses show prevalence rates that are in line with other African countries that use a similar medical model of collecting disability data.

5.1.2 Prevalence of disability by self-identified impairment type

***Key Finding 2A*: The 2017 Census found 1.4% of individuals who self-identified as having an impairment (1.6% men and 1.3% women), and 0.4% of individuals who self-identified as having other disabilities (disabilities not specified).**

Figure 5 shows the prevalence of disability using the impairment method of identification by impairment type and gender in the 2017 Census, including multiple disabilities. **For both men and women, amputated or atrophied leg is the main type of disability by impairment type** (nearly 31% and 30% for men and women, respectively), followed by deaf/mute disability (16% and 18%, respectively). The third major type of disability by impairment type among men in the 2017 Census is amputated or atrophied arm (with about 15%), while among women it is being blind (with 15%). Overall, in the 2017 Census there were 1.4% individuals with any disability by impairment type (1.6% men and 1.3% women) and 0.4% individuals with other disabilities (see full details in Table 1A in the annexes). 'Other disabilities' include characteristics of disability not categorized in the Census questionnaire. Yet, it is not clear what those characteristics are. Another observation is that the categories of disability/impairment do not accurately define the population identified. For example, "mental disability" is a very broad category, and it could include persons with psychosocial and learning disabilities.

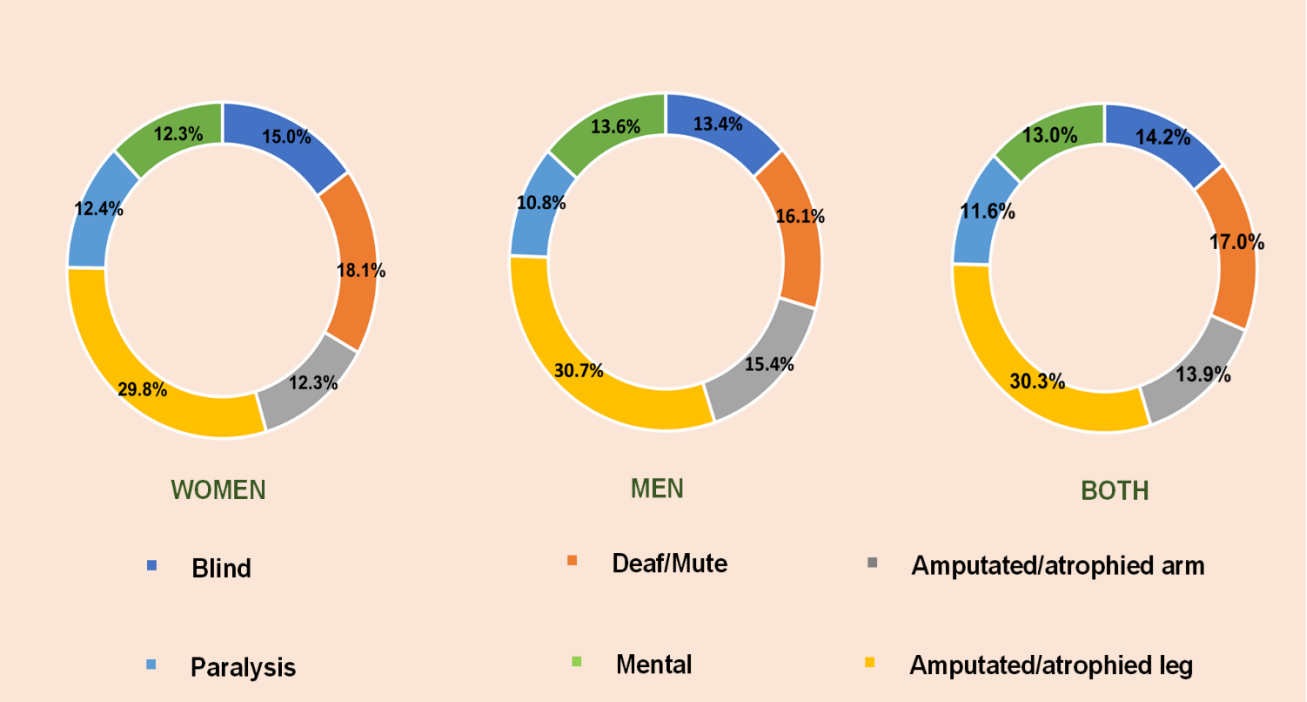


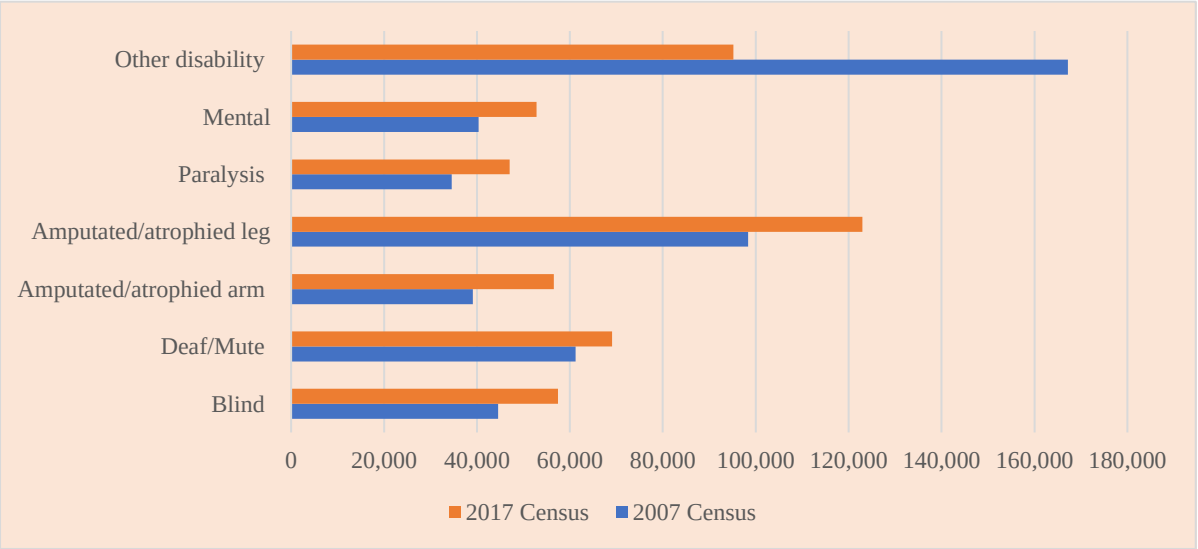
Figure 5. Prevalence of disability among those self-identifying as having a disability by impairment type, by gender, 2017

Graph 1 shows the rate of disability using the impairment method of identification in the 2017 Census, broken down by impairment type and other disabilities, and by five-year age group (rate per 10,000 individuals). The rate of disability by impairment type expresses the relation

between the number of persons with a disability by impairment type in the age group and the total population of that age group (number of people in the age group exposed to the likelihood of having disability by impairment type). Presenting prevalence of disability as rate per 10,000 individuals may help in understanding how common disability is in a given population group and aid in making comparisons between population groups.

As shown in graph 1, data from the 2017 census reveals that the rate of disability by impairment type and other disabilities varies with age, with older individuals likely to have more disabilities by impairment type and other disabilities compared to younger ones. There is also a variation in the rate of disability by impairment type according to type of disability by impairment type. Amputated or atrophied leg is the major type of disability by impairment type for most five-years age groups particularly between ages 15 to 79 years. In the older people (80 years or more) age group, blindness stands out as the most prevalent type of disability by impairment type. From 60-64 years onward, blindness, amputated or atrophied leg and other disabilities are the most prevalent disabilities. Blindness, amputated or atrophied arm, amputated or atrophied leg, and others, were categories in Census questionnaire.

With respect to prevalence of disability by impairment type and other disabilities by five-year age groups and gender, a pattern similar to the one reported above is found. However, the rate of disability by impairment type and other disabilities tends to be higher for men compared to women (Graph 1A and Graph 1B, annexes). It also tends to be a little higher in rural areas relative to urban areas (Graph 1C and Graph 1D, annexes).



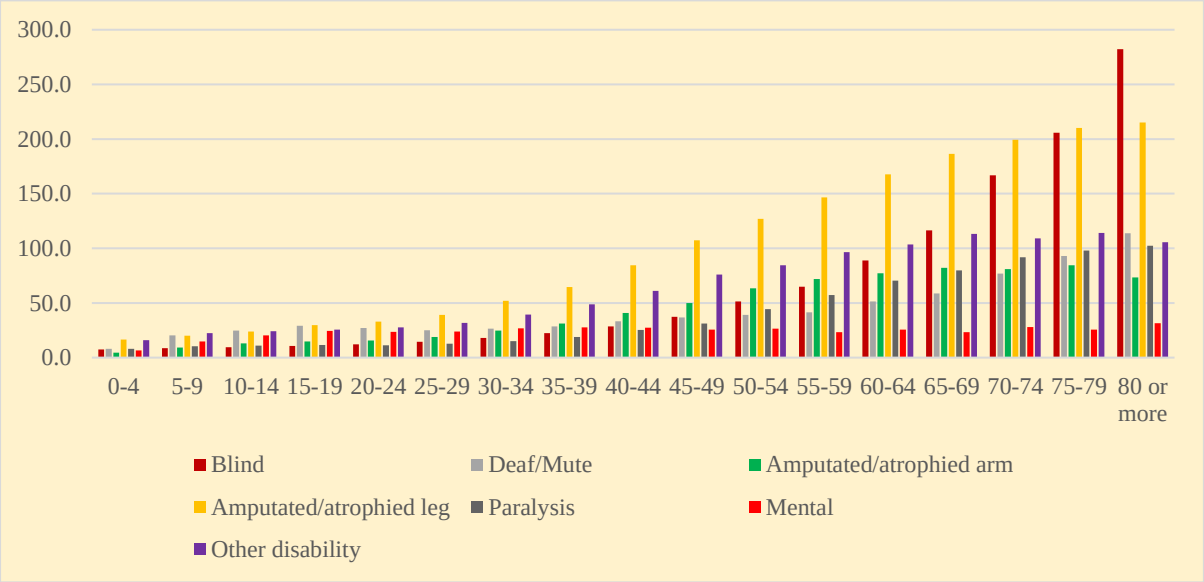
Graph 1. Prevalence of persons with impairments among those self-identifying as having a disability by impairment type by five-year age group (rate per 10,000 individuals), 2017 Census

Graph 2 compares disabilities by impairment type in the 2007 and 2017 censuses. It shows that there was an increase in disabilities by impairment type for all types between the two censuses among those self-identifying as having a "disability." In both the 2007 Census and the 2017 Census, amputated or atrophied leg was the main type of impairment followed by deaf or mute disability.

Results at a glance:

- **Amputated or atrophied leg is the major type of disability by impairment type for most five-years age groups**
- **Blindness, amputated or atrophied leg and other disabilities are the most prevalent disabilities in the age group of 60-64 years onward**
- **Blindness stands out as the most prevalent type of disability by impairment type in the older people age group**
- **There was an increase in disabilities by impairment type for all types between the 20017 and 2017 Census among those self-identifying as having a "disability."**

Graph 2. Disabilities using the impairment method of identification by impairment type in 2007 and 2017 censuses for those self-identifying as having a disability.



5.1.3 Prevalence of disability by self-identified functional domain

<u>Key Finding 2B</u>: The 2017 Census found that 1% of individuals self-identified as having a disability by functional domain.

Figure 6 displays the percentage of people self-identifying as having a disability who also report functional difficulties by functional domain and gender in the 2017 Census. *Difficulty with mobility (walking)* is the functional limitation which the highest number of people reported difficulties with (42.8%), followed by *difficulty seeing, even when wearing glasses*

(30%), and *difficulty hearing even when wearing a hearing aid* (14.5%). There appears not to be major gender differences in reporting functional limitations. Individuals with any disability by functional domain in the 2017 Census were 1% (full details in Table 2A in the annexes). It should be noted that the questionnaire of the 2017 Census of Mozambique did not include *difficulty with self-care, such as washing all over or dressing* and *difficulty communicating, for example understanding or being understood*, as recommended in the WG approach. This may also partially explain the low prevalence of disability identified using the functional method of identification.

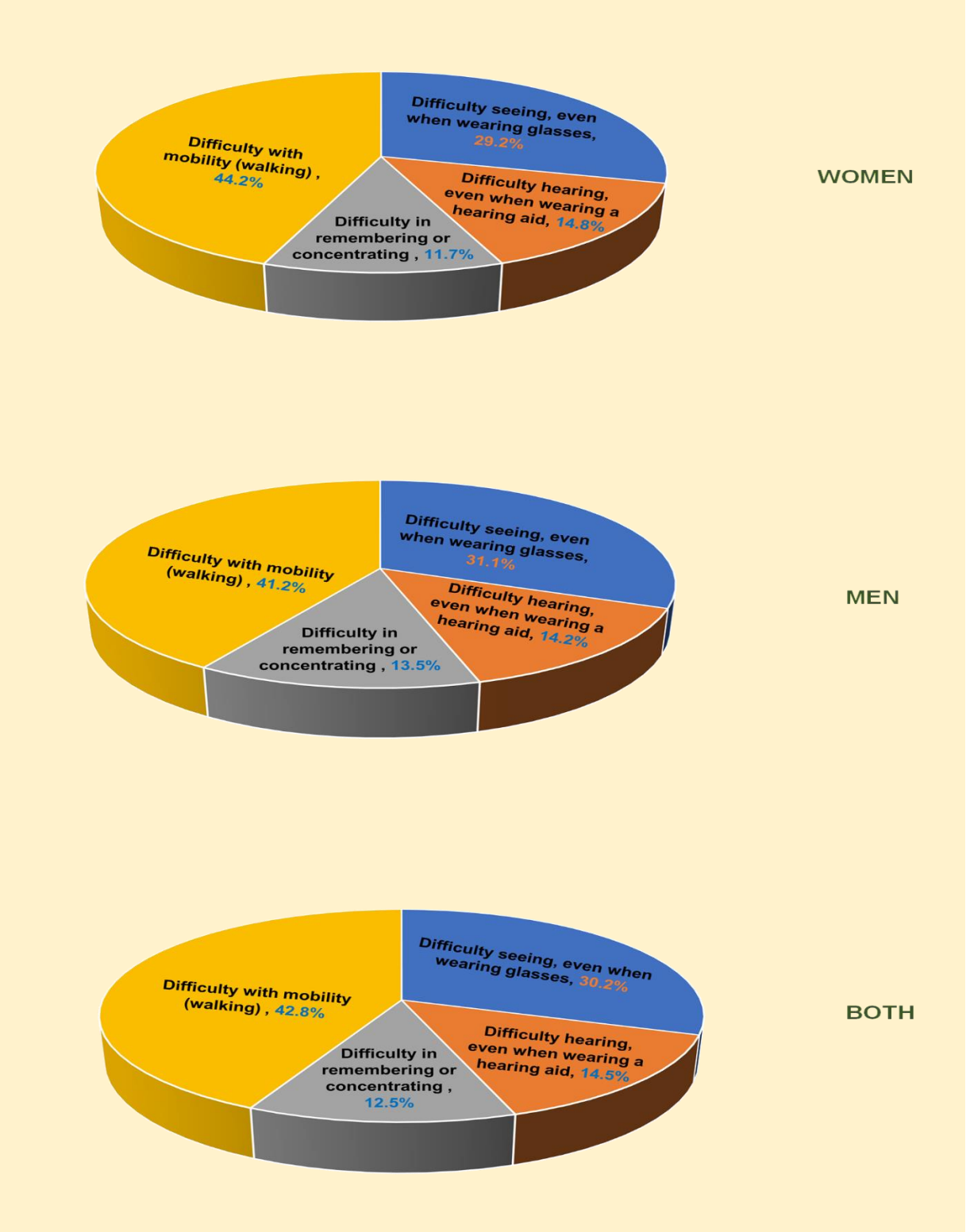
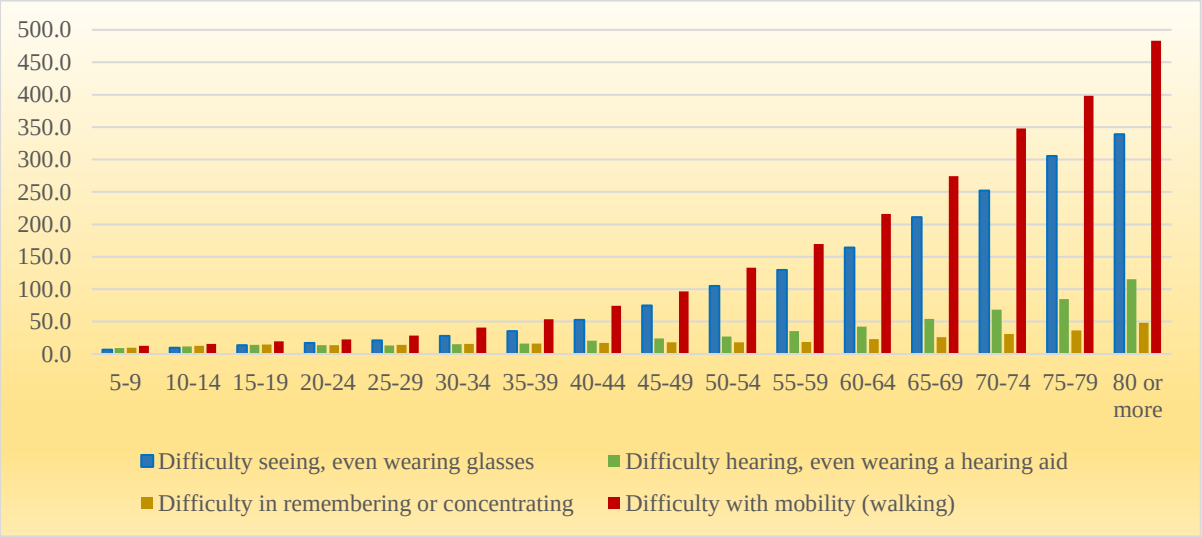


Figure 6 Prevalence of disability among those self-identifying as having functional limitations, by functional domain, by gender, 2017

Graph 3 presents the rate of functional limitations among those self-identifying as having a disability by functional domain by five-year age group (rate per 10,000 individuals). In general, it shows that the prevalence of disability by functional domain increases with age.

Difficulty with mobility (walking) and *difficulty seeing, even when wearing glasses* are major types of disability by functional domain among age groups from 20-24 years onwards. From age groups starting at 35-39 years, the rate of these two domains is more than 2 times higher compared to that of other domains. An observation is that women appear to have a high rate of disability by functional domain compared to men in same age groups (full details in Graphs 3A and 3B, in the annexes). The pattern of disability by functional domain by five-year age group in urban and rural areas appears to be similar (Graphs 3C and 3D, in the annexes).

Graph 3. Prevalence of persons with functional difficulties among those self-identifying as having functional limitations, by functional domain by five-year age group (rate per 10,000 individuals), 2017 Census



Note: The graph does not bring 0-4 age group as it is based on questions adapted from Washington Group Questions that were designed for ages above 4.

