Chad

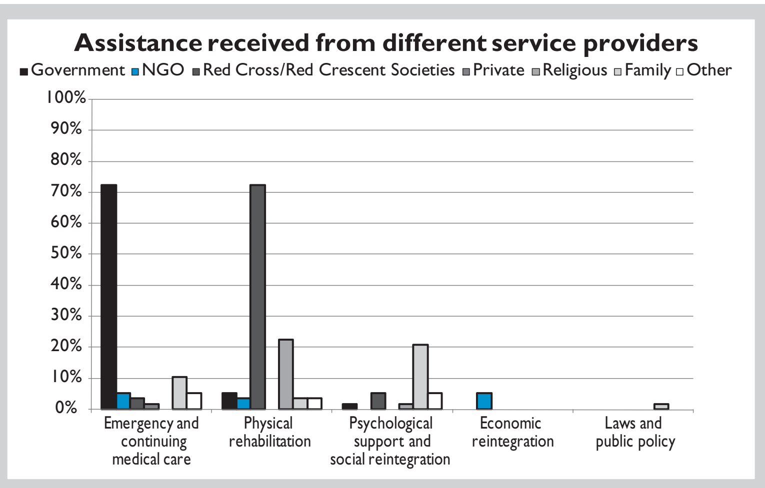
VA country summary

Total mine/ERW casualties since 1961: Unknown – at least 2,736				
Year	Total	Killed	Injured	Unknown
2004	32	7	25	0
2005	35	7	28	0
2006	139	41	98	0
2007	188	51	137	0
2008	131	24	99	8
Grand total	**525**	**130**	**387**	**8**

- *Estimated number of mine/ERW survivors:* Unknown, at least 1,588.
- *VA coordinating body/focal point:* The Directorate for Awareness and Mine Victim Assistance of the National Demining Center (Centre National de Déminage, or CND) was in charge of coordinating VA, but it lacked experience, funding and capacity.
- *VA plan:* None; the development of a plan was dependent on international financial and technical support. Past plans became obsolete without having been fulfilled.[10]
- *VA profile:* Hampered by intermittent internal conflict and over spilling border conflicts, as well as serious under-funding, services for mine/ERW survivors in Chad during 2005-2009 have been insufficient and unsystematic. The government has limited capacity to implement services for persons with disabilities, or even to fulfill the basic needs of the population as a whole. Most services were provided by the ICRC and NGOs. As of August 2009, many survivors still needed to be transferred to the capital N'Djamena for most services, although even there just a few facilities existed, which all lacked skilled staff and equipment. Chad's frail healthcare system was severely strained due to armed violence and the influx of internally displaced people (IDP) and Sudanese refugees. Some emergency medical evacuation for mine/ERW casualties was available from CND and international organizations carried out emergency programs related to the conflict. Rehabilitation was limited to just two centers and services not free of charge unless covered by the ICRC, which also established a referral system and provided training. There is a lack of physiotherapists and none work in mine-affected areas. Psychosocial support, vocational training and economic reintegration opportunities for survivors and persons with disabilities were extremely limited and exacerbated by widespread societal discrimination against them. Chad has legislation for persons with disabilities, but it is not adequately enforced. Casualty data collection improved over the period, but remained inadequate and a disability needs assessment remained stuck in the planning stages.[11]

Country indicators

- *Conflict period including mine/ERW use:* At least 30 years of internal conflict and the 1973 Libyan invasion resulted in mine use and ERW contamination. New ERW contamination in and around the capital N'Djamena occurred during fighting between government troops and rebel forces in February 2008.[1]
- *Estimated contamination:* According to the 1999-2001 Landmine Impact Survey (LIS), some 280,000 people live in some 249 mine/ERW affected communities (more than 1,000km²).[2]
- *Human development index:* 170th of 179 countries, low human development (compared to 167th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$530 – 185th of 210 countries (compared to US$283 in 2004).[4]
- *Unemployment rate:* Unknown.[5]
- *External resources for healthcare as percentage of total expenditure:* 23.5% (compared to 23.5% in 2004).[6]
- *Number of healthcare professionals:* Less than four 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:* Years of conflict have exacerbated poverty in Chad. Some 80% of the population depends on subsistence farming and herding. Poverty limits access to basic education; adult literacy rates are as low as 26%. Crop production is seriously affected by unpredictable rains, recurring droughts and locust infestations. Chad depends on foreign assistance for most public and private sector needs.[9]



