Mozambique Programme
Research collection

Shattered Dreams

Living conditions, needs and capacities of mines and Explosive Remnants of War survivors in Mozambique

October 2013

Ravim
Rede para Assistência às vítimas de Minas

HANDICAP INTERNATIONAL

Technical team

Data collected by: André Lucas Nhamajabo, Bernardete Marangabassa, Samuel Tauzene, Dinéria da Telma Armando, João António Chaúque, Mário Eugénio Júnior, Samuel Eugénio Sarange, Saquina Cossa
Drivers: Fernando Luis, Moisés Sono, Fernando Alberto
Assessment supervisors: Saskia Schoolland, Luis Wamusse (RAVIM)
Data entry: Acacio Julio Mugunhe, Adelaide de Jesus Nhamtumbo Tembe, Jorge Mário Binguane
Statistical analyses: Acacio Julio Mugunhe and Sergio Ndimande
Technical support: Elke Hottentot, Technical Advisor on Victim Assistance
Aude Brus, Technical studies and researches coordinator
Operational and logistic support: Demining team of Handicap International Mozambique

Publication

Author: Saskia Schoolland
Reading Group: Yann Faivre, Robert Burny, Elke Hottentot, Aude Brus
Editing: Elodie Finel, Knowledge Management, Handicap International Mozambique
Proofreading: Neal Nixon
Graphic design and layout: Vincent Caudry, Image In
Creation based on the visual identity of the Federation Publications of Handicap International **IC&K, Frédérick Dubouchet e Maude Cucinotta**
Photo credits: Aderito Ismael, Elodie Finel and Saskia Schoolland

The full report of the assessment is available on request:
Handicap International Mozambique
Address: Av. Agostinho Neto #49, C.P. 4331 Maputo Mozambique
Tel: +258 21 486 298 - Email info@hi-moz.org
and on the Internet: www.hi-moz.org/download/FullStudyVA.pdf

The electronic version of this publication can also be downloaded
in English: www.hi-moz.org/download/ShatteredDreams.pdf
and in Portuguese: www.hi-moz.org/download/SonhosDespedacados.pdf

Australian Government
AusAID

Ministry of Foreign Affairs of the Netherlands

HANDICAP INTERNATIONAL

UNDP

UN Partnership to Promote the Rights of Persons with Disabilities
ILO | OHCHR| UNDESA | UNDP | UNICEF | WHO

Ravim
Rede para Assistência às vítimas de Minas

CONTENTS

ACKNOWLEDGEMENTS

This report is for André, Thiago, Tina, dona Maria, Alfredo, Bernardo, Manuel, Domingos and all those who lost their dreams while stepping on a landmine. It caught them by surprise and it changed their lives dramatically. Most of them were still young when it happened in the context of a civil war. Even though for many the accident happened 20 years ago, it still feels as if it was yesterday and most of them did not receive the right support or means to walk on their own feet. Being interviewed for the assessment often presented the first time anyone from outside the community bore witness to the trauma that had besieged them. The acknowledgement that they do exist and that somebody cares about their suffering touched them. The research team sincerely hopes that their needs will be translated into concrete action and access to services, to improve their quality of life and full and ample participation into society. The assessment was implemented with support from the Australian Government (AusAID), the UN Partnership to Promote the Rights of Persons with Disabilities (UNPRDP) and the Dutch Ministry of Foreign Affairs, to whom we would like to express our sincere thanks. Our gratitude goes to the local interviewers who had to travel long distances to identify the survivors and who collected and listened to their stories with empathy. Our appreciation goes out to the national and provincial authorities, administrative posts at district level, the community leaders and the guides who facilitated the implementation of the assessment and helped to identify the survivors. Most of all however, our deepest respect for the creativity and strength of the survivors to cope under adverse circumstances.

"This is the first time somebody comes to see me because of what happened, and it happened 21 years ago. Thank you for acknowledging me. I am glad the government is taking our situation in consideration, even for an old woman like me."

FOREWORD

Mozambique went through almost 30 years of wars, during which landmines were placed throughout the country. 10 years fighting colonialism (1964-1974) and after a short period of peace, armed violence started again in the centre of Mozambique evolving into a civil war for almost two decades (1976-1992). As a result of both wars, mine contamination became a nation wide issue and many people were injured or killed by mines and other Explosive Remnants of War (ERW).

In 1998, the country ratified the Mine Ban Treaty, also known as "Ottawa Treaty" and became one of its leading countries, giving priority to mine clearance operation. By 2003, Mozambique had achieved the destruction of its stockpile, and **by the end of 2014, will declare itself as "a country free of mine"**.

During the MBT Review Conferences of Nairobi (2004) and Cartagena (2009), the Mozambican Government identified Victim Assistance as its new priority. If the threat of landmine and other Explosive Remnants of War is fading as the country is being cleared, **the difficulties of Mine/ERW victims remain and demand a long-term commitment** from the main Victim Assistance stakeholders: the National Demining Institute, the Ministry of Women and Social Action, Ministry of Health, civil society and other service providers.

The Government has already demonstrated a strong commitment towards people with disabilities through the ratification of the United Nation's Convention on the Rights of Persons with Disabilities; and by implementing a global response based on their needs, setting up a National Council on Disability (CNAD), approving and implementing its multiannual and transversal National Plans of Action (PNAD).

The area of Disability is complex and multifaceted. Needs may vary from one person to another, from one context to another. The results of the Needs and Capacities Assessment of Mine/ERW victims in Mozambique, transcribed in this publication, will give a better understanding of the specific issues of this part of the population of people with disabilities. **Thus allowing the ministries involved to define and implement necessary policies to create an inclusive society in Mozambique.**

I welcome this Needs and Capacities Assessment report that will allow us to develop within a **National Action Plan for mine/ERW Victims Assistance**, specific, comprehensive and efficient answers matching their needs.

For an open and inclusive Mozambican society!

Miguel Aurélio Maússe

National Director of Social Action
Ministry of Woman and Social Action
October 2013

EXECUTIVE SUMMARY

Landmines and explosives were used during the two wars that scourged Mozambique for a period of almost 30 years. They caused many casualties, though **there is little reliable data on the total number of mine and Explosive Remnants of War (ERW) survivors** since most of the accidents are neither declared to local police stations nor reported to the National Demining Institute (IND). Mozambique is aiming to meet its obligation under article 5 of the Mine Ban Treaty to destroy all anti-personnel mines by the end of 2014, therewith the threat for more accidents and casualties has gone, but adequate responses to ensure the inclusion of survivors alive today still have to be developed. Although **Mozambique has been one of the leading countries in the Mine Ban Treaty (MBT) and the Convention on Cluster Munitions (CCM)** ratification process, political and financial **priority has been given to mine clearance operations, relegating victim assistance (VA) as a secondary issue for the past 20 years**.
Data collection, including needs assessments, is a key implementation measure under article 5 of the CCM and the Mine Ban Treaty. So far, an overall assessment of the needs of mine/ERW survivors in Mozambique had not been made. Therefore, Handicap International in close partnership with RAVIM (National Victim Assistance Network), involving, amongst others, the Ministry of Woman and Social Action (MMAS), the Ministry of Health (MISAU), the National Institute of Demining (IND) and the National Council for Disability (CNAD), conducted a assessment to be able to present **all necessary data to allow the development of a National Action Plan on Victim Assistance** in line with the National Action Plan on Disability (PNAD) to assist and ensure the rights of mine/ERW survivors amongst the larger group of people with disabilities.
The assessment was implemented from September 2012 – May 2013 within 12 districts of the provinces of Inhambane and Sofala **based upon a relevant number of mine/ERW survivors to present representative information at a national level**. A mixed approach was applied, with a quantitative part targeting mine/ERW survivors and a control group of community members of the same age and sex as the survivors to assess the relative vulnerability of mine/ERW survivors. Completed by a qualitative study aiming at mine/ERW victims (survivors and affected families) and other actors to gather additional information and opinions of persons directly or indirectly in charge of assisting survivors.
Off all mine/ERW survivors assessed, 80,1% suffered the accident during the war more than 20 years ago and 79,4% are men. One third was struck by a mine/ERW during military service, two third while carrying out daily activities. Findings of the assessment indicate that survivors living in remote rural areas tend to face a similar socio-economic situation with the general population, though being still disadvantaged. **Three out of four survivors live under the poverty line**[1], as their community members. Yet the **quality of their housing, access to basic sanitary conditions and water** is lesser and as can be expected, they face more **functional limitations** compared to community members. Although most of the time, agriculture is the only opportunity to sustain their families, they face greater **difficulties cultivating their lands, constructing their houses and taking care of themselves and their family**.

[1] The international Poverty Line is considered 1.25US$ per day by the World Bank

Most survivors work, though less than other community members of the same age and sex, due to their disabilities and the obstacles they encounter, and tend to live off a pension more frequently when compared to their peers. In terms of access to basic health care services, educational level and community participation, no significant differences were identified between both groups.

At the level of the system of services, **poor rehabilitation facilities** were encountered due to old and/or **obsolete equipment** and a lack of raw material to produce or repair assistance devices. A lot of work and investment has to be done to improve the service delivery, with parallel community-based action to increase knowledge and access of available services. A significant number of **survivors are in need of adequate assistance devices to improve their mobility**. **Few survivors have had access to basic social protections schemes** or received any kind of support to cope with the aftermath of the accident, or even work options more suited to their abilities.
Personalized Social Support strategies should be developed to assist survivors to access services. **Inclusive policies**, their mechanisms and a strong and efficient **referral system** need to be developed to assure their basic human rights that will enable them to improve their quality of life. Survivors still struggle to fully live the lives they want, even though the accident occurred a long time ago. **Psychosocial approaches** should be developed to assist them to cope with the traumatic impact of the accident to attain maximum self-reliance, self-worth and autonomy.

The government has shown its implication on disability issues. It has designed and approved national policies, law and programs to **promote the inclusion of people with disabilities**. It has also ratified the United Nation Convention on the Rights of Persons with Disabilities (UNCRPD) and acceded to its optional protocol in January 2012; to date, however, **insufficient resources have been allocated to implement these laws**. Public service providers, in general, are not aware on how to include people with disabilities. They are insufficiently prepared and equipped to remove barriers. The staff is not trained to attend the specific needs and capacities of people with disabilities. Only a few service providers maintain a database on people with disabilities amongst users and should these exist, regular updates are not made. Therefore, it is **difficult to monitor and evaluate** progress made on inclusion in these services. Clear strategies should be developed and implemented on how to **promote social inclusion and empowerment of people with disabilities and guarantee access to their rights**.
Rights of people with disabilities should be divulged on a **national level**. The capacity of **Disabled People Organisations** (DPOs) should be developed so as to defend the interest of survivors and other people with disabilities, monitor implementation of policies and develop **communication** strategies to better **promote dialogue** and **inform** their target population.

PRINCIPLES & BENCHMARKS

PRINCIPLES & BENCHMARKS

Introduction

This publication comes from the needs and capacity assessment realised by **Handicap International** in close partnership with the National Victim Assistance Network, **RAVIM**. Its objective is to present **accurate data and recommendations** on **Victim Assistance** (referred as **VA** throughout this publication) to allow the development of a **National Action Plan on Victim Assistance** to support the rights of mine/ERW survivors in Mozambique.
The results of the assessment will provide all stakeholders with the **necessary information to develop adequate responses** that can improve the quality of life of mine/ERW survivors and guarantee their rights. Although this assessment addresses the needs, capacities and socio-economic conditions of survivors alone[2], VA aims to include and support people with disabilities due to other causes as well. It is in line with the official position of the Mozambican government, which states that **the needs of survivors should be addressed within a broader disability framework**. The findings will feed the National Action Plan on VA and its activities will be inserted in existing national Policies (e.g. the PNAD).

The publication is divided in 4 chapters:

Principles and Benchmarks provides the necessary background information to understand the situation of mine/ERW victims, the context, key data, definition and legal context as well as the objectives and design of the Needs and Capacities Assessment realised.

Mine/ERW victims in Mozambique, as titled, presents the situation of Mine/ERW survivors and victims in Mozambique today, as compared to the other members of their community, through the evidence-based results of the assessment.

Needs identified by sectors, review the qualitative and quantitative results and their analysis, presented by the sectors covered in Victim Assistance (Services in general, Health, Rehabilitation, Psychosocial support, Social Protection and Standards of Living, Education, Work and Employment).

And finally, the **Recommendations for the National Action Plan of Victim Assistance** are presented as well by the same intervention sectors and intervention axis, in line with the Cartagena Action Plan and Handicap International publication **Recommendations for National Action Plans on Victim Assistance**[3], 2009, reissued in 2011 and 2013 in Portuguese.

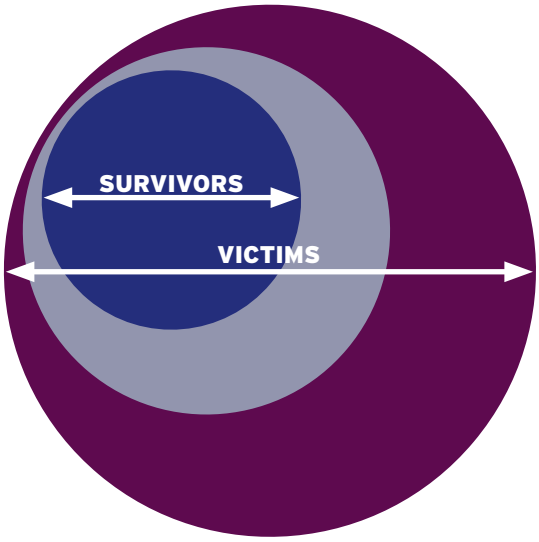
[2] This restriction of the Needs Assessment to Survivors only was decided due to the very specific context of Mozambique, with most survivors having suffered their accident over 20 years ago, and as such, face specific challenges compared to the overall population with disabilities.

[3] In Portugese: www.hiproweb.org/uploads/tx_hidrtdocs/VA_Recomendacoes_light.pdf
In English: www.hiproweb.org/uploads/tx_hidrtdocs/HI-RecommendationsEng-WEB.pdf

Key definitions

Mine/ERW Victim

As per the Convention on Cluster Munitions, the now internationally accepted definition of **victim** is: **"all persons who have been killed or suffered physical or psychological injury, economic loss, social marginalisation or substantial impairment of the realisation of their rights caused by the use of cluster munitions"**.



Mine/ERW Survivors
people who survived a mine or ERW accident.

Mine/ERW victims
(strict definition) sub-group limited to survivors and families who were directly affected by mines/ERW (including families of people who died in a mine/ERW accident).

Mine/ERW victims
(broad definition) include the three groups: survivors, victims (people directly affected by mines or ERW / families) and extended to communities affected by the presence of mines and ERW.

The group of victims is comprised of both direct and indirect, victims:

- Direct victims are people injured or killed, who are also referred to as **casualties**.
- Direct victims are also **survivors**, who are people injured by mines/ERW and who survived the accident.
- Indirect **victims** are family members of people injured or killed by mine/ERW as well as families living in mine/ERW-affected areas.

People with disabilities

As mine and ERW accidents often result in a disability due to the loss of a limb or another impairment. As such, it is important to briefly discuss Handicap International's understanding of disability. The organization defines people with disabilities as per the Disability Creation Process[4], namely as **"persons with lasting physical, mental, intellectual or sensory impairments, which, when combined with certain barriers (environmental, cultural, physical), prevent them from participating in society on the same basis as other people"**. This definition is line with the major international conventions and classifications, all of which broadly define disability not simply as an impairment, injury or illness – but rather as a complex interaction between a person's health condition and environmental or contextual factors.

A more comprehensive glossary can be found at the end of this publication, p. 81.

[4] Fougeyrollas P., Cloutier R., Bergeron H., Cote J., St-Michel G. Classification québécoise : Processus de production du handicap. Lac St Charles : Réseau International sur le Processus de Production du Handicap (RIPPH), 1998, www.ripph.qc.ca

Key data

The following section presents data in relation to disability prevalence in and policies on, as well as the victim assistance and the socio-economic context of, Mozambique.

- Landmines were laid during the two wars that raged in Mozambique for almost 30 years (peace agreement settled in 1992).

- By the time the second war was settled, Mozambique was amongst the poorest countries in the world. It had been strongly depending upon international aid for decades. This is changing and the country is developing fast.

- Yet, Mozambique still ranks amongst the ten lowest countries on the HDI[5].

- Life expectancy is 51 years (WHO, 2011).

- Gross National Income per Capita: US$510 (World Bank, 2012); the national poverty line: 1,25$ a day; the minimum salary in agriculture: 85$ a month (Governement of Mozambique, 2013).

- 30 years of armed conflict damaged or destroyed some 40% of the country's medical facilities.

- Mozambique aims to meet its obligation to destroy all anti-personnel mines under article 5 of the Mine Ban Treaty by the end of 2014.

- There is no accurate database or census available on the total number of mine/ERW survivors and people injured and killed in Mozambique.

- A national policy[6] for People with disabilities was approved in Mozambique in 1999 with the aim to mainstream disability across the public sector and policies; a national disability council (CNAD) was set-up to evaluate the first National Action Plan in the Area of Disability (PNAD 2006-2010) and to develop PNAD II (2012-2019).

- Mozambique ratified the United Nations Convention on the Rights of Persons with Disabilities and acceded to its optional Protocol on January 30th 2012.

- There is a small paragraph on VA in the National Disability Plan 2012-2019, but as of May 2012, funding to implement the plan had not been identified.

- In 2009, the first nationwide survey – performed by the Norwegian Foundation for Scientific and Industrial Research (SINTEF)[7] in partnership with the Forum of Mozambican associations of People with disabilities (FAMOD) and the National Institute of Statistics (INE) – estimated the number of people with disabilities at 6% of the population, equivalent to 1,4 million people across the country.

- This same SINTEF national survey indicated that mine and other war-related casualties were the cause of disability for 6,8% of all people with disabilities in Mozambique, making it the third cause after work and road accidents.

- RAVIM advocated and assisted mines/ERW survivors in accessing health and rehabilitation services and was involved in implementing socio-economic reintegration activities.