Results at a glance:

- **From age groups starting at 35-39 years, the rate of *difficulty with mobility (walking)* and *difficulty seeing, even when wearing glasses* is more than 2 times higher compared to that of other domains.**
- **Women appear to have a high rate of disability by functional domain compared to men in same age groups.**
- **The pattern of disability by functional domain by five-year age group in urban and rural areas appears to be similar**

5.1.4 Multiple disabilities

Multiple Disabilities Using the Impairment Method of Identification by Impairment Type in the 2007 and 2017 Censuses

Persons with disabilities may have multiple and overlapping disabilities at the same time. Figure 7 shows the prevalence of multiple disabilities (two or more) by impairment type among persons with disabilities in the population in the 2017 Census. Amputated or atrophied arm and amputated or atrophied leg were the most common combinations of disabilities by impairment type among both men and women found in the 2017 Census in Mozambique. Among persons with two or more disabilities in the 2017 Census, these two disabilities account for about 34% of cases and were the highest combinations of disabilities for women and men. As with the 2017 Census, amputated or atrophied arm and amputated or atrophied leg were the most prevalent combinations of disabilities by impairment type among persons with disabilities in the 2007 Census (full details in Table 3A and Table 3B in the annexes).

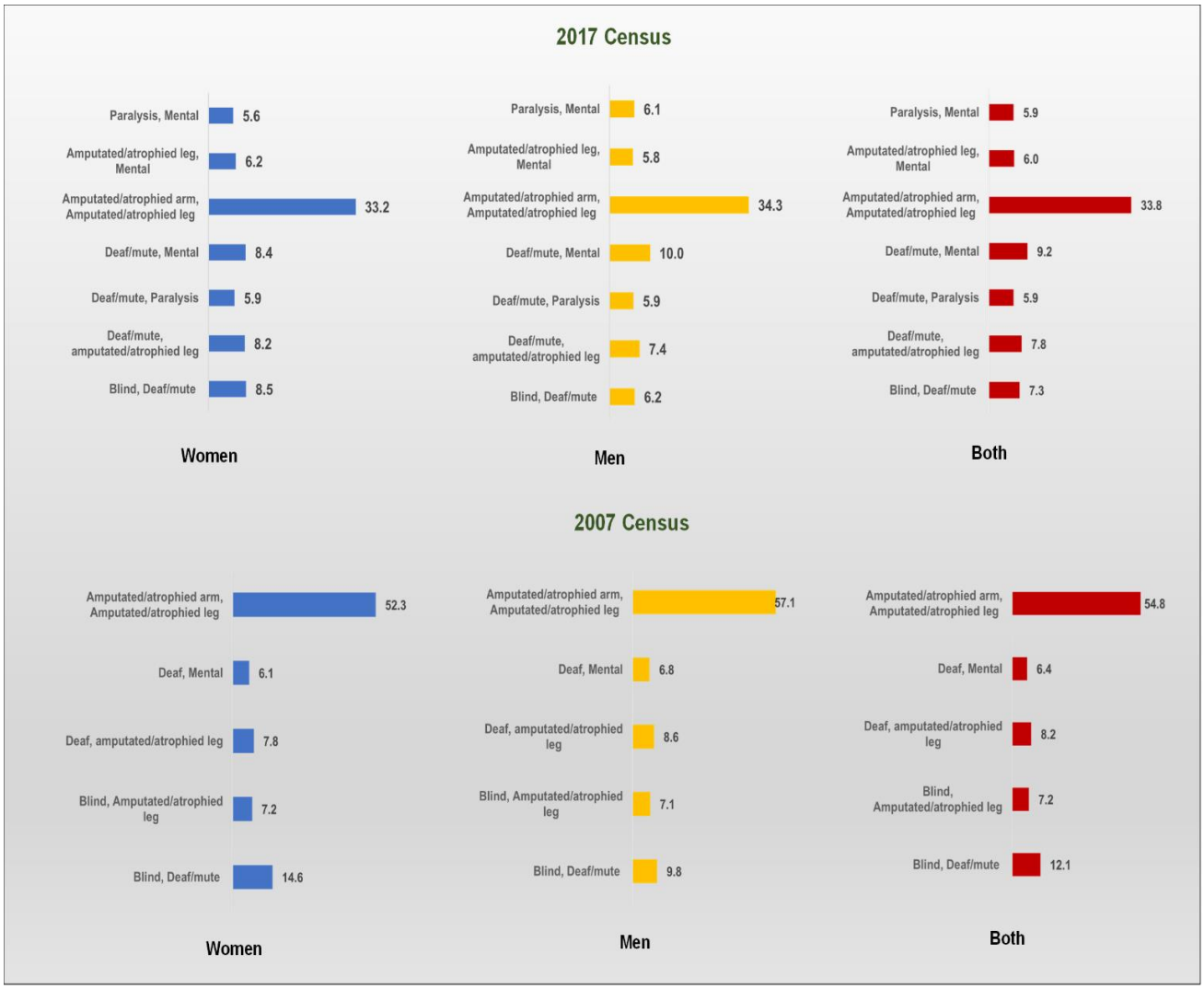


Figure 7 Prevalence of multiples disabilities using the impairment method of identification by impairment type (two or more) and gender, 2017 Census

Multiple Disabilities Using the Functional Method of Identification by Functional Domain in the 2017 Census

Figure 8 shows prevalence of multiple disabilities by functional domain in the 2017 Census. Just over a quarter of combinations of disabilities were formed by *difficulty seeing* and *difficulty with mobility (walking)* (with about 29% for both men and women), followed by a

combination of *difficulty seeing* and *difficulty hearing* (19%), and a co-occurrence of *difficulty in remembering or concentrating* and *difficulty walking* (about 17%). Looking at the ratio of males to females reporting multiple disabilities by functional domain, fairly close percentages were observed particularly in the *difficulty seeing* and *difficulty with mobility (walking)* combination (27.6% men versus 30.6% women), and in the *difficulty in remembering or concentrating* and *difficulty with mobility (walking)* co-occurrences (18% men versus 15.6% women). Overall, *difficulty seeing* and *difficulty with mobility (walking)* were likely to be combined with other functional domains (details on Table 4A).

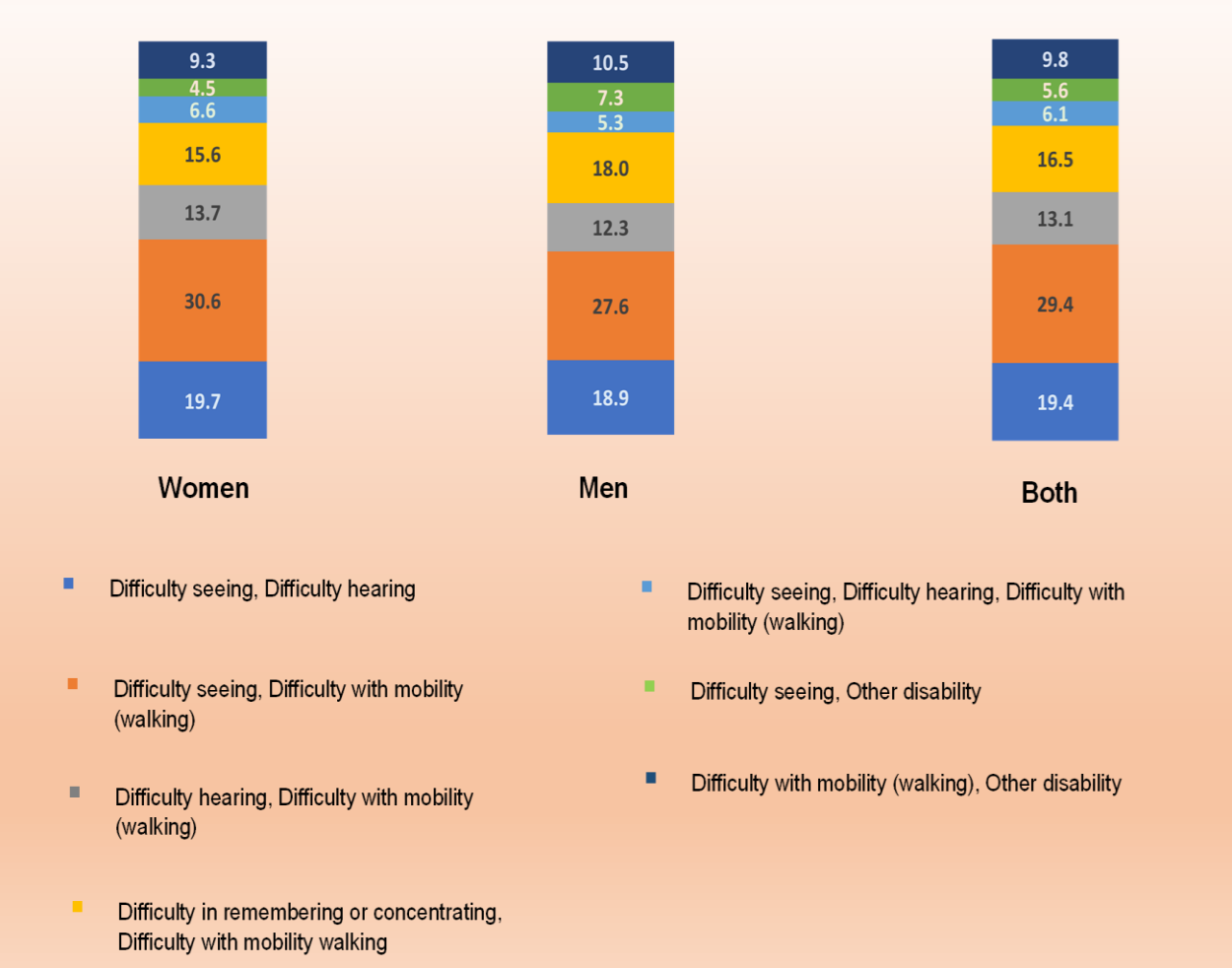


Figure 8. *Multiple Disabilities by Functional Domain, 2017 Census*

Results at a glance:

- **Amputated or atrophied arm and amputated or atrophied leg were the most common combinations of disabilities by impairment type among both males and females in both 2007 and 2017 censuses.**
- **Just over a quarter of combinations of disabilities were formed by *difficulty seeing* and *difficulty with mobility (walking)* (with about 29% for both men and women).**

5.1.5 Prevalence of disability by province and region of Mozambique

Prevalence of Disabilities by Impairment Type per Province and Region of Mozambique

Assessing distribution of prevalence of disability by province and region of Mozambique is important as it provides geographic information and analysis that can be used by policy and decision-makers to improve support for persons with disabilities. Table 2 presents prevalence of disability using the impairment method of identification by impairment type and other disabilities, by province and region of Mozambique in the 2017 Census. It also shows the rate of disability by impairment type per province and region. The rate of disability by impairment type in a given province shows the relation between the number of persons with disabilities by impairment type in the province and the total population of that province.

Table 2 reveals that the highest-ranking provinces in the country in 2017 in terms of rate of disability by impairment type were Inhambane (with 193 individuals with disabilities by impairment type per 10,000 persons), Nampula (185 individuals per 10,000), Gaza (158.9 per 10,000) and Zambézia (146.1 per 10,000). These four provinces are above the national rate of disability by impairment type in 2017, which was 144 individuals per 10,000 persons. With respect to regional variation in the rate of disability by impairment type, the North of Mozambique stands out with 159.7 per 10,000 individuals. The South and the Centre of Mozambique have 142.2 per 10,000 and 132.5 per 10,000 with disability by impairment type in the 2017 census (Table 2, a similar Table with frequencies is available in the annexes (Table 2A)). The variation in rate of disability in Mozambique appears to be related to geographic variations in socioeconomic conditions. The regions and provinces with high rate of impairments appear to be those with relatively poor socioeconomic conditions. Considering the wealth index, the National Survey on Indicators of Malaria in Mozambique 2018 shows those provinces with high rate of impairments are more likely to have few households in the highest wealth quintile category – Inhambane (about 11%), Nampula (nearly 15%), Gaza (31%), and Zambézia (8%).[77] The North of the country also tends to have few households in the highest wealth quintile followed by the Centre.[78]

Table 2 also shows prevalence of "other disabilities"[79] in Mozambique by province, region of residence and gender in 2017. In 2017 there were 35 persons with other disabilities per 10,000 individuals in Mozambique. Nampula province, Zambézia and Inhambane have the highest rate of other disabilities in the country – with 43.6 per 10,000, 42.4 per 10,000 and 35.7 per 10,000, respectively. The minimum rate of other disabilities is found in Gaza province with 25.6 per 10,000 individuals. In relation to gender, there appears to be a noticeable variation in the rate of other disabilities within Nampula (26.8 per 10,000 for men versus 23.2 per 10,000 for women) and Manica (5.3 per 10,000 for men versus 7.1 per 10,000 for women) provinces. There is variation in the rate of other disabilities per region of Mozambique. The North of the country has the highest rate of other disabilities (37 per 10,000 individuals) followed by the Centre (35.9 per 10,000) and the South (31.3 per 10,000). Within regions, there is also a variation in rate of other disabilities by gender, with men more likely to have a high rate of other disabilities in the North of Mozambique, and women more likely to have a high rate in the Centre and the South of the country Table 2, a tables with frequencies are available in the annexes (Table 5A and Table 5B).

Table 2. Prevalence of persons with impairments by impairment type and other disabilities among those self-identifying as having a disability per province and region of residence and gender, 2017 Census

Province	Disabled by impairment type				Other disabilities			
	Women	Men	Both	Rate of disability by impairment type per 10,000 persons	Women	Men	Both	Rate of other disabilities per 10,000 persons
	182,989	204,830	387,819		45,506	49,691	95,197	
Inhambane	7.5	7	7.2	192.5	23.2	26.8	25.1	43.6
Nampula	26.3	26.1	26.2	185.0	22.1	22.5	22.3	42.4
Gaza	6.1	5.3	5.7	158.9	5.9	5.0	5.5	35.7
Zambezia	18.9	18.8	18.8	146.1	8.4	7.2	7.8	33.6
Cabo Delgado	8.1	8	8.1	137.7	6.7	6.6	6.7	33.3
Sofala	7.2	7.5	7.3	129.3	7.1	5.3	6.2	31.7
Tete	7.7	7.9	7.8	118.7	3.3	3.3	3.3	29.4
Manica	5.4	5.9	5.7	118.5	6.5	7.4	6.9	29.1
Maputo Provincia	5.4	5.7	5.6	113.0	5.0	5.2	5.1	28.1
Niassa	4.7	4.8	4.8	107.9	7.7	7.3	7.5	28.0
Maputo Cidade	2.7	3.1	2.9	104.6	4.2	3.3	3.7	25.6
Total	**100**	**100**	**100**	**144.2**	**100**	**100**	**100**	**35.4**
Region								
North	39.1	38.9	39	159.7	34.6	39.4	37.1	37.3
Centre	39.2	40	39.6	132.5	45.2	42.3	43.7	35.9
South	21.7	21.1	21.4	142.2	20.1	18.3	19.2	31.3
Total	**100**	**100**	**100**	**144.2**	**100**	**100**	**100**	**35.4**

Figure 9 shows two maps of the rate of disability by impairment type per 10,000 individuals across provinces in Mozambique in 2007 and 2017. Overall, the maps reveal a reduction in the rate of disability by impairment type in 8 provinces of Mozambique between 2007 and 2017. The rate of disability by impairment type in Manica province remained around 118 per 10,000 across the two censuses. Maputo City (from 67.8 per 10,000 to 104.6 per 10,000) and Nampula (from 158.0 per 10,000 to 185.0 per 10,000) witnessed an increase of rate of disability by impairment type between the two periods. Although Inhambane province had a decrease in the rate of disability by impairment type, it remained the province with the highest rate of disability by impairment type in Mozambique across both censuses.

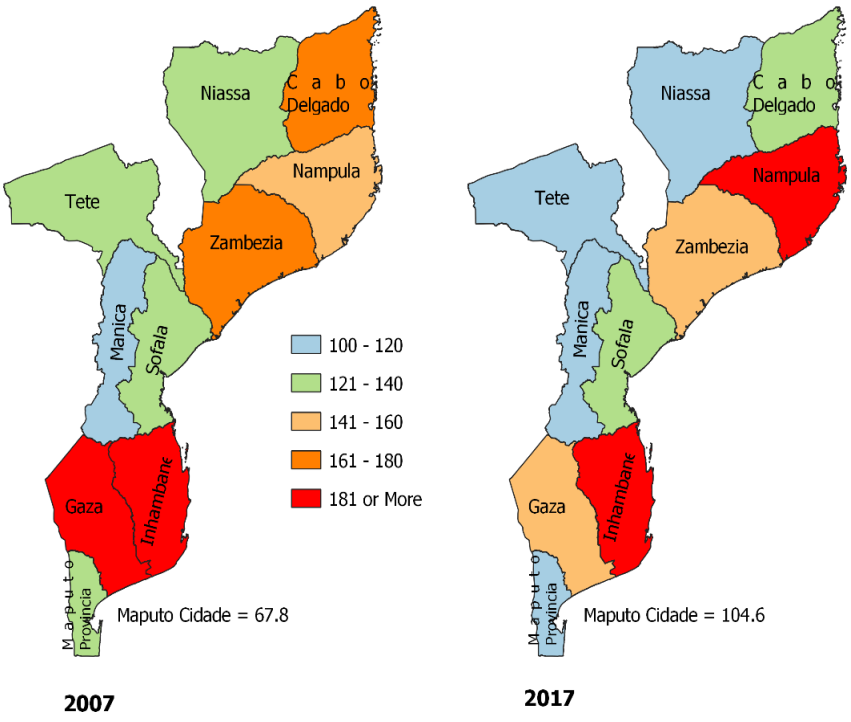


Figure 9. Rate of disability using the impairment method of identification by impairment type in Mozambique in 2007 and 2017 (per 10,000 individuals).

Prevalence of Functional Difficulties per Province and Region of Mozambique

Table 3 presents prevalence of functional difficulties by province among those self-identifying as having a disability using the functional method of identification by functional domain in Mozambique in 2017. Like disability by impairment type, Inhambane province has the highest rate of disability by functional domain – 143 persons per 10,000 individuals. The national rate of disability by functional domain stands at 99 persons per 10,000. All provinces of the Centre of the country are below the national average (Manica, Tete, Zambézia and Sofala); and Niassa from North of Mozambique. With respect to gender, a variation of about 2 percentage points between men and women is noticeable in Gaza (5.2 for men vs. 7.0 for women) and Nampula (23.9 for men vs. 21.3 for women) provinces (a similar table with frequencies is available as annex, Table 6A).

