

Angola



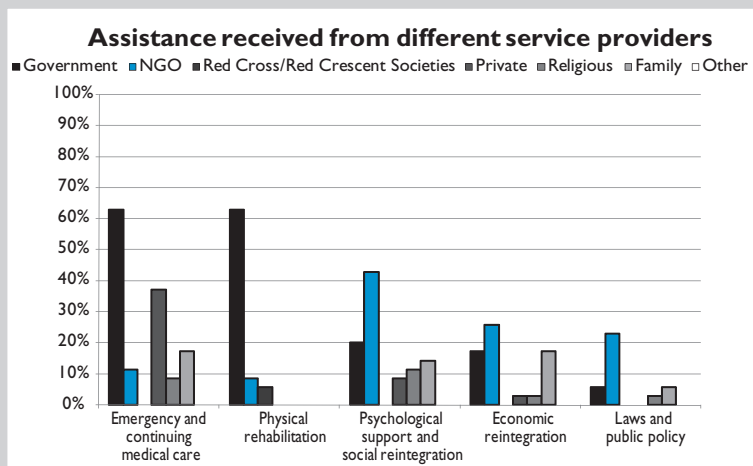
Country indicators

- **Conflict period and mine/ERW use:** Angola is heavily contaminated by mines and ERW. Mines have been used in great numbers by warring parties since the start of the war of independence in 1961 until the end of the conflict in 2002.¹
- **Estimated contamination:** According to the 2007 Landmine Impact Survey (LIS), 8% of communities in all provinces were mine/ERW-impacted, affecting 2.4 million people. This number is probably higher as some areas were inaccessible to survey teams.²
- **Human development index:** 162nd of 179 countries, low human development (compared to 166th of 177 in 2004).³
- **Gross national income (Atlas method):** US\$3,450 – 120th of 210 countries/areas (compared to US\$1,106 in 2004).⁴
- **Unemployment rate:** N/A (more than 50% un- and underemployment).⁵
- **External resources for healthcare as a percentage of total expenditure:** 7% (compared to 9% in 2004).⁶
- **Number of healthcare professionals:** 15 per 10,000 population.⁷
- **UNCRPD status:** Non-signatory as of 1 August 2009.⁸
- **Budget spent on disability:** Unknown.
- **Measures of poverty and development:** Angola has a high economic growth rate driven by the oil sector resulting in a reconstruction boom after four decades of war. However, corruption is high and most of the population still needs to live off subsistence farming activities. Nearly 70% of the population lives under the poverty line and average life expectancy is less than 39, among the lowest in the world.⁹

VA country summary

Total mine/ERW casualties since 1961: Unknown				
Year	Total	Killed	Injured	Unknown
2004	188	73	115	0
2005	101	26	75	0
2006	121	19	102	0
2007	54	14	38	2
2008	67	12	55	0
Grand total	531	144	385	2

- **Estimated number of mine/ERW survivors:** Unknown, unreliable estimates ranging between 23,000 and 80,000.¹⁰
- **VA coordinating body/focal point:** Officially, the Inter-sectoral Commission on Demining and Humanitarian Assistance (CNIDAH, Comissão Nacional Intersectoral de Desminagem e Assistancia Humanitaria) coordinates VA, and the ministries of health and social assistance and reintegration implement disability activities. But CNIDAH does not have the authority or capacity to direct the relevant ministries.
- **VA plan:** The National Plan for Integrated Action on Victim Assistance 2007-2011 was developed, but largely unimplemented.
- **VA profile:** In 2005, NGOs noted that CNIDAH had become more actively involved in VA and that the government had pledged that VA would become stronger.¹¹ Angola has significant oil revenues to invest in reconstruction and development. International donor assistance, also for VA/disability, has, therefore, gradually decreased. Amid the many reconstruction, demobilization and resettlement projects since the end of the conflict, disability was not a priority. Governmental health and social services were severely damaged as a result of decades of conflict and remained limited as of 2009. Private services were unaffordable for most mine/ERW survivors and supporting NGOs focused mainly on physical rehabilitation throughout 2005-2009. The absence of decentralized services and the cost of transport and services were serious obstacles to most survivors and persons with disabilities. Costs were not always covered by service providers. Access to healthcare improved due to (re)construction, facility upgrades and an improved road network, but overall it remained limited especially for those in rural areas. Physical rehabilitation provisions have declined since 2005 due to the failed nationalization process of the sector and the departure of all supporting international organizations as of 2009. None of the centers functioning in 2005 were fully operational as of August 2009, staff salaries were not paid and materials not available. Psychosocial support was only provided by local NGOs and disabled people's organizations (DPO) at



