

# VICTIM ASSISTANCE AFRICA

## STATES PARTIES WITH SIGNIFICANT NUMBERS OF SURVIVORS AND NEEDS

### Victim assistance in Africa since 1999<sup>1</sup>

Africa has the largest number of states with significant numbers of survivors in need of assistance, including 15 Mine Ban Treaty States Parties. The region of Africa also has shown strong support for the Mine Ban Treaty from its beginnings. As of 2013, among the 17 states with significant numbers of survivors in the region, all but two are States Parties, as well as one other area—Western Sahara. Just Egypt and Libya remain outside the treaty, but both recognize the need for victim assistance.<sup>2</sup>

In recognition of the importance of the Mine Ban Treaty in Africa, the first Meeting of States Parties in May 1999 was held in Maputo, Mozambique. Member states highlighted the symbolic importance of this location in the Maputo Declaration, underscoring the urgent humanitarian imperative of the treaty for Africa, “one of the most mine-affected continents on earth” and for Mozambique, a country that “has experienced the ravages wreaked by these weapons on the Mozambican people and the social fabric of the nation.”<sup>3</sup> During the First Meeting of States Parties, member states elaborated their plans for victim assistance.

“In Maputo, the following future actions were agreed upon: ...”<sup>4</sup>

- > Support a wider and integral scope of landmine victim assistance, including medical and rehabilitation aspects of individuals as well as communities and the reconstruction of the socio-economic conditions in affected communities.
- > Sharing of information on resource allocation at the donor and mine affected country level, as well as from operational agencies, in order to identify existing gaps and make most efficient use of available funding and avoid duplication. ...

At the first meeting of the Standing Committee<sup>5</sup> for matters relating to victim assistance, held later in 1999, survivors called on States Parties to take actions, including to:<sup>6</sup>

- > View victim assistance as a part of development strategy and human resource development, not as charity.
- > Facilitate victim assistance by allocating funds to a range of programs (medical care, physical and psychosocial rehabilitation, social and economic reintegration) to help survivors. Include mine victims and associations of persons with disabilities as equal participants in program planning.

Fifteen years after the First Meeting of States Parties, member states have returned to Maputo for the Third Review Conference of the treaty, to assess their progress and to develop a strategy to address remaining challenges.

In Africa, States Parties have made progress in addressing the rights and needs of survivors, in some cases despite great odds and while confronting related challenges such as armed conflict and poverty. Several states, such as Ethiopia, Mozambique, and South Sudan have integrated victim assistance into broader programs for persons with disabilities in order to benefit survivors

as well as other persons with disabilities. In Guinea-Bissau, the government has explicitly included mine/explosive remnants of war (ERW) survivors in its poverty reduction strategy as a means to ensure their inclusion in the country's development. Some governments, often with the benefit of international cooperation, have been able to increase access to and/or the availability of physical rehabilitation, such as in Algeria, Guinea-Bissau, and Sudan. In Senegal, government support for some years to the regional mental health facility to establish an outreach program enabled many survivors to receive these services. In Uganda, with support from international and national NGOs, the government has begun to codify accessibility standards that will help the realization of survivors' right to equal access to public and private buildings and infrastructure in their communities.

For all of these important steps forward, there remain as many challenges to be addressed to ensure that survivors in the States Parties of Africa have their needs met and their rights upheld. Many survivors and other persons with disabilities on the continent still lack access to the most basic healthcare or rehabilitation. In some cases, that is because the services do not exist; in other instances, survivors lack the means to reach them or to pay for them. Armed conflict, where it occurs, also often prevents survivors from travelling to and accessing services. While many effective projects have been implemented, most survivors throughout the continent are still unable to participate fully in their communities, in schools, or as income-earning members of their families on an equal basis to others.

## Gender and age

Throughout Africa, women and children survivors face even greater challenges than men to access needed services and to fulfill their rights. In both Ethiopia and Mozambique, governments and NGOs recognized that women survivors, along with other women with disabilities, were more disadvantaged than men in employment and education. In Uganda, Monitor sources reported that gender-appropriate services were not available to all persons with disabilities in health centers. Such gender discrimination was also common in other States Parties in the region. Some recent efforts to begin to address this discrimination have been identified. Ethiopia took steps to address this with employment legislation that specifically recognizes the additional difficulties faced by women with disabilities. In the Democratic Republic of Congo (DRC), peer support projects implemented by a national consortium of NGOs were designed to encourage equal participation of both women and men and this was achieved.

In many of the African States Parties there was also a lack of age-appropriate services available to child survivors. However, in Algeria, Mozambique, and Uganda, inclusive education programs were launched in 2012 to train teachers and ensure the accessibility of schools. In Senegal, the government increased funding for educational support to child and youth survivors; when funding was available, NGOs provided children affected by mines/ERW with educational kits and worked to improve their access to education. In South Sudan, the Ministry of Social Welfare worked with an international organization to adapt physical rehabilitation services for the needs of children with disabilities, including mine/ERW survivors, at a center in Juba.

<sup>1</sup> Unless otherwise indicated all information is based on country profiles by the Landmine and Cluster Munition Monitor, [www.the-monitor.org](http://www.the-monitor.org).

<sup>2</sup> Both Egypt and Libya have thousands of survivors on their territories.

<sup>3</sup> "Maputo Declaration," Maputo, Mozambique, APLC/MSP.1/1999/L.6, 6 May 1999., [www.apminebanconvention.org/fileadmin/APMBC/MSP/1MSP/Maputo\\_declaration\\_en.pdf](http://www.apminebanconvention.org/fileadmin/APMBC/MSP/1MSP/Maputo_declaration_en.pdf).