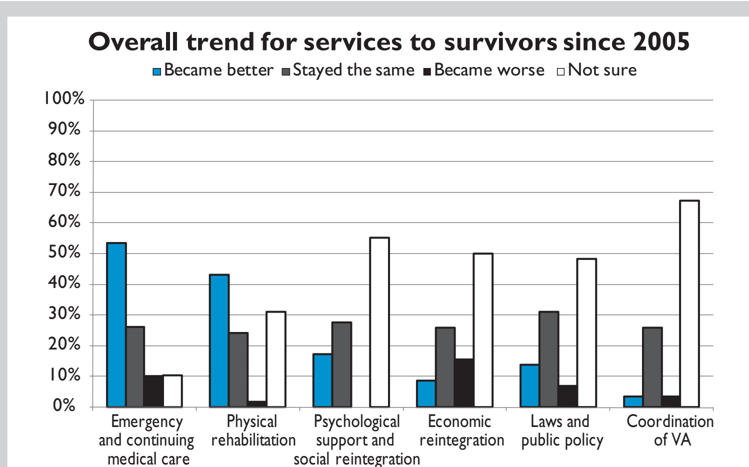
VA progress on the ground

Respondent profile

By July 2009, 58 mine/ERW survivors between 12 and 68 years old responded to a questionnaire on progress in VA since 2005 in Chad: 48 men, six women and four boys. Some 72% were the head of the household and 33% owned property. The majority of respondents (69%) lived in the capital of the country, 9% in large city with services, and the same percentage in remote areas without services. Almost half of the respondents (45%) had not received any formal education. All but one person were employed before the incident, after the incident 14% were unemployed. Only 12% of respondents found their household income to be sufficient.

General findings

Many respondents did not address all questions in the survey. According to the survey team, this was mostly because the respondents felt that the services asked about did not exist and to a lesser extent because they did not know enough about the situation to say if it had changed. In both cases, non-responses could be taken as negative progress in a specific area or as a complete lack of services, but have been counted separately as non-responses for the sake of accuracy. Nevertheless, for certain areas, such as medical care, some overall progress was observed. Progress was most prominent among those in the capital where most services were located. For other areas, such as economic reintegration and psychosocial support, no progress was seen, probably because these services were not available. However, just 14% of respondents said that they received more services now than five years ago and 7% thought that they received better services. Most respondents (55%) reported that services for child survivors were "never" adapted to their age. According to most respondents (59%), services for female survivors were "absent" and 12% thought that services for female survivors were "equal" to those available for men.



Just 14% of respondents had been surveyed by government or NGOs in the last five years (and were only asked once each) and the remaining 86% had not been surveyed. Just 26% thought that survey activity had resulted in them receiving more services or in

fewer difficulties obtaining a pension. Just one-quarter of those surveyed felt listened to. These responses would correspond with the lack of systematic data collection and the lack of access to services by survivors. Many survivors might not have been interviewed since the 1999-2001 LIS. In 2009, Chad stated that it wanted to ascertain the number of mine/ERW survivors by asking for the cause of disability in the disability census it aimed to carry out.[12]

Emergency and continuing medical care

Some 53% of respondents felt that, overall, medical care had improved since 2005 and 26% said it had remained the same. The largest group of respondents (45%) also thought that survivors "sometimes" received the healthcare they needed and 17% each said that the medical care was either "always" or "never" received. Just over half (52%) reported that the government provided more support to healthcare. Most progress was noted in the increased number of health centers (71% thought so), but only 50% felt that they could get healthcare closer to home. According to 66%, facilities had become better but much fewer (38%) thought that these centers had the necessary supplies and equipment. Some 43% of survivors felt that medical care had become more affordable. Less progress was evident in emergency care services: only 36% of respondents believed that there were more first aid workers and 26% found that there were more ambulances. Practitioner responses also found that there were more health centers in mine/ERW-affected areas; that facilities had become better; and that the quality of healthcare had improved.