community level, but in many cases they also suffered from the decreasing international support. As in 2005, formal counseling structures did not exist and there was insufficient trained staff. Economic reintegration opportunities were also limited due to the poor economic situation overall and a lack of awareness among survivors of existing services. Most initiatives were carried out by NGOs but government vocational training and economic aid programs existed. Various legislations covering the rights of persons with disabilities existed but

none of them were comprehensive and draft legislation pending since 2000 had not been approved as of 2009. Plans to systematically collect and analyze data about survivors and their needs had not been achieved, and accurate information about their needs or the services received was unavailable.¹²

VA progress on the ground

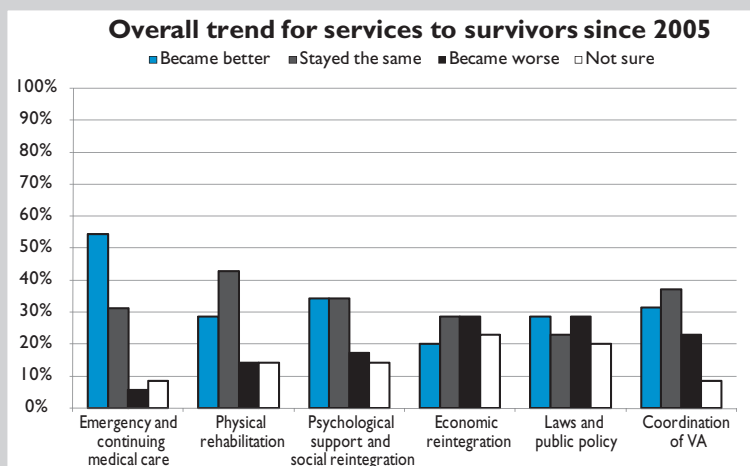
Respondent profile

For Angola, responses from 35 mine/ERW survivors to the questionnaire about VA progress since 2005 were used:¹³ 22 were men, 10 women, two girls and one boy. Respondents were between 15 and 53 years old and half were between 25 and 40. Two-thirds were heads of households and 34% of respondents owned property. Some 23% of people had completed secondary school or higher, and 14% did not receive any formal education. Many respondents were students at the time of their incident (13 or 37%) and just 6% were unemployed; after the incident unemployment increased to 17%, which is relatively low compared to other countries. However, just 14% of respondents said their household income was sufficient.

The largest group of people, 37%, lived in large cities with services; another 31% lived in the capital, Luanda, and 23% lived in villages with limited services. Aside from Luanda, respondents came from Huambo, Moxico, Benguela and Huila provinces. Due to a lack of reliable casualty data throughout 2005-2009, it is impossible to determine whether respondents fit the general profile. But the profile matched the LIS findings, which indicated that 68% of casualties were male (66% among respondents), and that the percentage of female casualties was higher than the worldwide average. The LIS reported that 75% of casualties were between 15 and 44 years old and most were recorded in Moxico.¹⁴

General findings

Survivors saw much more marked improvements in some areas of VA service provision than others, most notably in medical care. Economic reintegration was seen as the weakest area. For physical rehabilitation, survivor responses were significantly different from and more positive than practitioner responses. However, 80% of respondents did not think they received more services in 2009 than in 2005, and 66% did not think that the services were now better. Respondents from major cities saw more quality improvements than those in the capital or in villages; people in the capital responded slightly more positively on the quantity of services. Some 37% of respondents thought that the services for women were “a bit worse” compared to those available to men; 23% thought that services for women were better and 20% thought they were equal. Women responded more negatively: 58% said “a bit worse”; 17% said “equal” and 8% said “better”. Almost half of the respondents (46%) were not sure if services for children were adapted to their age and 20% said this was “never” or “almost never” the case.