<sup>4</sup> Reporting from the first meeting of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their destruction in Maputo, Mozambique to the intersessional Standing Committee meetings. Mine Ban Treaty, "Intersessional Work Programme Sept., Dec. 1999 & Jan. 2000: Victim Assistance," [www.apminebanconvention.org/intersessional-work-programme/sept-dec-1999-jan-2000/victim-assistance/meeting-report/#sthash.p5mTVbea.dpuf](http://www.apminebanconvention.org/intersessional-work-programme/sept-dec-1999-jan-2000/victim-assistance/meeting-report/#sthash.p5mTVbea.dpuf).

<sup>5</sup> Originally titled the Standing Committee of Experts on Victim Assistance, Socio-Economic Reintegration and Mine Awareness, and later as the Standing Committee on Victim Assistance and Socio-Economic Reintegration.

<sup>6</sup> Mine Ban Treaty, "Intersessional Work Programme Sept., Dec. 1999 & Jan. 2000: Victim Assistance," [www.apminebanconvention.org/intersessional-work-programme/sept-dec-1999-jan-2000/victim-assistance/meeting-report/#sthash.p5mTVbea.dpuf](http://www.apminebanconvention.org/intersessional-work-programme/sept-dec-1999-jan-2000/victim-assistance/meeting-report/#sthash.p5mTVbea.dpuf).

## Availability and access to services

### Eastern Africa<sup>7</sup>

#### Victim assistance process indicators

State Party	Mine Ban Treaty	All known survivors	Coordination	Plan	Needs assessment
<b>Mozambique</b>	1 March 1999	Estimated 10,901	National Disability Council (disability coordination)	National Disability Plan 2012–2019, component on mine/ERW survivors	2012, limited geographic area
<b>Burundi</b>	1 April 2004	Estimated 1,311	Interministerial and Intersectoral Coordinating Committee for Victim Assistance	National Victim Assistance Action Plan 2011–2014	None
<b>Eritrea</b>	1 February 2002	At least 2,777	Ministry of Labor and Human Welfare (disability coordination)	National Policy on Disability 2012–2016	None
<b>Ethiopia</b>	1 June 2005	At least 7,401	Ministry of Labor and Social Affairs (disability coordination)	National Plan of Action on Disability	None
<b>Somalia</b>	1 October 2012	At least 1,756	None	None	2013, in Mogadishu
<b>South Sudan</b>	9 July 2011	3,464 recorded	Victim Assistance and Disability Working Group (disability coordination)	South Sudan National Mine Action Strategic Plan 2012–2016	Several local surveys, 2010–2012
<b>Uganda</b>	1 August 1999	At least 2,234	Intersectoral Committee on Disability	Comprehensive Plan of Action on Victim Assistance 2010–2014	2009
<b>Zimbabwe</b>	1 March 1999	At least 1,313	None	None	None

Notes: “State Party” refers to those states that have ratified or acceded to the Mine Ban Treaty. “Mine Ban Treaty” is the date the Mine Ban Treaty entered into force for that state. “All known survivors” is the total number of survivors recorded in Monitor country profiles from when survivors began to be reported in a given country through the end of 2012. “Coordination” is the government coordination mechanism that includes efforts to address the needs of survivors. “Plan” is a national plan that aims to address the needs of survivors, sometimes along with the needs of other vulnerable groups. “Needs assessment” is a process by which states or other actors have determined what assistance survivors and/or a broader group of victims require.

<sup>7</sup> States Parties in Africa are listed according to the sub-regional groupings of the UN geoscheme for Africa. In East Africa, Mozambique is placed first, out of alphabetical order, to highlight its progress and challenges, in recognition of its role in hosting the Mine Ban Treaty First Meeting of States Parties in 1999 and Third Review Conference in 2014.

## Mozambique

Since monitoring began in 1999, most mine/ERW survivors in Mozambique have lacked access to victim assistance services of all kinds. The majority of survivors live far from where services are located and lack affordable transportation. There is also insufficient knowledge among survivors about the limited services that are available in provincial capitals. Thirty years of armed conflict damaged or destroyed some 40% of Mozambique's medical facilities; the rebuilding of facilities, particularly outside of major urban centers, has been slow. Since 2005, there have been some improvements in the availability of medical care in rural areas and six rehabilitation centers were renovated.

By 2009, all medical and rehabilitation centers were managed by the government, many of which had previously been managed by international organizations and the Mozambique Red Cross. However, even after the government assumed responsibility for the management of rehabilitation centers, they have remained dependent on international financial assistance for prosthetic materials. Production of prostheses in all centers was suspended in 2012 as a result of a decline in international funding for these materials, and this suspension continued throughout 2013. The supply of rehabilitation services has also been limited due to a lack of trained technicians. The launching of a national training course for prosthetists and orthotists in 2009, the first of its kind in the country, was expected to improve the quality of services. Five of Mozambique's ten rehabilitation centers offer accommodation but demand has often exceeded spaces available.

Throughout the period, survivors have had almost no access to economic and social inclusion programs or psychological assistance. International and national NGOs, including the national Network for Mine Victims (RAVIM), have reached a limited number of survivors to assist them in accessing services or to provide basic economic relief or support for income-generating projects.

### *Highlighted challenges and recommendations:*

- Previous investments in training rehabilitation technicians have not yielded benefits due to a lack of raw materials for prosthetics production, leaving technicians idle and survivors and other persons with disabilities in need. **A cost effective and sustainable national system of supply and stocking of materials should be developed.**
- The National Disability Plan, which explicitly includes survivors, contains measures to increase access to services but has not been adequately implemented. **All stakeholders, including survivors' organizations, should be dedicated to operationalizing all aspects of the plan.**

## Burundi

Since 1999, Burundi has been almost completely dependent on international organizations, and some national NGOs with international support, for nearly all services relevant to victim assistance—including emergency medical response, physical rehabilitation, economic inclusion, and psychosocial support. An internal armed conflict that lasted for more than two decades and ended in 2005 left much of the country's infrastructure devastated, including the national healthcare system.

