

Ethiopia



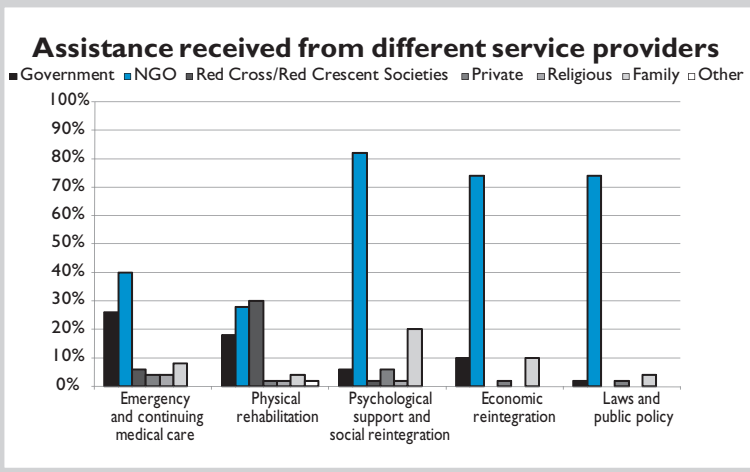
Country indicators

- **Conflict period and mine/ERW use:** Contamination by mines, cluster submunitions and other ERW in Ethiopia dates back as far as 1935 and is the result of national and international conflict, including several border disputes – most recently the 1998-2000 war with Eritrea.¹
- **Estimated contamination:** The 2003 Landmine Impact Survey (LIS) identified 1,916 suspected hazardous areas affecting 1,492 communities.²
- **Human development index:** 169th of 179 countries, low human development (compared to 170th of 177 in 2004).³
- **Gross national income (Atlas method):** US\$280 – 205th of 210 countries/areas (compared to US\$122 in 2004).⁴
- **Unemployment rate:** Unknown, but estimated among the highest in the world at approximately 50% unemployment among urban males between 15 and 30 years old.⁵
- **External resources for healthcare as percentage of total expenditure:** 42.9% (compared to 34.7% in 2004).⁶
- **Number of healthcare professionals:** Less than three per 10,000 population.⁷
- **UNCRPD status:** Signed the Convention on 30 March 2007, but not its Optional Protocol.⁸
- **Budget spent on disability:** Unknown.
- **Measures of poverty and development:** Ethiopia is one of the poorest countries in the world, with 85% of the population living on subsistence farming and 40% in absolute poverty. Life expectancy is just over 55 years. Ethiopia's poverty-stricken population depends on agriculture, particularly coffee, and is susceptible to frequent droughts. In 2005, Ethiopia's debt was canceled, but the country still remains highly dependent on external aid.⁹

VA country summary

Total mine/ERW casualties since 1935: Unknown – at least 16,844				
Year	Total	Killed	Injured	Unknown
2004	61	24	37	0
2005	31	13	5	13
2006	34	17	17	0
2007	84	31	49	4
2008	18	3	15	0
Grand total	228	88	123	17

- **Estimated number of mine/ERW survivors:** Unknown, but at least 7,398.¹⁰
- **VA coordinating body/focal point:** The Ministry of Labor and Social Affairs (MoLSA) is responsible for VA/disability and represents Ethiopia internationally as the VA focal point. However, the Ministry of Health (MoH) has also claimed responsibility. A Disability Council was created under the Prime Minister in 2008 for UNCRPD implementation.
- **VA plan:** None, but stakeholders have recommended the development of a plan since November 2006.
- **VA profile:** Throughout 2005-2009, VA/disability was not a priority issue in Ethiopia because of the overall dire development conditions in the country. Ethiopia acknowledged that progress was slow due to a lack of resources, poor government coordination, and a lack of capacity. Services remain largely urban-based – while some 80% of persons with disabilities live in rural areas – and unequally spread across regions, in line with the political interests of the government. Where activities did take place, they contributed to survivors' positive perceptions of progress. Nevertheless, survey results in the Somali region, which is under-served, indicated in 2008 that only 50% of survivors had received medical care, 1% had received physical rehabilitation, and no one had received any psychosocial support. These results resemble those of the 2003 LIS, indicating 48% of survivors had received medical care, 7% rehabilitation, and none had received vocational training. In some regions, the government limits NGO operations. As of 2009, sufficient medical care is still lacking and out of reach for most, despite improvements made in coverage and emergency response through long-term health sector development plans linked to Ethiopia's poverty reduction strategy. In principle, healthcare is free for people who can present a certificate proving they cannot afford it. MoLSA is responsible for management of the physical rehabilitation sector. In practice, centers are run by the regional Bureaus of Labor and Social Affairs offices (BoLSA) with extensive international support. Throughout 2005-2009,