[5] The Human Development Index (HDI): see glossary p.81
[6] Through Resolution 20/99 of the Council of Ministers, the Government of Mozambique produced its first National Policy on Disability in the year 1999.
[7] SINTEF, FAMOD & INE, Living Conditions Among People with Disabilities in Mozambique, Oslo, 2009

Legal Framework and key dates

Within the international arena there has been a growing recognition of the rights of mine/ERW victims. Victim Assistance is an integral part of two international disarmament agreements, notably the 1997 Mine Ban Treaty[8] (MBT) and the 2008 Convention on Cluster Munitions[9] (CCM).

Table 1: Overview of ratification dates of different treaties by the government of Mozambique

YEAR	International legal framework	Mozambique
1997	Mine Ban Treaty (MBT)	Ratified on August 25, 1998
2004	1st Review Conference of the States Parties to the MBT Nairobi Action Plan (NAP)	
2006	Convention on the Rights of Persons with Disabilities (UNCRPD)	Signed in 2010, Ratified on January 30, 2012
2006	Convention on the Rights of Persons with Disabilities Optional Protocol	Acceded on January 30, 2012
2008	Convention On Cluster Munitions (CCM)	Ratified on March 14, 2011
2009	2nd Review Conference of the States Parties to the MBT Cartagena Action Plan (CAP)	
2010	1st Meeting of States Parties on CCM Vientiane Action Plan[10]	

In 1999 the **Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction, commonly referred to as the Mine Ban Treaty (MBT)** or **Ottawa Treaty** entered into force. The ultimate goal of the Convention was "to put an end to the suffering and casualties caused by anti-personnel mines, that kill or maim hundreds (...)". The treaty stipulates that all State Parties are obliged to prohibit the transfer and use of anti-personnel mines and to destroy stockpiles, to seek international cooperation and provide assistance to victims, and to ensure transparency measures.

Article 6.3 of the MBT encompasses the duty of each State Party to **provide assistance to victims of landmines**. It states "Each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programs".

[8] Full text of the Mine Ban Treaty: www.icbl.org/index.php/icbl/Treaty/MBT/Treaty-Text-in-Many-Languages/English
[9] Full text of the Convention on Cluster Munitions: www.clusterconvention.org/documents/full-text-enfres
[10] Full text of the National Action Plan of Vientiane: www.clusterconvention.org/the-convention/action-plan

Thus, VA was not an obligation on equal footing with the other pillars of mine action and lacked clarity as to whom constitutes a victim and who is finally responsible for the provision of assistance. This gap was rectified by the **Nairobi Action Plan** (NAP) in 2004. This five year plan (2005-2009) provided guidance - amongst others - on VA, and obliged all State Parties to undertake VA efforts.

Furthermore, during the **second review of Conference of the MBT** in 2009 in Cartagena, Colombia in 2009, ten years after its entry into force, State Parties adopted the **Cartagena Action Plan** (CAP). Actions related to VA implied yet again a strengthened effort on the part of State Parties to provide VA and highlighted the need to consider VA within the broader disability, human rights and development frameworks.

This evolution of VA guided the development of an even more comprehensive understanding of this pillar of mine action in the 2008 Convention on Cluster Munitions (CCM).

Although Mozambique was one of the leading countries during the Mine Ban Treaty (MBT) and the Convention on Cluster Munitions (CCM) ratification process, political and financial priority has, up until now, been given to mine clearance operations thereby relegating VA as a secondary issue for the past 20 years.

Since the first MBT Review Conference in Nairobi (2004) and the following one in Cartagena (2009), **Mozambique has identified VA as the weakest component of its mine action program and has stated the need for a stronger commitment** from national VA stakeholders, including from the National Demining Institute (IND), the Ministry of Women and Social Action (MMAS), Ministry of Health (MISAU), civil society, and from service providers.

Presentation of the Assessment

General objective

Collect all necessary data in order to assess the needs of mine/ERW survivors and allow development of a comprehensive action plan to assist and ensure the rights of victims in order to assist the Mozambican government is in taking action under action 23 and 25 of the Cartagena Action Plan.

Specific objectives

- Assess and describe the needs of mine/ERW survivors in Mozambique based upon a relevant number of mine survivors.

- Provide data on socio-economic situation (age, gender, literacy, income, economic opportunities, family, housing) as compared to local community members.

- Provide data on social participation of mine survivors within communities and their level of access towards existing services (health, rehabilitation, psychosocial support, education, professional training and social protection) as compared to local community members.

- Provide qualitative information on the emotional, social and financial loss of survivors and family of people who have been injured or killed by a mine or ERW.

- Provide qualitative information on needs, coping and survivors strategies of survivors and family of people who have been injured or killed by a mine or ERW.

- Provide information to reinforce the capacity of the DPOs dedicated to VA to negotiate the rights of mine/ERW survivors and be more involved in needs-based planning, implementation and monitoring.

Key steps

Stage 1:
Preparation of the assessment
(October 2012- February 2013)

- Development of framework and research instruments.

- Collection of relevant information on main issues (victim assistance, survivors, territory, key stakeholders and logistical preparation).

- Presentation to, and authorization of the assessment by, the territory's stakeholders: Ethical committee of the Ministry of Health, Ministry of Women and Social Action, National Demining Institute and the Permanent Secretary, provincial Directory of Health and Social Action in Inhambane and Sofala province.

- Pre-test and adaptation of the research instruments.

- Identification and training of assessment teams.

- Inform all administrative post at district level - in person- about the assessment in order for them to inform local community leaders and facilitate identification of survivors.

Stage 2:
Data-collection
(February 2013-March 2013)

- Identification of mine/ERW survivors through administrative posts, local community leaders community secretaries, survivors themselves, DPOs and Handicap International demining database.

- Quantitative questionnaire with survivors and community members (control group) to assess access to services, socio-economic situation, needs and capacities; held in their homes.

- In-depth interviews with service providers at health & rehabilitation centres, social- and educational services and NGOs active in the districts.

- Focus group discussions with survivors and family members of people injured and killed by mine/ERW about the emotional, social and financial loss following the mine/ERW accident, access to services and community participation; held at a central location.

Stage 3:
Data analysis
(April 2013 – May 2013)

- Statistical analysis of quantitative data gathered
- Analysis of interview and report of discussion groups
- Writing of the report

Stage 4:
Feedback on results
(October 2013)

- Publication of the report
- Seminar to present the results and recommendations to the stakeholders

Firewood

The accident happened on the 12th of June 1982, I was collecting firewood for my mother to cook, I was twelve and still in primary school, it was during the war. When I woke up I was in the hospital and I realized that one of my legs was missing. My father was there with me. At that stage I did not realize the impact that the accident would have on my life. At first my friends did not want to play with me anymore, I dropped out of school and felt ashamed of myself. I always wanted to work in the mines in South Africa, just like my uncle and build my own nice house and construct a family. But due to my circumstance I was not able to realize that dream, I feel limited. I started working in the fields with my family in order to contribute to the family income. Nowadays I have a wife and six children. If I would have a prosthesis, I would have both my hands free. If I also would have some cattle, I could cultivate a bigger piece of land and could make some extra money to be able to send my children to school. Now we just have enough to feed ourselves and buy soap and sugar here at the local market. I often think that if I would not have the accident, I would not be like this.

Mozambique

Landmines/ERW

Landmines were used during the two wars that scourged Mozambique for a period of almost 30 years. Mines were imported from many countries and used by different parties during these wars to maim and kill the opposite side, form barriers, create fear amongst civilians and control the movement of the population.

During the first war, fighting colonialism (1964-1974), the Portuguese army placed landmines across the northern border in order to prevent FRELIMO – Mozambican anti-Portuguese political groups- to cross the border from Tanzania. Independence was achieved in 1974. After a very short period of peace, armed violence started again in the centre of Mozambique (1976-1977), this time by the military forces of former Rhodesia. This brief scenario of foreign military aggression marked the onset of military violence that evolved into a civil war waged between the FRELIMO-led government and RENAMO soldiers for almost two decades (1976-1992). Both sides relied heavily on the use of landmines. As such, over a period of 16 years, mines were placed throughout the entire country, most directly and intensely impacting the rural population. As a result of both wars, many people were made amputees by mine/ERW; a further approximate one million people died as a result of fighting and starvation and five million civilians were displaced[11].

Victims

There is little reliable data on the total number of casualties in Mozambique since most of the accidents are neither declared to local police stations nor reported to the National Demining Institute (IND). Therefore, the total number of recorded casualties is far below the actual number.

It is known though that the number of casualties has decreased lately, as Suspected Hazardous Areas (SHAs) are better known by the population, mine contamination has reduced drastically and risk education has contributed to decreasing risk-taking behaviours.

The Landmine Monitor reported that there was a minimum of 2444 casualties registered up to 2011[12]: 20 casualties in 2009 (16 killed, 4 injured), 36 casualties in 2010 (6 killed, 27 injured, 3 unknown) and 9 in 2011 (3 killed, 6 injured). This shows that landmines and ERW are still a tragic reality, impacting the lives of civilians 20 years after the war ended[13].

[11] "Mozambique". State.gov. 4 November 2011. Retrieved 4 March 2012. - www.state.gov/r/pa/ei/bgn/7035.htm
[12] www.the-monitor.org/index.php/cp/display/region_profiles/theme/2019 - August 2013.
[13] ICBL, Landmine Monitor 2010, Ottawa, 2009.

Table 2: Overview of casualties in Mozambique reported throughout different surveys

Survey	Number of casualties
Landmine Impact Survey (2001)[14] Most comprehensive survey	2.145 casualties until 2001 (no breakdown of those killed or injured)
IND registered	299 casualties between 2002 and 2011 (80 killed; 216 injured; 3 unknown)
RAVIM (2009)	542 survivors in the province of Maputo
HI Demining team (2010)	323 survivors in 12 districts of Inhambane and Sofala provinces
SINTEF national survey on Disability (2009)	Mine and war casualties accounted for 6,8% of cause of disability in Mozambique (2009)[15]

Victims assistance

Tremendous progress has been made in the clearance of mine/ERWs. Since 1999, Mozambique is striving to meet its obligation under article 5 of the Mine Ban Treaty to destroy all antipersonnel mines before the end of 2014. Thereafter Mozambique will enter a new phase where the threat of mines and ERWs will be regarded as a closed chapter. However, even when the last mine has been cleared and the last piece of suspected land has been released, the focus on victims ought to remain. Given the dismal situation faced by most survivors, it is clear that new focus on victims is required and that victim assistance efforts should be much improved upon.

Data collection, including the conduct of a needs and capacities assessment, is a key implementation measure under article 5 of the CCM and the Cartagena and the Vientiane Action Plan of MBT. **In order to respond to the needs of victims, national VA stakeholders need to know more accurately who the victims are and what challenges they face.**

An effective and efficient VA response cannot be carried out in isolation, but has to be part of a broader public health, development and poverty reduction strategies. As such, in order to ensure a comprehensive approach to inclusion of survivors at all levels of society, a National Action Plan on Victim Assistance/ Disability should include actions that target the provision of services in the following sectors/public policy areas: health, rehabilitation, psychological and psychosocial support, education, as well as work, employment and social protection. **The responsibility for VA in Mozambique is shared by the IND, the MISAU and the MMAS.**

[14] Republic of Mozambique, Canadian International Demining Corps and Paul F. Wilkinson & Associates Inc., "Landmine Impact Survey," August 2001. - www.sac-na.org/pdf_text/mozambique/start.pdf
[15] SINTEF, FAMOD & INE, Living Conditions Among People with Disabilities in Mozambique, Oslo, 2009

Handicap International

Victim Assistance

Handicap International has been providing assistance to victims since the early days of the organization's existence. In 1982, its first activities included the creation of orthopaedic and prosthetic centres in refugee camps on the Thai/Cambodia border. Handicap International played a key role in founding the **International Campaign to Ban Landmines** (ICBL), for which it was jointly awarded the Nobel Peace Prize, following the signing of the **Mine Ban Treaty** in 1997. Handicap International is a founding member of the **Cluster Munitions Coalition**, and actively campaigns in support of the **Convention on Cluster Munitions**, which came into effect on 1st August 2010. The organisation is also a founder and coordinating member of **Landmine and Cluster Munitions Monitor**, which, for the past ten years, has been monitoring these two international treaties and produced annual reports on their implementation. It published several reports on the plight of survivors amongst which the groundbreaking report Voices from the Ground[16]. These reports have contributed to the formulation of policies to guarantee social inclusion and human rights of those affected by the disastrous consequences of mines/ERW. It is, in fact, Handicap International's mission to work alongside people with disabilities and vulnerable population in general, to promote respect for their dignity and fundamental rights, to take action and raise awareness in order to respond to their essential needs and improve their living conditions.

Mozambique

Handicap International has been working in Mozambique for the past 27 years. It has been one of the strategic partners of the national government in coordinating and executing mine clearance operations in Inhambane and Sofala provinces. Nationwide, these provinces are considered amongst the most heavily impacted by mine/ERW. During the 90s, Handicap International supported the Ministry of Health (MISAU) in the development of rehabilitation services network throughout the country, resulting in instalment of ten provincial orthopaedic centres and 60 physiotherapy centres. Handicap International has also established a Physical Medicine and Rehabilitation Service (SMFR) and created a national training centre for rehabilitation professionals. Currently, Handicap International is assisting the Ministry of Woman and Social Action (MMAS) in developing and implementing methods to improve access to social and health services for mine survivors and people with disabilities in general in the municipalities of Matola and Maputo.

[16] Voices from the Ground (2009), Landmine and Explosive Remnants of War Survivors Speak Out on Victim Assistance, Handicap International: www.hiproweb.org/uploads/tx_hidrtdocs/Voices_from_the__Ground-report.pdf

Assessment Design[17]

Methodology

The assessment was implemented between October 2012 and May 2013.
To be able to present an overview of the living conditions of mine/ERW survivors and their access to services in a rural setting, we combined **quantitative and qualitative methods**.

The quantitative part, through a questionnaire, targeted mine/ERW survivors and used a **control group**[18] to determine the relative vulnerability of mine/ERW survivors.

The assessment questionnaire counted 83 questions, addressing:

- Informed consent
- Information about the survivor (GPS coordinates, geographical location, marital status, number of children, possession of identification documents, languages spoken)
- Circumstances of the accident, injury, types of injury, disability (Washington scale)
- Level and access to services (education/ health/rehabilitation/psychological/social/ professional training and traditional healers)
- Usage, access to and level of satisfaction with assistance devices
- Coping skills and psychological impact of the accident
- Community participation and perceived discrimination
- Barriers and facilitators in accessing public buildings
- Socio-economic position of the survivor and its family (income/expenditure/ household possessions/building material of house/access to water/means used for cooking/lighting)
- Awareness of rights and participation in DPOs
- Survivors needs and priorities to improve quality of life

[17] The full report is available on request (see page1) to get a more comprehensive description of the methodology.

[18] Control Group (also referred as "(other) members of the community": each time a survivor was interviewed, a person of the same age and sex in the immediate vicinity of the household was also interviewed at a separate time.

The qualitative part aimed at mine/ERW victims (survivors and affected families) and other relevant stakeholders (service providers, community leaders, Non-Governmental Organisations (NGOs) to gather additional information and opinions of persons directly or indirectly in charge of assisting mine/ERW survivors.

Focus group discussions with victims
Survivors and family members of people injured or killed randomly selected out of the group of survivors interviewed during the quantitative part. They were invited by the assessment interviewers to participate in a focus groups of 8-12 people per district and offered a perdiem for transport and a snack. When possible, at least half of the group consisted of survivors whilst the other half of family members of people injured or killed by landmine/ERW and an even number of men and women. This was coordinated and monitored by the local supervisor. The group discussion occurred at a central location only after the quantitative questionnaires had been completed.

The group discussions focused on:

- Perceptions, opinions, beliefs and attitudes towards challenges faced by mine/ERW victims
- Perceived psychological and social support after the accident and during their recovery
- How survivors feel about their participation and social inclusion within in their communities
- Needs and expectations towards service providers and/or support systems
- How the accident has affected economic inclusion and self-reliance

In-depth interviews with other stakeholders:
In order to measure the level of inclusion of the mine/ERW survivors and their families, other role players in the community, including community leaders (traditional and religious leaders), representatives of DPOs, public/private institutions (local NGOs, administrative posts) as well as services providers (hospitals, schools, social services) were interviewed.

They were interviewed on:

- Information on service delivery, availability, access and functioning of services, adapted educational methods
- Number of trained professionals
- Knowledge of disability issues
- Availability of medication, supplies and equipment, emergency transport available
- Main streaming and physical accessibility of services
- Awareness amongst staff (teachers, community leaders etc.)
- Availability and quality of mobility devices
- Specific policies available
- Budget for main streaming of services
- Attitudes, perception, beliefs towards challenges faced by mine survivors

Area of implementation

The assessment was implemented within the provinces of Inhambane and Sofala. They were selected as being amongst the most heavily mine/ERW impacted (see table # 3). They account for half of all the contaminated areas in Mozambique.

Table 3: Distribution of mined areas per province, IND database.

Province	Area (m^2)
Maputo	1.027.260
Gaza	1.647.250
Inhambane	2.498.463
Sofala	6.290.346
Manica	3.455.593
Tete	1.813.284
Zambezia	Declared free of mines
Nampula	Declared free of mines
Niassa	592.661
Cabo Delgado	309.109
TOTAL	**17.633.366**

Within each of the two provinces, six districts[19] were selected. The selection was based on history of mine/ERW contamination and programme-planning criteria, such as good access and safety.