Table 3. Prevalence of persons with functional difficulties by functional domain per province, region of residence and gender among people self-identifying as having a disability, 2017 Census

Province	Disabled by functional domain			
	Women	Men	Both	Rate of disabilities by functional domain per 10,000 persons
	138,107	128,136	266,243	

Inhambane	8.5	7.0	7.8	143.1
Nampula	7.0	5.2	6.1	117.5
Gaza	9.7	10.0	9.8	115.5
Zambezia	21.3	23.9	22.6	109.5
Cabo Delgado	7.7	7.0	7.4	103.2
Sofala	4.2	3.9	4.1	100.0
Tete	7.8	7.6	7.7	93.1
Manica	16.4	17.4	16.9	89.9
Maputo Provincia	7.6	7.7	7.6	79.4
Niassa	4.7	5.1	4.9	75.7
Maputo Cidade	5.0	5.3	5.2	74.1
Total	**100**	**100**	**100**	**99.0**
Region				
North	35.7	38.9	37.3	104.8
Centre	36.8	37.9	37.4	85.7
South	27.5	23.2	25.4	116.0
Total	**100**	**100**	**100.0**	**99.0**

Results at a glance:

- **The national rate of disabilities by impairment type in 2017 was 144 individuals per 10,000 persons.**
- **Inhambane province (193 individuals per 10,000 persons), Nampula (185 individuals per 10,000), Gaza (158.9 per 10,000) and Zambézia (146.1 per 10,000) have a rate of disabilities by impairment type above the national average.**
- **There was a reduction in the rate of disabilities by impairment type in 8 provinces of Mozambique between 2007 and 2017.**
- **The North of Mozambique has the highest rate of disabilities by impairment type (159.7 per 10,000 individuals), followed by the South (142.2 per 10,000) and the Centre (132.5 per 10,000).**

5.1.6 Relationship between measures in the 2017 census

Table 4 shows the relationship between methods of identifying disability in the 2017 Census of Mozambique. The question used to identify persons with disabilities was ”Do you have a disability/difficulty.” As noted earlier, this question is known to miss many persons with functional limitations and impairments. Of the 727,620 individuals who answered that they had a disability, 53.3% were also identified as having impairments, 36.6% were found to have functional difficulties and 12.4% had other disabilities. Among the 387,819 individuals who reported having impairments, 4.3% also reported having functional difficulties. However, what is unknown is how many persons with impairments or functional difficulties who took part in the census, were not identified as having a disability because they did not

respond 'yes' to the census question, "Do you have a disability/difficulty."

Table 4. Relationship between methods of identifying disability in the 2017 Census of Mozambique

Disability measure	Number	Disability by impairment type (%)	Disability by functional domain (%)	Other disability (%)
Disabled (Y/N)	727620	53.3	36.6	13.1
Disability by impairment type	387819	100	4.3	0.6
Disability by functional domain	266243	6.2	100	1.1
Other disability	95197	2.6	3.1	100

5.2 Causes of disability in 2007 and 2017 censuses

***Key Finding 3A*: Congenital and disease/illness are the main causes of disabilities in Mozambique, with more than 7 in 10 cases of any impairment attributed to them. Labour accidents and automobile accidents are important causes of disabilities.**

Among other reasons, causes of disability may be related to the socioeconomic context. Understanding the pattern of causes of disability and its variation is important and can be useful to a range of different actors. Table 5 presents causes of disability by impairment type in the 2007 and 2017 censuses of Mozambique. It shows that about 85% of cases of blindness, about 91% of deaf or mute disability, about 86% of mental disability and about 81% of paralysis in the 2017 Census tend to be attributed to congenital and disease/illness causes. These two causes of disabilities by impairment type are dominant in the 2007 census as well – responsible for about 85% of blindness, 91% of deaf/mute, 90% of paralysis, and about 89% of mental disability.

Although congenital, disease or illness are indicated as the main causes of amputated or atrophied leg disability (about 70% of cases) in the 2017 Census, amputated or atrophied leg is also shown to have originated from labour accident (about 7%), automobile accident (about 9%) and other causes (about 10%). Labour accidents (about 14%) and automobile accidents (about 10%) – which often may be prevented - are also important causes of amputated or atrophied arm in the 2017 Census. Similarly, in the 2007 Census, labour accidents and automobile accidents were also important causes of amputated or atrophied arm (16% and 9%, respectively) and amputated or atrophied leg disability (9% and 7%, accordingly).

Table 5. Causes of disabilities using the impairment method of identification by impairment type and other disabilities, 2007 and 2017 censuses

Type of disabilities by impairment type	Causes of disabilities									
	Congenital	Disease/ illness	Mines/ war	Military service	Labour accident	Automobile accident	Other	No information	Total	
2017 Census									%	n
Blind	41.4	43.4	0.8	0.6	2.8	0.9	10.1	0.0	100	57,434
Deaf/Mute	56.7	34.7	0.5	0.4	0.8	0.5	6.4	0.0	100	69,085
Amputated/atrophied arm	24.7	29.2	3.8	2.4	13.5	10.4	16.0	0.0	100	56,514

Amputated/atrophied leg	40.5	29.0	3.6	1.8	6.9	8.5	9.7	0.0	100	122,940
Paralysis	32.5	48.3	0.6	0.4	5.2	1.6	11.4	0.0	100	47,030
Mental	49.3	36.9	0.3	0.3	0.8	1.2	11.2	0.0	100	52,816
Other disability	37.0	38.1	0.9	0.7	3.7	2.1	17.6	0.0	100	95,197
2007 Census										
Blind	12.4	72.3	1.4	1.1	3.3	0.6	4.6	4.5	100	44,567
Deaf/Mute	33.1	57.9	0.8	0.6	0.6	0.2	2.4	4.4	100	61,203
Amputated/atrophied arm	15.1	37.9	5.4	5.4	15.6	8.6	10.4	1.7	100	39,099
Amputated/atrophied leg	19.3	46.4	5.5	4.4	9.1	7.4	6.2	1.6	100	98,375
Paralysis	20.1	70.1	0.7	0.6	1.5	1.2	3.8	2.2	100	34,538
Mental	32.6	56.2	0.5	0.5	0.6	0.9	5.3	3.4	100	40,372
Other disability	17.7	51.6	1.4	1.3	3.5	2.0	19.9	2.6	100	167,224

▪

<u>Key Finding 3B</u>: Congenital and disease/illness are the main causes of disabilities in Mozambique, with more than 6 in 10 cases of any functional limitation attributed to them.

Table 6 shows distribution of causes of disability among those self-identifying as having functional limitations by functional domain in the 2017 Census of Mozambique. Similar to disability by impairment type above, congenital and disease/illness are reported as main causes of *difficulty seeing, even wearing glasses* (about 75%), *difficulty hearing, even wearing a hearing aid* (84%), *difficulty in remembering or concentrating* (about 84%), and *difficulty with mobility (walking)* (69%). Labour accidents are indicated as important causes of *difficulty seeing, even wearing glasses* (4%) and *difficulty with mobility (walking)* (about 5%). Automobile accidents are also notable causes of *difficulty with mobility (walking)* (about 7%).

Table 6. Causes of disabilities among those reporting functional difficulties by functional domain among those self-identifying as having a disability, 2017 Census

Type of disabilities by functional domain	Causes of disability								
	Congenital	Disease/ illness	Mines/ war	Military service	Labour accident	Automobile accident	Other	Total	
								%	n
Difficulty seeing, even when wearing glasses	23.4	51.5	0.9	0.8	4.0	1.4	18.0	100	84,033
Difficulty hearing, even when wearing a hearing aid	43.7	41.4	0.8	0.8	1.3	1.0	11.0	100	40,459
Difficulty in remembering or concentrating	47.6	36.9	0.5	0.7	1.0	1.9	11.4	100	34,926
Difficulty with mobility (walking)	25.2	43.3	1.8	1.5	5.1	6.6	16.5	100	119,226

Results at a glance:

- **The major causes of disability are overwhelmingly congenital conditions and disease/illness.**
- **For limb impairments, labour and automobile accidents are also a very significant cause.**
- **Although congenital conditions and disease/illness are major causes of *difficulty seeing, even when wearing glasses* and *difficulty with mobility (walking),* labour accidents are also important causes of these limitations.**

Causes of disability among those self-identifying impairments or other disabilities by age group and gender in 2007 and 2017 censuses

The level of exposure to different types of disability may vary with age and gender, among other factors. Table 7 shows causes of disability by impairment type and other disabilities by age group and gender in the 2017 Census. Although congenital, disease or illness were found to be major causes of disability by impairment type, Table 7 reveals that the relevance of these two causes of disability by impairment type varies with age for both men and women. Congenital tends to be reported as a major cause of disability among those aged less than 18 years of age and disease/illness is dominant as a cause of disability among adults and older people. For example, while about 80% of blindness was attributed to congenital causes among men aged less than 18 years, 60.9% of those aged 61 years or more ascribed blindness to disease or illness. Although men and women both have congenital and disease/illness as major causes of disability by impairment type, there are notable variations by gender in the pattern of causes of disability by impairment type. Among men, labour accidents were reported as important causes of blindness in the 18-60 years age group (about 5%) and in the 61 years or more age group (about 5%); however, labour accidents display comparatively lower importance as causes of blindness among women of similar age groups. Although labour accidents and automobile accidents are shown to be important causes of amputated or atrophied arm and amputated or atrophied leg for both men and women, men tend to also report mines or war, and military service, as causes of these same disabilities when compared to women. Among age groups 18-60 years and 61 years or more, it is observed that ‘other causes’ are given as the cause of disability by impairment type, both for men and women of these age groups.

Table 8 presents causes of disability by impairment type and other disabilities by age group and gender in the 2007 census. Similar to the 2017 Census, findings from the 2007 Census show variation in the relevance of causes of disability by age group and gender. As in the 2017 Census, disease/illness also tends to be dominant as cause of disability among those aged 18-60 years and over 60 years of age.

Table 7. Causes of disabilities among those with impairments by impairment type and other disabilities by age group and gender among those self-identifying as having a disability, 2017 Census

Type of disabilities by impairment type	Age group	Causes of disabilities								
		Congenital	Disease/ illness	Mines/ war	Military service	Labour accident	Automobile accident	Other	Total	
MALES									%	n
Blind	0-17	79.6	14.9	0.1	0.1	0.8	0.4	4.0	100	6,329
	18-60	41.5	40.9	1.3	1.2	5.1	1.5	8.5	100	13,141
	Over 60	14.4	60.9	1.7	1.4	5.0	1.1	15.6	100	9,177
Deaf/Mute	0-17	66.5	28.6	0.0	0.0	0.3	0.3	4.4	100	14,363
	18-60	59.0	31.7	0.8	0.9	1.2	0.7	5.7	100	16,374
	Over 60	28.3	49.8	2.5	2.4	3.7	1.2	12.2	100	3,678
Amputated/atrophied arm	0-17	42.0	22.3	0.2	0.0	8.4	6.2	20.9	100	7,569
	18-60	19.0	23.5	5.3	4.6	18.2	14.5	15.0	100	20,186
	Over 60	11.6	28.7	10.1	6.7	20.2	9.9	12.7	100	5,099
Amputated/atrophied leg	0-17	69.8	16.0	0.1	0.1	2.5	3.9	7.6	100	15,808
	18-60	31.4	25.7	5.0	3.7	10.9	13.4	9.8	100	38,513
	Over 60	17.0	33.6	10.0	5.2	13.4	10.3	10.5	100	11,416
Paralysis	0-17	57.8	29.9	0.1	0.1	5.1	0.6	6.5	100	7,454
	18-60	27.4	49.4	1.0	0.9	6.6	3.1	11.6	100	10,987
	Over 60	11.1	64.3	1.4	0.9	4.8	2.4	15.1	100	4,755
Mental	0-17	61.0	30.5	0.1	0.1	0.4	0.8	7.1	100	11,662
	18-60	43.1	38.8	0.4	0.6	1.2	1.5	14.4	100	16,182
	Over 60	26.0	47.4	1.7	2.5	2.8	1.7	18.0	100	1,308
Other disability	0-17	59.4	27.2	0.0	0.0	1.0	0.7	11.6	100	16,713
	18-60	29.9	37.5	1.5	1.7	7.2	4.0	18.2	100	26,212
	Over 60	16.2	46.3	3.3	2.4	8.6	2.7	20.5	100	6,766
FEMALES										
Blind	0-17	81.1	14.6	0.1	0.1	0.5	0.3	3.3	100	6,120
	18-60	41.9	45.1	0.5	0.1	2.0	0.9	9.5	100	13,238
	Over 60	15.3	65.4	0.6	0.2	1.6	0.6	16.4	100	9,429
Deaf/Mute	0-17	65.3	29.2	0.1	0.1	0.3	0.5	4.5	100	11,785
	18-60	55.2	36.8	0.3	0.1	0.6	0.5	6.5	100	17,974
	Over 60	27.0	56.1	1.0	0.2	0.9	0.6	14.2	100	4,911
Amputated/atrophied arm	0-17	45.0	26.4	0.1	0.1	6.6	5.2	16.6	100	5,654
	18-60	23.4	37.9	2.4	0.4	10.7	9.6	15.7	100	13,908
	Over 60	13.9	45.2	5.1	0.8	10.7	8.5	15.8	100	4,098
Amputated/atrophied leg	0-17	73.2	16.1	0.2	0.0	1.6	3.1	5.9	100	14,020
	18-60	38.7	35.8	2.5	0.4	4.7	7.4	10.5	100	32,241
	Over 60	18.2	50.7	4.2	0.7	5.5	6.3	14.4	100	10,942
Paralysis	0-17	55.6	31.7	0.1	0.0	5.9	0.5	6.2	100	6,596
	18-60	25.8	53.7	0.3	0.2	5.1	1.4	13.4	100	12,015
	Over 60	13.0	65.8	0.6	0.2	2.3	1.2	16.9	100	5,223
Mental	0-17	60.2	31.0	0.1	0.1	0.4	1.0	7.2	100	9,095
	18-60	44.5	41.5	0.2	0.2	0.7	1.0	12.0	100	12,874
	Over 60	23.7	53.6	0.7	0.4	0.8	1.2	19.7	100	1,695
Other disability	0-17	57.5	29.0	0.0	0.0	0.8	0.6	12.1	100	13,416
	18-60	29.1	44.5	0.6	0.1	2.4	1.9	21.5	100	26,175
	Over 60	17.1	53.6	1.4	0.3	3.1	1.4	23.2	100	5,915

Table 8. Causes of disabilities among those with impairments among those self-identifying as having a disability, by impairment type, age group and gender, 2007 Census

Type of disabilities by impairment type	Age group	Causes of disabilities								
		Congenital	Disease/ illness	Mines/ war	Military service	Labour accident	Automobile accident	Other	No information	Total

MALES										%	n
Blind	0-17	31.4	53.0	0.5	0.2	1.4	0.4	3.5	9.7	100	3,124
	18-60	14.0	66.1	2.4	2.9	6.1	1.1	3.7	3.8	100	11,200
	Over 60	4.8	78.2	1.6	1.2	5.2	0.5	5.8	2.7	100	8,024
Deaf/Mute	0-17	37.1	55.9	0.2	0.1	0.1	0.1	1.6	5.0	100	13,170
	18-60	37.2	51.9	1.3	2.0	1.2	0.5	1.9	4.1	100	13,218
	Over 60	16.7	67.1	2.4	2.1	3.0	0.5	5.3	3.0	100	3,593
Amputated/atrophied arm	0-17	28.5	34.8	0.6	0.2	9.3	6.4	18.3	2.2	100	4,756
	18-60	11.4	28.6	7.5	10.9	19.7	11.3	9.1	1.6	100	15,475
	Over 60	6.4	35.6	7.9	7.8	27.5	7.0	6.4	1.5	100	3,426
Amputated/atrophied leg	0-17	39.7	39.4	0.6	0.2	4.3	5.2	8.9	1.8	100	9,126
	18-60	16.3	36.5	7.8	9.4	12.3	10.4	5.9	1.5	100	37,098
	Over 60	7.9	45.0	7.7	5.8	19.3	7.6	5.2	1.6	100	9,436
Paralysis	0-17	41.1	54.0	0.2	0.0	0.4	0.5	1.9	2.0	100	4,894
	18-60	17.4	68.6	1.1	1.7	2.9	2.5	3.7	2.2	100	8,658
	Over 60	6.5	80.0	1.0	0.8	3.1	1.0	5.5	2.2	100	3,410
Mental	0-17	42.1	51.1	0.1	0.0	0.2	0.6	3.0	2.9	100	8,549
	18-60	27.6	57.2	0.6	1.3	1.0	1.5	7.3	3.6	100	13,472
	Over 60	13.9	66.6	1.6	1.2	1.9	2.1	8.7	3.9	100	938
Other disability	0-17	32.7	44.4	0.2	0.1	0.9	0.8	18.2	2.7	100	24,918
	18-60	14.7	47.1	2.5	3.7	6.9	3.7	19.2	2.3	100	46,375
	Over 60	6.3	54.7	2.8	2.1	9.1	2.5	20.0	2.6	100	12,387
FEMALES											
Blind	0-17	28.6	55.4	0.5	0.2	0.7	0.3	2.7	11.7	100	2,711
	18-60	13.0	75.7	1.2	0.3	1.7	0.5	3.5	4.2	100	10,927
	Over 60	4.5	82.8	0.9	0.2	1.3	0.3	6.9	3.2	100	8,581
Deaf/Mute	0-17	36.5	56.0	0.3	0.1	0.1	0.2	1.5	5.4	100	10,874
	18-60	33.8	58.6	0.6	0.1	0.3	0.2	2.1	4.3	100	15,558
	Over 60	13.1	75.4	1.2	0.3	0.4	0.2	6.7	2.8	100	4,790
Amputated/atrophied arm	0-17	30.6	41.6	0.5	0.1	7.2	4.8	13.0	2.3	100	3,525
	18-60	14.0	49.6	5.0	1.0	11.9	7.8	9.1	1.6	100	9,476
	Over 60	6.4	56.2	6.6	1.6	11.6	6.4	9.8	1.5	100	2,441
Amputated/atrophied leg	0-17	37.4	45.6	0.6	0.2	2.7	4.7	6.9	1.9	100	6,884
	18-60	19.4	56.8	4.7	0.9	5.4	5.5	5.8	1.5	100	27,451
	Over 60	8.4	65.5	5.1	0.9	6.4	5.1	6.9	1.8	100	8,380
Paralysis	0-17	37.2	58.0	0.2	0.1	0.3	0.2	2.1	1.9	100	4,186
	18-60	15.6	75.5	0.7	0.2	1.0	1.0	4.1	2.0	100	9,390
	Over 60	4.3	84.7	0.5	0.1	1.2	0.8	5.9	2.7	100	4,000
Mental	0-17	42.4	50.4	0.4	0.1	0.3	0.6	2.7	3.1	100	6,449
	18-60	29.5	59.9	0.4	0.1	0.4	0.5	5.5	3.7	100	9,733
	Over 60	9.9	73.7	0.8	0.2	0.6	1.3	9.1	4.5	100	1,231
Other disability	0-17	30.3	47.8	0.2	0.1	0.6	0.5	18.0	2.6	100	21,120
	18-60	13.7	57.8	1.2	0.2	2.0	1.7	20.9	2.6	100	49,625
	Over 60	5.4	61.6	1.7	0.3	2.1	1.5	24.4	3.1	100	12,799

Results at a glance:

- **Congenital tends to be reported as a major cause of disability among those aged less than 18 years of age and disease/illness is dominant as a cause of disability among adults and older people.**
- **Although labour accidents and automobile accidents are important causes of amputated or atrophied arm and amputated or atrophied leg for both men and women, men tend to also report mines or war, and military service, as causes of these same disabilities when compared to women.**
- **As in the 2017 Census, disease/illness tends to be dominant as a cause of disabilities among those aged 18-60 years and over 60 years of age in the 2007 Census.**

Causes of disability among those self-identifying functional difficulties by age group and gender, 2017 Census

Table 9 presents causes of disability among those self-identifying as having functional limitations by functional domain by age group and gender in the 2017 Census. With the exception of *difficulty with mobility (walking),* among those aged less than 18 years, more than half of cases of disability by functional domain are ascribed to congenital causes for both men and women. Among adults aged 18-60 years and 61 years or more, disease/ illness dominates as a major cause of disability, markedly among women of these age groups. However, for *difficulty with mobility (walking)* men show a pattern of causes of that functional limitation distinct from that presented by women.