Since the end of the conflict and with the improving security situation, there have been some modest improvements in the availability of and access to some services, particularly physical rehabilitation, for mine/ERW survivors. In 2009, some international organizations began expanding beyond the capital city to bring services to rural areas. In 2010, the government of Burundi opened a new rehabilitation center supported by funding from Thailand, and the ICRC renovated an existing center in the capital. In 2012, the ICRC built a dormitory at this same center for people living outside the capital. Despite these improvements, victim assistance stakeholders did not note any major changes in the availability or accessibility of services to survivors in 2012-2013, although an increased awareness of gender issues was observed.

Psychosocial support for mine/ERW survivors has been extremely limited with programs offered intermittently by international organizations and by a national network of former combatants when funding has been available.

### *Highlighted challenges and recommendations:*

- Fees are a barrier for many survivors seeking to access physical rehabilitation services. **Solutions must be found to ensure access for those who cannot afford to pay.**
- Burundi's national victim assistance plan aims to link survivors to available services. **Government and NGO stakeholders should incorporate the plan's actions into their overall work plans.**

## Eritrea

Basic physical rehabilitation, psychosocial services, and economic inclusion have been provided through a national community-based rehabilitation (CBR) network, which the government started in 1995 and gradually expanded by 2008 to include the areas most affected by mines/ERW.

NGO and ICRC programs, and other support benefiting survivors and other persons with disabilities began to decline in 2003, decreasing significantly between 2005 and 2009. The specific impact on the availability of services due to this decrease in the number of service providers was not recorded or made public. However, in 2008 it was reported by UNICEF that victim assistance efforts had remained minimal.

As requested by the Eritrean government in 2011, international and national NGOs and UN agencies reduced or concluded their activities in the country. This left the state health system and CBR network as the providers of all services for mine/ERW survivors, together with the national disabled veterans association.

### *Highlighted challenges and recommendations:*

- Better skilled health personnel are needed, particularly in remote areas, while emergency medical response time and follow-up care also require improvements. **Training in healthcare and logistics should be organized.**
- Access to education remained a challenge for survivors and psychological support for survivors needs to be further strengthened. **Networks of persons with disabilities and disabled veterans should be supported in increasing assistance in these areas.**

## Ethiopia

There has been an overall, gradual increase in the availability of services in rural and remote areas of Ethiopia since 1999. However, many survivors and other persons with disabilities continue to live in poverty and far from existing facilities, which prevents them from accessing these services.

Improvements have been made in healthcare coverage and emergency response through long-term health sector development plans linked to Ethiopia's poverty reduction strategy. However, the availability of physical rehabilitation remains limited in some regions and services are still concentrated in urban areas. Most service users, particularly persons with disabilities living in rural areas, have difficulty in getting to physical rehabilitation centers. Improvements in the quality and accessibility of physical rehabilitation services were reported since 2009, though challenges in accessibility remain. Ethiopia has continued to build three new rehabilitation centers to address the shortage of coverage for rehabilitation and prosthetic devices.

Economic inclusion opportunities were significantly reduced in 2009 due to the closure of Landmine Survivors Network/Survivor Corps Ethiopia. Psychosocial support and economic reintegration services are rarely available and are inadequate to address the needs of mine/ERW survivors and other persons with disabilities.

### *Highlighted challenges and recommendations:*

- Demand for mobility devices is greater than what is available. **The number of prosthetic and orthotic centers should be increased to cover all regions and existing outreach programs should be expanded, including by incorporating peer support referrals.**
- Opportunities for work and vocational training services are needed for survivors and other persons with disabilities. **More economic inclusion programs should be developed and existing training centers should offer physically accessible premises.**

## Somalia

The Mine Ban Treaty entered into force for Somalia in October 2012, at which time there was no victim assistance program and very few services available, even in the capital, Mogadishu. Since 1999, there have been minimal services to address the needs of mine/ERW survivors in Somalia. There is a lack of adequate rehabilitation services and facilities, qualified medical practitioners, and social inclusion programs for persons with disabilities throughout the country. There is also an insufficient availability of mobility and other assistive devices; locations where they have been available have been difficult to reach due to conflict and poverty. Persons with disabilities, including survivors, also have few to no economic inclusion opportunities. In 2013, survivors in Mogadishu reported that they still did not have access to healthcare, education, or employment opportunities.

Ongoing conflict has eroded the minimal health resources available. The ICRC provides essential support to the two hospitals in Mogadishu where most conflict casualties are treated. Physical rehabilitation centers run by the Somali Red Crescent Society operate in Mogadishu, Galkayo (Puntland), and Hargeisa (Somaliland). The ICRC and a few NGOs offered livelihood-support or vocational training for persons with disabilities including mine/ERW survivors. There is almost no psychosocial support, despite a dire need for such services.

**Highlighted challenges and recommendations:**

- Somalia lacks coordination and planning of victim assistance for mine/ERW survivors, including health and disability services. **Establishing such coordination should be a priority for the government and one that is supported by the international community.**
- An extensive survey of mine/ERW survivors in Mogadishu demonstrated a significant need for work and training opportunities for economic inclusion. **Opportunities for training should be introduced, where possible by connecting survivors with existing vocational and business training for persons with disabilities, while expanding those services.**

**South Sudan**

As a result of decades of conflict, since 1999, mine/ERW survivors in South Sudan have lacked basic services of all kinds. The limited services available have been almost entirely provided by international organizations. Throughout the period, emergency medical care has been inadequate to address the needs of mine/ERW survivors and others wounded as a result of the armed conflict, a situation worsened by the high number of casualties caused by the outbreak of violence at the end of 2013. Ongoing medical care reaches just a fraction of the population.