These responses do not appear to correspond with Chad's reports on the healthcare situation. In 2008, Chad noted that less than 40% of the population had access to basic healthcare.[13] Additionally, the World Health Organization (WHO) reported repeatedly that Chad's health indicators were "in the red" and that the sector was uncoordinated, under-funded, under-equipped and lacking qualified staff. The WHO added that the scale of the need combined with the deteriorating security situation has "severely limited access to primary health care for all."[14] A number of factors likely contributed to the survivors' perception of improvement, most importantly that most respondents were from N'Djamena where the only facilities providing specialized medical assistance are located. These centers received some training and equipment support in 2005-2009.[15] Also, mine/ERW survivors can receive free medical care if they obtain a document from CND medical staff;[16] it is unknown how many survivors have such certificates. The increased presence of NGOs and the ICRC supporting the health sector to deal with the effects of increased conflict and the influx of IDPs and refugees might also have contributed. These operators would have provided services free of charge or would have covered the treatment cost. Emergency transport was non-existent unless provided by NGOs, and the road network was poor, further delaying a rapid response. Reportedly, the purchase of ambulances was financed in May 2009.[17]

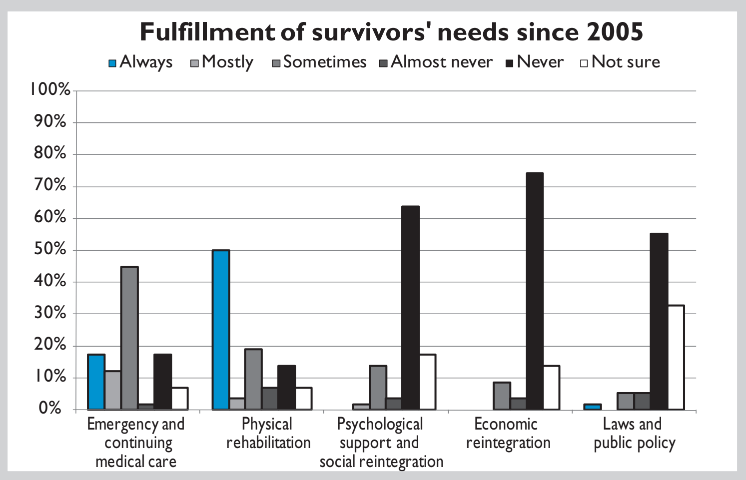
Physical rehabilitation

Some 43% of respondents thought that, overall, physical rehabilitation had improved since 2005 and 24% said that the situation had remained unchanged. Half of all respondents thought that survivors "always" received the physical rehabilitation they needed and 19% thought that the needed services were "sometimes" received. The government provided more support to physical rehabilitation, according to 41% of respondents. Nearly three-quarters of respondents (72%) thought that staff was trained better and 71% thought that the rehabilitation teams had more complete skills. Some 66% found that the quality of physical therapy and mobility devices had improved. Least progress was seen in the number of physical rehabilitation centers (only 21% thought they had increased) and just 2% believed that there were more mobile workshops to carry out minor procedures. Practitioners reported some progress in the same areas as indicated by survivor respondents (trained professionals and more complete rehabilitation teams).

The survivors' perceptions correspond with the fact that there are only two prosthetic-orthotic facilities in Chad, one in the capital and one in Moundou (the second largest city in south-western Chad), both managed by NGOs with extensive ICRC support. Some other facilities provided limited basic physical rehabilitation. The ICRC organized referral and transport for survivors from mine-affected areas to the capital, and also covered transport and accommodation costs. While treatment is not free of charge, the ICRC sometimes also covered treatment costs.[18] The ongoing support and training from the ICRC would also have contributed to increasing the quality of services. In 2005-2009, some other quality measures have been taken, such as the development of recognized physical therapy training.[19]

Psychological support and social reintegration

More than half of respondents (55%) could not say whether there had been an overall improvement in psychological support and social reintegration since 2005; 17% indicated there had been improvement. However, the majority (64%) also thought that survivors "never" received the psychosocial support they needed. Only 14% of respondents indicated that the government provided support to this type of services. Survivors saw very little improvement in any specific area. Just 22% reported being more involved in community activities; 7% found that psychosocial services had increased; 5% said that peer support groups had been created; and 2% noted more opportunities to get formal counseling. Practitioners thought there was some improvement in there being more social workers and counselors. However, practitioners also thought that the government had reduced its efforts for psychosocial support or "did nothing".