Among men, while congenital causes are dominant for those aged less than 18 years (about 58%), more causes emerge as important sources of *difficulty with mobility (walking)* for age groups 18-60 years and over 60 years. For example, among men aged 18-60 years, disease/illness (about 35%), labour accidents (about 9%), automobile accidents (about 12) and other causes (about 14%), are important causes of the *difficulty with mobility (walking)* functional limitation.

In contrast to men, among women aged 18-60 years, about 49% indicated disease/illness as a cause of *difficulty with mobility (walking)*. Also, in contrast to men, among women in the age group 18-60 years, labour accidents (about 4%) and automobile accidents (about 6%) are not comparatively expressive as causes of the *difficulty with mobility (walking)* functional limitation, as they do among men of this age group. Besides *difficulty with mobility (walking),* it is worth noting that 'other causes' are also prominent causes of disability by functional domain for both men and women.

Table 9. Causes of disability among those with functional difficulties by functional domain by age group and gender among those self-identifying as having a disability, 2017 Census

Functional domain	Age group	Causes of disabilities								
		Congenital	Disease/ illness	Mines/ war	Military service	Labour accident	Automobile accident	Other	Total	
MALES									%	n
Difficulty seeing, even when wearing glasses	0-17	53.8	31.2	0.1	0.2	2.2	1.2	11.3	100	5,258
	18-60	22.9	48.0	1.3	1.5	7.0	2.3	16.9	100	22,251
	Over 60	12.0	57.1	1.8	1.6	6.0	1.4	20.1	100	13,929
Difficulty hearing, even when wearing a hearing aid	0-17	56.7	34.4	0.1	0.2	0.5	0.7	7.4	100	6,530
	18-60	46.5	37.1	1.3	1.7	2.3	1.4	9.7	100	9,051
	Over 60	20.9	51.1	2.9	2.6	3.8	1.0	17.8	100	3,291
Difficulty in remembering or concentrating	0-17	61.3	29.6	0.2	0.3	0.4	1.3	7.0	100	7,312
	18-60	42.9	38.1	0.7	1.1	1.8	2.9	12.5	100	9,115
	Over 60	22.2	46.3	2.0	2.3	3.6	3.1	20.6	100	1,516
Difficulty with mobility (walking)	0-17	58.4	25.2	0.2	0.4	2.0	3.7	10.1	100	10,341
	18-60	23.3	35.1	3.0	3.5	9.0	12.2	13.8	100	29,506
	Over 60	12.0	48.6	3.7	3.2	8.1	6.2	18.2	100	14,967
FEMALES										
Difficulty seeing, even when wearing glasses	0-17	52.6	32.8	0.1	0.5	1.3	1.4	11.4	100	4,869
	18-60	23.9	54.0	0.4	0.1	2.4	1.0	18.2	100	23,372
	Over 60	13.2	61.2	0.8	0.2	1.8	0.7	22.2	100	14,354
Difficulty hearing, even when wearing a hearing aid	0-17	55.7	34.9	0.2	0.4	0.5	1.0	7.2	100	5,809
	18-60	44.0	43.0	0.5	0.2	0.8	1.0	10.5	100	11,058
	Over 60	20.4	57.3	1.2	0.2	1.0	0.6	19.3	100	4,720
Difficulty in remembering or concentrating	0-17	60.8	29.4	0.4	0.9	0.3	1.3	7.0	100	6,126
	18-60	42.9	41.5	0.4	0.4	0.7	1.6	12.5	100	8,741
	Over 60	19.5	52.6	1.0	0.1	1.1	1.3	24.4	100	2,116
Difficulty with mobility (walking)	0-17	57.6	26.7	0.5	1.0	1.5	3.6	9.1	100	8,872
	18-60	22.9	48.9	1.2	0.4	3.8	5.8	17.0	100	32,426
	Over 60	12.1	56.7	1.4	0.2	2.9	3.1	23.6	100	23,114

Results at a glance:

- **With the exception of *difficulty with mobility (walking),* among those aged less than 18 years, more than half of cases of disability by functional domain are ascribed to congenital causes for both men and women**
- **Among men, while congenital causes are dominant for those aged less than 18 years (about 58%), more causes emerge as important sources of *difficulty with mobility (walking)* for age groups 18-60 years and over 60 years.**

5.3 Composition of households

Compositional characteristics of households may reveal the social position of persons with disabilities within households. Table 10 presents the distribution of persons with and without disabilities (by impairment type and by functional domain combined), by gender and relationship to head of household in the 2017 Census. It shows that about 45% of persons with disabilities in the 2017 Census of Mozambique are heads of their households (55% for

men and 34% for women). Only 22% of persons without disabilities are in a similar social position as head of household. The difference in household headship role between persons with disabilities and without disabilities is most pronounced among **women with disabilities who are more than twice as likely to be heads of their household compared to women without disabilities (34% vs. 14%).** Among men, there is still a significant difference: men with disabilities are more likely to be heads of their households compared to men without disabilities (55% vs. 31%). These findings suggest that persons with disabilities are likely to be in a position of responsibility demanding more household responsibilities from them, including caring for others, relative to persons without disabilities. It should be noted that the relatively higher percentage of heads of households among those with disabilities by impairment type may be a consequence of a confounding effect of age, and this may be the reason for the larger difference among women, because they tend to live longer than men (the 2017 Census report indicated life expectancy in Mozambique as 51 years for males and 56.5 years for females). Analyses disaggregated by age are presented in Graph 4 below.

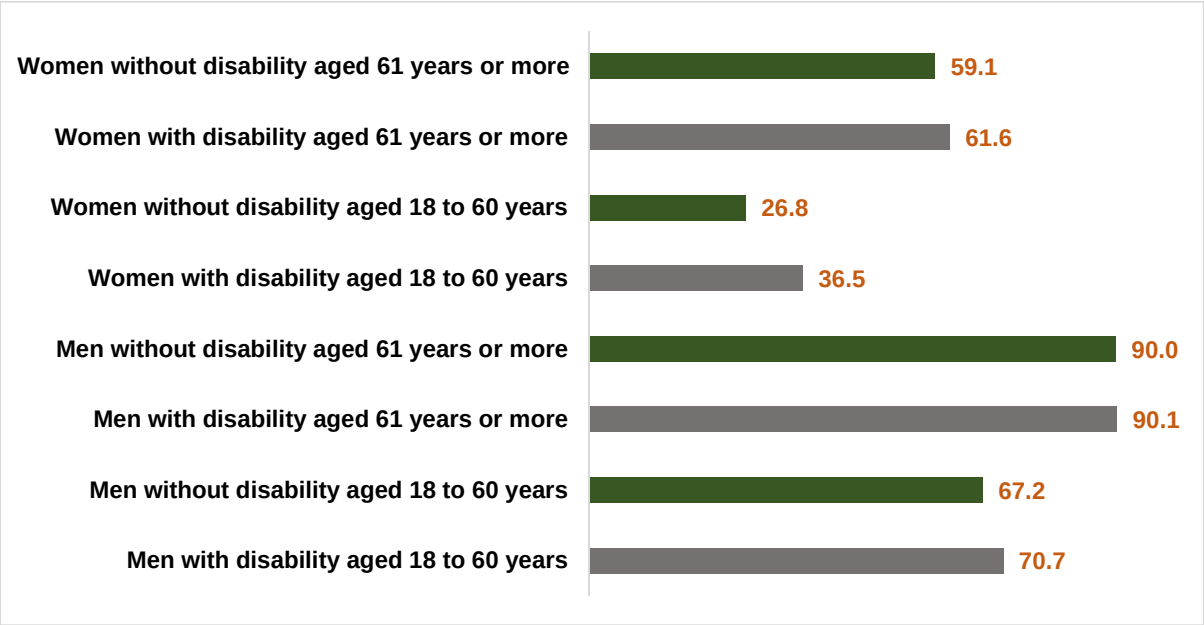
Table 10. Distribution of persons with and without disabilities by gender and relationship to head of household, 2017 Census

Relationship to the head	With disabilities			Without disabilities		
	Women	Men	Both	Women	Men	Both
	321,096	**332,966**	**654,062**	**13,633,347**	**12,538,138**	**26,171,485**
Head	34.1	55.2	44.8	14.4	30.9	22.3
Husband/wife	25.8	2.8	14.1	25.1	2.4	14.2
Biological Son/daughter	22.8	28.1	25.5	43.2	50.1	46.5
Parents	3.7	0.5	2.1	0.6	0.1	0.3
Stepchild	1.0	1.3	1.1	1.2	1.4	1.3
Adopted Son/daughter	0.6	0.8	0.7	0.8	0.9	0.8
Son/daughter-in-law	0.8	0.3	0.6	1.4	0.3	0.9
Grandchild	3.4	3.9	3.6	6.0	6.5	6.3
Other relative	7.2	6.4	6.8	6.7	6.5	6.6
Non-relative	0.6	0.8	0.7	0.6	0.9	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**

Note. This tables combines persons with disabilities by impairment type and persons with disabilities by functional domain.

Graph 4 displays percentage of persons who are head of household among those with and without disabilities by age and gender in the 2017 Census. It shows that men and women aged 18-60 years with disabilities are more likely to be heads of household than men and women of same age group without disabilities. The gap in household headship among persons with and without disabilities aged 18-60 years is most pronounced among women: 4 in 10 women aged 18-60 years with disabilities are heads of household (36.5%) compared to 3 in 10 among women of same age group without disabilities (26.8%). Difference in household headship for individuals aged over 60 years appears not to exist among men with and without disabilities; among women with and without disabilities, the difference in household headship is small (61.6% vs 59.1%, respectively). These results show that women and men with disabilities aged 18-60 years are likely to be in a position of responsibility demanding more household responsibilities from them, including caring for others, compared to women and men without disabilities of same age group.

Graph 4. Percentage of persons with and without disabilities who are head of household by age and gender, 2017 Census



5.4 Language, marital status and other social characteristics

Pattern of speaking Portuguese by disability status

As an official language spoken throughout Mozambique, speaking Portuguese may help with communication and accessing information and services. Figure 10 shows the pattern of speaking Portuguese by disability status and area of residence in the 2017 Census. **It shows that persons without disabilities are more likely to speak Portuguese compared to those with disabilities (58.3% vs 50.4%)**. Within each disability status, men are more likely to speak Portuguese than women. The lower likelihood of persons with disabilities speaking Portuguese are observed in rural and urban areas, particularly for women with disabilities. For men with disabilities, those in urban areas display a similar pattern of speaking Portuguese to their counterparts without disabilities – around 53%.

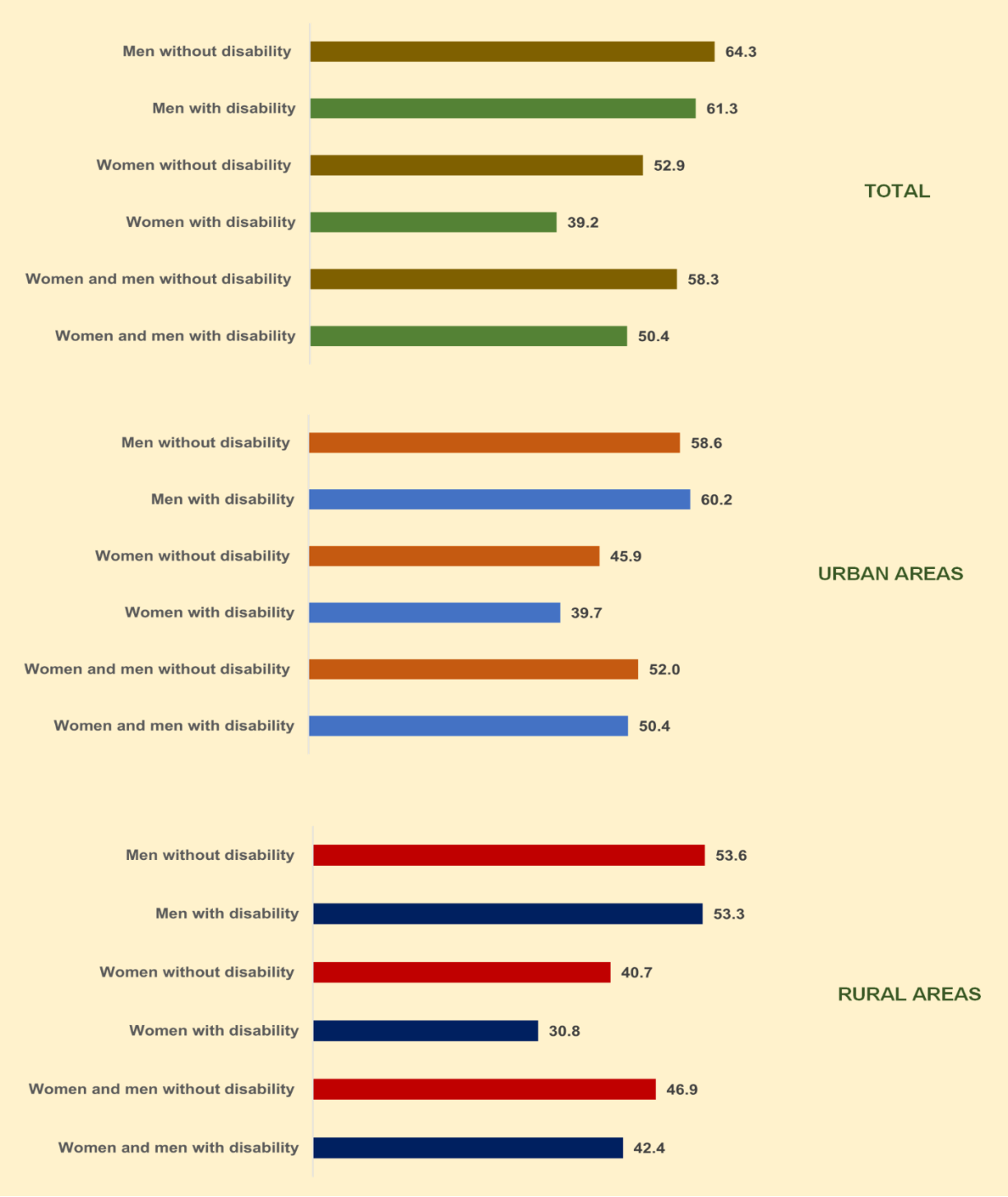


Figure 10. Pattern of speaking Portuguese by disability status and area of residence, 2017 Census.

Pattern of language often spoken at home by disability status

Table 11 presents the distribution of persons with and without disabilities, by language most frequently used at home and gender in the 2017 Census. It shows that the lowest rate of disabilities is found among those who frequently speak Portuguese at home (213.7 per 10,000) while those who often speak Xitswa at home display the highest rate of disabilities (457.6 per 10,000). In addition to Xitswa, Elomwue (384.5 per 10,000), Emakhuwa (358.1 per 10,000) and Xichangana (349.2 per 10,000) are among languages with the highest rate of disabilities. However, the difference in the rate of disabilities across most language-based population groups is not significant.

Table 11. Distribution of persons with and without disabilities by language most frequently used at home and gender, 2017 Census

Language	Persons with disabilities			Persons without disabilities			Rate of disabilities per 10,000
	Women	Men	Both	Women	Men	Both	
	347,724	360,878	708,602	11,296,397	10,259,037	21,555,434	
Xitswa	5.5	4.7	5.1	3.6	3.3	3.5	457.6
Elomwue	8.7	8.8	8.8	7.3	7.1	7.2	384.5
Emakhuwa	29.4	30.4	29.9	26.4	26.6	26.5	358.1
Xichangana	10.9	8.8	9.8	9.4	8.4	8.9	349.2
Other Mozambican languages	14	13.4	13.7	13.4	13.2	13.3	327.9
Cindau	4.1	3.3	3.7	3.9	3.5	3.7	318.3
Echuabo	4.5	4.3	4.4	4.6	4.3	4.5	314.8
Foreign languages	0.3	0.4	0.3	0.4	0.5	0.4	265.2
Cisena	5.6	5.8	5.7	7.1	7.0	7.0	259.4
Cinyanja	5.2	5.1	5.2	7.0	7.3	7.1	234.2
Portuguese	9.8	12.9	11.3	16.2	18.0	17.1	213.7
Deaf	1.7	1.9	1.8	na	na	na	na
Unknown languages	0.3	0.3	0.3	0.9	1.0	0.9	115.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**318.3**

Note. Information about language was collected for those aged 5 years or more; na=not applicable.

Pattern of religious affiliation by disability status

Table 12 presents distribution of persons with and without disabilities by current religious affiliation and gender in the 2017 Census of Mozambique. It shows that variation in the rate of disabilities across most religious groups is small. Non-affiliated individuals (311.1 per 10,000) and those affiliated to the Catholic religious denomination (295.1 per 10,000) have relatively the highest rate of disabilities in the 2017 Census. Those affiliated to the Anglican denomination (249.9 per 10,000) and the Evangelical or Pentecostal denomination (236.6 per 10,000) have the lowest rate of disabilities.

Table 12. Distribution of persons with and without disabilities by current religious affiliation and gender, 2017 Census (percent)

Religious Affiliation	Persons with disabilities			Persons without disabilities			Rate of disabilities per 10,000
	Women	Men	Both	Women	Men	Both	
	366,602	382,657	749,259	13,633,347	12,538,138	26,171,485	
No Religion Information	2.6	2.3	2.4	2.1	2.0	2.0	324.5

No Religion	13.3	17.7	15.5	12.0	15.8	13.9	311.1
Catholic	28.8	28.7	28.7	27.3	26.8	27.1	295.1
Other Religion	5.3	5.1	5.2	5.2	4.9	5.0	286.3
Zion/Siao	17.0	14.3	15.6	16.8	15.0	16.0	272.2
Islam	17.8	18.1	18.0	18.8	19.1	18.9	264.6
Anglican	1.6	1.4	1.5	1.8	1.7	1.7	249.9
Evangelical or Pentecostal	13.6	12.4	13.0	16.0	14.7	15.4	236.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**278.3**

Pattern of marital status by disability status

The 2017 Census Report defined marital status as "the situation of an individual according to laws, practices and customs, with respect to marriage or marital life."[62] In the 2017 Census, data on marital unions was collected for those aged 12 years or more. Mozambique has one of the highest rates of child marriage in the world, with almost half of girls marrying before the age of 18.[80] In 2019, the Government of Mozambique introduced a law setting the legal age of marriage at 18, thereby making marital unions illegal for individuals younger than 18 years (Family Law, Law Nr. 22/2019 from December 11). In spite of this legislation, child marriage still occurs throughout the country and understanding the pattern of disability among younger people in marital unions is an important area to understand, not least in relation to stigma surrounding marriage and disability. In relation to children, it is important to collect data on child marriages so that policy interventions can address this harmful practice.