Despite the very challenging security situation, there have been some improvements in the availability of physical rehabilitation for mine/ERW survivors. In 1999, South Sudan had just one physical rehabilitation center, in the capital Juba. In 2003, an additional rehabilitation center at the Rumbek Regional Hospital was opened with support from an international organization. By the end of 2010, the regional government assumed full management of the center. In 2008, the ICRC introduced a physical rehabilitation training program at the Juba rehabilitation center and by 2009 it had been upgraded to a Rehabilitation Referral Center.

From 1999, there were little to no economic inclusion initiatives for mine/ERW survivors, a situation that improved somewhat with increased international funding for victim assistance from 2007 to mid-2012. These programs were implemented by national organizations, including disabled persons' organizations and coordinated by the national mine action center with support from the UN, within the framework of the National Victim Assistance Strategic Framework 2007–2011. However, these programs were insufficient to meet demand and they ended in mid-2012 when international funding ceased. Psychological support for mine/ERW survivors is entirely absent in South Sudan.

**Highlighted challenges and recommendations:**

- Victim assistance projects funded through the UN and implemented by national and local organizations, including survivor associations, closed in June 2012, significantly reducing economic inclusion opportunities for mine/ERW survivors and other persons with disabilities. **Any existing mainstream economic inclusion programs should be adapted to include survivors and persons with disabilities, and programs should be expanded in line with the significant demand.**

**Uganda**

In 1999, most services used by mine/ERW survivors were provided by international organizations responding to the needs of thousands of internally displaced persons (IDPs) and refugees based in northern Uganda. Services were mainly limited to emergency medical care, trauma response, and physical rehabilitation. Most of these were free for mine/ERW survivors.

With the significant reduction in violence in northern Uganda in 2006 and progress toward peace in neighboring countries, several international organizations, including the ICRC, closed or reduced their programs in Uganda between 2008 and 2013, transferring the responsibility to provide victim assistance services to relevant government ministries. At the same time, mine survivors who were IDPs returned home to other parts of the country, increasing the need for updated surveys and expanded services in those areas. The formation of the Uganda Landmine Survivor Association (ULSA) in 2004 increased opportunities for peer support and survivor-led advocacy, though ULSA's activities have been limited due to its dependence on scarce external funding. However, ULSA has supported the development of dozens of local survivor associations in western and northern Uganda.

The departure of international programs has been only partially offset by some additional programs being offered by the government and national NGOs to attempt to fill gaps. Physical rehabilitation has been most affected with marked decreases in availability and decline in quality of prosthetics; just a small percentage of all persons with disabilities in need of assistive devices receive services. There are also gaps in economic inclusion and psychological support as well as the means to access services. As a result, there are more survivors in need of services currently than there had been in 1999.

Some improvements were seen in the physical accessibility of public and private buildings and infrastructure, as a result of national standards developed in 2010.

### Highlighted challenges and recommendations:

- The quality of physical rehabilitation declined with the withdrawal of international support. **The government should strengthen its ability to manage the rehabilitation program effectively, including its capacity to procure adequate materials and equipment.**
- Accessibility standards have great potential to improve survivors' access to services. **The Uganda Building Control law should be implemented and resources dedicated to its enforcement.**

## Zimbabwe

Most mine/ERW survivors live in rural areas with poor access to services, particularly rehabilitation facilities, which are largely located in urban centers. To ensure prosthetics are available, the ICRC Special Fund for the Disabled (SFD) continues to provide materials, technical support, and management training to three rehabilitation centers, while government funding for materials and components has been progressively increasing.

### Highlighted challenges and recommendations:

- A long-term strategy to build the capacity of human resources is needed to ensure continuity of services and retain staff. **Partnerships with regional and international bodies that provide assistance with training and management should be developed.**
- Old and unreliable ambulances must travel long distances from the minefields to the hospitals. **Strategically planned improvement of emergency transportation measures is needed.**
- Rehabilitation services are normally found at provincial and district levels and absent at the community level; there is also a shortage of transport to rehabilitation centers. **Decentralization of rehabilitation services, where possible, as well as community outreach programs and transport programs should be developed.**

## Northern Africa

### Victim assistance process indicators

State Party	Mine Ban Treaty	All known survivors	Coordination	Plan	Needs assessment
Algeria	1 April 2002	3,551	Interministerial Committee	National Victim Assistance Plan finalized in 2014, pending government approval	2011–2012
Sudan	1 April 2004	At least 1,321	Victim Assistance Working Group; Victim assistance/disability coordination working group in Darfur (disability coordination)	No active plan; previous plan expired 2011	Ongoing; 2012 in Darfur

## Algeria

Since 1999, Algeria has provided emergency and continuing medical care without cost for mine/ERW survivors and other vulnerable groups. In 2001, international organizations began to increase the availability and improve the quality and capacity of rehabilitation services. By 2009, this support had ended and all rehabilitation programs were managed by the Ministry of Health. In 2012, the government improved access to rehabilitation for survivors and other persons with disabilities by establishing a program to cover the costs of these services.

While registered survivors and the family members of victims have been entitled to a small pension during the reporting period, civilian survivors and families often protested that pensions were insufficient to cover basic costs. Pensions for military victims have generally been higher. In 2004, government programs for persons with disabilities began offering economic inclusion opportunities, but unemployment remained high among all persons with disabilities over the decade, including for mine



survivors. Since 1999, international and national NGOs have offered a limited number of micro-credit projects for mine/ERW survivors and other persons with disabilities. The largest gaps are in availability of psychological support; the limited assistance available in this area has mainly been provided by international organizations and local survivor associations.

Mine/ERW survivors must be registered with the government in order to receive a range of benefits, including healthcare, rehabilitation, and pensions. However, the estimated number of survivors is significantly higher than the number registered.