The following districts were selected:

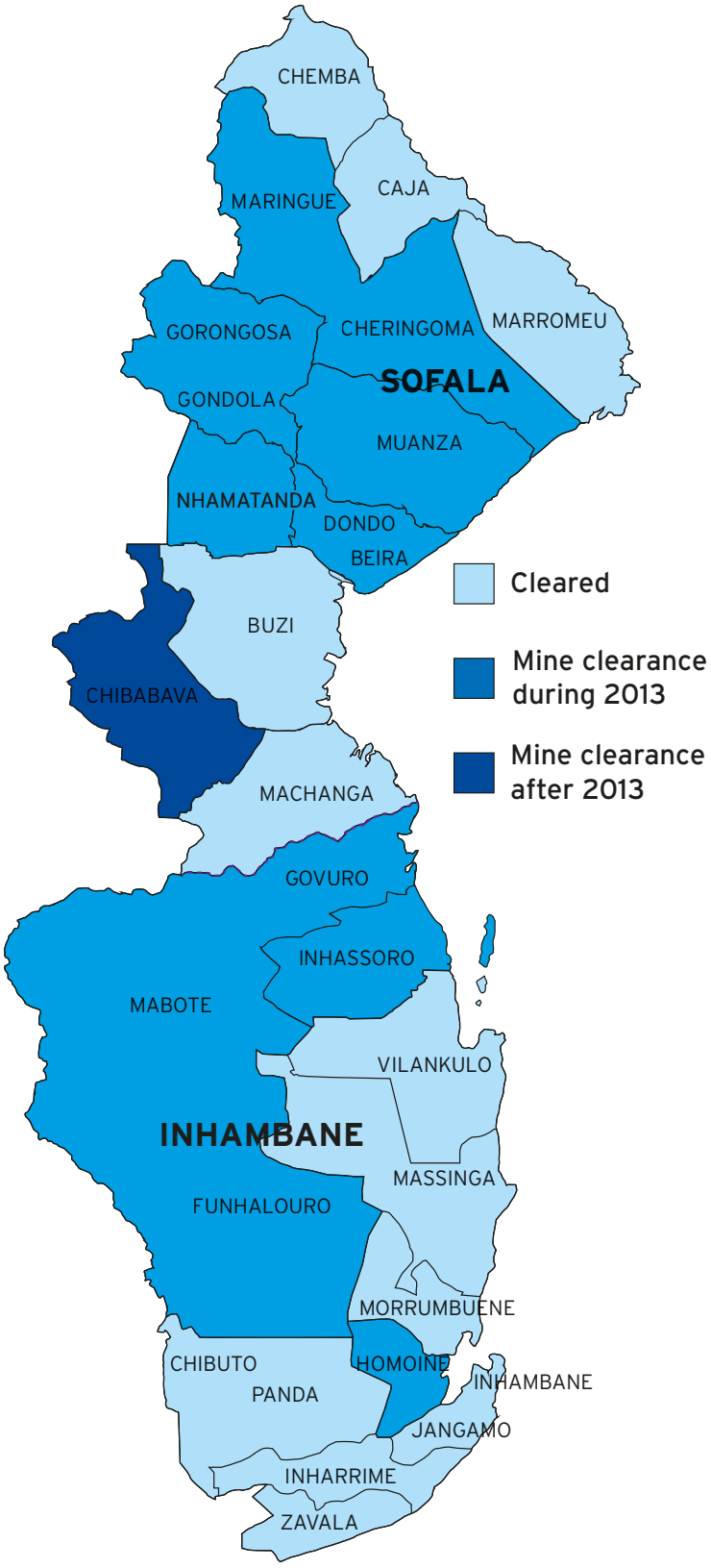
- **Inhambane:** Govuro, Inhassoro, Vilankulo, Massinga, Morrumbene, Homoine

- **Sofala:** Chibabava, Machanga, Buzi, Gorongosa, Nhamatanda, Dondo

Together they form a bordering territory, which facilitated the logistic coordination of the assessment, see map next page.

[19] Districts are the territorial units in charge of the organization and functioning of the local state administration.

Map: Stages of Handicap International mine clearance programme in the Provinces of Inhambane and Sofala



Sampling[20]

The Triola method[21] was used to define the sample size of survivors of the assessment to get **results representative of the overall population of survivors in the country** based on the data of the Landmine Monitor (2444 casualties registered by 2011[22]).

This statistical formula indicated that a minimum of 292 mine/ERW survivors had to be interviewed to get a representative sample that ought to yield reliable information at a national level. The sample was based on the calculated number of mine/ERW survivors, divided per district, meaning that an average of 25 survivors[23] were interviewed per district. In the event that a smaller number of survivors were encountered in a given district, this was compensated by interviewing more survivors in those districts where more survivors had been identified.

Control group
A case/control assessment was undertaken to compare people identified as mine survivors to controls. One age-sex and cluster matched control was selected for every case identified.

Sampling criteria
Survivors were identified based on snowball sampling/chain referral sampling methods. Various actors were asked to identify mine/ERW survivors, including community leaders, administrative posts in the districts, service providers, local community members, representative organizations, DPOs and mine/ERW survivors themselves. In addition, more were identified through the database of the demining teams of Handicap International containing data for some of the districts.

Inclusion criteria
Both civilian and military survivors were included in the assessment. Where possible, women were prioritised in the assessment, as women are a minority among the overall group of landmine/ERW survivors. Several studies show, however, that they tend to be more vulnerable than men[24]. Survivors of small arms/light weapons and people impaired through other causes were excluded from the assessment. No more than one survivor from the same household was interviewed.

[20] For a full description of the methodology, the Assessment report can be downloaded at: www.hi-moz.org/download/FullStudyVA.pdf
[21] TRIOLA Mario F. Elementary Statistics 2006, Revised
[22] www.the-monitor.org/index.php/cp/display/region_profiles/theme/2019
[23] No strict sampling criteria were applied as there is no comprehensive database or census that would have allowed for the use of a stratified target group (following gender or age, for example).
[24] Bine, A.C. & Masslberg, Gender Sensitive Victim Assistance, The Journal of Mine and ERW Action, 15.2 Summer 2011

MINE/ERW VICTIMS IN MOZAMBIQUE

MINE/ERW VICTIMS IN MOZAMBIQUE[25]

As compared to other members of their community (control group)[26]

General considerations

Relative vulnerability of mine/ ERW survivors compared to other community members

Findings of the assessment underscore that mine/ERW survivors living in remote rural areas overall face a **similar socio-economic situation** than their community peers, although still disadvantaged. Three in four survivors live under the poverty line; the same as other community members. The quality of housing, access to basic sanitary conditions and drinking water is significantly less for survivors. Most of them work, though less than other community members. They more often live off a pension, face more functional limitations (visual impairment, mobility impairment, memory or concentration) and more difficulties with taking care of daily living activities (fetching water, collecting wood for cooking. Most of the time they need assistance or to hire somebody to build or reform their houses). Most of the people included in the assessment work in agriculture. It is a very intensive labour as it is still realized through traditional methods and basic equipment (hoes and machetes). Few possess equipment or have knowledge about more recent technologies, to improve their productivity or have access to formal markets. Nevertheless survivors and community leaders confirm that, due to their functional limitations, survivors are disadvantaged in comparison to other community members. They hold less equipment to improve their productivity (like ox-wagon, cattle etc) and cannot cultivate the same amount of land as others in their community.

Most of the time they just manage to grow food for their own living and cannot sell the surplus to generate some income. They lack transport facilities and most roads are still unpaved. Combined with reduced mobility and little access to basic social protection strategies, this can lead to a **poverty trap**[27].

In terms of educational level, access to basic health care services and community participation, no significant differences were identified between both groups. In general the whole population (survivors and community members) have gone through the same aftermath of war. Due to the level of mine/ERW contamination in Mozambique, the threat of landmines is the reality of all community members. This might explain why a relatively high proportion of mine/ERW survivors also have some position as community leaders and participate in community activities in a similar manner as other community members.

[25] Although mostly mine/ERW survivors were interviewed, mine victims (i.e. families of people killed or injured by a mine/ERW) participated in focus groups of the qualitative part of the Assessment.
[26] For a fully detailed methodology of the assessment, see P. 2
[27] See glossary p.81

Mine/ERW survivors are not a homogeneous group

There are clear **differences in income level, level of impairment** and the extent to which the accident **affected their daily life**. It should be taken into account while developing adequate VA responses; subgroups have to be identified in relation to their socioeconomic situation, access to basic rights and functional limitations. **Groups with severe mobility loss and/or living under the poverty line have to be prioritized.**

Mine/ERW victims as a wider group should benefit from VA

Victim Assistance should not only benefit survivors, but also family members of people who have been injured or killed by a mine or ERW.

Though this assessment focused more on survivors, it was revealed that most victims report difficulties to access socioeconomic assistance, they lack employment opportunities as well as social, emotional and financial loss. They find themselves dependant on the goodwill of others and are exposed to poverty. Though the majority of the survivors are male, **women** make up the largest group of **indirect victims**, being the spouses, mothers, sisters and daughters (and subsequent caregivers) of the men who are injured/disabled/killed by mines and ERW, especially when the deceased was head of the household. Some received support from their family; some try to access support from the authorities but report they do not manage to obtain any kind of assistance. They try to find small jobs to sustain their family, but it is almost never enough to sustain themselves and/or send the children to school. Children report losing their parents and suddenly becoming the main income generator and having to take care of their brothers and sisters. Some report receiving some kind of pension in the beginning, but this stopped and they did not manage to access it anymore. Apart from the socio-economic loss, there is also the emotional loss of a loved one. People who have lost their partner feel they suddenly carry all the responsibility and lack emotional support.

Profiles of Mine/ERW Survivors in Mozambique

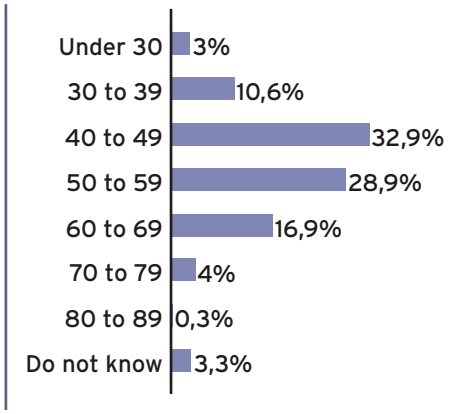
The following description contained the results of both the quantitative (questionnaires) and qualitative (focus groups and in-depth interviews) parts of the Assessment[28].

The "typical survivor" is male and suffered his accident with a mine/ERW in his twenties during the war, either while in military service or as a civilian.

Sex and age repartition

Of the total sample of survivors the majority is male (79 %) and one fifth (21 %) is female.
The youngest survivor identified in the assessment was 19 years old and the oldest 81. Of the total sample interviewed, the majority is above the age of 40 (86,4%).

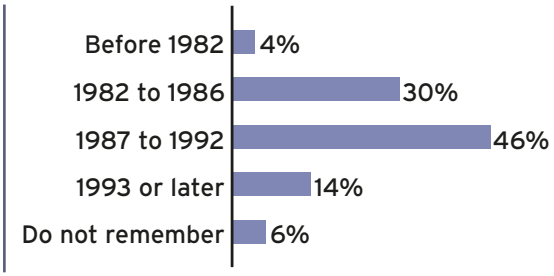
Graphic 1:
Age distribution of the mine survivors included in the assessment



Year, age and circumstances in which the mine/ERW accident happened

Most of the survivors (80,1%) suffered their accident during the war, a third (35%) as a soldier. The majority suffered their accident between 1987 and 1992 (46,2%); or between 1982 and 1986 (29,9%). 14% suffered a mine/ERW accident after 1992, when peace had already been achieved.
33% of the accidents happened while carrying out Activities of Daily Living (ADL) like fetching wood to cook, getting water or working on their land.
When people suffered their accident, the majority (73,3%) was aged between 15 and 39, in their productive age, while 14,9% were still children (under 15 years old).

Graphic 2:
Year when the accident happened



Family situation

Most survivors are in a stable relationship, and have several children. Their family situation is similar to that of other community members.

Civil status

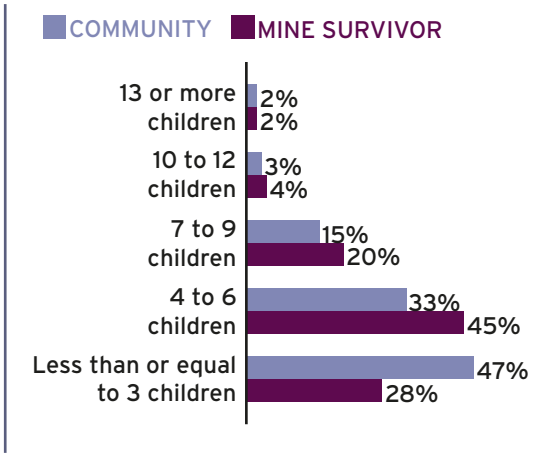
Most survivors (77 %) are either married or in a relationship, 8% never married, 4% are separated and 10 % are widowed. In this regard, there is no significant difference as to the control group.

[28] See Assessment Design p. 21 or the full Assessment report: www.hi-moz.org/download/FullStudyVA.pdf

Graphic 3:
Civil status of mine/ERW survivors and of the control group

Household structure
The majority of survivors have children (86 %). 45% of them have between 4 to 6 children. Survivors tend to have more children than other community members, but the difference is small and not significant.

Graphic 4:
Number of children of mine/ERW survivors versus those of community members

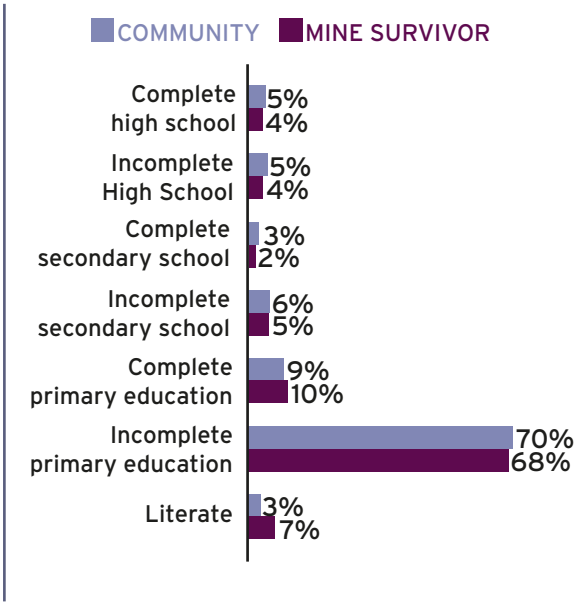


Level of education[29]

The average survivor did not finish primary school and did not attain a desired level of education. Most discontinued school due to the socio-economic situation of their family, because of the war or never attended school in the first place. There is no significant difference between community members and mine/ERW survivors.

One out of three survivors never attended school (33%). There is almost no difference with the control group (34%).

Graphic 5:
Within the mine/ERW survivors and control group who attended school: maximum education level obtained



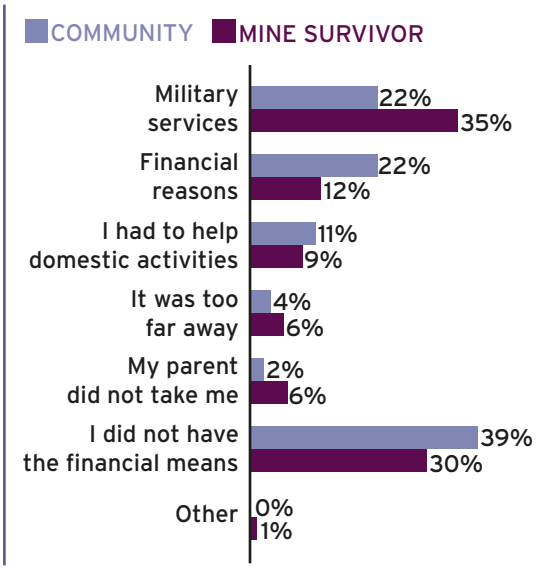
[29] Level of education attained, ability to read and write, gender and literacy level and linguistic profile.

Of the 67 % of survivors who frequented school, the majority (68 %) did not complete primary school. A mere 10 % (n=21) completed primary school and only 3% (n=3) continued in secondary school. The same pattern was revealed for other community members.
11,1% of those who frequented school are illiterate and **almost all** (95 % of survivors and 88% of the other community members) report that they **did not complete school** to the level they desired.
Most survivors (42%) mention that they did not manage to complete school because their family **did not possess sufficient financial resources** or because they had to participate in **military service** during the war (35%).

Of the total group of survivors, 58,4% speaks or understands Portuguese and all speak one or several local languages, more commonly used. There is no significant difference as to the control group. The fact that only a small majority speak Portuguese can be explained by the fact that the language was taught in school, and both survivors and other community members were not able to finish primary school. **This very fact constitutes a major obstacle for the rural population in general in terms of accessing "official" information, mostly available in Portuguese.**

Overall, there is no significant difference in school attendance between community members and mine/ERW survivors. Community members faced similar difficulties as mine/ERW survivors though they are relatively slightly better off as a few more managed to finish secondary school, and a small percentage confirmed that they were able to conclude school until the desired level (12%). The overall similar pattern could be explained by the fact that all respondents faced the same difficulties in going to school, due to the war, the related limited economic development of Mozambique and reduced access to education at that time.

Graphic 6:
Reasons for discontinuing school for mine/ERW survivors and community members



Identification document

Most survivors hold some kind of identification document (88%). There is no significant difference as to the control group (89%).

Professional and activities performed

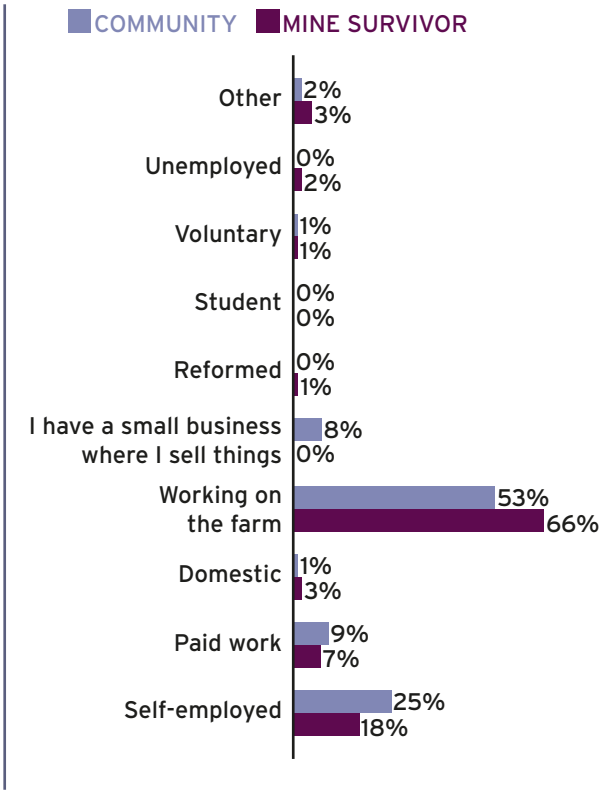
Overall most survivors work, and agriculture is their main way of sustaining themselves. There are significant differences with community members who work more and more often have their own business.