Figure 11 shows the distribution of persons with and without disabilities by current marital status and gender among those aged 12 years or more in the 2017 Census. It shows that persons with disabilities are less likely to be married or living together relative to those without disabilities (76.0% versus 89.1%); but disproportional more likely to be divorced or separated (7.9% against 5.0%) and widowed (16.1% versus 5.9%) in comparison to their counterparts without disabilities. Although both women and men with disabilities are less likely to be married compared to their peers without disabilities, women with disabilities are even more likely than men with disabilities to be divorced, separated or widowed. For example, there are about 11.0% of women with disabilities who are divorced or separated compared to only about 7.0% among women without disabilities. Similarly, there are about 27.3% widows among women with disabilities while among men without disabilities there are only about 9.2%.

<u>Key Finding 4</u>: Persons with disabilities are less likely to be married or living together, and more likely to be divorced, separated or widowed compared to persons without disabilities.

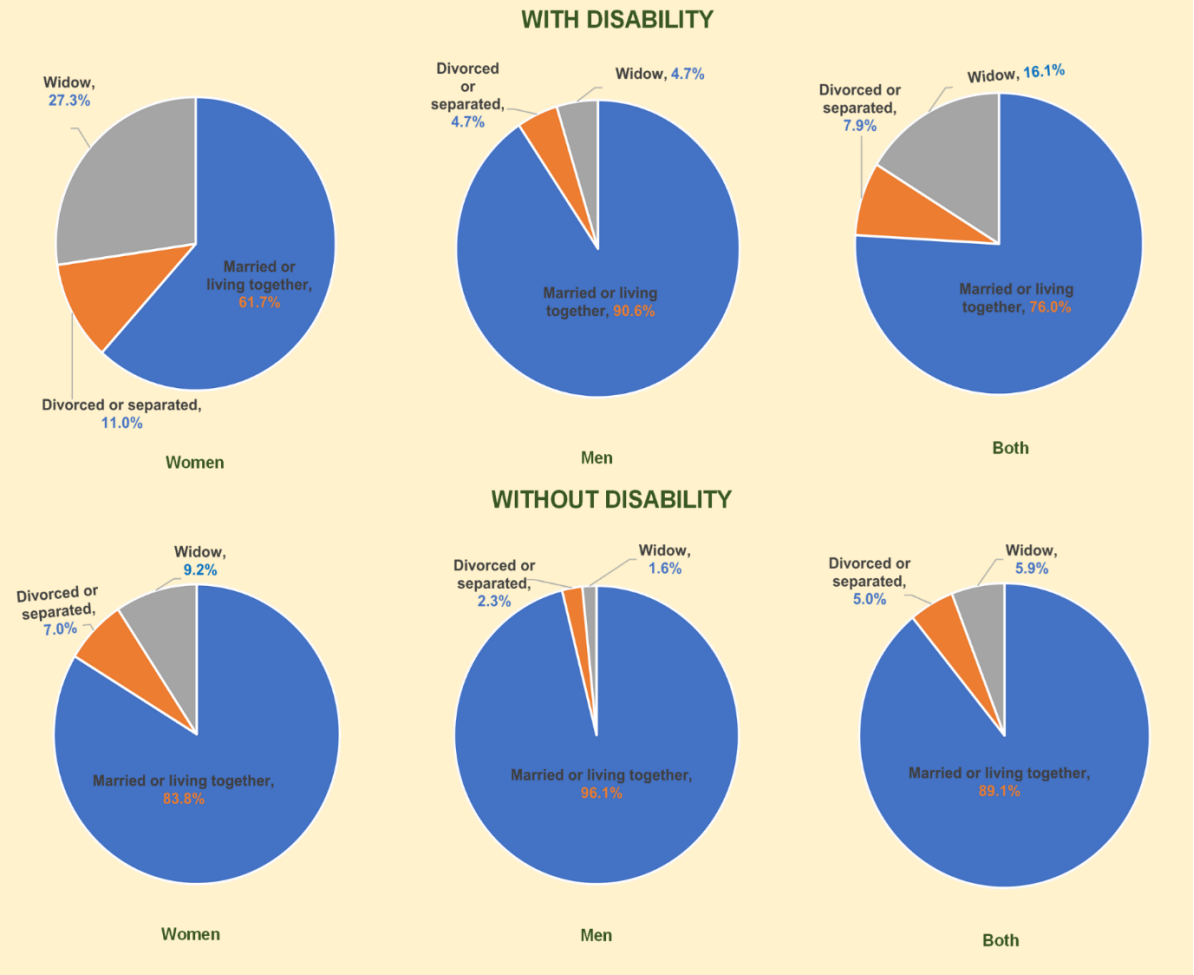


Figure 11. Distribution of persons with and without disabilities by current marital status and gender among those aged 12 years or more, 2017 census

Looking at marital status by age groups (Table 13), findings indicate that persons with disabilities aged 20 to 60 years are less likely to be married or living together compared to persons without disabilities. However, it is older persons with disabilities (aged over 60 years) who are more likely to be divorced or separated (26.2% versus 10.6%) and widowed (65.9% against 42.8%) compared to their peers without disabilities. This trend persists when disaggregating by gender. The results are likely to have implications on the degree of loneliness and the level of immediate social support enjoyed by older persons with disabilities. Previous studies have suggested a positive association between marriage among adult individuals and wellbeing, particularly for older persons[81], widows[82] and people without employment (which appears to be the case for most people with disabilities).[83]

<u>Key Finding</u> 5: Girls with and without disabilities are more likely to be married or living together before the age of 18 compared to boys with and without disabilities, suggesting that child marriage in Mozambique continues to be an issue and one that is gendered.

Looking at the 12-14 and 15-19 age groups, it is clear that girls and young women with disabilities are more likely to be married or living together than boys and young men with disabilities (e.g., among 15-19 years old, young women: 5.4% versus young men: 1.2%), as is the case for girls and young women without disabilities compared to boys and young men without disabilities (e.g., among 15-19 years old, young women: 12.3% versus young men: 2.9%). Whilst it is not clear how many girls with disabilities are married or living together (because data was disaggregation considering the 15-19 age group), the data still shows that child marriage remains an issue in Mozambique, particularly for girls with and without disabilities – this is also likely to be an underestimate given the issues with the Census methodology outlined above.

Table 13. Distribution of persons with and without disabilities by current marital status, gender and age group among those aged 12 years or more, 2017 Census

Marital Status	Age groups	Persons with disabilities			Persons without disabilities		
		Women	Men	Both	Women	Men	Both
Total		138,189	198,463	336,652	4,699,283	4,090,871	8,790,154
Married or living together	12-14	0.4	0.1	0.2	0.8	0.3	0.5
	15-19	5.4	1.2	2.9	12.3	2.9	7.9
	20-60	78.5	69.9	73.4	82.5	87.4	84.8
	Over 60	15.7	28.8	23.4	4.5	9.5	6.8
Total		100	100	100	100	100	100
		24,670	10,239	34,909	390,677	98,170	488,847
Divorced or separated	12-14	0.3	0.2	0.2	0.5	0.9	0.6
	15-19	3.3	1.7	2.8	7.8	5.0	7.2
	20-60	70.9	70.3	70.8	81.5	81.8	81.6
	Over 60	25.5	27.7	**26.2**	10.2	12.3	**10.6**
Total		100	100	100	100	100	100
		61,204	10,396	71,600	520,268	66,179	586,447
Widow	12-14	0.1	0.3	0.1	0.4	2.4	0.6
	15-19	0.2	0.6	0.3	0.7	3.0	1.0
	20-60	34.3	30.9	33.8	56.5	49.0	55.6
	Over 60	65.4	68.3	**65.9**	42.5	45.6	**42.8**
Total		100	100	100	100	100	100

Pattern of adolescent girls' births by disability status

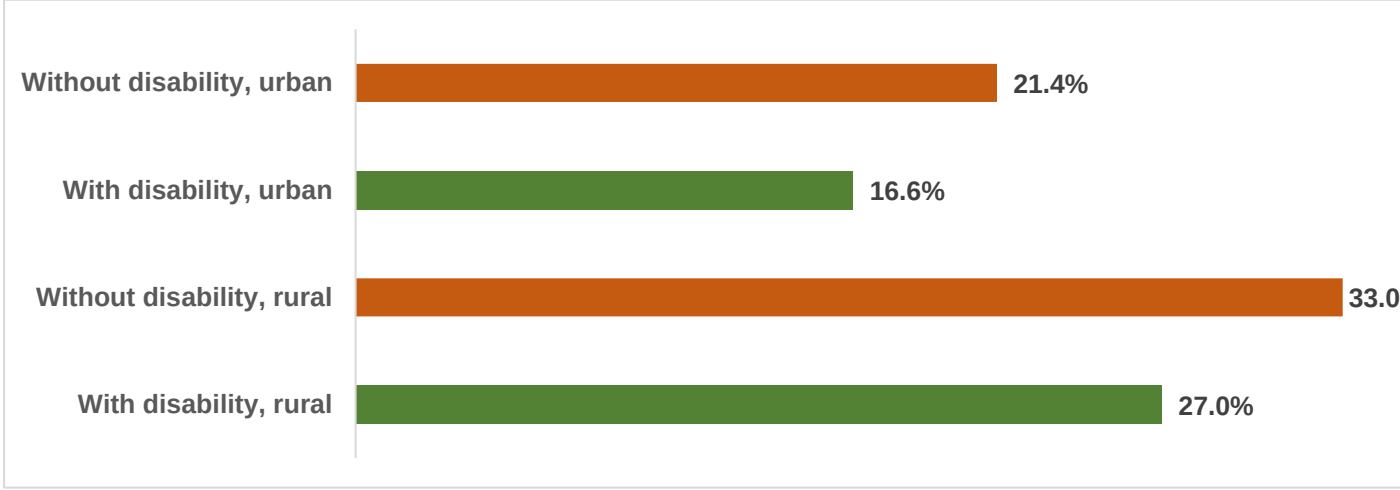
Pregnancy and childbearing for individuals aged less than 20 years is an issue of concern in Mozambique and other sub-Saharan African countries, as they are often associated with adverse health and life outcomes for adolescents and their children.[84] Adolescent girls face major health consequences as a result of early pregnancy and childbearing, including obstetric fistula, eclampsia, puerperal endometritis and systemic infections, which can be the

cause of short and long-term disability. In addition, girls who become pregnant before 18 are more likely to experience violence within a marriage or partnership. Adolescent girls with disabilities face additional barriers in accessing quality healthcare due to stigma and discrimination about their worth and sexuality, and are at even greater risk of violence, including sexual violence and rape.[85] These barriers were also highlighted in the study's interviews with OPDs representatives, who expressed concerns that sexual and reproductive health (SRH) services and information do not meet the specific needs of persons with disabilities, particularly adolescent girls with disabilities. Adolescent girls with disabilities face a number of barriers in accessing SRH services, including negative attitudes from health professionals, privacy and confidentiality issues, communication barriers, physical accessibility and mistreatment.[86]

***Key Finding 6*: Although births to adolescents aged 15-19 years of age are higher among girls without disabilities in comparison to girls with disabilities, there is still a significant percentage of girls with disabilities giving births at a young age – about 27% in rural areas and 17% in urban areas.**

Graph 5 shows the percentage of adolescent girls (15-19 years) who have given birth by disability status and area of residence in the 2017 Census. It indicates that early childbearing is higher among girls without disabilities in comparison with girls with disabilities in both urban and rural areas. In urban areas, about 17% of girls with disabilities have given birth compared to about 21% among girls without disabilities in the same area. In rural areas, fewer girls with disability have given birth compared to girls without disabilities (27% vs. 33%). However, there are still a significant number of girls with disabilities who are facing early pregnancy and early childbirth (17% in the urban areas and 27% in the rural areas), and the number could be even greater due to the way in which the disability-related questions were asked in the census. The implications of early pregnancy and childbearing on the short and long-term health, education and employment outcomes of girls with disabilities, as well as the health of their children, needs to be taken into consideration in designing disability-inclusive policies and programmes for adolescent girls.

Graph 5. Percentage of adolescent girls (15-19 years) who have given birth by disability status and area of residence, 2017 Census



Results at a glance:

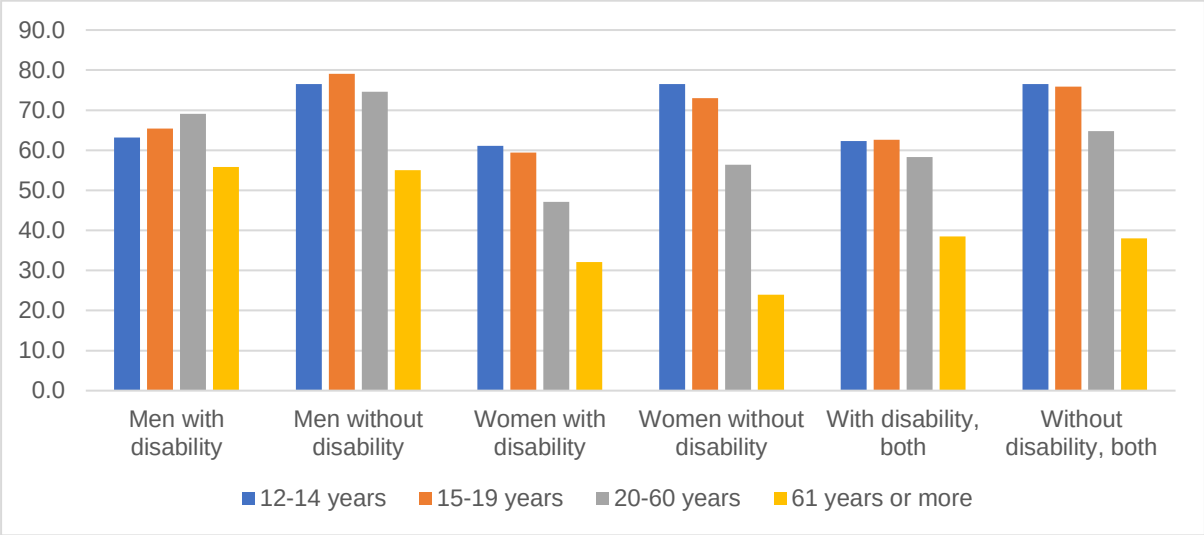
- **Persons with disabilities are less likely to speak Portuguese than peers without disabilities, particularly so among women.**
- **Although Xitswa speakers display a relatively high rate of disability, there are no major differences across most language-based population groups.**
- **There are no major differences in the rate of disability among most religious groups – despite a high rate among those without religious information.**
- **Persons with disabilities aged 20 to 60 years are less likely to be married or living together compared to persons without disabilities. Older persons with disabilities (aged over 60 years) are more likely to be divorced separated and widowed compared to persons without disabilities.**
- **In the 12-14 and 15-19 age groups, girls and young women with disabilities are more likely to be married or living together than boys and young men with disabilities.**

5.5 Education

Education is a key social characteristic as it influences other aspects of people's lives and wellbeing. In sub-Saharan Africa where accessing education is often a challenge for children, those with disabilities may face further barriers in accessing education in general and high-quality education in particular. Graph 6 presents the percentage of persons with and without disabilities who have ever attended school by age group and gender in the 2017 Census. In interpreting these results it is important to keep in mind that many persons become disabled after their school years, therefore the impact of disabilities on education is seen most greatly in the youngest cohorts.

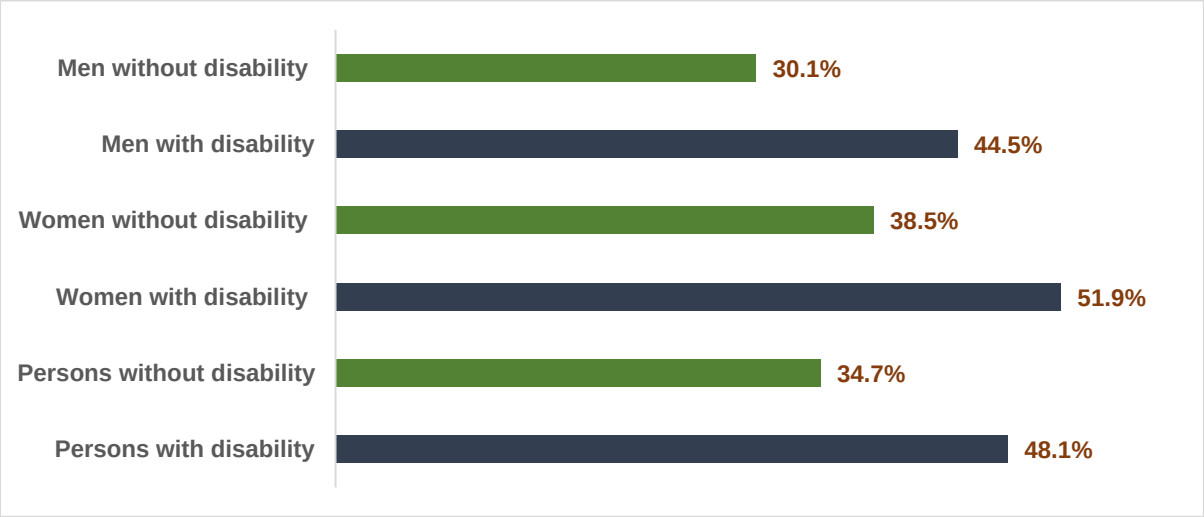
In general, the percentage of women who have ever attended school tends to be lower relative to that of men, regardless of disability status; except among those aged 12-14 years for whom the difference by gender is marginal. Although the level of ever having attended school in urban areas is generally higher relative to rural areas, the likelihood of ever having attended school is lower among those with disabilities compared to those without disabilities in both geographic areas (full details in Graph 6A and Graph 6B, in the annexes).