**Highlighted challenges and recommendations:**

- Psychosocial support is not widely available and the limited support available is not sustainable. **Accessible and sustainable state-managed psychological support should be developed in conjunction with complementary NGO-operated services.**
- Bureaucratic and administrative barriers prevent some survivors from accessing benefits to which they are entitled. **Survivors should receive assistance in registering, as needed, to ensure full access to these benefits.**

**Sudan**

Assistance for landmine survivors in Sudan has been irregular and insufficient to address the size of the problem since 1999, in large part due to years of conflict that have seriously damaged infrastructure. However, in that time there have been some improvements in physical rehabilitation and economic inclusion.

With support from the ICRC, the National Authority for Prosthetic and Orthotics (NAPO) grew Sudan’s rehabilitation capacity from a single rehabilitation center, in Khartoum, to a total of six satellite centers and mobile units by 2009. However, reduced funding to NAPO from 2007 to 2010 decreased the supply of raw materials and created long waiting periods. In 1999, there were few to no economic inclusion initiatives or psychosocial support for mine survivors available; the situation improved significantly with increased international funding for relevant projects from 2007–2012.

From 2011 through 2013, poor security conditions in Sudan’s southern states and the Darfur region prevented survivors from accessing services. The establishment of a victim assistance program as part of the African Union/UN hybrid operation in Darfur in 2012 increased economic inclusion opportunities for both survivors and other persons with disabilities there.

**Highlighted challenges and recommendations:**

- International funding for economic inclusion initiative and psychological support for survivors in Sudan (outside of Darfur) has declined and has not been offset by other government-funded programs, decreasing services available to survivors. **Existing mainstream economic inclusion initiatives and psychological support should be expanded and efforts should be made to ensure that survivors and other persons with disabilities have access.**
- Recent UN surveying in Darfur has identified many unmet needs among survivors and other persons with disabilities. **Darfur should receive particular attention to ensure that these needs are addressed in a coordinated manner because of the absence of both government and international support there to date.**

**Western Africa**

**Victim assistance process indicators**

State Party	Mine Ban Treaty	All known Survivors	Coordination	Plan	Needs assessment
Guinea-Bissau	1 November 2001	1,405 recorded	National Mine Action Center (CAAMI)	National Victim Assistance Strategy	None
Senegal	1 March 1999	At least 636	Casamance Regional Coordination Committee	National Victim Assistance Action Plan 2010–2014	2009



## Guinea-Bissau

Abject poverty and the near total lack of the most basic services have prevented most survivors from getting any of the assistance they needed in the period since 1999. There are few facilities near mine-affected areas and there is a lack of basic infrastructure such as roads and public transportation, including emergency transportation. Aside from the opening of a rehabilitation center with support from the ICRC in the capital in 2011 (the only one in the country), there has been little progress overall in improving assistance to survivors in Guinea-Bissau in recent years due to political turmoil and a lack of funds and of government support. The rehabilitation center, managed by the Ministry of Health, increased the accessibility of its services by establishing an outreach service in 2013.

### Highlighted challenges and recommendations:

- International cooperation for post-conflict reconstruction and political stabilization efforts remain critical to establishing an environment where services and programs for survivors can be developed and sustained. **These broader programs must reach the most vulnerable members of society including survivors and other persons with disabilities.**

## Senegal

In Senegal's Casamance region, where most survivors live, services are much more limited than elsewhere in the country. Years of conflict and continued intermittent violence devastated infrastructure and has prevented access to services. Aside from healthcare, since 1999, the government has relied on international and national NGOs, including the Senegalese Association of Mine Victims (ASVM), to assist survivors.

Evacuation of injured victims has consistently been a challenge and follow-up medical care has been limited, though the availability of free follow-up medical care and physical rehabilitation improved at the Ziguinchor Regional Hospital (CRAO) in 2013. Psychosocial support has been provided by ASVM and the Kenya Psychiatric Center. However, the support of the national mine action center for their outreach services was cut in 2012. The Kenya Psychiatric Center had been the only facility providing psychological support to mine survivors and other persons with disabilities for all regions of Casamance.

Throughout the period, economic inclusion and education opportunities remained inadequate to meet the needs of survivors. There were few programs targeting survivors and they had difficulties accessing broader programs open to all vulnerable groups. Military survivors supported by the Ministry of Armed Forces received significantly better services than civilian survivors and other persons with disabilities.

### Highlighted challenges and recommendations:

- Government support played an important role in helping survivors reach existing services, including psychosocial support. **Such outreach services should be sustained.**
- NGOs and the national survivor network, in particular, play an important role in facilitating access to services through referrals and transportation, but they lack sustainable funding. **Cost-effective referral programs should be supported as a means to overcome obstacles survivors face in reaching services.**

## Central Africa

### Victim assistance process indicators

State Party	Mine Ban Treaty	All known Survivors	Coordination	Plan	Needs assessment
Angola	1 January 2003	At least 4,770	Sub-Commission for Assistance and Reintegration	Comprehensive National Victim Assistance Action Plan 2013–2017	Launched 2010, still underway in 2013
Chad	1 November 1999	At least 1,600	Directorate of Awareness and Victim Assistance	2012–2014 National Plan of Action on Victim Assistance	None
Democratic Republic of Congo (DRC)	1 November 2002	1,401 recorded	Working Group on Victim Assistance	National Strategic Plan for Assistance to Mine Victims 2010–2011	2011

## Angola

In 1999, Angola was still in the midst of a series of armed conflicts that did not end until 2002. These conflicts contributed to the destruction or deterioration of infrastructure such as health centers, hospitals, and roads. While several international organizations provided basic services such as emergency medical care and physical rehabilitation, overall care was grossly inadequate throughout the country.