Significantly less ($p<0.05$) survivors work as compared to the control group. This might be partly explained by their impairment and/or lack of mobility. Although **the majority of survivors work (74 %), compared to (93%) of the community members.**

The majority of survivors work on their lands (66%) and one in five survivors works as a labourer (18 %). Only a very small amount of survivors work in a paid job (7%). Community members have significantly more often ($p<0.05$) their own business, or work for themselves (8%).

Overall, the majority of respondents work on their land. Agriculture is the main activity in the rural areas where the assessment was implemented. The financial income of this trade is used to buy goods that cannot be produced locally. Activities performed during the agricultural cycle are primarily aimed at producing food to satisfy the basic needs of the family and community members. The work is mainly performed with handheld hoes and machetes. With the income that they receive through trading, they buy goods such as salt, soap, cooking-oil, dried fish, and clothes.

Graphic 7:
Percentage of mine/ERW survivors and community members by professional categories



FOCUS: Differences between survivors who suffered as a soldier or as a civilian

Significantly more civilian survivors ($p<0.05$) worked as compared to former soldier survivors. The civilian survivors also significantly more often worked on their lands than the former soldier survivors, and they significantly more ($p<0.05$) report that they had to change their profession due to the accident. This might be partly explained because of the possibility of a pension scheme that survivors who suffered as a soldier are entitled to (though not all of them do actually receive a pension).

Socio-economic situation

Three in four survivors live under the national poverty line. Overall, there are no major differences in income distribution and access to food between survivors and community members. Housing conditions of survivors however, are more precarious than those of other community members. Fewer survivors work, compared to other community members and more survivors live off a pension. Civilians who suffered a mine/ERW accident have less access to a sufficient amount of food to feed their families than the ones injured as soldiers.

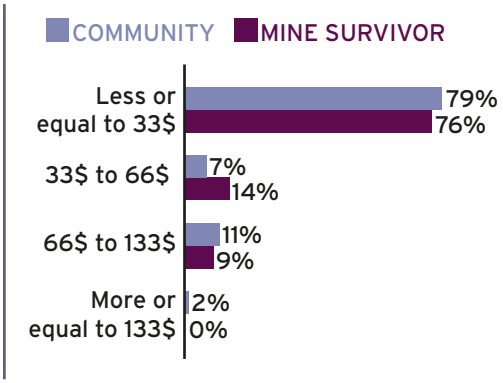
Income situation

The income of participants was calculated to represent per capita consumption on a household level, to be able to compare it to the national poverty line, 37,5 $ dollar a month or 1,25$ a day (WHO, 2008) per family member.

Overall figures show that 54,7 % of people living in a rural setting live under the poverty line in Mozambique. This was confirmed by the present assessment: **three in four survivors (76%) live under the poverty line as compared to 79% of the control group**. It is interesting to see that survivors are slightly better off.

This may be partly explained by the fact that they are more likely to receive some kind of pension. This will be further explained below. The overall distribution of income for survivors and the control group showed similar patterns and there were no significant differences between both groups. The fact that the majority of the population lives below the national poverty line is not surprising given that Mozambique is still among the ten lowest countries on the Human Development Index.

Graphic 8:
Income distribution per month on a household level for survivors and other community members



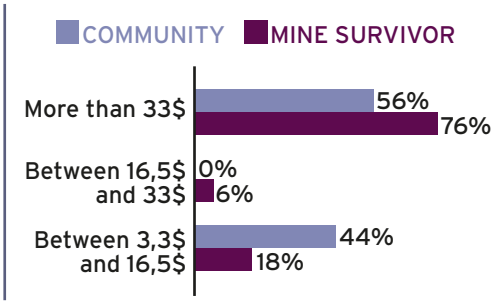
Social protection

Significantly more ($p<0.05$) survivors than the control group receive a pension or some kind of social security, with 38% of the survivors versus 11% of other community members.

Amongst the survivors receiving a pension, the majority (76%) collects more than 33$ a month, while one in five (18%) receive between 3,30 $ and 17 $ on a monthly basis. It should be noted that this value is represented per household and no breakdown per capita is given.

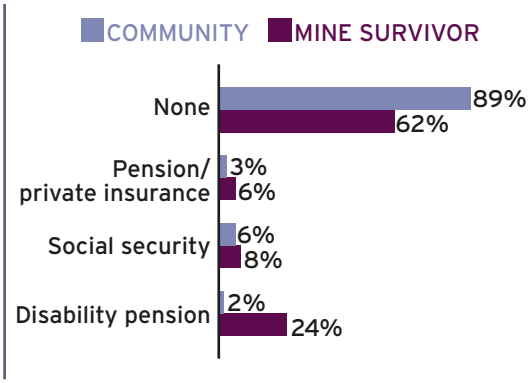
Graphic 10:

Amount of pension received for survivors and other community members



Graphic 9:

Percentage of mine/ERW survivors and control group receiving a pension



FOCUS: Soldier vs. Civilians

Surprisingly enough there were no significant differences in income or access to pension schemes between survivors from the army and civilians. 47% of the former soldiers did not receive a pension. This might partly be explained by difficulties in legalising their situation, or the specific kind of function/contract at the time of the accident. The acknowledgement and amount of the pension is dependent on the level of disability; professional category (rank) and number of years of service. A medical committee of the Ministry of Defence evaluates the level of disability and based on the analyses and set categories an amount is attributed.

Access to food

More than half of the survivors (66%) state they do not always have enough to eat. Only 16 % confirms they always have sufficient food to feed their families. In this regard, there is no significant difference as to the control group (63%). This is in line with the findings that the majority of survivors and community members live under the national poverty line and therefore do not always have enough access to food to feed their families.

Though there is a significant ($p<0.05$) difference between survivors who suffered the accident in the military or as a civilian. "Civilians" significantly more often ($p<0.05$) report that they do not always have enough to eat, as compared to ex-soldiers.

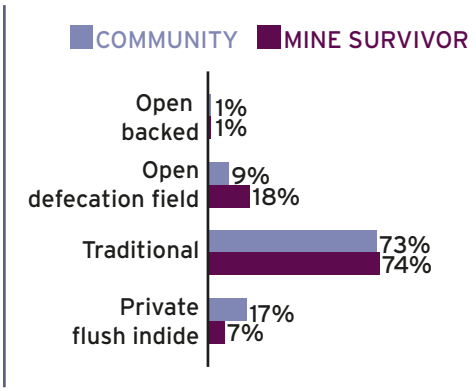
The majority of the survivors (76,6%) get their food from their own production.

Housing conditions

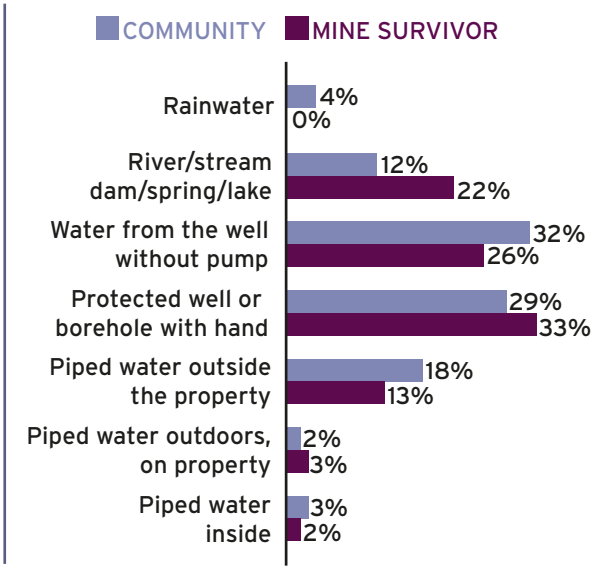
Houses: The houses of the survivors are encountered in a **more precarious state**. They significantly more often ($p<0.05$) have no windows and dirt floors in their houses as compared to community members. Community members significantly more often ($p<0.05$) have glass windows, rooftops made of zinc, floors made of cement and walls made of cement or bricks, which implies a better socio-economic situation. In the rural context houses are constructed in such a way that people have different houses for different family members or functions (as if it were separate rooms). Survivors significantly more often ($p<0.05$) possess "one house" (one room) as compared to community members.

The control group significantly more often ($p<0.05$) had improved sanitary facilities as compared to the survivors. Survivors significantly more ($p<0.05$) often reported that **they do not have any sanitary facilities** and for their rudimentary sanitation requirements have to go to open defecated fields (18%). Significantly more ($p<0.05$) survivors report that their sanitation facilities are not adequate to them.

Graphic 11:
Conditions of sanitary facilities for survivors and community members



Graphic 12:
Access to water for mine/ERW survivors and other community members

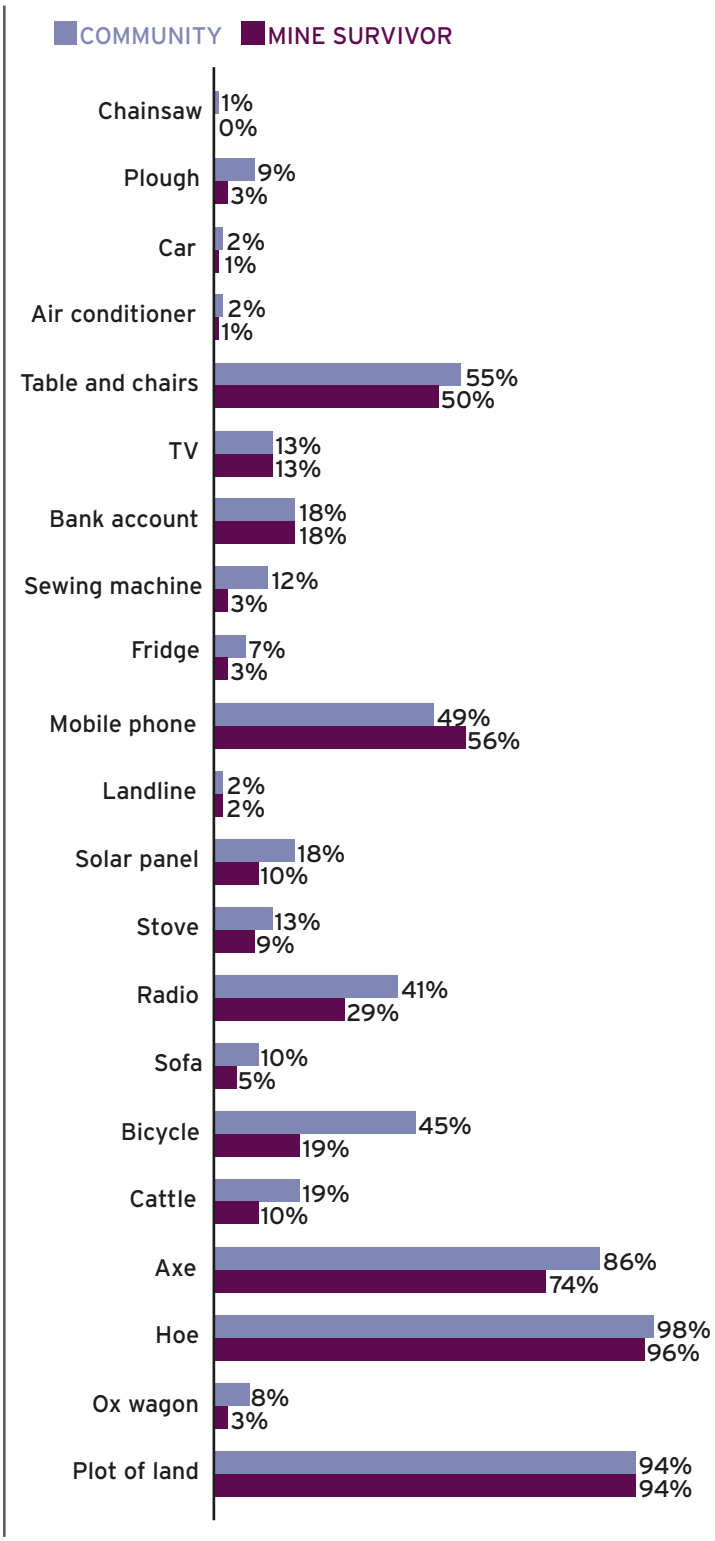


Access to water and domestic power: Significantly more ($p<0.05$) **survivors have only access to unprotected drinking water** as compared to the control group. They significantly more often ($p<0.05$) report they only have access to water from the well/ stream or rain water.
Ways to cook food or lighten the house are equivalent for survivors and the control group with the majority using wood to cook and petroleum to illuminate the house.

Household possessions: the questions assessed the possession of different items in the household as an alternative way to assess socio-economic situation and differences between survivors and community members. The items ranged from basic items, such a table and chairs to items such as refrigerator, tractor, solar panel. There were significant differences between community members and survivors. Community members significantly more ($p<0.05$) often held more "luxury items" such a bicycle, a solar panel, cattle, a radio, a sewing machine, a plough, or an ox wagon. This would suggest that they possess better conditions to cultivate their land and shows that despite same income pattern, they are relatively better off than survivors. Almost all of both groups own a piece of land (94%).

These findings can be partly explained by the fact that survivors face more difficulties in constructing their own houses due to their functional limitations. They often need to hire somebody to be able to assist them to build their house, for which they do not always funds. The same applies to the toilet facilities. Also access to water is an obstacle as due to their physical limitation they have more difficulty carrying the water, it takes them a long time and they report that they sometimes lose the water on their way back home.

Graphic 13:
Household possessions of mine/ERW survivors as compared to other community members



Impact of the accident

Disability

As can be expected survivors overall face more physical limitations than community members. The majority of the survivors have suffered a lower limb amputation and face mobility loss and more difficulties taking care of themselves.

More than one in two survivors has suffered a lower limb amputation as a result of the accident (61%); 11,5% suffered an upper limb amputation. In 14,2% of the people the accident affected their vision. One fifth of survivors (20,3%) have scars as a result of the accident. A small minority suffered two lower limb amputations (3,1%) or two upper limb amputations (0,3%). Overall, 16,1% have a multiple disability due to the accident.

The **Washington scale** was used to check the level of disability also in comparison to the control group. According to the Washington scale methodology if a person has at least one affirmative answer to the screening questions then the person is considered with a disability.

There were significant differences ($p<0.05$) with **survivors facing more difficulties** than the control group in relation to seeing - **visual impairment**, walking or climbing stairs - **mobility impairment**, memory or concentration problems and taking care of themselves, as in taking a bath or dressing themselves - **Activity of Daily Leaving: ADL**[30]. Which leads to the conclusion that survivors overall encounter more physical limitations than community members.

When people suffered their accident, the majority (73,3%) was aged between 15 and 39, in their productive age, while 14,9% were still children (under 15 years old).

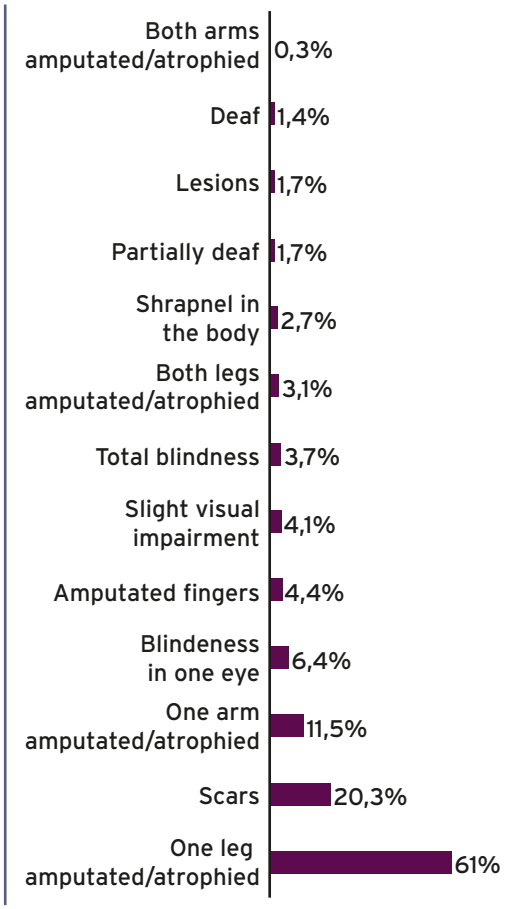
Table 4: Washington Scale level of impairment for mine/ERW survivors

	No impairment	Slight impairment	Major impairment	Totally disabled
Q1 Visual impairment	71,4%	19,3%	7,6%	1,7%
Q2 Hearing impairment	87,4%	10,3%	2%	0,3%
Q3 Mobility impairment	19,9%	18,9%	57,8%	3,3%
Q4 Memory or concentration problems	67%	27,3%	5,3%	0,3%
Q5 Problems taking a bath or dressing	65%	20,7%	13,7%	0,7%
Q6 Problems understanding or being understood	91%	6,3%	2,7%	0%

[30] Activities of daily living (ADLs) is a term used in healthcare to refer to daily self-care activities within an individual's place of residence, in an outdoor environment, or both.

Survivors face more difficulties taking care of themselves and their family members. They less often shop for groceries, fetch water, collect wood or take care of family members, including children. These differences were significant ($p < 0.05$), and show that survivors tend to be in a more vulnerable or dependent position as compared to community members.

Graphic 14: type of impairment suffered because of the mine/ERW accident

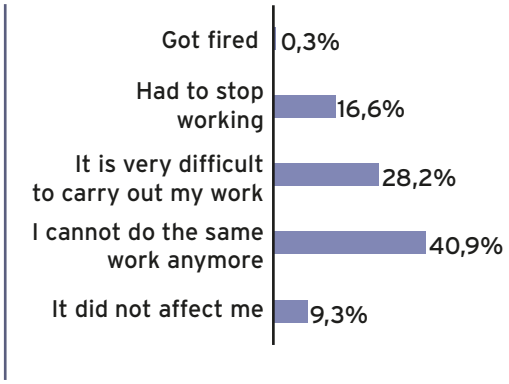


Graphic 15: household activities performed by survivors compared to control group

Economical impact

The accident had a major impact on the way of sustaining their families Almost half of the survivors **did not manage to carry out the same professional activities** (40,9%). 28,2% experienced difficulties carrying out the same work and 16,6% had to stop working. Overall 17,8% of the survivors received some kind of assistance.