Graph 6. Percentage of persons with and without disabilities who have ever attended school by age group and gender, 2017 Census

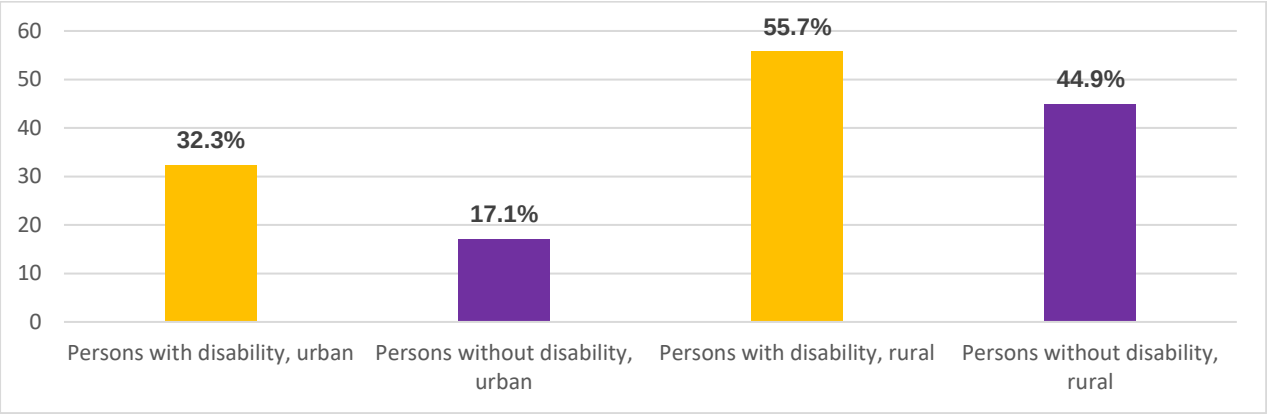


Graph 7 shows the percentage of youth aged 15-24 years who are illiterate by disability status and gender. It shows that youth with disabilities aged 15-24 years are more likely to be illiterate than youth without disabilities of the same age group (48.1% versus 34.7%). When analysing by gender, regardless of disability status, female youth are more likely to be illiterate than male youth. Among youth with disabilities, for example, 51.9% of female youth are illiterate compared to 30.1% of male youth. When analysing by area of residence, youth in rural areas display a higher percentage of illiteracy than youth in urban areas, regardless of disability status (Graph 8). In urban areas in particular, youth with disabilities are almost twice as likely to be illiterate than their peers without disabilities (32.3% versus 17.1%).

Graph 7. Percentage of youth aged 15-24 years who are illiterate by disability status and gender, 2017 Census



Graph 8. Percentage of youth aged 15-24 years who are illiterate by disability status and area of residence, 2017 Census



Although knowing the situation of ever having attended school by disability status is important, understanding the pattern of completed level of education by disability status is often seen as more important as higher levels of completed education are typically associated with more socioeconomic returns. Figure 12 shows the distribution of persons with and without disabilities by gender and completed level of education in the 2017 Census, among younger cohorts (age 12-40 years). It shows that persons with disabilities are less likely to have completed any level of education (52.0% with none completed level of education against 39.9% among persons without disabilities), less likely to have completed a primary level of education (33.3% vs 40.0%) and less likely to have completed a secondary level or more of education (11.0% vs 17.0%) than peers without disabilities. Regardless of disability status, women are less likely to have completed any level of education than men.

<u>Key Finding 7</u>: Persons with disabilities have much lower levels of completed education than persons without disabilities. Gender also adds another layer of disadvantage for women with disabilities in completed level of education

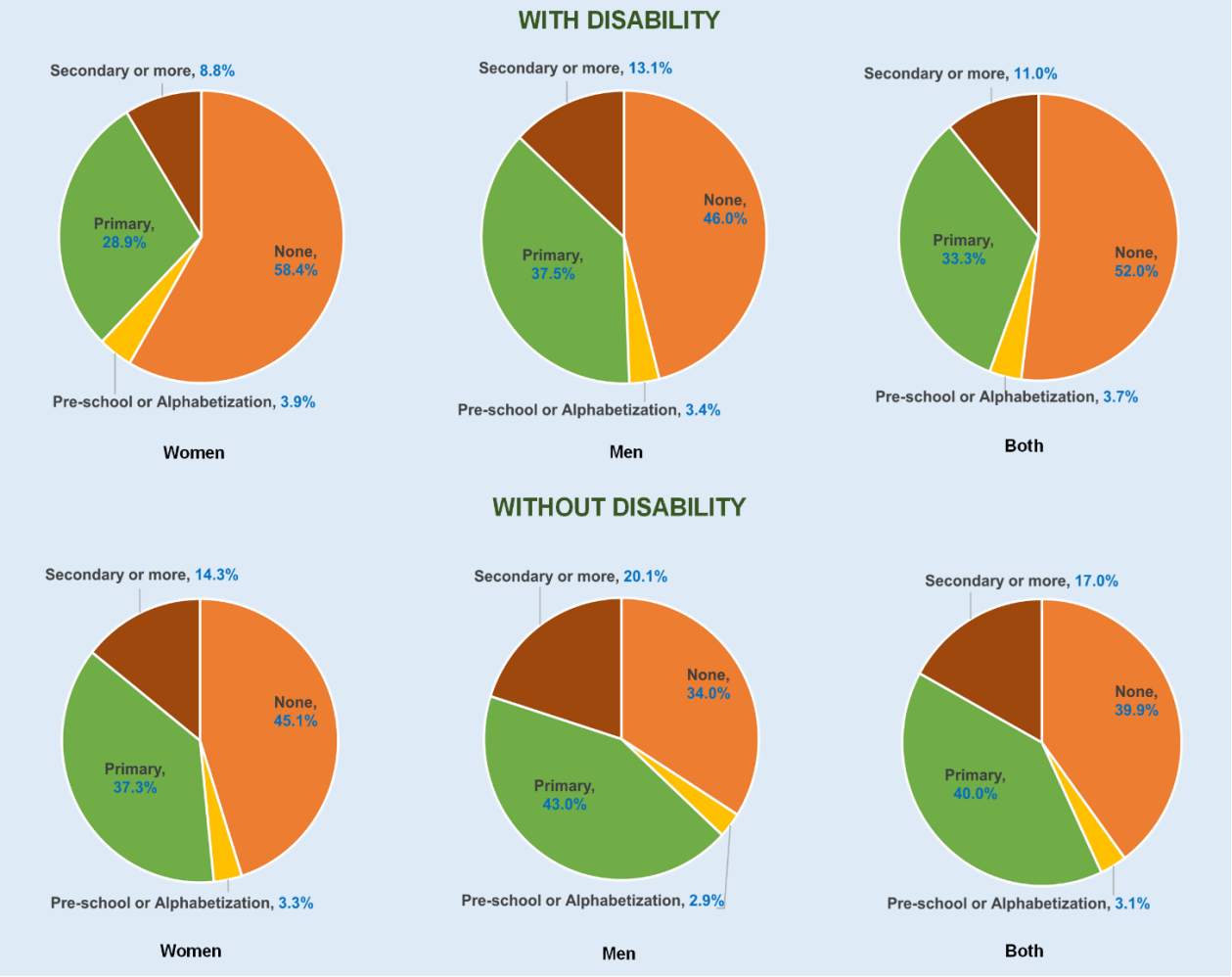


Figure 12. Distribution of persons with and without disabilities by gender and completed level of education among those aged 12-40 years, 2017 Census

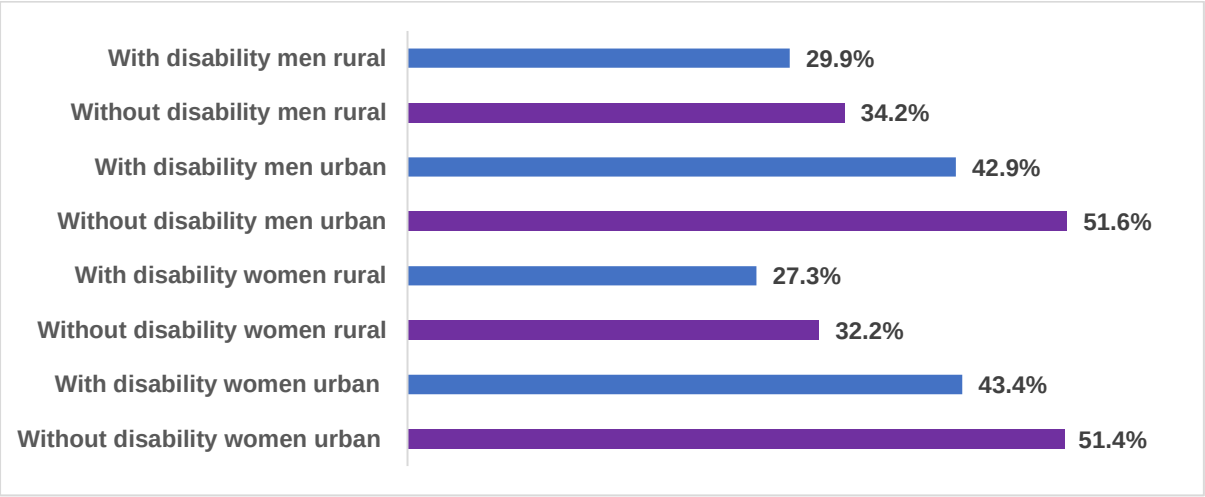
When disaggregating by age groups (Table 14), it is found that in all age groups, individuals with disabilities are less likely to have completed any level of education compared to those of same age group without disabilities. Persons with disabilities have lower percentages of completed primary school in virtually all age groups: aged 12-17 years (38.0% vs. 50.5%), aged 18-24 years (34.8% vs. 39.8%), aged 25-40 years (30.5% vs. 32.4%). The wide gap in the first age group (12-17 years) between persons with and without disabilities, compared to the following older ages groups, suggests that the progress in access and retention of children and young people in primary education has not been the same for children and youth with disabilities, particularly girls. OPDs representatives also shared the same concern as part of this study, highlighting that girls with disabilities tend to drop out of school earlier.

Table 14. Distribution of persons with and without disabilities by age group, gender and completed level of education, 2017 Census

Highest level of education completed	Persons with disabilities			Persons without disabilities		
	Women	Men	Both	Women	Men	Both
PERSONS AGED 12-17						
	31,188	37,161	68,349	1,830,418	1,802,253	3,632,671
None	**55.0**	**53.1**	**53.9**	**39.2**	**38.9**	**39.0**
Pre-school or Alphabetization	3.8	4.0	3.9	3.9	4.1	4.0
Primary	**36.7**	**39.1**	**38.0**	**50.2**	**50.8**	**50.5**
Secondary or More	4.5	3.8	**4.1**	6.8	6.3	**6.5**
Total	100	100	100	100	100	100
PERSONS AGED 18-24						
	36,848	37,368	74,216	1,942,798	1,557,106	3,499,904
None	**52.2**	**43.3**	**47.8**	**39.7**	**28.6**	**34.8**
Pre-school or Alphabetization	3.2	2.4	2.8	2.6	1.9	2.3
Primary	**31.9**	**37.6**	**34.8**	**37.9**	**42.1**	**39.8**
Secondary or More	12.7	16.7	**14.7**	19.8	27.4	**23.2**
Total	100	100	100	100	100	100
PERSONS AGED 25-40						
	73,481	76,555	150,036	2,631,706	2,284,700	4,916,406
None	**62.9**	**43.9**	**53.2**	**53.1**	**33.8**	**44.1**
Pre-school or Alphabetization	4.4	3.7	4.0	3.4	2.6	3.1
Primary	**24.1**	**36.6**	**30.5**	**28.0**	**37.4**	**32.4**
Secondary or More	8.6	15.8	**12.3**	15.4	26.2	**20.4**
Total	100	100	100	100	100	100

Levels of current school enrolment among girls and boys are critical for youth and adult populations' educational profile in coming years. Graph 9 presents the percentage of children aged 3-17 years currently enrolled in school by disability status, age and area of residence in 2017 Census. It shows that school enrolment among children aged 3-17 years tends to be higher among children without disabilities compared to children with disabilities. Within the same disability status, girls show lower school enrolments compared to boys. Enrolments in rural areas are mostly lower compared to urban areas, regardless of disability status. However, differences between boys and girls of the same disability status in school enrolments are higher in rural areas than in urban areas. These figures confirm the OPDs representatives' perceptions that girls with disabilities in rural areas tend to be considerably less represented in school.

Graph 9. Percentage of children aged 3-17 years currently enrolled in school by disability status, age and area of residence, 2017 Census



Results at a glance:

- **The percentage of women who have ever attended school tends to be lower relative to that of men, regardless of disability status (except among those aged 12-14 years).**
- **Youth with disabilities aged 15-24 years are more likely to be illiterate than youth without disabilities of the same age group (48.1% versus 34.7%).**
- **52.0% of persons with disabilities age 12-40 years are less likely to have completed any level of education compared to 39.9% among persons without disabilities.**
- **Persons with disabilities aged 12-40 years are less likely to have completed a primary level of education (33.3% vs 40.0%) and less likely to have completed a secondary level or more of education (11.0% vs 17.0%) than peers without disabilities.**
- **Regardless of disability status, women are less likely to have completed any level of education than men.**
- **Enrolments in rural areas among boys and girls aged 3-17 years are mostly lower compared to urban areas, regardless of disability status.**
- **Differences between boys and girls aged 3-17 years of the same disability status in school enrolments are higher in rural areas than in urban areas.**

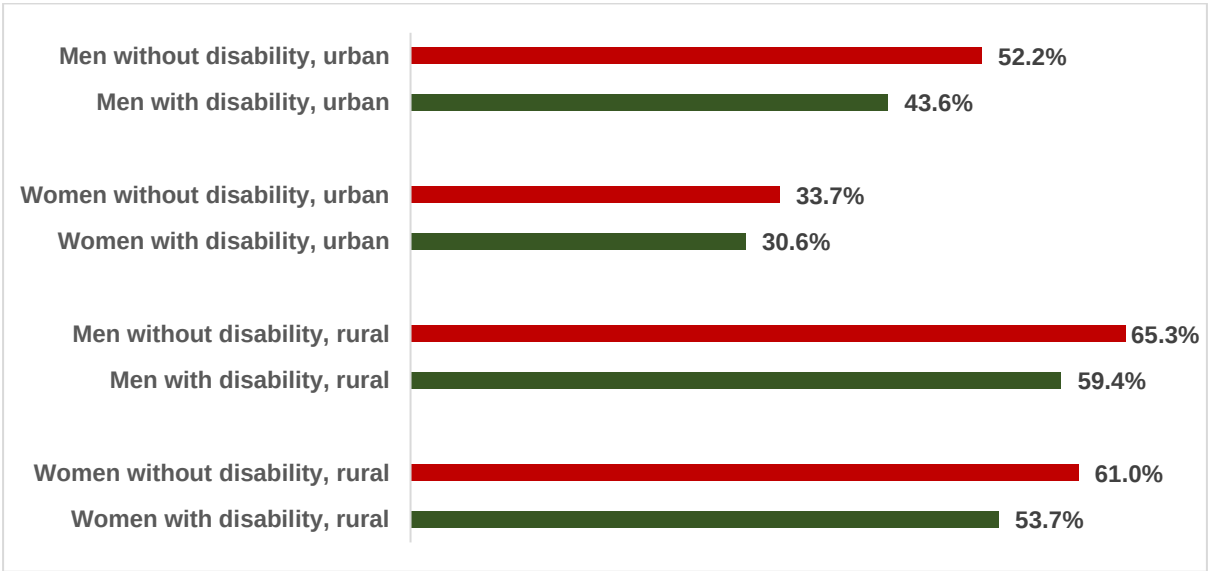
5.6 Employment

Employment in sub-Saharan African countries is a significant challenge, [87] and persons with disabilities can face additional barriers in finding decent paid work.

***Key Finding 8*: Working age individuals without disabilities are more likely to be employed than those with disabilities. However, working age women with disabilities are less likely to be employed than working age men with disabilities.**

Graph 10 shows the distribution of persons with and without disabilities by current employment status, gender and area of residence (among the working age population) in the 2017 Census of Mozambique. It indicates that regardless of gender and area of residence, working age individuals without disabilities are more likely to be employed than those with disabilities (by impairment type and by functional domain combined). For example, among working age women with disabilities in urban areas, 30.6% are employed against 33.7% among women without disabilities. Within the same disability status, working age women are less likely to be employed than working age men. In rural areas, for example, 53.7% of working age women with disabilities are employed against 59.4% working age men with disabilities in the same geographic area. The gap is even higher in urban areas where about 30.6% of women with disabilities are employed relative to about 43.6% of men with disabilities. Individuals residing in urban areas are less likely to be employed relative to working age individuals living in rural areas, regardless of gender and disability status. Among working age women with disabilities, 30.6% of residents in urban areas are employed compared to 53.7% among those living in rural areas. However, as shown below, a large proportion of working age individuals are in non-remunerated or low paying activities. The distribution of persons with and without disabilities by employment status and taking into account the method of disability identification is available as annexes to the study (Graph 10A and Graph 10B).

Graph 10. Persons with and without disabilities by current employment status, gender and area of residence (among working age population), 2017 Census

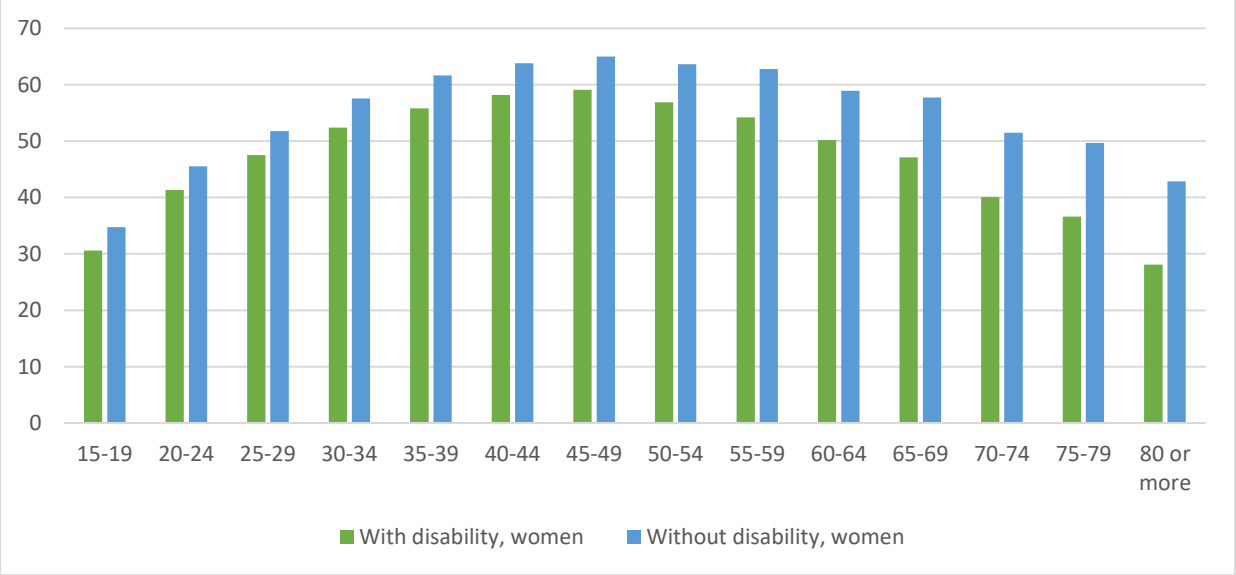


Note. This graph combines persons with disabilities by impairment type and persons with disabilities by functional domain.