In 2002, it was estimated that fewer than 30% of Angolans had access to any healthcare services, with lower percentages in rural areas where most survivors lived. With the stabilization of the security situation, the government and international community began investing in rebuilding the healthcare system and other basic infrastructure, increasing access to basic medical facilities. A government project, begun in 2012, facilitated emergency medical transport to hospitals in collaboration with the police and fire department.

In 2005, international organizations began closing their programs and transferring management of healthcare facilities and rehabilitation centers to the government. By 2008, all 11 physical rehabilitation centers were managed by the Ministry of Health. However, by 2009 production of prosthetics in all centers had declined due to a lack of materials and unpaid staff salaries. This decline continued until mid-2013 when the national mine action center began efforts to improve the quality of services in five provinces, funded by the Ministry of Health's National Rehabilitation Program.

A limited number of economic inclusion projects have been available to survivors over the period, either through international organizations, national and local organizations of persons with disabilities, or government agencies such as the Ministry of Assistance and Social Reintegration (MINARS) and the national mine action center. These projects have fallen far short of the overall need.

### *Highlighted challenges and recommendations:*

- The production of prosthetics in physical rehabilitation centers has declined under government management due to a lack of investment in the centers. **An effective national strategy should be developed to sustain the operation of rehabilitation centers.**
- Few survivors have had access to economic inclusion programs and psychosocial support. **Greater efforts should be made to facilitate access to existing programs for survivors and develop additional ones.**

## Chad

Services for mine/ERW survivors in Chad have been hampered by intermittent internal conflict and cross-border conflicts, as well as serious under-funding since 1999. To access most services, many survivors still must be transferred to N'Djamena where the existing facilities are located; however, these facilities are very inadequate in comparison to the needs. Rehabilitation has been limited to just two centers whose services are not free of charge, unless covered by the ICRC.

There is a persistent lack of physiotherapists and trained service providers; none work in mine-affected areas. The government operates few programs focused on education, employment, and rehabilitation for persons with disabilities. There have been no notable changes in the accessibility, availability, or quality of victim assistance services in Chad since 1999.

### *Highlighted challenges and recommendations:*

- There remains an overall need to establish services and capacities outside N'Djamena. **Service providers need to be identified, trained, and mobilized to improve accessibility to victim assistance services in all areas of Chad, and especially in remote and affected areas such as the northern part of the country.**
- Psychosocial support, vocational training, and economic reintegration opportunities for survivors and persons with disabilities are extremely limited. **A network of actors within the affected communities should be developed to provide psychological support and information on available services to survivors.**

## Democratic Republic of Congo

Since 1999, most survivors and other persons with disabilities in the DRC have remained unable to access services. The size of the country, combined with armed violence, the lack of transportation, lack of infrastructure, and the financial cost of obtaining assistance all have made it difficult for survivors to access the limited number of services, which are available only in major cities.

Armed violence increased the demands on services at the same time that some NGOs faced funding difficulties. Most services have been provided by NGOs. The physical rehabilitation sector is under-resourced and there were few functioning centers. Opportunities for psychological assistance are limited to ad hoc projects carried out by NGOs and survivor groups .

In 2012, the number of projects providing services to survivors increased and there were encouraging improvements in the availability and quality of victim assistance services in DRC in the fields of economic inclusion, physical rehabilitation, and psychological support. However, a number of such projects only received funding for one year and ended when they were unable to secure other sources of support.

**Highlighted challenges and recommendations:**

- Available physical rehabilitation and psychosocial services are inadequate to meet the needs of mine/ERW survivors. **Increased resources to the sector are needed to expand the availability of these services.**
- Many victim-assistance NGOs depend almost entirely on irregular international funding channeled through the mine action sector which has resulted in a lack of sustainability. **Projects providing small grants for income-generating and collective enterprise activities that have proved successful and appropriate to the needs of survivors, with a focus on local market realities and sustainability, should be supported.**
- The availability of physical rehabilitation and psychosocial services required significant improvements. **Increased resources to the sector and strategic planning are needed for establishing these services.**

## Survivor inclusion and participation in Africa

Survivor leaders and networks of survivors in Africa have a long history of participation in the universalization and implementation of the Mine Ban Treaty. Survivor leaders from Mozambique were active in the First Meeting of States Parties to the Mine Ban Treaty in Maputo in 1999. Five years later, the first global survivors' summit was held in Africa, in conjunction with the First Review Conference in Nairobi. Strong leadership among survivors in several African countries has ensured ongoing mobilization and advocacy by survivors for improved access to services and programs and the realization of the rights of survivors and other persons with disabilities.

Among the 15 African States Parties to the Mine Ban Treaty with significant numbers of survivors, all of those that have had victim assistance coordination mechanisms for at least some of the time since 1999 have included survivors as a member of these mechanisms when they have been active: Algeria, Angola, Burundi, DRC, Senegal, South Sudan, Sudan, and Uganda. In these countries, survivors have been involved in developing national plans and, in some cases (Angola and Uganda), monitoring and assessing the impact of plans once they were in place.

In South Sudan, Sudan, and Uganda, survivors have also participated in the coordination of disability issues in addition to their participation in victim assistance coordination. In Sudan, a landmine survivor leader later joined the government's national disability council. In Uganda, survivors have also been represented on the national CBR steering committee.

In Mozambique, where there has been no coordination mechanism specifically for victim assistance, survivors have been represented by disabled persons' organizations in the national disability council. They have also had direct participation in the evaluation of the national disability plan and the development of a specific component related to the needs of survivors in the disability plan that was approved in 2012. In Ethiopia, some organizations of disabled veterans and umbrella groups of persons with physical disabilities that participate in coordination bodies have survivors among their memberships. In Chad, where victim assistance coordination has been very irregular, survivors have been included in a national rehabilitation network that was formed in 2012.