Graphic 16: Consequences of the accident on professional activities of the mine/ERW survivors



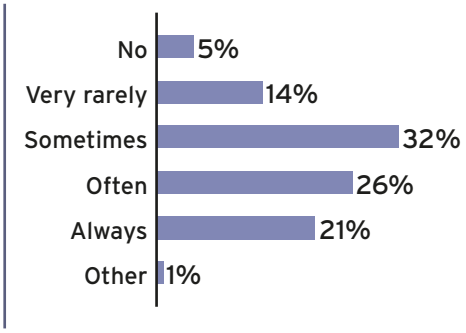
Psychological impact

When survivors are asked whether they think back to the accident, one in five (26%) report they often think back and one in four (21%) state that they " always" think back to the accident.

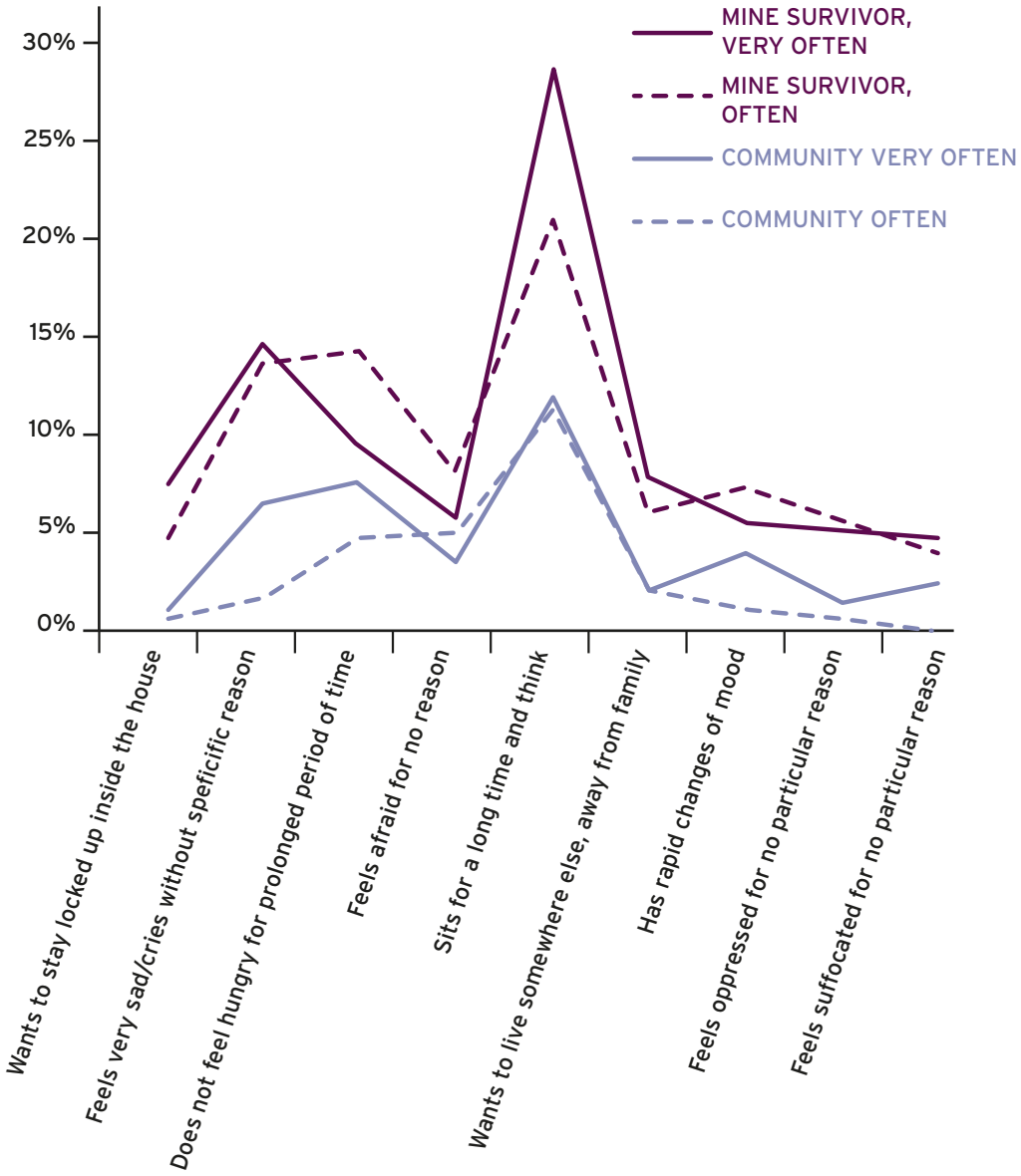
There are significant differences ($p<0.05$) between the survivors and the community members on mental health related issues. More survivors feel sad or have the feeling they need to cry without a specific motive, experience mood changes, feel depressed or angry without a specific reason or sit for a long time and think.

This shows that the accident caused a significant change in the mental health status of survivors and that **many did not come to terms with their situation**. This reveals that the accident is a traumatic event for mine/ERW survivors and that the memory and **the impact of the accident still affects their daily life and well-being**. Many report that if they face difficulties, they think back to the accident and think: *if I had not have suffered the accident I would not be like this.*

Graphic 17: percentage of survivors on the frequency to which they think back at the accident



Graphic 18: Psychological well being of survivors and community members



Loss of partner / friends

Most survivors had to restructure their life due to the accident and many reported that immediately after the accident they felt abandoned and discriminated against, including by family and friends. Many were abandoned by their spouses shortly after the accident, often without any explanation. Thus, besides the accident, they also had to deal with social rejection, leaving them deeply scarred. They had to rebuild a family, in some cases with others also being in a less privileged situation. Most report that after some time, it got better and some of their friends returned. Others express tremendous gratitude for the people or family that took care of them. They mention that if a specific family member (mother, father, uncle, brother) had not been there to take care of them, they would have *died of suffering*.

Perception (self- and from the community)

The group of survivors seems to split into two groups in relation to community participation and perceived discrimination. Half of them feel in the same position and with the same possibilities as other people in their community. The other half feels more prejudiced, with less opportunities and face more difficulties or discrimination.

Self perception of survivors

Dependency

Before the accident mine/ERW survivors felt free to go everywhere and contribute to the family income. After, **they depend on family members or the good will of others**. This gives them a sense of impotence. It hurts them not to be able to guarantee well-being for their families and create the right conditions to feed and send their children to school.

Feeling invisible and useless to society

If the accident had an impact on their productivity, many report that **they feel useless or not welcome in society**. It is especially cruel to them as many suffered the accident while fighting for their country. They contributed to a bigger cause, were important, and now that they are with a disability they feel sidelined and neglected, including by the authorities. Many survivors feel they cannot contribute in the same way anymore and it makes them feel like a **burden to their family**. They feel of no value and guilty because they cannot contribute as much as other family members or as they would like to.

Prejudice and Stigma

39% of survivors have experienced some kind of discrimination, 61% state that no one ever referred to them in a derogative way. Some survivors report that they received support from their community members, neighbours and family and participate normally in community activities. They feel they have the same opportunities and are not being treated differently than other people.

For those who feel discriminated against, this occurs for almost half of them on a frequent basis (39 %) and the other and larger half (58%) experience it more accidentally.

They feel people look at them differently or laugh behind their backs. They are subject to humiliation and violence and most of the time they feel powerless. They do not have the strength to defend themselves, mainly because they feel limited in their movements and in the case of danger, they cannot run away.

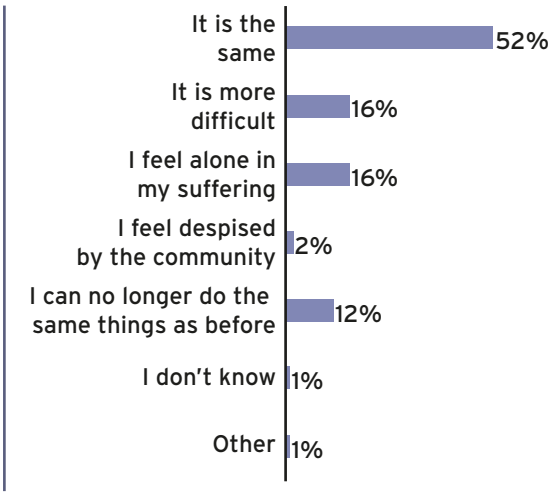
In many cases **survivors experience a combination of the two reactions**, they find people who treat them well, support them and care about them and in fewer occasions people who mock them, act aggressively (violence), or blame them for the accident. Yet, most of them still participate in community activities and are invited as the other community members.

Perception on community participation
One in two survivors (52 %) feels he has the same lifestyle as other people in his community and does not necessarily face more difficulties. 40% feel that they could be elected community leader and 30,1% already held some position as a community leader.

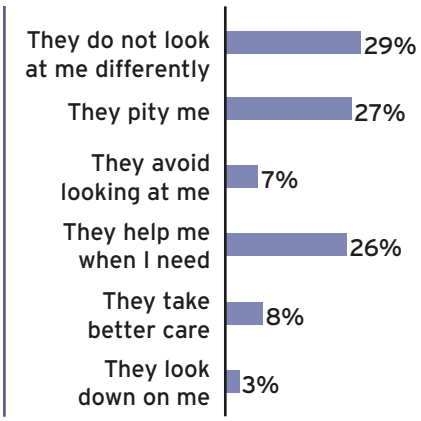
The other group has the feeling that life if more difficult for them (16 %), they feel lonely in their suffering (16 %), or regret that they cannot do the same things as before (12 %) or feel discriminated by their community members (2%).
Survivors and community members participate in almost the same way in community festivities, rituals, weddings, family visits, going to local markets and going to church. Though a few less survivors participated in community festivities and significantly more community members frequently visit family. But overall the patterns of participation held strong similarities.

Three in ten survivors (29%) feel there is no difference in the way people look at them as to any other member of the community. One in four (26 %) feel supported by their community and feel they can count on them when they need help. One in ten (8 %) feel they get a special treatment and get better care. And one in three (37 %) feel that people pity them, avoid looking at them, or look down on them.

Graphic 19: Perception of mine/ERW survivors on whether they have the same quality of life as other people in their community



Graphic 20: Perception of mine/ERW survivors on how community members see them



Perception of survivors by their community

Community members[31]

Most of the other members of the community (51,9%) report that they see no difference between mine/ERW survivors and other people; other would say they are joyful people (37%). Only a small minority, one in ten, would say that they think survivors are either sad, filled with anger or disappointed with life.

Most of them confirm that they participate in community activities (77,6%) or in community councils (46,5%), can be elected as a community leader (53,1%) and have the same opportunities as others (58,1%).

Community members evaluate that the biggest problems for mine/ERW survivors are that they cannot manage to carry out the same activities as before their accident (74%), or that they have become limited in their movements (22,7%).

This perception of mine/ERW survivors can be partly explained by the fact that landmines were a threat for a long time to the overall population living in rural areas and therefore close to their own reality.

Perception of survivors by community leaders

The community leaders report that survivors participate in community activities and some are active members of the community council. A few report that they have perceived some discrimination, but that most of the time the community feels sympathy for survivors and tries to assist or help them when possible. Most community leaders say that if they did witness some kind of discrimination, they would intervene and defend the survivors. Despite popular stories that disability may also be caused by some kind of curse, **all community leaders have a very clear view on what causes disability**. They state that survivors do not hold the same opportunities as other community members. According to their opinion, survivors are more limited in their movements and do not have the same strength. They feel that survivors are isolated in their suffering, and therefore unable to carry out all the activities they would like to and are thus constrained to make an extra effort in their every daily activities.

[31] Almost all of the community members (95,5%) who were interviewed did have contact with the mine/ERW survivors.

Mother and child

I was running from the armed forces when I stepped on a landmine. I had my little girl on my back, she lost her foot, I lost my leg. Everything changed in that moment. I was 29 and I had to rebuild my life. My husband abandoned me with our six children. He just left me like that, without even saying goodbye. I think he thought I was not of any use to him anymore. That is actually what many people think. In the beginning my family also thought the same. It took some time to get their support. It hurts when I think back of that time. But I survived, I had to do it all by myself. It is still hard and sometimes at night when I lie down, I think about the accident. My biggest preoccupation is how to feed my children. I have my own field to cultivate, but it is very tough, my crutches are too heavy and not the right size. They are not adequate for me. Look at my hands, there are blisters everywhere and it hurts here up my arm, but I have no choice. If I had some cattle, things would be easier and I would be able to produce more. My daughter is 18 now, she has a little baby, she dreams of having her own family and going back to school and opening her own hairdressing-salon, but I am afraid she will never manage. She feels limited and she cannot move around so easily. On days when it is warm or when the climate changes, the amputation hurts. We have never received any kind of assistance from the government. But I cannot complain, we are alive and as long as we can feed ourselves we are good. When I go to church on Sundays I pray to God that he will protect my children and I, and prevent them from making any mistakes.

NEEDS IDENTIFIED BY SECTORS

NEEDS IDENTIFIED BY SECTORS

Services

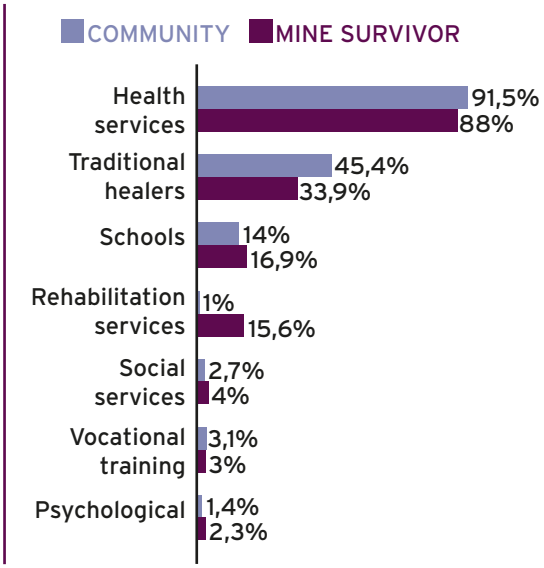
In general, **public services are not sufficiently prepared and equipped** to attend to people with disabilities and **staff is not specifically trained** to attend to them. Few services keep datas on attendance of people with disabilities or update them with regularity. Consequently **it is difficult to monitor and evaluate progress made on service delivery**. A lot of services report that some kind of community liaison is in place, though most of the times without a specific focus on people with disabilities.

Needs identified by survivors

The most expressed needs have to do with better assistive devices, to improve their mobility. Also commonly expressed: support or access to small loans to be able to start their own business; support to improve the quality of their housing. There is also a strong need for cattle or material to facilitate their agriculture practice and improve their production. A final and important need is access to water. As in many instances people have to walk long distances and due to their disability they have more difficulty carrying water.

To assess the level of needs and usage of services of rehabilitation, health, social services and psycho-social assistance, two questions were asked: to survivors and community members, what did you need over the past five years, and to survivors, what was available and what did you use?

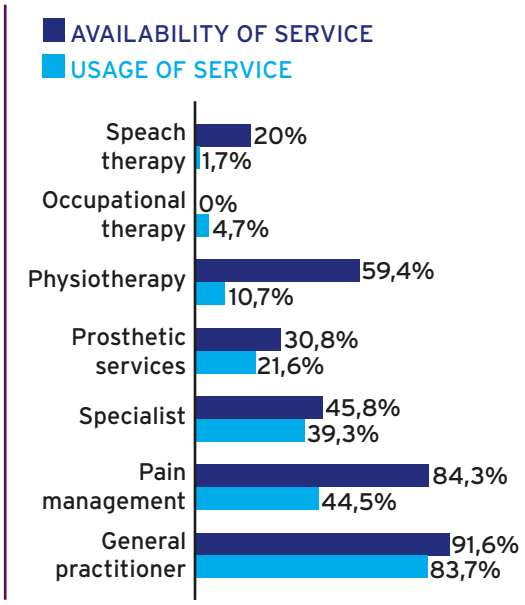
Graphic 21: Expressed needs for services by mine survivors and community members over the past five years



Apart from the need for rehabilitation services, as to be expected, survivors and community members almost express the same needs for health, educational, social, vocational and psychological services.

Survivors express a high need for general practitioners (83,7%), pain management (44,5%), specialist (39,3%) and surprisingly enough a relatively low need for rehabilitation services (21,6%) and physiotherapy (10,7%).
This data will be further elaborated.

Graphic 22: Usage of services by mine/ERW survivors and availability of services



Needs identified by service providers

Most of the time staff of public services had very clear views on what is needed to improve access to their services and quality of life of people with disabilities. Social action staff especially were well aware of the rights of people with disabilities and all were able to mention specific items of the main convention. In general staff stated that rights of people with disabilities should be disseminated on a national level and within communities. They mention that physical access should be improved to public buildings and public servants should be trained to attend to people with disabilities. Most mention that special programmes should be developed in order to assist and empower people with disabilities to access education, work and health, and the importance of answering the need for adequate assistive devices and psychosocial support to improve self-esteem of survivors/people with disabilities.

Accessibility of services

When people were asked whether they face barriers to enter into public places, the most experienced difficulties are **straight stairs (49,5%), inadequate transport (30,4%), or public buildings without ramps (19,7%)**. 34,8% stated that they do not face any problems.

Health[32]

Most survivors have access to basic health care services. More specialised medical care is less available and more difficult to access.

Access / Need

The assessment shows **progress in the installation of basic sanitary services in rural areas**. Most survivors (88%) need and access basic health care services, with hardly any difference between survivors and local community members. This can be partly explained as health posts and health centres can be found close to the communities of the survivors. Half of the survivors did not encounter major difficulties (48%) to access basic health care services. Compared to the control group, survivors report significantly more need for specialised care (39,2%). Half of them manage to be attended. Some of the survivors present in the group discussion manage to set-up self-made equipment. **Crutches made of wood; an empty rice bag, kitchen-gloves and self-fabricated sitting pads to facilitate crawling over the floor.** Many report bodily pain and experience pain when the weather changes. It was not properly identified if people felt they would receive the right support or access to assistive devices if they would go to the health services.

Barriers

The most recurrent need expressed is for **better assistive devices**. Most report that these services are far away and they **do not have sufficient money** (24%) or **adequate transport** (32,3%) to reach the health facility. People either walk or go by chapa (local public transport), this takes them between 30 minutes and three hours. The overall feeling is that they are abandoned to their own destiny. **Access** to services and **information** seems way out of their reality and possibilities.