Most people (71%) had been surveyed by NGOs or the government at least once in the last five years. More than half of respondents (54%) said that as a result of the survey they had received more information about services; 37% also said they had received more services; 23% felt listened to; and 20% said they had fewer difficulties with bureaucracy. Some 46% of survivors had had a chance to explain their needs to the government. These responses might be slightly too positive, as most respondents were contacted through a network of disability organizations

and through rehabilitation centers in relatively accessible areas. However, the responses also confirm the involvement of local authorities, mine action operators, local disability organizations and, to a lesser extent, CNIDAH in collecting casualty and survivor information. Additionally, the LIS and a CNIDAH assessment started in 2009 might also have covered the same target areas. Unfortunately this information has not been unified, verified or organized for use.¹⁵

Emergency and continuing medical care

More than half of respondents (54%) found that, overall, healthcare had improved since 2005 and 31% thought it had stayed the same. Some 37% also thought that survivors “mostly” received the healthcare they needed and 20% said survivors “never” or “almost never” received the needed assistance. Two-thirds of respondents thought that the government had increased its support to the health sector. Nearly three-quarters said that they could obtain healthcare closer to home. A majority of people noted that there were more healthcare centers than before (63%) and 71% said that the facilities were better. Respondents from the capital and major cities were more positive than those from rural areas. Areas of less improvement among all respondents were: more first aid workers (40%), easier-to-obtain referrals (37%) more complete medical teams (29%), and improved emergency transport (23%). Among practitioners, 40% saw improvement, but they noted improvements in the same areas as survivors: more and better facilities. Practitioners saw the least progress in the availability of more complete teams, referral and emergency response. Just 25% of practitioners thought there were more supplies and medication. They also, at best, found that the government had maintained its efforts, but had not increased them. Several noted that affordability and accessibility improvements were made possible by non-governmental operators.

The above results would confirm statements by Angola that of all VA components most progress had been made in medical care, through the construction of new facilities and upgrading of existing ones.¹⁶ One major contributing factor is the improved road network. However, facilities were unequally distributed in Luanda and a few other major cities as evidenced in the difference in responses above. Particularly in rural areas healthcare was still much more limited and access hampered by high transport costs. Emergency services were always free of charge but to be able to benefit from social security to obtain free continued care, people needed to be able to pay a contribution. It was also noted that one of Angola’s main challenges in 2009 was to actually effectively utilize the improved infrastructure.¹⁷ Gaps in qualified personnel and supplies were addressed to a lesser extent than infrastructure work and continued to be reported.

Physical rehabilitation

Some 43% of respondents said that physical rehabilitation had stayed the same since 2005; 29% saw improvement and 14% saw deterioration.¹⁸ Also, 29% said that survivors only “sometimes” received the physical rehabilitation they needed and 26% thought these services were “never” or “almost never” received; 20% said “mostly” or “always”. Responses were much more positive in Luanda and Huambo than elsewhere. People saw most progress in the affordability of services (80%), free-of-charge repairs (66%), and better-trained staff (60%). But just 3% thought there were more centers; 14% said they could get assistance closer to home; and 23% found it easier to get referrals. No practitioners saw improvement in physical rehabilitation and 40% actually saw deterioration. They were also clearly negative about government efforts. On most progress indicators relating to establishing more centers, better infrastructure, improved quality, free replacement devices, and increased affordability, all practitioners responded that the government “did nothing” or “reduced its efforts.”

These at first sight contradictory results can be explained by the different perceptions between those receiving services and those supporting rehabilitation services. Between 2005 and 2009 the physical rehabilitation sector depended greatly on support from international NGOs and the ICRC. In 2005, these organizations ensured availability of materials, management support, staff training, salaries and transport for patients to support the government-run National Program for Physical and Sensorial Rehabilitation (PNR). This Ministry of Health (MoH) program began in 2001 and aimed to provide comprehensive rehabilitation for persons with disabilities by developing sustainable national capacity. The PNR was scheduled to end in 2005 but has been extended several times (most recently until 2010) as sufficient national capacity was still lacking despite continuous international financial and technical support. Nevertheless, as part of the nationalization process, operators have gradually reduced their support between 2005 and 2009 with the last operator leaving in August 2008. Financial support also ended because the MoH was not able to prepare its extension request on time. As soon as international support ended, the centers started functioning at reduced capacity, because materials were not available, staff not paid, and the number of patients decreased because transportation costs were not covered.¹⁹ One practitioner said, “Even if the services remained free, patients cannot now get there and even if the staff is there, they are technically unemployed because there are no materials (or patients).”