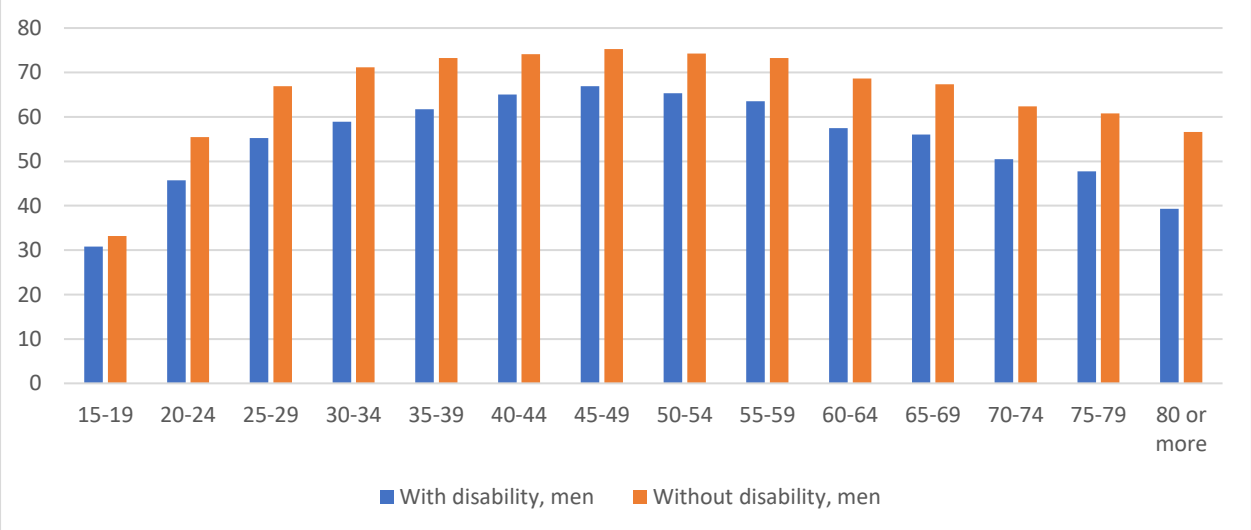
Graph 11 presents distribution of persons with and without disabilities by current employment status and age among working age women in the 2017 Census. It shows that for both working age individuals with and without disabilities, the likelihood of being

employed varies with age. From age group 15-19 years it steadily grows, reaches the peak around middle age groups, and starts a declining trend around age group 60-64 years. However, in all age groups, those with disabilities show lower employment percentage relative to their peers without disabilities. Similar pattern in observed among men (Graph 12).

Graph 11. Distribution of persons with and without disabilities by current employment status and age (among working age population women), 2017 Census



Graph 12. Distribution of persons with and without disabilities by current employment status and age (among working age population men), 2017 Census



Note. This graph combines persons with disabilities by impairment type and persons with disabilities by functional domain.

Pattern of employment by sector or type of activity by disability status

Table 15 shows the distribution of persons with and without disabilities by sector or type of activity and gender, among the working age population in the 2017 Census. Self-employment without employees is the major type of activity for both persons with and without disabilities: 60.6% among working age persons with disabilities compared to 56.2% among their counterpart without disabilities. It is followed by home work without pay – 23.8%% among those with disabilities and 24.8% for those without disabilities. Within each disability status, men are more likely to be employed in the Public Administration/Government Agency and the Private sector relative to women; women are more likely to be self-employed without employees and to be home workers compared to men of the same disability status. For example, among those with disabilities, the percentage of self-employed persons without employees is 58.5% for men versus 62.9% for women. The distribution of persons with and without disabilities by sector of activity and taking into account the method of disability identification is available as annexes to the study (Table 15A and Table 15B). It is worth noting that sectors or activities employing a large percentage of working age individuals are not-remunerating (e.g. Homeworker without pay) or are low-paying informal activities (as much of Self-employed worker without employees).

Non-remunerating and low-paying informal activities are typical in sub-Saharan Africa[68], and these figures confirm that in Mozambique also it remains the main type of work in which persons with disabilities are most likely to be involved.[5] These figures also suggest that, when compared to persons without disabilities, persons with disabilities remain disproportionally less likely be employed in the Public Administration (largest employer in Mozambique), despite the implementation of the Estratégia da Pessoa Portadora de Deficiência na Função Pública (Strategy for Persons with disabilities in the Public Administration) from 2009 to 2013. This reflects the different barriers identified by OPDs representatives in relation to access to employment in general and in the public administration in particular. One organisation representing persons with psychosocial disabilities mentioned the “mental soundness” criteria as a discriminatory legal barrier to work in the Public Administration.

Table 15. Distribution of persons with and without disabilities by sector or type of activity and gender (among working age population), 2017 Census (percent)

Sector or type of activity	Persons with disabilities			Persons without disabilities		
	Women	Men	Both	Women	Men	Both
	141,402	165,662	307,064	3,806,401	3,859,077	7,665,478
Public Administration/Government agency	1.3	3.6	2.6	2.5	5.4	4.0
Private sector	5.5	9.8	7.8	4.9	12.4	8.7
Cooperative sector	0.0	0.1	0.1	0.0	0.1	0.1
Non-for-profit institution	0.1	0.2	0.1	0.1	0.2	0.2
Domestic worker in a private house	1.0	1.9	1.5	1.8	2.1	1.9
Self-employed worker with employees	1.4	2.9	2.2	1.4	3.4	2.4
Self-employed worker without employees	62.9	58.5	60.6	59.8	52.6	56.2

[5] UN DESA (2018) Disability and Development Report: Realizing the Sustainable Development Goals by, for and with persons with
disabilities

Home worker without pay	27.1	20.9	23.8	28.7	21.0	24.8
International organization	0.0	0.0	0.0	0.0	0.1	0.0
No information on sector or type of activity	0.6	2.1	1.4	0.8	2.9	1.9
Total	**100**	**100**	**100**	**100**	**100**	**100**

Results at a glance:

- **Working age individuals with disabilities are less likely to be employed than those without disabilities.**
- **Among working age women with disabilities in urban areas, 30.6% are employed against 33.7% among women without disabilities.**
- **Within the same disability status, working age women are less likely to be employed than working age men – in urban areas, 30.6% of women with disabilities are employed relative to about 43.6% of men with disabilities.**
- **Self-employment without employees is the major type of activity for both persons with and without disabilities: 60.6% among working age persons with disabilities compared to 56.2% among their counterpart without disabilities.**
- **Home work without pay is the second major type of activity for both persons with and without disabilities – 23.8%% among those with disabilities and 24.8% for those without disabilities.**
- **Within each disability status, men are more likely to be employed in the Public Administration/Government Agency and the Private sector relative to women.**

5.7 Living Conditions

Characteristics of households may reveal the state of living conditions of persons with disabilities. Table 16 shows the distribution of households with and without persons with disabilities by dwelling building material index, age of the household head and geographical area of residence in the 2017 Census. An index of dwelling building material is high when walls, roofs and floors of a household building are made of conventional building material. In rural areas, the percentage of households with a high index of dwelling building material is closer between households of persons with and without disabilities. Among households headed by persons aged 30-60 years, for example, it is 17.5% for households of persons with disabilities and 15.9% for households of persons without disabilities. In urban areas, households of persons with disabilities display a slightly high percentage of those with a high index of dwelling building material (62.1% versus 57.9%, respectively). Overall, regardless of the disability status, the percentage of households with a high index of dwelling building material is lower in rural areas relative to urban areas. Among those aged over 61 years, the percentage of those with a high index of dwelling building material is closer between the

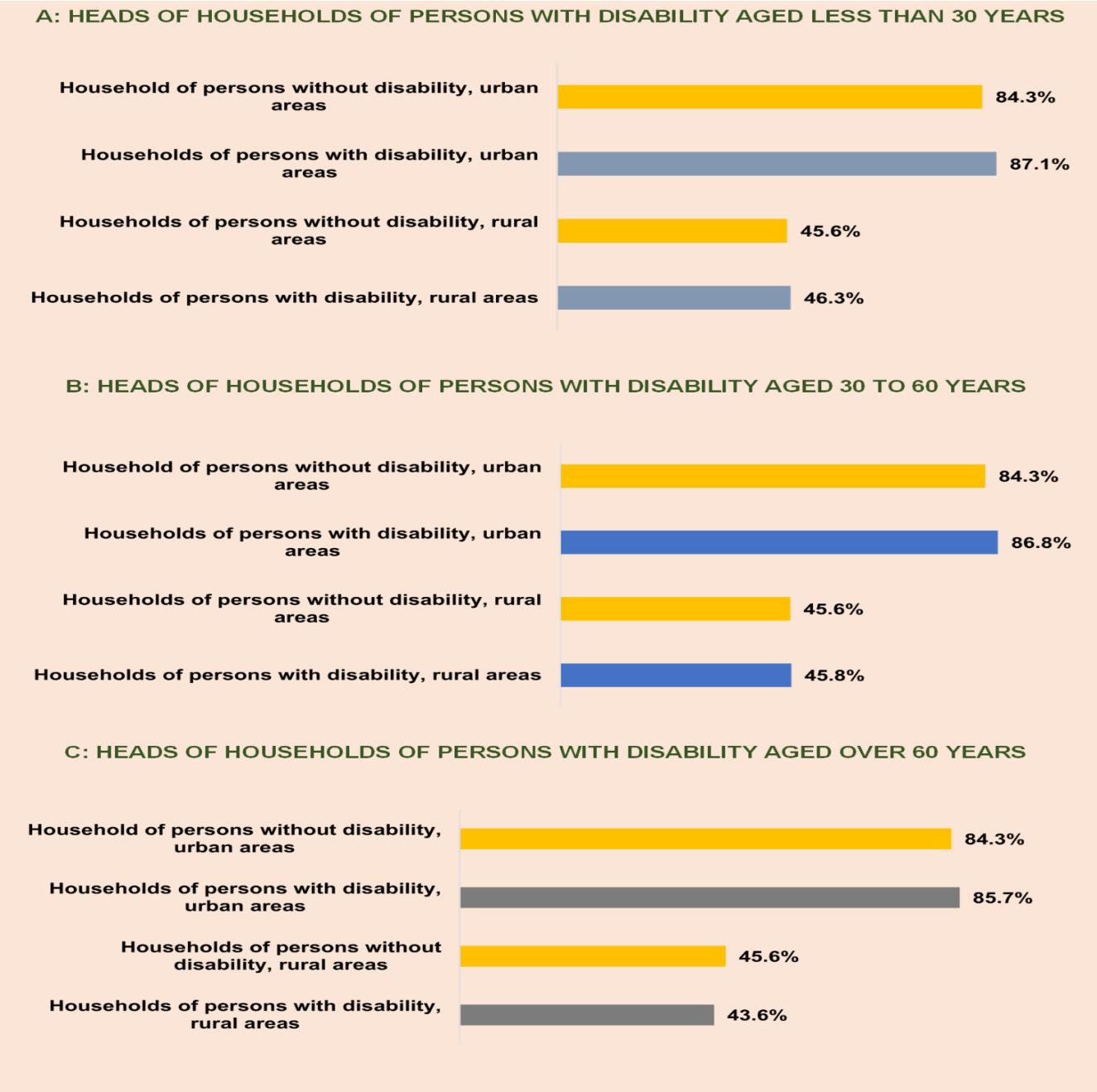
disability status, particularly in rural areas. The finding among those aged over 60 years may reflect the fact that those who become disabled at age 60 may have already created living conditions (e.g. having a house). (A table with frequencies is available as an annex to the study – Table 16A). In addition, youth with disabilities may also be living with their parents. OPDs who took part in this study highlighted that youth with disabilities usually face higher barriers to establishing their own households, being left with no other option but to live with their parents or other caregivers, limiting their right to live independently.

Table 16. Distribution of households with and without persons with disabilities by dwelling building material index and area of residence, 2017 Census (percent)

Index of dwelling building material	Households of persons with disabilities	Households of persons without disabilities
HOUSEHOLD HEADS AGED LESS THAN 30 YEARS		
RURAL	6,600	296,263
High	**19.5**	**16.1**
Medium	5.3	3.9
Low	19.7	20.2
None	55.6	59.8
Total	**100**	**100**
URBAN	3,621	145,912
High	**63.2**	**58.5**
Medium	10.5	10.1
Low	12.6	14.1
None	13.7	17.3
Total	100	100
HOUSEHOLD HEADS AGED 30 TO 60 YEARS		
RURAL	27,833	518,292
High	**17.5**	**15.9**
Medium	4.4	4.0
Low	20.1	20.4
None	57.9	59.7
Total	100	100
URBAN	14,064	239,967
High	**62.1**	**57.9**
Medium	10.4	10.2
Low	13.0	14.3
None	14.5	17.7
Total	100	100
HOUSEHOLD HEADS AGED 61 YEARS OR MORE		
RURAL	16,632	111,939
High	**15.6**	**15.4**
Medium	4.1	3.9
Low	22.2	21.3
None	58.1	59.4
Total	100	100
URBAN	6,816	44,307
High	**58.6**	**56.5**
Medium	11.0	10.6
Low	14.3	14.9
None	16.2	17.9
Total	100	100

Notes: High (walls, roof and floors made of conventional building material); Medium (at least two parts of dwelling made of conventional building material); Low (at least one part of dwelling made of conventional building material); None (No conventional dwelling building material).

Figure 13 presents percentage of households of persons with and without disabilities with an improved source of water for drinking by area of residence in the 2017 Census. It shows that the percentage of households with an improved source of drinking water in rural areas is virtually the same for households of persons with disabilities and households of persons without disabilities – about 46%. It is only among households of persons with disabilities with a head aged over 60 years where it is slightly lower in comparison to households of persons without disabilities in rural areas. In addition, in urban areas the proportion of households of persons with disabilities using an improved source of drinking water is closer to that in households of persons without disabilities.

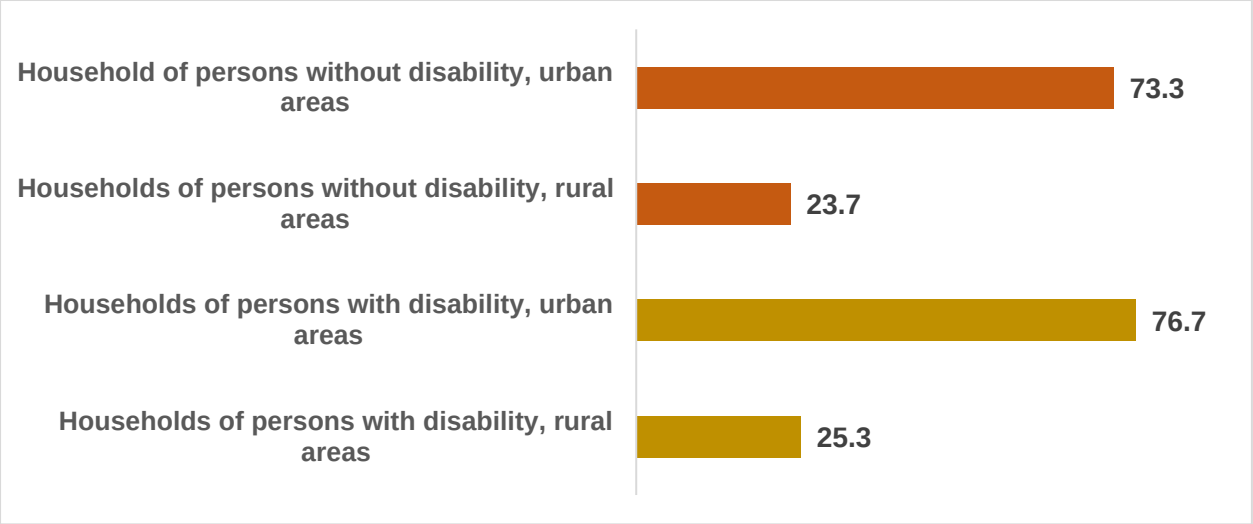


Note. Improved sources of drinking water were considered to be piped water; water from fountain; water from protected well or borehole; water from a spring source; water from a car with a water tank; and mineral or bottled water.

Figure 13. Percentage of households of persons with and without disabilities with an improved source of drinking water by age of the household head and area of residence, 2017 Census.

Graph 13 presents percentage of households with and without persons with disabilities using an improved type of sanitation (type of toilet) in the household by area of residence in the 2017 Census. Regardless of household disability status, the percentage of households using an improved type of sanitation in rural areas is very low and there is not a significant difference between households of persons with disabilities compared to those of persons without disabilities (23.7% versus 25.3%). In urban areas, close to four quarters of households use an improved type of sanitation. Although households of persons with disabilities have a slightly high percentage, the difference between the two types of households is not significant- 76.7% for households of persons with disabilities and 73.3% for households of their counterparts without disabilities.

Graph 13. Percentage of households of persons with and without disabilities using an improved sanitation (toilet) by area of residence, 2017 Census.



Note. This graph combines households of persons with disabilities by impairment type and households of persons with disabilities by functional domain. A household was considered as using an improved sanitation if it used flush toilet; non-flush toilet; improved latrine and traditional improved latrine. Households with no information on type of sanitation used in the household were excluded from the estimation of households using an improved sanitation.

Results at a glance:

- **Among households headed by persons aged 30-60 years, the percentage of households with a high index of dwelling building material is 17.5% for households of persons with disabilities and 15.9% for households of persons without disabilities.**
- **In urban areas, households of persons with disabilities display a slightly high percentage of those with a high index of dwelling building material (62.1% versus 57.9%, respectively).**
- **The percentage of households with an improved source of drinking water in rural areas is virtually the same for households of persons with disabilities and households of persons without disabilities – about 46%.**
- **The percentage of households with an improved source of drinking water in urban areas is 87.1% for households of persons with disabilities and 84.3% for households of persons without disabilities.**
- **Regardless of household disability status, the percentage of households using an improved type of sanitation in rural areas is very low and there is not a significant difference between households of persons with disabilities compared to those of persons without disabilities (23.7% versus 25.3%).**
- **In urban areas, 76.7% of households of persons with disabilities have improved type of sanitation (type of toilet) compared to 73.3% for households of persons without disabilities.**

5.8 Access to information and communications technologies

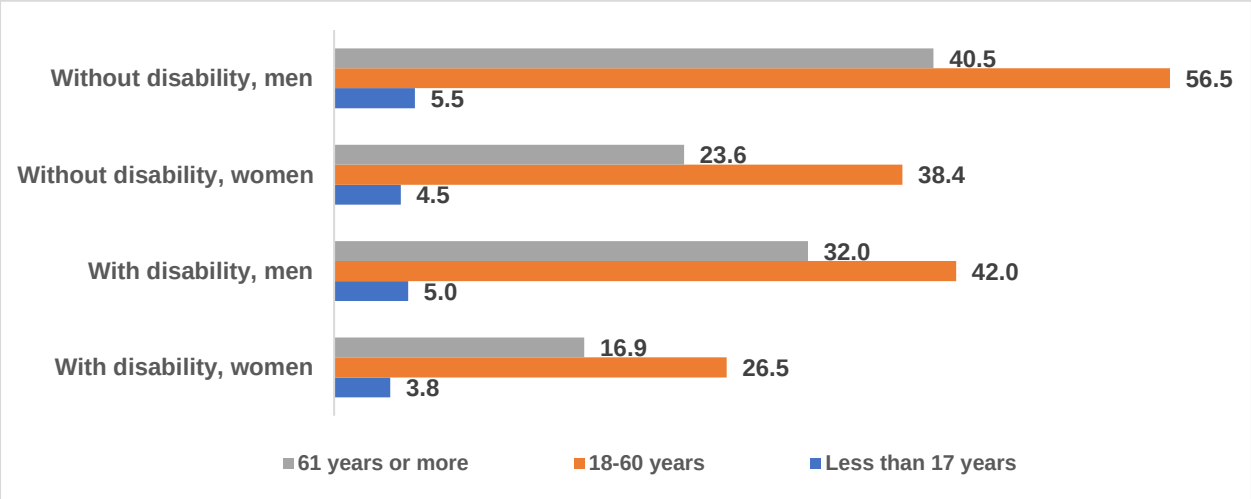
Information and communication technologies (ICTs) has become essential for accessing information, communication and a central aspect of development processes. Persons with disabilities might face additional barriers accessing technologies if their specific accessibility needs are not adequately considered. The CRPD requires the Government to take specific measures in different technologies sectors to make sure these are also accessible for persons with disabilities. Nevertheless, the ICT legislation does not address accessibility issues for persons with disabilities in Mozambique[88] and persons with disabilities continue facing ICT accessibility barriers including to access basic services.[89] COVID-19 has increased the urgency of ensuring persons with disabilities, particularly women and girls with disabilities, have access to ICTs to remain connected, engage with their representative organisations and ensure they are not further left behind.