Health Services Providers

Ten interviews with health care providers at district or provincial level were carried out; of which three with staff of the orthopaedic centres, three with the nurse of a health centre (level 1), five with the medical director of the health centre (level 2); one with the director of rural hospital.

TABLE 5: Breakdown of responses by staff of health services whether specific services/ strategies are in place

	YES	NO
Database, differentiating people with disabilities	25%	75%
People trained to work with people with disabilities	50%	50%
Physical access	75%	25%
Sign language	25%	75%
Priority in attendance	92%	8%
Free attendance	50%	50%
Assistive devices for internal use	83%	17%
Community liaison in place	75%	25%
Psychological assistance available	33%	67%
Knowledge about rights of people with disabilities	33%	67%

[32] In matter of access to health services, the rehabilitation services are in the following section, p.52.

The Ministry of Health is responsible for medical attention and physical rehabilitation through 10 orthopaedic centres and housing in seven residential centres. (Centres managed by MMAS).

In most health services, the staff interviewed are **not specifically trained** to attend to people with disabilities. There is hardly any employee that knows of **sign language**. People with disabilities do receive proprietary attendance, but **free medical assistance is not always in place or known by staff**. Most health centres do have assistive devices for internal use. Most health service do have ramps to facilitate access for people with disabilities though most state that the quality of these ramps could be improved and not all consulting rooms and toilets are accessible. **Community liaison** seems to be well developed and in some instances there is a **close link with the programme of social action**. Most staff has heard of the rights of people with disability but is not able to mention specific aspects, besides free attendance.

Spy

I was a spy during the war, I was not in official military service but a civilian. I used to inform about tactics of the rival groups. One day when I was on my way to the field I stepped on a landmine. I will never forget that day, it changed my life forever, it was 12 June 1986. I lost my leg, but also lost my life there. I was still young, but from that day could not move freely anymore. I first arrived in the provincial hospital and later was transferred to the military hospital in the capital. I was actually assisted quite well in the hospital. When I came back, my younger brother took care of me, I live with him until today. If I am alive it is because of him. In the beginning I could still do somethings, but then I also lost my vision. It was not because of the accident, it just happened. For some time I did have a tricycle, but the tyres do not work well anymore and I have no money to repair it. At the time I had it, it was nice, I could ask the children in the village to push me around and could stay with my friends, but now I am tied up to the house, I cannot go anywhere. I am very grateful to my brother. He was working in South Africa, but now he is also unemployed . Things are more difficult, but they treat me like part of the family, I eat the same food and they take care of me. Also in the community I am treated well, I have never experienced any kind of discrimination from them. But I feel alone, I dream of having a wife who could take care of me, but I have no means, so it will just never happen. It makes me feel sad. Actually people have come here before and asked me things, but so far I have not seen any benefit, apart from the tricycle many years ago. I am disappointed, it is not with you, but nothing changes.

Rehabilitation

FOCUS: Assistive devices (usage, needs and mobility)

Half of the survivors use an assistive device, mainly prosthesis or crutches. Half of them report that these devices are no longer adequate. There is a low demand for rehabilitation centres, though the majority of the survivors need some kind of assistive device to improve their mobility.

Usage of assistive devices

54% of mine/ERW survivors use an assistive device.

The majority use prosthesis (38 %), crutches (27 %) or a walking stick (28%), a small minority of 3% uses self-made wooden crutches because of lack of adequate assistive devices.

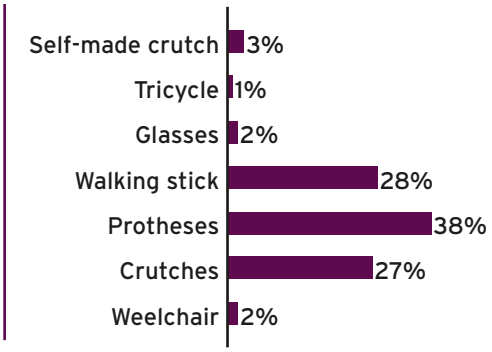
Most of them received their assistive devices from the hospital (58,3%) or from some governmental or social service (16%). Others received them through family or an NGO. A small minority had to pay for their mobile aids; in between 3,3 $ and 33$ for their devices (11,9%), whereas the majority (88,1%) received them free.

Need for assistive devices

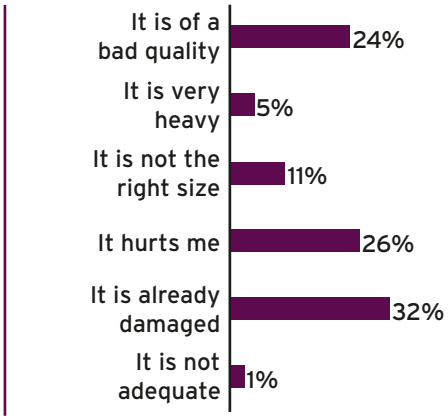
Of the survivors who use assistive devices more than half of them (56 %) report that their assistive devices are not adequate for them.

Most of the survivors **maintain the devices themselves** (37%). In other instances they are maintained by the health services (32%) or suffer from a lack of maintenance (18 %).

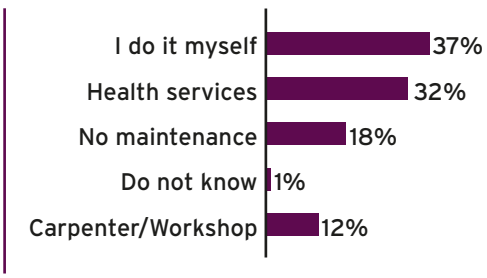
Graphic 23: Type of assistive device used by mine/ERW survivors



Graphic 24: Reasons why assistive devices are not adequate



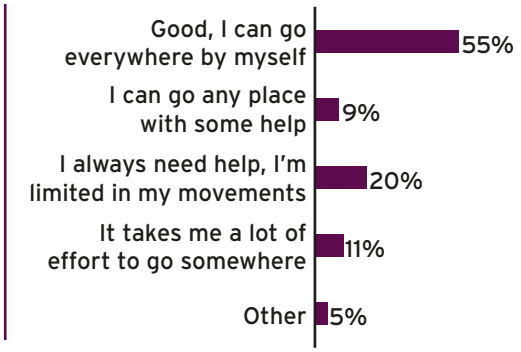
Graphic 25: Maintenance of assistive device



Mobility

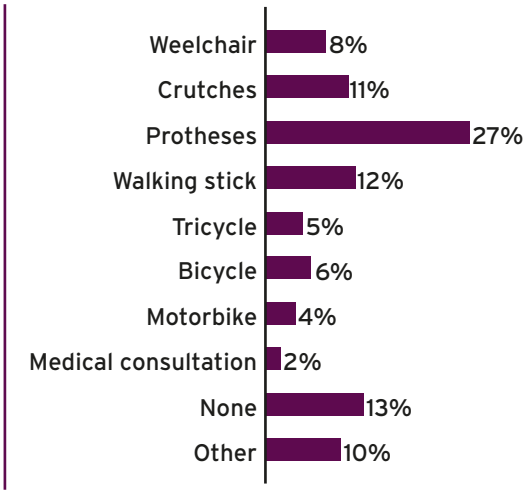
When survivors are asked to evaluate their mobility half of them (55 %) considers their mobility good, and state they can go everywhere by themselves. 9% can move around with the help of another person, one in five survivors (20%) always need help to move around and 11% just stay around the house.

Graphic 26: Evaluation of mobility by mine/ERW survivors



When asked what people need to maintain a good mobility **one in four survivors (27%) need prosthesis**, **almost one in four survivors (23 %) need crutches or a walking stick** and **almost one in ten (8%) need a wheelchair**.

Graphic 27: Needs of survivors in order to improve their mobility



Access / Needs

When looking at the demand for physiotherapy and orthopaedic services, it does not seem to reflect the actual need (Graphic 22 p. 49). One in five (21,6%) expressed the need for rehabilitation services. Of those who express this need, 30,8% got attended. Only 10,6% of the survivors stated they needed physiotherapy services, of those who expressed this need, more than one in two were attended (59,4%). This still reflects a very low number of survivors who actually had access to physiotherapy services.

Barriers

The results show that survivors underreport their need for these services. As **half of them** report that **their assistive devices are of insufficient quality and/or not adequate anymore**. It also shows a **lack of knowledge** of services to which they are entitled to and/or awareness on availability of or actual functioning of these services. **96,7% of the survivors report that there are no such services close to their community**, which might also explain the low demand, these services being based in provincial capitals. Most survivors have difficulties travelling longer distances, due to the **lack of accessible public and private transport** and the **poor state of the roads** (mostly untarred and covered with sand). This is consistent with the finding within the SINTEF[33] study , showing that more than 70 % of people with disabilities expressed the need for rehabilitation services, when only 25% effectively receive these services (less than 15% for assistive devices services).

Providers

During the assessment, **rehabilitation services were encountered in very poor conditions. Despite motivated staff**, there was reported a **lack of material** to be able to produce assistive devices for at least the last two years. **Equipment to produce assistive devices was outdated** (most of it still from 1986), spare pieces are hard to obtain and production of assistive devices has not been updated to more recent developments. If staff manages to produce assistive devices, most of the time they are still made of heavy material and without sophistication. There is **no kind of community liaison service** in place in order to reach people with disabilities in their communities, and a lot of them are **left unattended**. It was shocking to witness that in some instances the rehabilitation centre was attached to the provincial hospital (recently totally rebuilt) and it stayed behind the hospital in a **total state of abandonment**. The building was difficult to access due to sandy roads; there was no signage to show directions, with broken windows, outdated equipment and a total lack of material to produce devices.

[33] SINTEF, FAMOD & INE, Living Conditions Among People with Disabilities in Mozambique, Oslo, 2009

Psycho-social support

Access / Need

A fifth of the survivors interviewed received some kind of professional support to deal with the accident; this was mostly from somebody who attended them at the hospital (16,1%).

Graphic 28: Support structure reported by survivors after the accident

Most of the survivors report that they cope due to the support given by their family (34%), 22% considered they overcame the situation, 20 % accepted their destiny, whereas 18 % got their strength from religious practices or groups.

The need for psychological assistance (see graphic 21, p.48: 2,3%) seems highly underreported, considering the psychological impact of the accident. **One in two survivors (47%) still thinks a lot about the way the accident affected their life**. Most of them (72,7%) report that the accident caused **sadness**. They report that **they have lost part of their dreams** (28,3%) or they still feel hurt (14,5%) by it (multiple answers possible).

They present **many of the symptoms of trauma like recurrent memories, flashbacks, nightmares, feelings of anger and loss of self-esteem**. Especially when they would like to realise something and they are confronted with their limits due to the accident. Then the memory of the accident and how it affected their life comes back and they feel **paralysed/broken**.

As most accidents occur at a more mature age, **people have strong difficulties in coming to terms with a mutilated body**. Accepting to face people looking at their mutilated body and society in an impaired way requires "a psychological rebirth", for which **few have received the necessary support**.

The results of the assessment concerning **the need for psychological assistance** are in accordance with results of the SINTEF study and a needs assessment among mine/ERW survivors in Cambodia[34], where **emotional support** is ranked as important in the overview of assistance.

The findings show that **survivors still struggle to fully live the lives they want. For most of them, the accident has been a traumatic event**. However, one person may experience an event as traumatic while another would not suffer trauma as a result of the same event. Not all victims will actually become psychologically traumatized.

A brief explanation of trauma is presented in the MEMO next page to contextualise the need for specialised support in this direction, so far it is not commonly recognised as a basic necessity for people with disabilities.

[34] Handicap International, Victim Assistance in Cambodia, The Human Face of Survivors and their Needs for Assistance, 2011

There was a significant difference between survivors and community members in the level of distress experienced. This surprised the assessment team, also due to the fact that most of the time the accident occurred 20 years ago, and still seemed to play such an important role in the life of most victims. It evidences signs of trauma as explained below and calls for an appropriate response. The assessment showed the **mine/ERW victims need for existence, the need to be acknowledged, valued and accepted**.

Memo

Psychological trauma is a type of damage to the psyche that occurs as a result of a severely distressing event. A traumatic event involves a single experience, or an enduring or repeating event or events that completely overwhelm the individuals ability to cope or to integrate the ideas and emotions involved with that experience, as in the occasion of a mine/ERW accident. The sense of being overwhelmed can be delayed by weeks, years or even decades, as the person struggles to cope with the immediate circumstances. Psychological trauma can lead to serious long-term negative consequences and trauma victims, young and old, organise much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders, and affects. Trauma can be caused by a wide variety of events, but there are a few common aspects. There is frequently a violation of the person's familiar ideas about the world and of their human rights, putting the person in a state of extreme confusion and insecurity. This is also seen when people or institutions, depended on for survival, violate, betray or disillusion the person in some unforeseen way. Most victims received little assistance to be able to cope and adapt their lives to their new circumstances.

Social Protection and standards of living

Access / Needs to social services and programmes

Most survivors have not been included in basic social protection programmes.

There is a significant difference ($p<0.05$) between survivors and community members, where survivors more often were attended by social services. **13% of the survivors were attended or visited by staff of the social services, as compared to 5 % of the community members.**

Only 8% of the 13% of survivors who benefitted from social services received an assistive device and 6,8% got some monetary or alimentary support. However the majority (78%) of the survivors did not receive any benefits or assistance.

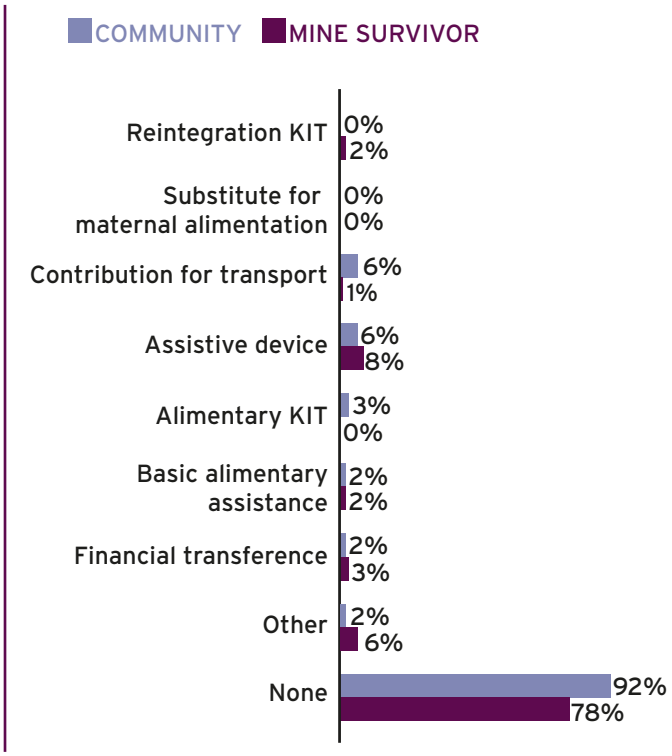
The expressed need for social services (4%) as shown in graphic 21, page 48, seems highly underreported, considering that three in four survivors and community members live under the poverty line.

Barriers

This under expressed need might be partly explained by **lack of awareness** or **difficulty to access information** about the programme.

Despite the fact that people with a disability are one of the six priority groups for the National Institute of Social Action's (INAS) social programmes, it seems that so far **only a small minority** of this population has been reached.

Graphic 29: Type of benefits received from social services



Social Protection Providers

11 interviews with representatives of social action were carried out, of which seven were district directors of social action and four were technical staff of social action.

Table 6: Breakdown of responses by staff of social services whether specific services/ strategies are in place

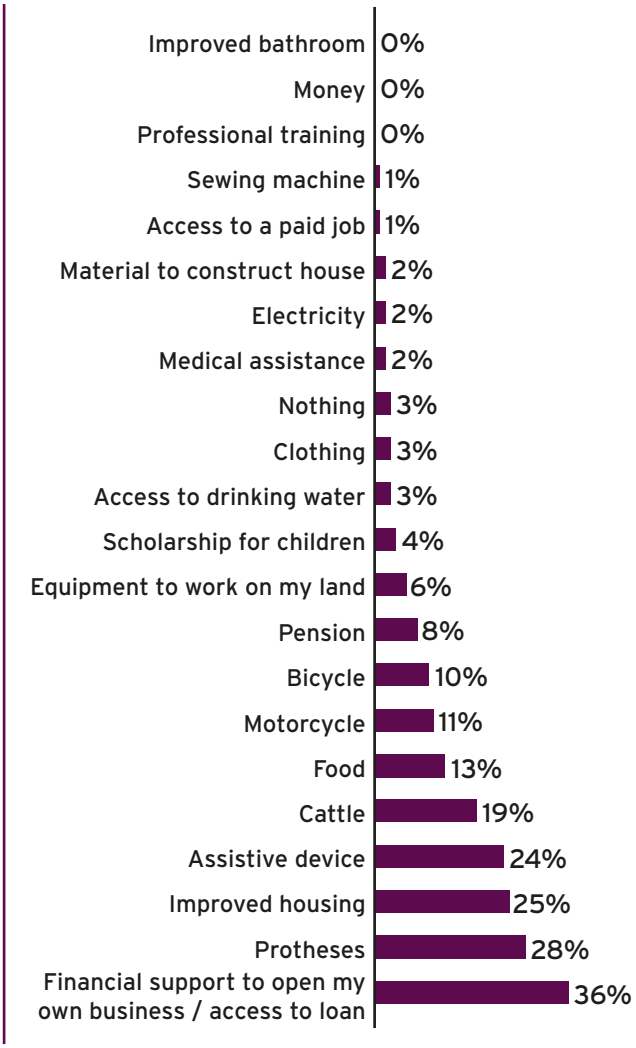
	SIM	NÃO
Identification of vulnerable groups in place	82%	18%
Database on people attended available	9%	91%
Staff trained to work with people with disabilities		100%
At least one staff member versed in sign language available	27%	73%
Staff aware about the rights of people with disabilities	91%	9%
Social inclusion programmes in place	64%	36%
Link between DPMAS and INAS well defined	27%	73%
Programme to facilitate access to services for people with disabilities	18%	82%
Special strategies to work with people with disabilities		100%
Partnerships with NGOs established	46%	54%

The Ministry of Woman and Social Action (MMAS) is responsible for the Disability sector in Mozambique, with INAS as its main operational body. First strategy of INAS gave priority to community approach and participation of vulnerable groups in their own development. The four main objectives of MMAS for 2010-2014 with regard to people with disabilities are i) to ratify the Convention on the Rights of Persons with Disabilities (signed in October 2010, ratified in January 2012), ii) to implement the national strategy for people with disabilities inclusion within the public sector, iii) the Disability National Plan (PNAD) iv) and the new Basic Social Protection Strategy. The National Strategy for Basic Social Protection (ENSSB), which was approved in August 2011, includes people with disabilities among the priority groups of the new program.