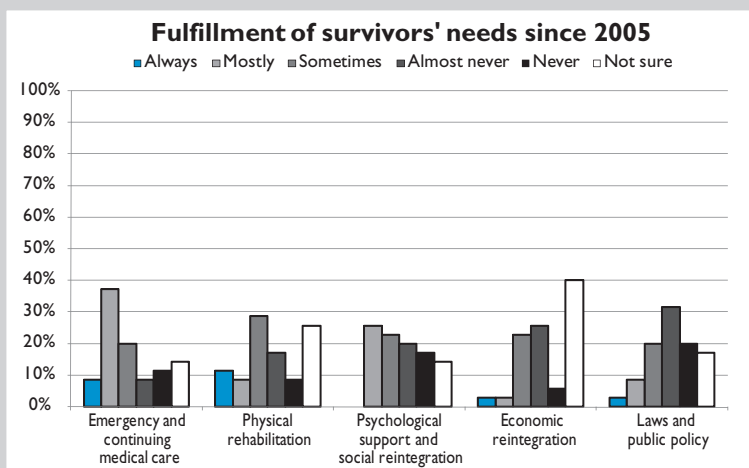
A lack of political will and MoH involvement was often cited among rehabilitation personnel and supporting organizations for the failed sustainability of the PNR. One practitioner working in the sector also noted that NGOs had pulled out of the sector without ensuring that sustainable alternatives were in place. In May 2009, the government acknowledged that it continued its efforts to sustain the services by supplying staff and equipment, but that physical rehabilitation was the area of least progress.²⁰

However, survivor responses were much more positive, particularly on affordability and staff training, as these were the two areas where progress was made. At first, NGOs covered the costs and services remained free of charge once the centers were nationalized. Throughout 2005-2009, Angola also invested in training, either through the supporting international organizations or by sponsoring technicians to follow courses abroad or via correspondence. Some survivors might not have noticed the changes because they happened too recently. This might explain the more positive response in Luanda and Huambo where international support only ceased in July 2008. Management issues, such as difficulties paying staff, might also have gone unnoticed. Where survivors noticed least progress (number and proximity of services), no government efforts were reported: no new centers were established and most centers were in provincial capitals without outreach activities in 2005-2009. This would also explain the more positive response from those living in the major cities of Huambo and Luanda.

Psychological support and social reintegration

Some 34% of respondents said that psychological support and social reintegration services had improved since 2005; the same number of people thought they had remained unchanged. One-quarter said that survivors “mostly” received the services they needed and 37% said this was “never” or “almost never” the case. Most survivors (60%) felt more empowered and 42% thought that survivors were considered to be “charity cases” less often. Between 30% and 35% thought that there were more services, that the quality had improved and that there were more social workers. Twenty percent thought that the government gave more support to psychosocial activities or that more peer support groups had been created. All practitioners thought that psychosocial services had remained the same and that the government had not increased its efforts.

Throughout 2005-2009, the government reported that it relied mainly on national NGOs and DPOs for psychosocial support services at the community level, but that there was no formal counseling infrastructure and a lack of trained staff.²¹ Psychosocial support was supposed to be included in the PNR, but this never materialized. Most respondents in the survey were reached through the DPO network, which would have influenced their response. Some survivors also mentioned receiving this assistance through their family and the military survivors (seven) responded more positively. But overall survivor responses confirmed the lack of formal counseling and of peer support groups. One practitioner noted, “There are no psychologists in the physical rehabilitation centers; there are some support programs for survivors but usually they only target the veterans and DPOs which, although more and more present, lack the means to systematically carry out psychosocial support.”