According to one surveyor for this report, none of the 28 survivors interviewed had heard of psychological support and social reintegration.[20] Throughout 2005-2009, access to psychosocial support has been extremely limited in Chad.[21] Some limited activities were carried out by religious organizations, social workers and disabled people's organizations (DPOs), but it is unknown if survivors have access to these. Chad reported some improvements in 2007-2008 by stating that the number of trained social workers was increasing;[22] the social workers are employed in major hospitals.[23]

Economic reintegration

Half of respondents did not know whether, overall, economic reintegration opportunities had improved since 2005; 26% thought the situation had remained the same; and 16% saw deterioration. Nearly three-quarters of respondents (74%) believed survivors "never" received the economic reintegration they needed. The area of most progress was decreased educational and professional discrimination, where 26% of respondents felt improvement had occurred. Some 19% said that they could access education and vocational training closer to home or that survivors had better access to programs not designed specifically for them. Very few respondents reported that employment opportunities had increased or that vocational training programs better met market demands (7% saw progress on each indicator). No survivors thought that pensions had improved. Practitioners confirmed that educational and professional discrimination had decreased, but further they overwhelmingly reported that the government had "done nothing" or "reduced its efforts" in the area of economic reintegration. Overall, practitioners agreed that survivors "never" received the economic reintegration opportunities they needed.

Already in 2001, the LIS noted that none of the recent survivors it identified had received vocational training.[24] In 2004-2005, some NGOs lobbied the government to increase the number of economic reintegration opportunities for persons with disabilities. This goal was also included in a national disability plan,[25] which was not implemented due to a lack of funds. Thus, in 2005-2009, vocational training and economic reintegration opportunities remained extremely limited in Chad.[26] Chad has not reported any significant activities throughout 2005-2009. The two NGOs facilitating contacts with survivors for this report both provide some economic reintegration services, which is likely to have influenced responses, as, for example, a very low percentage of respondents was unemployed. In principle, access to education for children with disabilities and children of disabled parents is free.[27]

Laws and public policy

Some 31% of respondents said that the enforcement of their rights through laws and public policies had stayed the same in the past five years, but 48% was not able to respond. More than half of respondents (55%) believed that the rights of survivors were "never" respected and 33% was not sure or did not respond. The greatest progress was reported in the development of legislation and policies relevant to survivors (29% saw improvement) and in increased awareness about the rights of persons with disabilities among the general public (26%). However, only 14% of respondents found that legislation and policies benefiting survivors were better enforced and 9% of respondents thought that it was easier to access information about VA services. Some 14% of respondents reported that discrimination against survivors decreased in the period. The only area where practitioners saw progress was also the development of legislation and policies relevant to survivors.

A law protecting the rights of persons with disabilities and regulating access to services was passed in May 2007.[28] However, the extent to which the law has been implemented is unclear and there was a lack of awareness about the law's provisions. In late 2008, a CND project proposal for advocacy activities to promote the law stated that "the implementation decree for the law" had not yet been adopted.[29] Likewise, the national disability strategy was not implemented and negative societal attitudes continued to exist, as disability was often seen as a curse for a sin committed. Several DPOs exist and, already in 2004, it was recommended that DPOs and NGOs would form a coordinating committee to advance disability activities. However, the committee does not exist. Every year, a national disability day is held in February to raise awareness.[30]

When asked for a response to preliminary survey findings, a representative of Chad thought that it would be a legitimate reaction if survivors said that nothing had changed since 2005. The person added that Chad had tried to assist its survivors, but that it was a large and impoverished country with many competing priorities, sometimes as basic as providing clean water. The representative went on to say that VA should be at the center of the international communities' worries, but it has instead been the area of the Mine Ban Treaty that has failed in part because VA generated so many expectations.

VA process achievements

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

Note: In 2007, Chad only reported on casualties in its Article 7 report.

Throughout 2005-2009, Chad acknowledged that it had made limited progress on VA and but it also stated that it stayed committed to the issue. Chad has not been able

to report many concrete achievements in the coordination, planning or implementation of VA between 2005 and 2009. What limited assistance has been provided to survivors was usually with the assistance of international NGOs. However, Chad has difficulties satisfying the basic needs of most of its citizens and has only invested in very few disability initiatives.