All staff interviewed from SDSMAS (district level of social action) during the assessment, report that there is a **mechanism of identification** of vulnerable groups. In some instances good working links with community leaders are established and an **awareness program** is carried out in the communities. Though most staff report **lack of (human) resources and transport** and therefore, they do not manage to "cover the whole district". The majority **do not keep a database** of number of people with disabilities attended or cannot determine people with disabilities within their database. In some instances people with disabilities are mentioned to benefit from basic social protection (alimentary or financial support) or succeed to receive assistive devices through social action (and INAS). Though in many instances it was reported that not all requests for assistive devices could be honoured.

Apart from a bureaucratic link to apply for assistive devices and social protection support, **no collaboration between social action and *permanente* of INAS is defined**. Though the *permanente* of INAS are the ones to identify vulnerable groups within the communities. **Staff of social action is not specifically trained to work with people with disabilities.** In general **no specific strategies to aim at social inclusion and empowerment of people with disabilities** are in place. Remarkably, all staff interviewed are aware and have a sound knowledge of rights of people with disabilities.

Graphic 30: Expressed needs to improve quality of living by survivors



FOCUS: Needs to improve the quality of living

When asked about their needs to improve their quality of life, three in ten (36%) survivors express the need for financial support, a micro credit or a loan to invest in better production skills or create their own business. One out in two (52%) survivors expressed the need for better assistive devices or prosthesis to improve their mobility. One in four survivors report the need to improve the quality of their houses.

Education

Access / Needs to educational services

Most survivors find it very hard to maintain their children in school, although education facilities can be found in their close surroundings. **Due to their socio-economic condition**, many end up withdrawing their children from school against their will, forced most of the time to repeat their own story regarding education.

For the larger group of victims: families of people killed by a mine/ERW, children report losing their parents and suddenly becoming the main income generator and having to take care of their brothers and sisters, and no longer being able to attend school, or afford it for the others. This was the same for the spouse left with no support.

It was also reported during the in-depth interviews that children with disabilities face difficulties to access school due to **lack of assistive devices and adequate transport**.

Only in a few instances community outreach strategies are in place to actively seek children with disabilities to ensure their inclusion.

Inclusive School Programmes have been launched and people living under the poverty line can receive an atestado da probreza (proof of poverty), of which they are exempted from school fees. Yet, most victims report that **they find it difficult to maintain their children in school**. Parents report that they still face quite **a lot of hidden cost**, which they cannot always cover, particularly as family members can be numerous.

Providers

Ten interviews with school directors or pedagogical directors were carried out of which five were of a primary school and five were of a secondary school.

Table 7: Breakdown of responses by staff of social services whether specific services/ strategies are in place

	YES	NO
Community awareness-raising and mobilization in place	70%	30%
Special programme to include children with disabilities in place	30%	70%
Children with disabilities who attend are included in their educational services	50%	50%
Teachers/staff trained to work with people with disabilities	30%	70%
Staff versed in sign language available	20%	80%
Staff aware about the rights of people with disabilities	80%	20%
Ramps to access the building	40%	60%
Adapted toilet facilities		100%

The Ministry of Education (MINED) promotes the rights of all children to basic education, including those who have learning difficulties or are physically challenged. A special education department was created and an " Inclusive School Program" was launched in 1998 to promote the integration of children with special needs into ordinary education, to provide in service training and to improve coordination between parties on inclusion of people with disabilities in education.

Nevertheless, most schools report that they do not have special programmes in place to better include and attend children with disabilities. Some report that they (used to) carry out some kind of awareness program within the community, conduct meetings with community leaders and parents to convince about the importance of participation in school. Though most staff is not specifically trained to attend children with disabilities apart from social inclusion module within their university curriculum. Half of the schools visited have ramps to facilitate access; none of the schools had their toilet facilities adapted.

Work and employment

Most of the survivors had to find new ways to sustain their families because of the accident. Few received assistance to better fit their work to their abilities.

Access / Needs to occupational training and employment services

For most survivors living in the rural areas, **agriculture is the only opportunity to sustain themselves** or to survive. Though policies are in place to promote the inclusion of people with disabilities into the formal market, few survivors actually manage to. In general survivors report in the group discussions that they **do not experience the same opportunities to access a salaried job**, if they have already tried they are **easily sidelined** when vacancies arise. **Access to a professional training centre seems out of reality for most of the survivors.** Survivors state that these services **do not exist close** to their community (3,7% states it exists in their proximity), or they are **not aware** these services exist. There are no significant differences with the control group. This is consistent with the finding of *the local diagnostic of people with disabilities in the suburban areas of Maputo and Matola*[35] where occupational training programmes benefit 2,5% of the population and three-quarters of them were not aware such programme existed.

Barriers

In general survivors feel that they **do not have the same opportunities** as other people in their communities. **They are limited in their movements** and cannot carry out the same activities as before, which is very difficult to cope with. The only opportunity they see to sustain their families is **agriculture**. Though at the same time they report that they cannot carry heavy weight, cannot walk long distances or sometimes can only do work "sitting down" due to lack of assistive devices. The consequence is that **they manage to grow crops for their own survival**, but do not manage to cultivate bigger pieces of land, which would allow them to also sell products and generate some income. Most of them feel **denied access to the formal labour market and sidelined or neglected when opportunities arise**. Others report that due to the accident they did not manage to **continue their education or gain qualifying skills**. They feel that this would have **increased their chances**. For many people it is very hard to get out of the **poverty trap**[36]. Many have dreams to improve their conditions. They report that if they would have some means or **'starting capital'** they feel they could improve their living conditions and better adapt the way they sustain themselves to their physical possibilities. They see their peers or family members being able to construct their houses, have opportunities and have a better socio-economic situation. Some report that they feel anger inside and it is difficult for them to witness this, as they could have been much better off as well.

[35] Handicap International, People with disabilities in the suburban areas of Maputo and Matola, Maputo 2010
[36] See Glossary p.81

Rights

In general, few survivors are members of a DPO or are aware of their rights and Conventions that guarantee the rights of people with disabilities. If survivors are a member of a DPO, they are more likely to be a former soldier.

Access to rights

One in four survivors is member of a DPO (24,7%). The majority (83,6%) is a member of ADEMIMO (an association in pro of military people with an impairment). Which leads to the significantly higher ($p>0.05$) number of former soldier survivors who are members of a DPO and aware of the main conventions, which guarantee their rights. One third (29,5%) of them became member in 1994 right after the war, possibly in defence of their interest.

In general only a few, one in nine survivors, are aware of the main conventions guaranteeing the rights of people with disabilities. Even less (9%) have heard of the Ottawa Treaty, although they are the main ones concerned.

Almost half of them (43,8%) are aware that they have priority schools attendance, hospitals, banks and transport due to their disability. One in three receive this kind of priority in reality.

Barriers

In several occasions survivors face barriers and obstacles while trying to access their rights and feel they are not seen as **'full citizens'**. For example, the right to a driving license is sometimes refused to them, despite several temptations. Many people seem to desist in advance, anticipating possible disappointments.

Organised civil society (NGOs) so far does not seem to have appropriated themselves of the Convention of people with disabilities, ratified in 2012. Compared to public service providers, fewer staff were aware of the rights of people with disabilities. Apart from a small number of NGOs, no special components were developed as part of their projects or strategies to better include people with disabilities as beneficiaries of their social support programmes.

RECOMMENDATIONS FOR THE NATIONAL ACTION PLAN ON VA

RECOMMENDATIONS FOR THE NATIONAL ACTION PLAN ON VA

Overall recommendations

The following recommendations presented are based on the results of the assessment and are meant to provide useful information for the development the elaboration of the **National Action Plan on Victim Assistance Plan (VA Plan)**.

The recommendations are grouped according to the main thematic areas of VA: health, rehabilitation, psychological support, social protection and standards of living, education, work and employment.

As recommendations are addressed to service providers and policy-makers and as mentioned in the introduction, VA should be seen within the **broader disability framework**. Thus, most recommendations are written in order to address "the larger group of people with disabilities". If recommendations are specific to victims or survivors, they are mentioned as such. As Mozambique strives to meet its obligation under article 5 of Mine Ban Treaty, the threat of landmines will be largely gone; therefore the **recommendations focus** less on emergency care and **more on social inclusion and access to services by mine/ERW victims**.

- **Identify subgroups** within the group of victims based on criteria such as: **level of impairment**; multiple impairments; living **under the poverty line**. Prioritise their assistance and social inclusion, taking as a starting point their identified needs and capabilities.

- **Build, disseminate, promulgate and monitor the VA plan** among departments of Ministries involved and its **decentralised levels**, and other stakeholders involved (DPOs, NGOs).

- **VA should also include families of those injured or killed as eligible recipients of assistance** to cope with the financial, social and emotional loss. With attention on specific needs of **women, the largest group of indirect victims**.

- **Communicate on and disseminate the rights of people with disabilities** on a national level and within local communities choosing **most appropriate communication strategies** (soap-operas, billboards, song text, theatre plays, leaflets).

Regarding the development of the National VA Plan itself

- The VA plan must be linked to **broader disability, human rights, development frameworks and national strategies** (such as the CNAD, PNADII, PARPA and BSPS[37]).

- **Ensure data collection** throughout the main Ministries involved in service provision for victims and people with disabilities in general to be able to **monitor progress and evaluate service delivery**.

- Develop and implement **sector-based answers around the needs** of the victims and people with disabilities; a **transversal approach between the different Ministries involved** (health, social action, education, employment),

- **Designate an inter-ministerial, multi-stakeholder national steering mechanism** to oversee the elaboration of the National Action Plan on Victim Assistance (VA plan) and to monitor its implementation. Include the main governmental ministries responsible for programming adequate responses, DPOs, NGOs, victims and other relevant stakeholders.

- **Develop Terms of Reference (ToR) on responsibilities and outcomes expected** from the main stakeholders involved in developing the VA plan.

- **Secure and allocate** (inter)-national **resources** to guarantee implementation of the VA plan throughout the different Ministries in charge.

- **Assess additional resources** needed to be able to fully implement the VA plan.

- Elaborate the VA plan with **Specific, Measurable, Achievable, Relevant and Time-bound (SMART) objectives and indicators** to improve quality of life for mine/ERW victims and people with disabilities.

A lot of advancement has been made with regard to drafting of policies and ratifying international agreements to improve access to services and human rights for people with disabilities in Mozambique. The challenge remaining is to allocate budget, develop and implement appropriate strategies of social inclusion and empowerment in systematic coordination between all stakeholders and monitor and evaluate progress on service delivery by Ministries as well as civil society and DPOs. **All these actions should become policies that result in better quality of life for survivors in order to allow them to fully participate into society.**

[37] All acronyms are detailed p. 83

By intervention sector

The recommendations following are based on the results of the assessment[38] including, when interviewed, the recommendations of the relevant services providers.

Health

- **Improve accessibility** to health services through **barriers and obstacle elimination**, including access to consultancy rooms and bathrooms.

- Ensure that **emergency, continuing medical care and medication are free of charge** to casualties of explosive devices and mines/ERW survivors.

- Ensure with relevant **specialised** medical stakeholders that referral hospitals have **adequate equipment** and supplies.

- Improve availability of **assistive devices for internal use** of health structures.

- **Improve referrals** between hospital and other service providers (such as social action, psychosocial assistance).

- **Train health professionals** on specific issues for attendance of survivors and their families and on the rights of people with disabilities.

- **Improve access to specialised services** (rehabilitation, reconstructive surgery, pain management and occupational therapy).

When asked what is needed to improve living conditions and attendance of people with disabilities, **healthcare providers mention the following aspects**:

- **Disseminate the rights** of people with disability on a wider scale.

- **Train medical staff** and other public servants to better attend the needs and capacities of people with disabilities.

- Improve **physical access** to health services and other buildings.

- **Improve the inclusion** of people with disabilities in **public services and job opportunities**.

- Install **psycho-social support** for people with disabilities.

[38] Assessment report: The electronic versions of this document are available online in English and Portuguese, as is the initial assessment report with its full methodology, see p. 2

Rehabilitation

- **Ensure data collection** from survivors in order to **monitor progress and evaluate service delivery**.

- Improve **physical access** to rehabilitation services, **eliminate barriers and obstacles**, improve signalisation.

- **Allocate necessary technical, human and financial resources to ensure service delivery of rehabilitation services and assistive devices.**

- Ensure the supply chain and stock of **material to be able to produce assistive devices and prosthesis**.

- When feasible, **update the equipment** used to produce assistive devices and update quality of the material used.

- Set-up and follow **case management and referral** to relevant services (physiotherapy, pain management, speech therapy, psycho-social support).

- **Train staff** on most recent techniques, referral systems, Community-Based Rehabilitation (CBR) and most recent policies regarding people with disabilities.

- **Promote** the availability, knowledge and use of **assistive devices** among survivors and their families.

- Develop **community outreach strategies** to search for survivors within their communities, identify their needs with regard to rehabilitation services and assistive devices, facilitate their transport and accommodation.

- Conduct studies on **client satisfaction** of survivors on the existing rehabilitation services in collaboration with local universities/medicine faculties.

- Guarantee **maintenance** of assistive devices

Rehabilitation services need to be thought of in a "twin-track" approach: in one hand, to re-install and upgrade services themselves from the top-down, and on the other, to develop community outreach strategies to go directly to the people in need, from the bottom-up. The assessment shows a gap in quality and supply of assistive devices and rehabilitation services. A lack of equipment prevented the manufacturing of assistive devices for at least the last two years. The actual level of service delivery can be considered a step backwards in the facilitation of the inclusion of people with disabilities in society. **Availability of assistive devices is highly important for reducing activity limitations and restrictions in social participation, such equipment has a huge potential in breaking the disability-poverty vicious circle and therefore, is a first priority.** This might be regarded as a logical severity hierarchy, as the first on the list to be in place to ensure the next level. When rehabilitation services are reinstalled, community outreach programmes to identify people with disabilities in need have to be developed and implemented at the same time. Transport and accommodation to facilitate access should be available, as well physiotherapy services.

Psycho-social support

- Develop **pilot projects on inclusion** of psychological support for victims in main **referral** hospitals as well as creation of peer support at district level to attain maximum **self-reliance, self-worth and autonomy**.

- Ensure that staff is trained/prepared to **assist victims to cope** with the psychological impact of the accident and the challenges faced.

- Develop a training module to **train psychologists and social workers** on psycho-social support for victims and on how to form peer support groups.

- **Capitalize** (lessons learned process) on successful methodologies on psycho-social support and **advocate** for implementation on a **national scale**.

The results of the assessment showed people with trauma and a strong need for psychological assistance, even when accidents occurred 20 years ago.
This poses a real challenge to existing services, as **psychology is still a recent study in Mozambique** and currently first shifts of students leave their universities.

Therefore:

- **Partnerships** have to be established **between public health services and INGOs** to develop adequate inclusive psychosocial approaches for people with disabilities and victims.

- **Good practices** can be derived from psycho-social approaches being developed and included in hospitals in Mozambique to attend **people with HIV AIDS**.

- The local **rural context**, socio-cultural values and specific challenges faced by victims should be taken into consideration and responses should be developed in close collaboration and consultation with the target population itself.

- These psycho-social interventions **should not be carried out in isolation** and should be part of **personalised social support strategies** (see Glossary, p. 81)

- Psychological and psycho-social support should be **mainstreamed** into work and income policies, educational and training strategies

- The suffering of victims should be recognised by national authorities in order to **gain visibility and promote self-respect**. As having suffered a mine/ERW accident is particularly disturbing, they have become victims of a weapon of war. If the authorities do not work towards their social inclusion or access to, or give an open recognition of their suffering, they fall in a deadening pitfall of social invisibility.

Social Protection and standards of living

- Ensure **data collection** for victims through Ministry of Woman and Social Action (MMAS) and its operational institute (INAS) to be able to **monitor progress and evaluate service delivery** to victims.

- Allocate necessary **technical, human and financial resources** to ensure service delivery of social protection, access to assistive devices and social inclusion.

- Ensure that victims most in need (multiple impairment/living under the poverty line) are **included in social protection programmes** and assisted first.

- Assist victims in **orientating and accessing** complementary services as soon as possible (rehabilitation, psychological and peer support, education and employment).

- Develop and implement **personalised social support strategies** (see Glossary p. 81) in close collaboration with service providers and victims, prioritise areas of life most in need of assistance, enable and assist individuals in their own development.

- Develop strategies for the MMAS and INAS to work in close partnership in order to **identify victims in their communities** and to **promote** their social inclusion.

- Ensure that the **"District Fund for Development" is available** to victims and report on number of granted applications to victims.

- Support victims in obtaining an **"atestado de probreza"** (proof of poverty), also being exempted from paying school fees.

- **Train staff** of MMAS to be able to attend victims and people with disabilities, understanding their specific challenges

- **Empower and include people with disabilities** to participate in their own development.

From providers
Needs identified by representative of social action in order to better attend people with disabilities by social action and improve quality of life of people with disabilities:

- Ensure **sufficient assistive devices** and functioning **rehabilitation services**.

- **Disseminate the rights of people with disability** on a lager scale and **raise awareness** amongst service providers.

- Improve access to **educational and health services, work, financial support** for people with disabilities.

- Develop and implement **psycho-social support** for people with disabilities.

- **Train staff of Social Action** on how to attend to people with disabilities.

- Allocate **sufficient human and financial resources** to be able to attend people with disabilities.

- **Include them in social protection strategies.**

Education

- Ensure that **children with disabilities and children of victims** have access to educational opportunities in their communities (e.g. scholarships).

- Strategies have to be designed or reinforced, to **prevent dropout** figures of children of victims.

- Improve **accessibility**, access to **transport** and supply of adequate **assistive devices** for children with disabilities.