Economic reintegration

The most negative survivor responses were given in the area of economic reintegration: 29% thought that, overall, services had deteriorated and 29% thought they had stayed the same since 2005. The largest group of respondents (31%) also said that survivors “never” or “almost never” received the economic reintegration assistance they needed; 23% said “sometimes”; and 6% said “mostly” or “always”.²² Of those responding to the question, 84% also thought that unemployment was so high that survivors were the last to be chosen for a job.²³ Survivors saw most progress in increased opportunities to access vocational training (60%), education and to receive services closer to home (57% each). But they saw much less improvement in the availability of employment opportunities (29%), increased pensions (26%), more job placement (23%), decreased discrimination in employment and education (20%), or better enforcement of employment quotas (11%). Among practitioners, 40% saw progress in economic reintegration opportunities, mostly in increased access to education and vocational training. Like survivors, they noted least progress in employment opportunities and job placement.

Several NGO and government-run economic reintegration activities exist. In 2005-2009, the government operated several vocational training centers, but survivors had limited access to these because they were often not aware of their existence. Since 2005 the government has started focusing on the development of community-based income-generating cooperatives – an approach it took from an NGO. However, many government initiatives principally targeted veterans. Some international NGOs decreased

their economic reintegration activities since 2005.²⁴ DPOs and local NGOs gained more capacity in the area (often still with international support). But high general unemployment rates, a large number of persons of working age with disabilities, their high illiteracy rates and concentration in urban areas were considered to be serious obstacles throughout 2005-2009. Fewer services were available in rural areas than in urban areas.²⁵

Laws and public policy

Equal numbers of survivors thought that the protection of their rights had deteriorated or had improved (29% each); 23% saw no change. More than half (51%) found that survivors' rights were "never" or "almost never" fulfilled. Survivors noted most progress in increased awareness among the general public about the rights of persons with disabilities (57%). But fewer noticed that new policies and legislation relevant to survivors had been developed (23%); that legislation was enforced more (26%) or that they had increased recourse to legal action when their rights were violated (29%). Most practitioners (60%) thought that the protection of the rights of survivors had remained the same.

Several laws and decrees dealing with disability exist, but knowledge of the laws is poor and no implementation measures were created for some of them. The various laws provide protection to some groups of persons with disabilities but exclude others. The laws are not monitored,²⁶ and already in 2005 a CNIDAH symposium noted that even though laws exist, they are not implemented.²⁷ This remains unchanged in 2009 and more comprehensive draft disability legislation has been pending since 2000. At the end of 2008, procedures to approve the draft legislation were started, but no further progress has been reported. Commenting on laws and public policies, one practitioner said, "The government has not done anything and still is not doing anything. Whatever advances are made are due to the work of DPOs."

When asked to respond to preliminary survey results, the CNIDAH representative correctly assessed that they would find that some improvement had been made. The representative noted that the most progress had been made on medical care, that psychosocial support was too limited but given at the community level and that the government had increased its cooperation with the private sector for employment opportunities. The person added that laws were the weakest point, particularly employment quotas. On physical rehabilitation, the representative added that services had not improved but that the changes for survivors were not that significant as there had been difficulties all along, also commenting that international organizations had not implemented sufficient hand-over periods.

VA process achievements

Year	Form J with VA	ISC VA statement	MSPVA statement	VA expert	Survivor on delegation
2005	NO	YES	NO	YES	NO
2006	YES	YES	YES	YES	NO
2007	NO	YES	YES	YES	NO
2008	NO	YES	YES	YES	NO
2009	NO	YES	N/A	YES	NO

In 2005, CNIDAH said that it was "very much concerned" about the situation of mine/ERW survivors, and that it had launched efforts in favor of mine survivors and other persons with disabilities, but that it would not be able to carry out "this great task" without assistance.²⁸ Also in 2005, it was said that the government had pledged more financial support to VA and NGOs sensed that CNIDAH was becoming more active on the issue. However, due to constantly decreasing international support, competing national priorities, a lack of capacity and coordination, the positive signs of 2005 have not been seen through.