In the remaining four countries—Eritrea, Guinea-Bissau, Somalia, and Zimbabwe—there are no coordinating bodies in which survivors could participate.

Even among countries with regular survivor participation, this participation has not always been strong or effective, often due to a lack of resources for survivor representation or a lack of capacity among survivor associations and networks. In just two countries--Senegal and South Sudan--survivor networks have received some limited support from mine action programs or other government bodies to strengthen their capacity. International funding and technical assistance have been the main source of support for survivors' NGOs and networks, particularly through the now-closed Landmine Survivors Network (later known as Survivor Corps), Handicap International, and the ICBL.

In 12 of the 15 African States Parties, survivors have participated in the implementation of the treaty. Survivors provided peer and other psychological support in Algeria, Burundi, DRC, Ethiopia, Mozambique, Senegal, South Sudan, Sudan, and Uganda. Survivors have designed and implemented economic inclusion programs in Algeria, Burundi, Ethiopia, Senegal, South Sudan, Sudan, and Uganda. In several countries, including Chad, DRC, and Mozambique, survivors have worked as prosthetists, drawing from their own experiences to provide appropriate care. Survivors have also been involved in needs assessments and referral programs in Algeria, Angola, Mozambique, Sudan, and Uganda. No information is available about the involvement of survivors in the implementation of services in Guinea-Bissau, Somalia, or Zimbabwe.

#### ***Survivor participation challenges and recommendations in the region:***

- Survivors participate most effectively in coordination and decision-making bodies when they are able to represent the views of a wider group of persons with disabilities, war victims, or other relevant groups. **International donors and national governments should invest in the capacity of survivor leaders and networks to be equal partners and experts in coordination bodies.**
- The involvement of survivors in the design and implementation of programs that benefit them is important to ensure that these programs meet the particular needs of all survivors. **Survivors interested in these types of work should have training and educational opportunities to facilitate that involvement.**

## **International cooperation and national support**

During the period since 1999, services to meet the needs of mine/ERW survivors in all 15 of the States Parties with significant numbers of survivors in Africa have relied at least to some extent on international funding and technical assistance. International cooperation has included funding for national budgets and dedicated victim assistance projects as well as support from international organizations and international NGOs to fill gaps in existing services. Currently Burundi, Chad, Guinea-Bissau, and South Sudan are still almost entirely reliant on this support for a range of services and programs for survivors and others with similar needs. In countries such as Ethiopia, Mozambique, Senegal, and Uganda, a decrease in international support since 1999 has been at least partially replaced by national resources. In Algeria, Angola, Eritrea, and Sudan (with the exception of Darfur), the cessation of international cooperation has resulted in most services, to the extent that they are available, being provided through government ministries with national resources.

#### ***Remaining resource challenges in the region:***

- In Angola, Mozambique and Uganda, the ending of international funding and technical assistance for physical rehabilitation has resulted in decreases in the availability and quality of services, often due to the insufficient supply of raw materials or a lack of experience among national technicians. In all three countries, increased resources are needed to sustain these services, which are often a critical first step for survivors' full inclusion in their community.
- In DRC and South Sudan, dedicated international victim assistance funding for socio-economic inclusion projects implemented by local and national NGOs provided much needed support for mine/ERW survivors and other vulnerable groups with similar needs. These projects should be restarted with both international and national support.
- Government support for outreach services, including psychosocial support, in Senegal's Casamance region helped to overcome access challenges that many survivors face and should be re-started and sustained.
- In Ethiopia and Mozambique, national disability plans seek to improve efforts to address the needs of all persons with disabilities, including mine/ERW survivors. In Burundi, the national victim assistance plan shares this same goal. All three plans require that the necessary funding be allocated to ensure their full implementation.

## **Other states and areas in Africa**

There are significant numbers of survivors living in two states not party to the Mine Ban Treaty, Egypt and Libya, and one other area, Western Sahara.

In Egypt, survivors have been vocal over the years calling for greater support and recognition of their rights. Since 2005, victim assistance activities for the governorate of Matruh have been overseen by the National Committee for Supervising the Demining of the North West Coast, including the registration of survivors for a pension and physical rehabilitation. International organizations such as the UN Development Programme (UNDP) also worked with local NGOs to assist survivors.

Libya has not had any specific victim assistance coordination since 1999, though survivors have always had free access to basic healthcare and rehabilitation. When these services were interrupted by the armed conflict that started in 2011, international support temporarily increased to replace some services. At least through the end of 2012, the new Libyan government indicated that it was not yet in a position to consider planning or coordinating efforts to ensure that all needs of survivors are addressed.

While Western Sahara cannot join the Mine Ban Treaty, the Polisario government signed Geneva Call's "Deed of Commitment" in 2005 that obliges them to support humanitarian mine action activities such as victim assistance, among other commitments. It has also worked together with international and local NGOs, including a national survivor network, to find ways to address the significant needs of Saharawi survivors. In 2013, Polisario authorities committed to develop legislation to protect the rights of survivors and other persons with disabilities.

## Development and disability indicators

Development indicators have been presented in victim assistance reporting since 2006, when it was found from Landmine Monitor reporting on 24 States Parties, that:

*There appears to be a relationship between a country's Human Development Index (HDI) ranking and the provision of emergency and continuing medical care. States Parties with higher HDI rankings tend to have better emergency and continuing medical care, while countries that are underdeveloped continue to struggle to meet the basic needs of the population as a whole, including people with disabilities and, among them, landmine survivors.*

ICBL, *Landmine Victim Assistance in 2006: Overview of the Situation in 24 States Parties*, published by Standing Tall on behalf of the ICBL Working Group on Victim Assistance, 3rd Edition, April 2007, p. 12, [victimassistance.files.wordpress.com/2014/06/landminevic2006.pdf](http://victimassistance.files.wordpress.com/2014/06/landminevic2006.pdf).