***Key Finding 9:* Persons with disabilities are significantly less likely than persons without disabilities to access information and communication technologies. Of all persons, women with disabilities are least likely to own a phone and have access to ICTs, highlighting the gender and disability-related barriers they face.**

Graph 14 presents possession of a cell phone among persons with and without disabilities by age and gender in the 2017 Census. It shows that possession of a cell phone varies with

disability status, age and gender: it is higher among individuals without disabilities relative to those with disabilities; it is higher among men than women of same age group and disability status; and it is higher among those in the age group 18-60 years, followed by those in the age group 61 or more. For example, among those aged 18-60 years, possession of a cell phone is higher for men without disabilities compared to men with disabilities (56.5% vs. 42.0%); a similar pattern is observed among women (38.4% vs. 26.5%). Pattern of possession of a cell phone by method of disability identification is available as annex to the study (Graph 14A and Graph 14B).

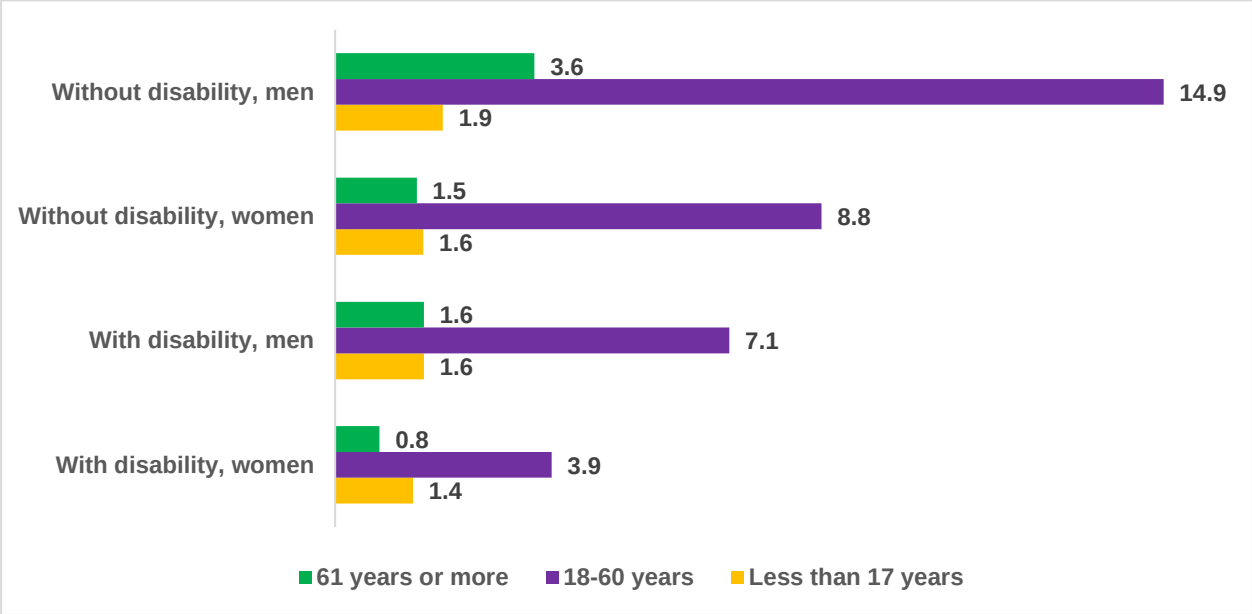
Graph 14. Possession of a cell phone among persons with and without disabilities by age and gender, 2017 Census



Note. This graph combines persons with disabilities by impairment type and persons with disabilities by functional domain.

Graph 15 presents access to internet in the past three months among persons with and without disabilities, by age and gender in the 2017 Census. It indicates that access to the internet is generally low across disability status, age group and gender. However, among those who have access to the internet, mostly aged 18-60 years, persons without disabilities are more likely to have accessed it compared to those with disabilities. For example, among men aged 18-60 years, only 7.1% have had access to the internet within the group of those with disabilities compared to 14.9% for men without disabilities. There is also a clear gender divide: women without disabilities are less likely to access the internet than men without disabilities, as are women with disabilities compared to men with disabilities. Of all the categories, women with disabilities have the lowest access to the internet across all age ranges. This suggests that women with disabilities are doubly disadvantaged when it comes to accessing the internet, due to their gender and their disability status. Graph 15A and Graph 15B in the annexes show distribution of access to the internet taking into account the method of disability identification.

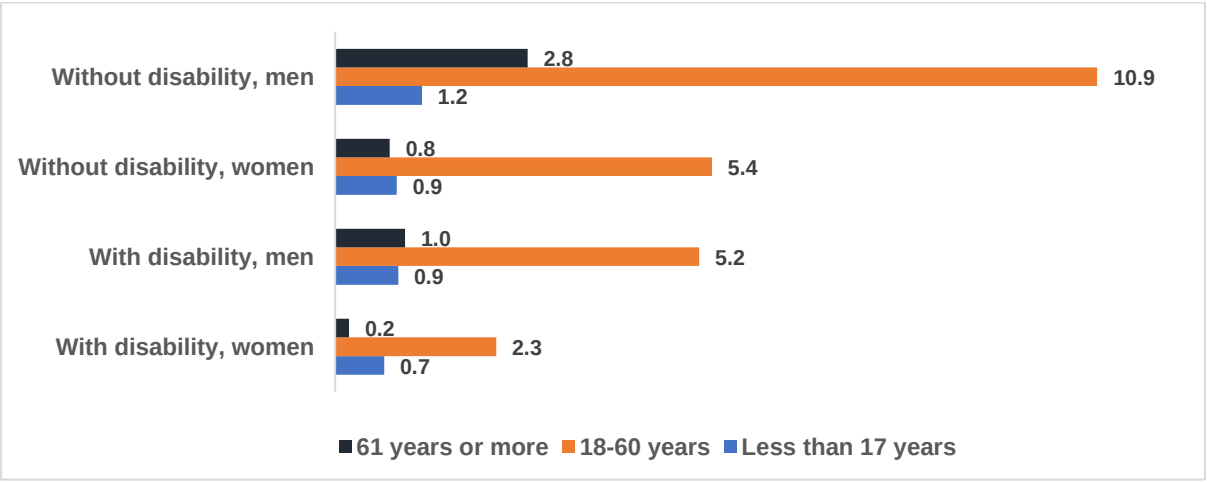
Graph 15. Access to the internet in the past three months among persons with and without disabilities, by age and gender, 2017 Census



Note. This graph combines persons with disabilities by impairment type and persons with disabilities by functional domain.

Graph 16 shows access to a computer in the past three months among persons with and without disabilities, by age and gender in the 2017 census. It shows that individuals with disabilities are less likely to have had access to a computer in the three months before the census date than their peers without disabilities. Access to a computer is higher among men than women, regardless of disability status. Distribution of access to a computer by method of disability identification is shown in Graph 16A and Graph 16B in the annexes.

Graph 16. Access to a computer in past three months among persons with and without disabilities by age and gender, 2017 Census



<u>Key finding 10</u>: Persons with disabilities and their representative organizations faced additional barriers to participating and influencing the 2017 Census process.

Interviews with Organization of Persons with Disabilities (OPDs) leaders revealed technical capacity limitations among the Census staff in collecting disability data as well as stigmatized views of disabilities, particularly against women with disabilities. Enumerators were afraid of asking the disability questions. In fact, they would not ask a disability related question until they saw a person with an apparent disability, missing many people with hidden disabilities. OPDs representatives also indicated that they have not been able to take part in key stages of the process.

Results at a glance:

- **Possession of a cell phone, access to internet and to a computer varies with disability status, age and gender: it is higher among individuals without disabilities relative to those with disabilities; it is higher among men than women of same age group and disability status**
- **Among persons aged 18-60 years, possession of a cell phone is higher for men without disabilities compared to men with disabilities (56.5% vs. 42.0%) and higher for women without disabilities compared to women with disabilities (38.4% vs. 26.5%).**
- **Among men aged 18-60 years, 7.1% with disabilities have had access to the internet compared to 14.9% for men without disabilities.**
- **Women and men aged 18-60 years with disabilities have had less access to a computer compared to women and men aged 18-60 years without disabilities (2.3% vs 5.4%, for women) and (5.2% vs 10.9%, for men).**

6. Conclusions and Policy Considerations

6.1 Understanding the results

The present study sought to understand the dimension, structure and trends of disability in Mozambique on the basis of 2017 and 2007 censuses data as well as to assess the placement of Mozambique's approach on disability data collection in the context of global and regional trends. To achieve this aim, an analysis of Census data was carried out, and complemented by an evidence review and interviews with key stakeholders on disability.

The 2017 Census identified 727,620 individuals to have disabilities, corresponding to 2.7% of the population; while the previous census held in 2007 reported 2.3% of the population as having disabilities (475,011 individuals). While the 2007 Census sought to categorize persons with disabilities by impairment type, the 2017 Census also had questions adapted from the WG methodology to identify disability by functional domain. The 2017 Census found that roughly half of the 2.7% identified as having a disability (1.4% of the total population) also reported having an impairment (1.6% men and 1.3% women), 0.4% individuals with other disabilities, and 1% of individuals with any disability by functional domain.

Although there was an attempt to integrate Washington Group questions in the 2017 Census in Mozambique, the inclusion of the "do you have a disability question" (also used in the 2007 Census) undermines this effort as this is a measure known to seriously underestimate the number of persons with disabilities. This study has found that the 2007 and 2017 censuses in Mozambique adopted approaches of collecting data on disability that rely heavily on the medical model which tends to capture only severe disability cases. The review of evidence from other African countries, particularly similar contexts in sub-Saharan Africa, has found that countries using the same type of disability questions as Mozambique used in the 2007 and 2017 censuses identify a very low number of persons with disabilities. In contrast, countries that have introduced international comparable questions based on the WG models obtained higher prevalence rates, particularly compared to their previous census exercises that did not use the WG questions. It has also been noticed that inconsistent implementation of the WG questionnaire might also lead to lower prevalence rates. Given this background, the disability prevalence rate provided by the Census (2007 and 2017) is very questionable (2.3% and 2.7% respectively) and considerably lower if compared to the WHO world estimated of 15%. Interviews with stakeholders in Mozambique, carried out for this study, also pointed to concerns that the disability prevalence rate does not represent the real spectrum of disability in Mozambique.

Accessibility and active participation of persons with disabilities and their representative organizations throughout the process has not been adequately considered in the Census. Specific groups such as persons with psychosocial disabilities, persons with intellectual disabilities, persons with albinism and persons with communication impairments have found it even harder to participate in the process. Interviews for this study have revealed stigmatized attitudes towards persons with disabilities particularly women with disabilities, as they strived to participate as head of households.

Despite these limitations of census data on disability in Mozambique, the census remains the main source of disability data in the country providing a comprehensive picture of disability on particular social outcomes as compared to the rest of the population. Therefore,

its findings should be used for policy and programmatic purposes, whilst efforts are strengthened to get a more accurate disability prevalence rate. The analysis of Census data for this study revealed that congenital and disease/illness are the main **causes of disabilities** in Mozambique, with more than 7 in 10 cases of any impairment and more than 6 in 10 cases of any functional limitation attributed to them. Labour accidents and automobile accidents, which may be prevented, are in second place as important causes of disabilities in the country.

In relation to **marital status**, persons with disabilities are less likely to be married or living together, and more likely to be divorced, separated or widowed compared to persons without disabilities. According to the 2017 Census, 76% of persons with disabilities and 89.1% of persons without disabilities were married or living together. Among those who have been in a marital union, 7.9% of persons with disabilities were divorced or separated compared to 5.0% for persons without disabilities; and 16.1% of persons with disabilities were widowed compared to 5.9% of persons without disabilities. The higher likelihood of persons with disabilities not being in a marriage or marital relationship indicates that they might have less access to the social support that this relationship normally entails. Child marriage remains a concern in Mozambique, and disability adds an additional layer of vulnerability for girls with disabilities.

When looking at **adolescent childbearing** (15-19 years), adolescent girls with disabilities are less likely than girls without disabilities to have early childbearing in both urban and rural areas. However, the data shows that a significant number of adolescent girls with disabilities are going through early pregnancy and early childbearing in Mozambique (about 17% in urban areas and 27% in rural areas), which will have a significant impact on their health and life outcomes, along with those of their children. These figures are likely to be related to the structural and attitudinal barriers adolescent girls with disabilities face in accessing SRH services (as outlined by OPDs representatives who took part in the study and other sources of evidence). The way service providers interact with persons with disabilities, particularly with adolescent girls with disabilities, can help break down barriers and send positive messages to colleagues, partners and community members.[90] It can also improve the quality of the service.[91]These results are also likely to be reflective of sexual violence against adolescent girls with disabilities, as evidence shows that women and girls with disabilities are at increased risk of violence.[92]

In relation to **education**, the Census data shows that persons with disabilities are less likely to have ever attended school relative to their counterpart without disabilities. Regardless of disability status, women are more disadvantaged compared to men, especially in adult age groups. When looking at completed level of education, in young cohorts (12-40 years), individuals with disabilities are more likely to not have completed any level of education compared to those of same age group without disabilities. Although the difference between individuals with and without disabilities decreases with age, when looking at specific levels of education, persons with disabilities also fall behind persons without disabilities. This indicates that access and retention in the education system of persons with disabilities in Mozambique remains disproportionally low compared to persons without disabilities. Girls with disabilities convey particularly higher levels of disadvantage. OPDs representatives have pointed out several challenges in the education system for persons with disabilities, starting from an overall prioritization of special education over inclusive education. They also mentioned the lack of capacity to provide adequate support to the specific needs of children

with disabilities, and a learning experience of the same standard of quality as children without disabilities. However, it is not clear how those aspects are reflected in the data besides the disproportionally lower rates in attendance, completion of levels of education and enrolment.

Not surprisingly, the limited access to education has also been affecting access to **employment**. Regardless of gender and area of residence, working age individuals without disabilities are more likely to be employed than those with disabilities. Within the same disability status, working age women are less likely to be employed than working age men; and residents of rural areas are more likely to be employed than those of urban areas. More than half of those employed are in self-employed work without employees or home work without pay. This confirms that persons with disabilities are disproportionately more likely to be involved in informal activities than persons without disabilities. These figures also suggest that policy measures in Mozambique to reduce the disproportional gap between employees with and without disabilities in the public administration sector have not achieved its results.

With respect to **living conditions**, there appears to be similarities between households of persons with disabilities and households of persons without disabilities, mostly in rural areas. However, this finding may be a result of a confounding effect of age – as for example, those who become disabled at age 60 may have already created living conditions (e.g. having a house).

Access to information and communications technologies varies with age, regardless of disability status, and is higher among those aged 18-60 years. However, persons with disabilities are less likely to have access to ICTs compared to persons without disabilities; and women are less likely to have access to ICTs compared to men, regardless of disability status. This requires particular attention since the COVID-19 pandemic has been accelerating the technological migration of essential services, making it more urgent that persons with disabilities have access to ICTs, particularly mobile technology. However, the migration process has not always taken into consideration the specific needs of persons with disabilities, which risks exacerbating and deepening poverty, inequality and exclusion of persons with disabilities. In addition, the digital exclusion of persons with disabilities can also make it harder for OPDs; evidence from the COVID-19 pandemic shows that OPDs found it difficult to reach persons with disabilities during lockdowns due to their limited access to technology. [93]

6.2 Policy Considerations

Drawing on the findings of this study, a number of policy considerations have been identified. Further engagement with persons with disabilities and OPDs on the findings will help ensure their priorities and recommendations are included.

1. Improve the quality of data and evidence on disability in Mozambique, including through the full integration of the Washington Group approach for all data collection (including the 2027 Census) and ensuring more active consultation with persons with disabilities and their representative organizations.
2. Conduct more detailed studies (disability surveys, survey modules on general surveys, qualitative studies) on the extent and characteristics of disadvantages observed on basis of census data (e.g., on marital life, education and employment), on the one hand, to know better the extent of the environmental challenges facing persons with disabilities

and, on the other hand, to identify interventions that are more likely to meet the interests and needs of persons with disabilities.

3. Meaningfully involve and engage with persons with disabilities and OPDs in the development and design of new policies, in addition to the design of the next Census process, from the inception stage up to the administration of the questionnaire.
4. Conduct specific studies to unpack characteristics of congenital conditions and illnesses implicated in the context of Mozambique. Such a study may help for discovering points for preventative interventions.
5. Improve labour and road safety to reduce the risk of labour accidents and automobile accidents being a leading cause of disability in Mozambique.
6. Adopt adequate policies to address the growing number of older persons with disabilities and adapt interventions in line with the disability prevalence figures by province, regional and rural/urban criteria.
7. Improve the design of disability-inclusive policies and programs for adolescent girls and address the structural and attitudinal barriers that adolescent girls with disabilities face in accessing sexual and reproductive health services.
8. Mainstream disability inclusion in child marriage interventions to improve data on violence and harmful practices against girls with disabilities in Mozambique.
9. Increase support for children with disabilities to access and stay in the education system and benefit from a learning experience at the same standard as children without disabilities.
10. Develop and fund a strategy to address disability employment gaps to identify and address the key barriers to employment facing persons with disabilities.
11. Support OPDs led formal and informal employment initiatives throughout the country in terms of preferential access to markets, access to services' opportunities and provision of training for upgrading or upscaling their activities.
12. Address the barriers that persons with disabilities face in accessing ICTs, particularly in relation to mobile technology, and adopt ICT accessibility policy measures to fill the existing gap in line with CRPD obligations, to reduce barriers related to disability and ensure that mainstream information technology institutions prioritize persons with disabilities, especially women with disabilities, in their programs.

Endnotes

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