- Develop a training module to **train teachers and schools directors** in line with the existing module on inclusive education in their training curriculum.

- **Train teachers according to this module** to be able to scope for the specific learning and psycho-social needs and how to include their parents and classmates/peers.

- Develop and implement c**ommunity outreach activities to identify children with disabilities** or parents below the poverty line.

- Improve **accessibility** to education services, eliminate barriers and obstacles. The accessibility of a school must include the **facilitation of movement within the facility** and the development of **accessible toilets**.

- Ensure **data collection** for children with disabilities to be able to monitor their inclusion level into the education system.

From providers

The following suggestions were made by the direction of the schools interviewed to better include children with disabilities into educational services and improve living conditions of people with disabilities:

- **Train teachers** on how to include and deal with children with disabilities.

- **Scholarships** for children or for parents with disabilities who have no means to send their children to school.

- **Psycho-social support** for children with disabilities/improve self-esteem.

- **Raise awareness** about the rights of people with disabilities.

- **Assistive devices** available.

- Create **database about participation of children** with disabilities within educational services.

- Improve **physical access** to schools.

- **Community mobilisation and awareness raising.**

Work and employement

As most victims work in agriculture, support victims in i**mproving their productivity in the field** (modern tools, knowledge on new methods and opportunities and cattle to cultivate wider pieces of land) and **ensure their mobility** with assistive devices to have their "hands-free" (see Recommendations on rehabilitation, p. 69)

- While developing **approaches to improve socio-economic** and/or employment position of victims take into consideration **the age of mine/ERW survivors**, the fact that they **live far apart** and have **difficult access to transport.**

- Ensure the **5% norm on inclusion of people with disabilities** -survivors included- is reached within national service providers, then share monitoring and evaluation.

- **Build capacities of social, community and other field workers** to support victims in defining a realistic **personal plan of action towards economic inclusion**, and to **inform, orient and refer** them to relevant services.

- Ensure victims are **included into livelihood services** (technical, vocational, education and training services, micro-finance providers, job placement services, employment programmes).

- Training opportunities (such as apprenticeships with master trainers or local businesses, community training and peer to peer services) should be **market-driven and accessible**.

- **Business training and coaching** is available for victims starting or **developing self-employment activities**.

Water

The well is one kilometre from my little house. I tell you, it is a long way for me with my crutches! I have to control the bucket of water that I carry on my head. I think it takes me 30 minutes to walk to the well. But the journey back to my house with my bucket with water is very difficult. When I put a step with my single leg and one of my crutches, my body shakes a bit. And if the bucket is full with water on my head, I am losing water... The way back to my house takes me much longer. The other difficulty is the road. There are so many holes in the sandy road and so many stones. At any time I have to avoid getting off balance. Over the years it happened to me several times that I was not focused on my steps for just a second and I landed with my foot on a stone or in a hole. When that happens I lose sometimes half of the water in my bucket. It takes me, roughly, three hours to get my water. But when I get back I can rest for a while. When I look at the full bucket with water I sometimes feel happy. I cook some water to make food for my little girl and me. For the vegetables and cassava I do not have to walk too far. It is just beside my house where I have a small piece of land. I make a little money by selling food to other people in the village. I am alone, I did have a husband, but he left me. Sometimes he comes to visit me, but he lives with his other wife. There are other men, but they just want to take advantage of me and then go, they don't like a woman with a disability. That is my life.

By intervention axis

Empowerment of civil society: DPOs

Few survivors are members of a DPO. Of the ones who are members of a DPO, most are ex-military survivors, even though few of them know about their rights. For example, the UNCRDP signed by the Mozambican Government. A limited percentage were able to mention aspects of this Convention, though these agreements immediately affect them. **DPOs should improve their capacity to fight for the rights of the groups they represent and lobby for access to services.** To do so, they should:

- **Advocate** the interests of their target population at **national meetings**, be involved in **needs-based planning** and closely **monitor** and report on **implementation of UNCRPD**, programmes and policies in pro of victims and people with disabilities.

- **Implement national campaigns** to raise awareness about the rights of victims and people with disabilities. Organise events and meetings on **district/province level** to promote dialogue and raise awareness.

- Develop **specific communication strategies**, using accessible language, to **promote dialogue** with their members and **raise awareness** of people with disabilities on their human rights, their benefits or advancements in the field of people with disabilities. **Most survivors** encountered in the field **have cell phones**, which might be an opportunity in finding **creative ways to communicate** with them.

- Make sure **communication strategies** are inclusive of all types of deficiencies.

- Establish partnership or develop relations **with human rights organisations** and relevant stakeholders.

- **Develop lobby mechanisms** to access basic human rights.

- **Report and follow-up cases of violation of human rights** or severe neglect, abandon and discrimination to the appropriate Ministries and advocate for access to appropriate services.

- **Assist** victims who suffered a mine/ERW accident while in the army and who have not received the **appropriate compensation or pensions** to access their rights.

- Identify, train and **coach a group of victims to represent victims in the development of the VA plan**, facilitate their transportation and accommodation

Mainstreaming VA in existing legal framework

The government has shown its concern on disability issues, by designing and approving national policies, law and programmes to promote the inclusion of people with disabilities, and by ratifying the UNCRPD and acceeding to its optional protocol in January 2012.
So far however not enough sufficient resources have been allocated or invested to implement these laws.
Therefore, it is a priority to:

- **Identify and allocate resources.**

- **Train staff and service providers** to assist and be prepared to attend to people with disabilities.

- **Rights of people with disabilities** have to be **disseminated on a national scale**.

- **Customised approaches aiming at empowering** the individual and social inclusion have to be developed and implemented.

- Databases to allow **monitoring and evaluation** need to be created and updated regularly.

Though people with disabilities are one of the priority groups of the MMAS, no clear improvements have been made to allow people to access basic social protection measurements and assistive devices.

- Clear strategies could be developed and implemented by **Social Action in close collaboration with INAS** on how to **promote social inclusion and empowerment** of people with disabilities and guarantee access to the Basic Social Protections Measures.

- Strategies could be developed to take advantage of the **fieldwork of the permanentes of INAS** in order to **identify** people with disabilities in their communities and address their needs in close collaboration with the MMAS.

- Accessing Basic Social Protection is a necessary step to allow autonomy.

Despite the **decrete 53/2008** which orientates the removal of **arquitectonical barriers** in public buildings and services in order to facilitate access for people with a disability, a lot of survivors still encounter accessibility problems outside the household.

- Investment is needed in making buildings more accessible

- As well as a lot of investment to include people with disabilities to allow their full participation into society.

Personalised Social Support[39]

Personalised social support strategies should be developed in close collaboration with service providers and victims. These strategies have to take into account the **age and gender of the victim**. It should be taken into consideration while developing an appropriate response that most victims suffered the accident more than 20 years ago. They are now in a **more advanced age**, live in remote **rural areas** with sandy unpaved roads and **difficult access to transport**. Most have little or no formal education. **Appropriate responses should be tailored to the needs identified by them**, which can be summarised as follows:

- Financial support to start their own business.
- Improve quality of their housing.
- Good quality assistive devices to improve their mobility.

Therewith taking into consideration that an individuals **level of living** is also defined by the ability to **exercise choice** and to affect the course of his or her life; **empowering victims to participate in their own development**.

It is important that while developing a VA plan and policies, **all areas of life** (work, education, health, leisure, psycho-social situation, etc.) of the victims are assessed. While developing assistance, the **circle of influence** (family members and support structure) **should be embodied in helping them** to recover and improve their living conditions.

[39] See Glossary p. 81

Shopkeeper

The accident happened while I was in military service, during the war, I had to leave school to serve. I was with three colleagues, we were all hit when the mine exploded, I lost my leg, my colleague lost his arm and unfortunately the third one died. I was transferred to the military hospital were I received treatment and a prostheses, which I use until today. When I came back to my hometown, I decided to overcome my situation and that I would build a future for me, and my family. There was a man in the village that knew how to use a sewing machine, so I asked him to teach me. I arranged money for my first investment. I am privileged as I receive a small pension because of the accident. I bought the sewing machine and started my own little business as a tailor. Have a look at this skirt; I make them in all sizes. From there I grew bigger, I opened my own shop were I sell rice to the community. I am actually always full of plans; I want to earn money to send my children to university. Do you see that stage? I just built it, which is a new idea. I will do shows here, there is hardly anything going on in the community. I invited a famous singer and my place can fit around 300 people here, I will ask for an entrance fee, sell soft drinks and beer and rent that little room up there for somebody to sell food during the show. The one thing which really upsets me is that my next investment is a car so I can drive around and transport goods, as they are very heavy to carry. I have all the right papers, I followed all the procedures, but when I was almost about to get my driving licence they suddenly denied it to me. They told me a person with a disability couldn't drive! Can you believe it?! I am still so angry and trying to find ways to arrange it. I will succeed, but I am outraged about so much discrimination from the official authorities. My biggest treasure in life is my wife. Without her support I would not have come so far and been able to build this all.


PERIGO MINAS!
INFORMAÇÕES SOBRE O PERIGO DAS MINAS E MUNIÇÕES
PERIGO MINAS!
SINAIS DE PERIGO

ANNEXES

ANNEXES

To go further on VA

Bine, A.C. & Masslberg, A, **Gender sensitive Victim Assistance**,
Journal of ERW and mine Issues, 15.2
Summer 2011

Handicap International, **Full circle of impact; the Fatal Footprint of Cluster-munitions on Communities and People**, 2007
www.hiproweb.org/uploads/tx_hidrtdocs/Full_report_Circle_of_Impact_2007.pdf

Handicap International, **Voices from the Ground: Landmine and Explosive Remnants of War Survivors Speak out on Victim Assistance**, 2009
www.hiproweb.org/uploads/tx_hidrtdocs/Voices_from_the__Ground-report.pdf

Handicap International, **Victim Assistance in Cambodia, The Human Face of Survivors and their Needs for Assistance**, 2011
www.hiproweb.org/uploads/tx_hidrtdocs/Voices_from_the_Ground-report.pdf

Handicap International, **Recommendations for National Action Plans on Victim Assistance**, 2011-2015
In English: www.hiproweb.org/uploads/tx_hidrtdocs/HI-RecommendationsEng-WEB.pdf
In Portuguese: www.hiproweb.org/uploads/tx_hidrtdocs/VA_Recomendacoes_light.pdf

Handicap International, **People with disabilities in the suburban areas of Maputo and Matola**,
Maputo 2010
In English: www.hiproweb.org/uploads/tx_hidrtdocs/Relatorio_GB_BD.pdf
Synthesis in Portuguese: www.hiproweb.org/uploads/tx_hidrtdocs/SyntheseDiagnosticoLocalDeficiencaMaputo2010_01.pdf

Victor Igreja, **The Monkeys' Sworn Oath Cultures of Engagement for Reconciliation and Healing in the Aftermath of the Civil War in Mozambique**, PhD thesis, 2007
https://openaccess.leidenuniv.nl/bitstream/handle/1887/12089/front.pdf?sequence=6

SINTEF Health Research & INE & FAMOD, **Living Conditions among People with Disabilities in Mozambique: A National Representative Study**, January 2009
www.sintef.no/home/Publications/Publication/?pubid=SINTEF+A9348

Washington University, **Applying the capabilities approach in examining disability, poverty and gender**, paper produced for conference on promoting women's capabilities, examining Martha Nussbaum capabilities approach, University of Cambridge, 2002
www.awid.org/Library/Applying-the-capabilities-approach-in-examining-disability-poverty-and-gender

A|Z

Glossary

Anti-personnel Landmines
According to the Mine Ban Treaty, anti-personnel mines are mines that are designed to explode by the presence, proximity or contact of a person and that will incapacitate, injure or kill one or more persons.

Anti-vehicle Landmines
According to the Mine Ban Treaty, anti-vehicle mines are munitions designed to be placed under, on or near the ground or other surface area and to be exploded by the presence, proximity or contact of a person or vehicle.

Cluster Munition
According to the Convention on Cluster Munition, a cluster munition is a conventional munition that is designed to disperse or release explosive sub-munitions each weighing less than 20 kilograms and includes those sub-munitions. These include explosive, failed, unexploded, abandoned munitions and sub-munitions.

Explosive Remnants of War (ERW)
Means the unexploded ordnance and abandoned explosive ordnance that excludes mines, booby-traps or other devices .

Human Development Index (HDI)
HDI is a comparative measure of life expectancy, literacy, education and standards of living for countries worldwide. It is a standard means of measuring well-being, especially child welfare. It is used to distinguish whether the country is a developed, a developing or an under-developed country, and also to measure the impact of economic policies on quality of life. HDI is estimated and reported by United Nations Development Program (UNDP).

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

Mined Area
According to the Mine Ban Treaty, mined areas are areas that are dangerous due to the presence or suspected presence of mines.

Person/people with Disabilities
The Convention on the Rights of Persons with Disabilities states: 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.

Personalised Social Support[40]

"Personalised social support can be defined as a voluntary and interactive approach involving participative methods with the person asking for or accepting assistance, with the objective of improving their situation and relationship with their environment or even transforming them. [...] Social support provided to a person is based on respect and the intrinsic value of each individual, as a party to and subject of rights and obligations". It is based on a global analysis of a person's life and aims to foster their empowerment by helping them to better formulate and organise the preparation and realisation of a (personalised) project.

Poverty Trap[41]

Poverty trap is defined as "any self-reinforcing mechanism, which causes poverty to persist. If it persists from generation to generation, the trap begins to reinforce itself if steps are not taken to break the cycle".

Specific / specialised services

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

Support services

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

Survivors

Survivors are persons injured as a direct consequence of landmines and ERW.

Victim Assistance

According to the Mine Ban Treaty and the Convention on Cluster Munition, victim assistance includes (not limited to) 'casualty data collection, emergency and continued medical care, physical rehabilitation, psychological support and social integration, economic integration and laws and public polices to ensure the full and equal integration and participation of survivors, their families and communities in society.

Victims

According to the Mine Ban Treaty and Convention on Cluster Munitions, victims are "all persons who have been killed or suffered physical or psychological injury, economic loss, social marginalisation or substantial impairment of the realisation of their rights" caused by the use of weapons of war. In this light, there are two types of victims:

- **Direct victims** are persons injured or killed as a direct consequence of landmines and ERW;
- **Indirect victims** include families and communities of those killed or injured as a direct consequence of landmines and ERW. It also includes mines and ERW impacted communities that suffer economically or otherwise due to the presence of contamination.

[40] Practical Guide on Personalised Social Support: www.hiproweb.org/uploads/tx_hidrtdocs/GuideASPGBBD.pdf - In Portuguese: www.hiproweb.org/uploads/tx_hidrtdocs/GuideASPPORBD_01.pdf
[41] Costas Azariadis and John Stachurski, "Poverty Traps," Handbook of Economic Growth, 2005, 326

ANNEXES

Acronyms

ADL	Activities of Daily Living
ADEMIMO	Association of Soldiers with Disabilities of Mozambique
BSPS	Business Sector Programme Support
CAP	Cartagena Action Plan
CBR	Community-Based Rehabilitation
CCM	Convention on Cluster Munitions
CNAD	National Council for the Area of Disability
DAC	Disability Action Council
DPO	Disabled People Organisation
DPMAS	Direction Provincial of Women and Social Action
ENSSB	National Strategy for Basic Social Protection
ERW	Explosive Remnants of War
FAMOD	Forum of Associations of People with Disabilities in Mozambique
FRELIMO	Liberation Front of Mozambique - Frente de Libertação de Moçambique
HI	Handicap International
HIV AIDS	Human Immunodeficiency Virus infection - Acquired ImmunoDeficiency Syndrome
ICBL-CMC	International Campaign to Ban Landmines and Cluster Munitions Coalition
INAS	National Institute of Social Action
IND	National Institute of Demining
INAS	National Institute of Social Action
INE	National Institute of Statistics
KAP	Knowledge Attitudes and Practices (survey method)
MBT	Mine Ban Treaty
MISAU	Ministry of Health
MMAS	Ministry of Woman and Social Action
MoU	Memorandum of Understanding
NAP	Nairobi Action Plan
NGO	Non-Governmental Organization
PARPA	Program of Action to Reduce the Absolute Poverty
PNAD	National Plan for Disability
RAVIM	Network for Assistance to Mine Victims
RENAMO	Mozambican National Resistance
SDSMAS	District Service of Health, Woman and Social Affairs
SHA	Suspected Hazardous Areas
SINTEF	Norwegian Foundation for Scientific and Industrial Research
SMFR	Physical Medicine and Rehabilitation Service
ToR	Terms of References
UNCRPD	United Nations' Convention on the Rights of Persons with Disabilities
UNDP	United Nation Development Program
UNHCR	United Nation Refugee Agency
VA	Victim Assistance
WHO	World Health Organisation

s

Shattered dreams

This publication comes from the **Needs and capacity assessment** realised by Handicap International and RAVIM, the National Victim Assistance Network.

Its objective is to present accurate data and recommendations to allow the development of a National Action Plan on Victim Assistance to support the rights of mine/ERW survivors in Mozambique.

The results of the assessment will provide all stakeholders with the necessary information to develop adequate responses that can improve the quality of life of mine/ERW survivors and guarantee their rights within a broader disability framework.

The publication is divided in 4 chapters:
Principles and Benchmarks provides background information to understand the situation of mine/ERW victims, and the objectives and design of the Assessment.

Mine/ERW victims in Mozambique presents their situation today, as compared to the other members of their community, through evidence-based results of the Assessment.

Needs identified by sectors reviews the qualitative and quantitative results and their analysis, presented by specific sectors covered in Victim Assistance.

Recommendations for the National Action Plan of Victim Assistance, presented by intervention sectors and intervention axis, in line with the Cartagena Action Plan.

HANDICAP INTERNATIONAL
Programa Moçambique
Avenida Agostinho Neto nº49 - C.P. 4331 Maputo
T. +258 21 486 298 F. +258 486 302
info@hi-moz.org

Ministry of Foreign Affairs of the Netherlands

Australian Government
AusAID

UNDP

UN Partnership to Promote the Rights of Persons with Disabilities
ILO | OHCHR | UNDESA | UNDP | UNICEF | WHO

Ravim
Rede para Assistência às vítimas de Minas

HANDICAP INTERNATIONAL