Relevant development indicators for the period of the Mine Ban Treaty Nairobi Action Plan (2005-2009) can be found in country chapters examining progress in victim assistance in 26 States Parties in *Voices from the Ground: Landmine and Explosive Remnants of War Survivors Speak Out on Victim Assistance*, Handicap International (Brussels -September 2009), [reliefweb.int/sites/reliefweb.int/files/resources/778DB75940854604492576450012486A-Full\\_Report.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/778DB75940854604492576450012486A-Full_Report.pdf).

State Party	Disability rights		Health expenditure Total % of GDP					Physicians per 1,000 people
	CRPD	Regional Mechanism	1999 Baseline	2009	2010	2011	2012	2007-2012
Algeria	4 December 2009	Continental Plan of Action for the African Decade of Persons With Disabilities 2010-2019	<u>3.4</u>	4.6	4.2	4.4	5.2	1.2
Angola	19 May 2014		<u>4.1</u>	4.4	3.4	3.4	3.5	0.2
Burundi	22 May 2014		<u>5.6</u>	7	8.8	9	8.1	N/A
Chad	Signed		<u>5.9</u>	4.5	4	2.8	2.8	N/A
DRC	No		<u>4.2</u>	9.1	7	6.1	5.6	N/A
Eritrea	No		<u>4.7</u>	3.1	3.2	2.7	2.6	N/A
Ethiopia	7 July 2010		<u>3.9</u>	4.5	4.7	4.1	3.8	0.0
Guinea-Bissau	Signed		<u>5.8</u>	6.8	7.1	6.3	5.9	0.0
Mozambique	30 January 2012		<u>5.3</u>	6	5.7	6.4	6.4	0.0
Senegal	7 September 2010		<u>4.5</u>	4.8	4.8	5	5	0.1
Somalia	No		<u>N/A</u>	N/A	N/A	N/A	N/A	0.0
South Sudan	No		<u>N/A</u>	2.4	2.1	1.7	2.6	N/A
Sudan	24 April 2009		<u>3.8</u>	7.4	6.5	6.7	7.2	0.3
Uganda	25 September 2008		<u>6.7</u>	9.3	9.2	9.3	8	0.1
Zimbabwe	29 September 2013	<u>N/A</u>	N/A	N/A	N/A	N/A	0.1	

State Party	ILO 159	Human Development Index Rank 2012	IHDI value 2012	Health expenditure Per capita (US Dollars) 1999 Baseline, 2009–2012					Out-of-pocket payments as a % of health spending
				<u>\$53</u>	\$174	\$181	\$233	\$279	
Algeria	No	93/187	N/A	<u>\$53</u>	\$174	\$181	\$233	\$279	15.0
Angola	No	148/187	0.285	<u>\$19</u>	\$174	\$144	\$178	\$190	26.7
Burundi	No	178/187	N/A	<u>\$7</u>	\$14	\$19	\$21	\$20	28.3
Chad	No	184/187	0.203	<u>\$11</u>	\$28	\$29	\$25	\$25	66.4
DRC	No	186/187	0.183	<u>\$12</u>	\$17	\$15	\$15	\$15	32.5
Eritrea	No	181/187	N/A	<u>\$8</u>	\$10	\$12	\$12	\$15	52.5
Ethiopia	28 January 1991	173/187	0.269	<u>\$4</u>	\$15	\$14	\$14	\$18	41.2
Guinea-Bissau	No	176/187	0.213	<u>\$10</u>	\$36	\$38	\$35	\$30	43.2
Mozambique	No	185/187	0.22	<u>\$13</u>	\$25	\$22	\$33	\$37	5.0
Senegal	No	154/187	0.315	<u>\$24</u>	\$49	\$48	\$54	\$51	34.1
Somalia	No	N/A/187	N/A	<u>N/A</u>	N/A	N/A	N/A	N/A	N/A
South Sudan	No	N/A/187	N/A	<u>N/A</u>	\$30	\$32	\$32	\$27	56.7
Sudan	No	171/187	N/A	<u>\$15</u>	\$112	\$119	\$119	\$115	73.7
Uganda	27 March 1990	161/187	0.303	<u>\$16</u>	\$42	\$43	\$41	\$44	49.3
Zimbabwe	27 August 1998	172/187	0.284	<u>N/A</u>	N/A	N/A	N/A	N/A	N/A

Notes: "State Party" refers to those states that have ratified or acceded to the Mine Ban Treaty. "CRPD" is the Convention on the Rights of Persons with Disabilities. Statistics on health expenditure as a total percent of the gross domestic product are compiled by the World Bank and are available at: <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>. Physicians per 1,000 people: <http://wdi.worldbank.org/table/2.15>. "ILO 159" is the International Labor Organization's Convention on Vocational Rehabilitation and Employment of Persons with Disabilities (1983) [http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:11300:0::NO::P11300\\_INSTRUMENT\\_ID:312304](http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:11300:0::NO::P11300_INSTRUMENT_ID:312304). The "IHDI" Inequality-adjusted Human Development Index is a measure of the level of human development of people in a society that accounts for inequality. Lower index numbers and rankings (out of 187) indicate a lower level of human development. It is published by the United Nations Development Programme at: [data.undp.org/dataset/Table-3-Inequality-adjusted-Human-Development-Inde/9jnv-7hyp](http://data.undp.org/dataset/Table-3-Inequality-adjusted-Human-Development-Inde/9jnv-7hyp). Health Expenditure per capita in current US\$: <http://data.worldbank.org/indicator/SH.XPD.PCAP/countries>. Out-of-pocket payments as a percentage of health spending: <http://wdi.worldbank.org/table/2.15>.