As one of the 26 countries with the greatest numbers of survivors and, therefore, the greatest responsibilities, but also the greatest needs and expectations for assistance, CNIDAH had

expected sustained technical support to develop plans and improve coordination. These were two of the weaknesses already identified in 2004. Further weaknesses were the limited availability of services and a lack of information about the number and needs of mine survivors.²⁹

As part of its commitment to implementing the Nairobi Action Plan, Angola presented its 2005-2009 objectives in November 2005, but they were not SMART. The objectives were reworked and a plan (National Plan on for Integrated Action on Victim Assistance 2007-2011) was developed, but never formally presented.³⁰ Overall, the aim was to improve service provision for all components of VA for 80% of mine/ERW survivors and/or affected communities. Given that there could be up to 80,000 mine/ERW survivors, this is a challenging target. Most of the deadlines have been set for 2011 and many of the objectives focused on capacity building and institutional strengthening, awareness raising, and information gathering, rather than service provision.³¹

Due to a lack of capacity and financial means, CNIDAH has not been able to operationalize the plan or monitor relevant activities. Its activities have been limited to discussions with several ministries and operators on how they envisioned implementing their responsibilities and fundraising meetings.³² A lot of progress was also dependent on a better understanding of the number and needs of survivors, which had not been achieved by 2009, and on improved coordination.

A sub-commission of CNIDAH, which includes representatives of relevant ministries and non-governmental actors, has coordinated and monitored VA since 2001. However, already in 2005 it was reported that the commission did not meet regularly and later it was also noted that NGOs were not systematically invited; DPOs and survivors were even less involved.³³ The presence of a short-term international consultant, who also stimulated the development of the VA plan, led to temporarily improved coordination on VA/disability in 2006-2007 through stakeholder meetings and the creation of thematic working groups. In 2009, CNIDAH acknowledged that, without international technical support, these efforts had slowed down in 2008 and that longer-term technical assistance was needed.³⁴ Internal reorganization and logistical challenges were also obstacles in 2008.

CNIDAH also said that it did not have a mandate to direct the two ministries implementing service – the MoH and the Ministry of Social Assistance and Reintegration. Coordination between ministries was weak and further hampered by a decentralization policy in which provincial authorities need to coordinate activities and allocate budgets, but often do not see VA/disability as a priority.

Survivor responses confirm the coordination challenge, with just 31% saying they know who is in charge of VA coordination and saying that VA coordination improved. Just 11% thought that survivors were involved in coordination meetings and 23% said that they received regular information about VA achievements. However, 49% thought that their needs were taken into account when setting VA priorities. This could be related to the increased DPO activity, NGO assessments and CNIDAH visits to some VA/disability projects. The majority of practitioners (60%) also thought that the government had not taken more responsibility for VA/disability issues and had not included survivors or their needs in planning. The same percentage (60%) did not see more coordination among relevant government bodies or improved coordination between government and NGOs. Some 80% said that there was no better coordination with the broader disability sector and/or found that planning had resulted in fewer gaps in services. None thought they received regular information about VA achievements.

Some 54% of survivors said that the government lacked the political will to improve VA. This might be true at the ministerial level with, for example, the lack of progress in taking national ownership of the PNR. CNIDAH confirmed that the government had many other priorities, but that the main challenge was a lack of technical assistance.

Conclusions

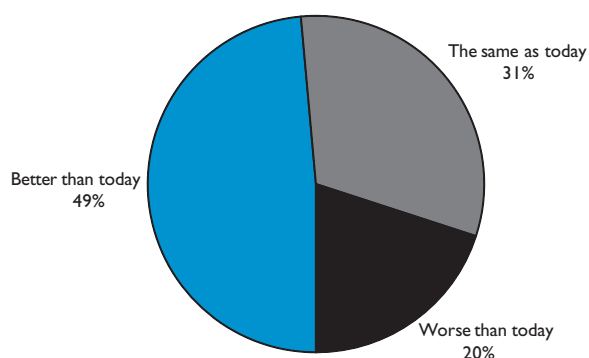
- Areas where survivors saw most improvement were also those highlighted by CNIDAH, particularly medical care. Overall, however, services remained limited particularly in rural areas.
- The negative consequences of the increased malfunctioning of the PNR for physical rehabilitation were not yet felt by survivors, but developments might be too recent.
- Generally, practitioners saw less progress than survivors, potentially indicating challenges of working with authorities, but also that systems were at least kept operational for survivors.
- Despite significant economic growth, many vulnerable groups, including mine/ERW survivors and other war disabled have not benefited from the growth, likely resulting in even bigger disparities and gaps in society.
- Discrimination against survivors and other persons with disabilities persisted due to a lack of adequate legislation and awareness resulting particularly in fewer employment opportunities but also in social isolation.
- DPOs increased their capacity, but needed ongoing support to become effective advocates for the rights of survivors and persons with disabilities.
- The (possibly premature) departure of NGOs left gaps particularly in economic reintegration and physical rehabilitation.
- CNIDAH lacked the mandate and capacity to coordinate effectively; ministries appeared to lack a sense of ownership; and survivors were rarely involved.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 49% of survivors felt that it would be better than today; 31% felt it would be the same; and 20% felt it would be worse. To assist in a better future ahead the following suggestions may be taken into account:

- Urgently address the lack of ownership and malfunctioning of the PNR and the physical rehabilitation sector before survivors start to feel the effects even more.
- Develop economic reintegration opportunities for mine/ERW survivors and all war disabled, including enforcement of employment quotas and increased employment follow-up.
- Ensure that positive service provision developments in cities are also extended to rural areas.
- Ensure that a VA/disability body with sufficient mandate and capacity to coordinate the sector exists by, in the short term, providing technical assistance to CNIDAH and clarifying its role vis-à-vis ministries and in the medium or longer term have a unified disability coordination mechanism.
- Approve comprehensive disability legislation, develop a comprehensive disability plan and set up a body to coordinate and monitor implementation.
- Integrate VA (and the 2007-2011 plan) more in disability issues and ensure that relevant ministries see assistance to mine/ERW survivors as part of their mandate.
- Systematically include survivors and other persons with disabilities in VA/disability coordination, implementation and monitoring and improve relations with NGOs.

What do you think your situation will be like in five years?



- Continue to build the capacity of DPOs, particularly to enlarge their target group and to include psychosocial support activities in their work.



Palmira Vanala in her shop
© Handicap International

In their own words...

The main priority for VA in the next five years is:

- Better enforcement of the laws (several).
- Job prospects.
- Improve equipment and training of prosthetic-orthotic technicians.
- Create training and employment opportunities and remove structural barriers.
- Have training in remote areas and create conditions to also reintegrate persons with visual disabilities.
- Concretely, I don't know.
- Give access to economic reintegration mechanisms, because if a person has this he can do other useful things.
- Reintegration of survivors not on the job market.
- Reintegrate all survivors into the society.

In their own words...

If countries really cared about survivors they would:

- Give more economic reintegration and not let survivors depend on donations.
- Help persons with disabilities more and more often.
- They don't care.
- Raise awareness and more psychosocial support.
- Create **one** institution to coordinate the [disability] actions of all actors.
- Provide opportunities for people with all types of disabilities.
- Adopt laws and, in the case of Angola, monitor and enforce the law on employment of the disabled (several).
- Operate an institute for comprehensive reintegration.
- Give more employment opportunities.
- Adopt concrete policies for rehabilitation and economic reintegration.

In her own words: the life experience of Palmira Vanala

Palmira, 37, stepped on a mine on her way back from school when she was eight and lost her right leg. She lived with her uncle in Caala (30km from Huambo) because her parents had disappeared. When she was a teenager they moved to Huambo so that she could for the first time get a prosthetic leg and continue her studies. At age 27 she met a man and got pregnant, but the man did not want a wife with a disability and her uncle kicked her out of the house as well. Because the man died shortly after, his family accused her of being a witch.

Alone and abandoned she had to find a way to make a living, and she started to sell alcoholic drinks. Her small business grew quite fast. But by now she had three children whom she had to care for by herself and her income was not enough to feed her children every day. Thanks to an international organization she was selected to participate in an income-generating gardening project in Huambo. She works there in the mornings and runs her shop afterwards. With this double job she will be able to meet the needs of her children and maybe she will even be able to buy a plot of land for a house. But first and foremost, she wants to be able to earn enough money to send her children to school.