While Chad set some broad goals and reiterated that it aimed to develop a plan of action, progress was entirely subject to funding. Chad has appealed to the international community since 2002 for more international funding and technical assistance to better meet the needs of survivors. It also expected that by identifying itself as one of the 26 countries with the responsibility for the greatest numbers of survivors but also with the greatest needs and expectations for assistance, this international support would be garnered. However, one government representative said that this support had not been forthcoming and added, "Chad is all alone, taking actions at national level and with the means it has." In every statement Chad has made between 2005 and 2009, it appealed for international support to start its VA activities.

As of 2009, Chad has not been able to provide detail on the extent of the problem it is facing or to elaborate SMART objectives for 2005-2009.[31] In 2007, CND as the VA focal point and the UNDP, which supported CND's other mine action activities, estimated that an international consultant would be needed to assist in drafting a national VA plan.[32]

While a VA department was established at the mine action center in 2003 and a VA director was recruited in 2004, CND (or its predecessor) has not been able to effectively engage government bodies and NGOs already in the country to successfully combine forces to develop a VA plan and activities. Nevertheless, it has been reported that the VA focal point at CND was instrumental in raising VA awareness and in the development of the 2007 disability legislation.[33] Chad also stated in 2008, that it had started contacting ministries, NGOs and other stakeholders to cooperate on the development of a VA plan, adding that the plan would be ready by the end of 2008.[34] In May 2009, Chad, again, stated that the development of a VA plan was ongoing and subject to funding.[35] CND planned to present it for the Second Review Conference in November-December 2009.[36]

In addition to funding and capacity constraints, instability within the CND prior to its reorganization in 2007 hampered progress in the planning and implementation of VA activities.[37] Some practitioners responded that they had seen slight improvements in coordination recently because CND now had a sufficient mandate to act. Among survivors, 21% believed the government had become more involved in VA; but only 9% of reported that the government allocated more national funds to VA in 2009 than in 2005.

In their own words…

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

- Motored tricycle and prosthesis.
- Training and micro-credit.
- Provide training, education and awareness.
- Construction of health centers.
- Hospitals with surgeons.
- Financial support to build on land survivors own.
- To ensure that survivors receive their rights.
- Create training and income-generating activities.
- Training and literacy training.

In their own words…

If countries really cared about survivors they would:

- Support them financially.
- Help them take care of their children, so that they can attend school.
- Cover costs for survivors.
- Improve health centers.
- Support more disabled people.
- Appoint a representative to coordinate services for survivors.
- Monitor activities.
- Provide housing, rehabilitation, education and training.

Conclusions

- A lack of consistent coordination capacity and resources prevented the planning and implementation of VA.
- Many basic service systems were incapable of responding to survivors needs, despite some assistance offered to survivors by CND and international relief efforts.
- VA efforts, as far as they existed, were *ad hoc* and contingent on the availability of funds.
- Psychological support and economic reintegration were not available to most survivors.
- Services for all persons with disabilities were extremely inadequate and could not be seen as an alternative for the fulfillment of the needs of survivors.
- Planning and coordination remained underdeveloped due to chronic financial and capacity challenges.

Suggestions for the way forward

When asked about how they saw their situation in five years: 28% of survivors thought it would get worse; 24% said it would be the same as today; 17% thought it would get better; and 31% did not respond. To assist in a better future the following suggestions may be taken into account:

- Hold regular VA coordination meetings engaging ministries, local NGOs, DPOs and international organizations, or plan a series of meetings to address specific issues.
- Create a simple multi-year VA plan with specific objectives, clear timeframes and actions to achieve objectives, based on available or likely resources, and adjust it as more means or capacity become available.
- Designate responsibilities among all relevant stakeholders for implementing the plan and ensure that those taking on responsibilities have coordination support.
- Present the plan, along with a clear funding strategy and funding prospects, and transparently report on national and international contributions.
- Include survivors and DPOs in planning and coordination to better understand their needs and the scope of the problem. Support the creation of survivor associations and strengthen their capacity.
- Systematically include VA/disability in other health, rehabilitation, development, and relief efforts and ensure access of survivors/persons with disabilities.
- Endorse, monitor and enforce legislation protecting the rights of persons with disabilities.

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