the ICRC gradually aimed to phase out its direct financial support and handed over more responsibility to the government, but as of 2009 it still provided contributions. Other international NGOs phased out earlier. Despite the construction of new centers, it was still thought their number remains insufficient, and existing centers lack staff and resources. Survivors could not afford transport or accommodation costs. Psychosocial support and economic reintegration services, mostly operated by NGOs, remain limited and are inadequate to

deal with the needs of mine/ERW survivors and other persons with disabilities. Economic reintegration is further limited by extreme poverty, conflict and geographic obstacles. The disabled people's organizations (DPO) have insufficient capacity to effectively advocate for the rights of persons with disabilities and, despite legislation, discrimination is common. In 2009 there was still no national casualty data collection mechanism or readily available casualty data. In 2005-2009, international institutions continued to fund several large-scale healthcare reform, poverty alleviation, and conflict resolution programs relevant to VA/disability which would likely have been beneficial for mine/ERW survivors.¹¹

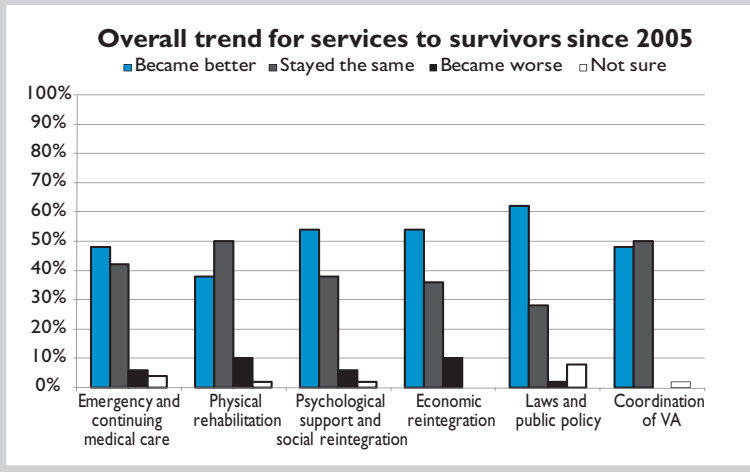
VA progress on the ground

Respondent profile

For Ethiopia, 50 survivors between 18 and 66 years old responded to a questionnaire on VA progress since 2005: 46 men and four women. Some 90% were heads of households, and 56% were soldiers prior to the mine/ERW incident. Just 8% reported not having employment after the incident.¹² Almost half (46%) had secondary school level education or higher. Most respondents' mine/ERW incident occurred before 1991. All respondents lived in the capital, Addis Ababa, but were originally from all over the country and had received services in various parts of the country. The respondents' profile does not correspond entirely with the existing data on mine/ERW survivors, which indicates many are civilians living in rural areas. However, several of the older casualties would likely have been military injured during or shortly after the conflict.¹³

General findings

Overall, respondents saw progress (or at least not deterioration) in most services. However, these results must be qualified by the fact that all respondents lived in the capital and were beneficiaries of a particular NGO. While this affects the results, it does nevertheless give a snapshot of the situation of survivors in the country as a whole. Most respondents (68%) did not say they received more services compared to 2005. Some 42% thought services were better. While the geographical scope and female participation in the survey is too limited for accurate extrapolation, 38% of respondents said services for women were equal to those for men. Some 18% thought



services were better, but another 18% thought they were “much worse”. The four women surveyed did not respond more negatively. Some 38% of survivors thought services for child survivors were never adapted to their needs; 20% said this was only “sometimes” the case and another 20% did not know.

Most survivors (84%) had already been surveyed by the government or NGOs in the past five years – 28% of them four times or more. Half of all respondents believed survey activity had resulted in their receiving more services and 58% felt being listened to as a result. Even though casualty data collection is not nationwide, data is collected during demining operations, and surveys have been carried out by the UN and NGOs to determine survivors’ needs. The fact that the respondents live in the capital made them an easier target group for survey activity.

Emergency and continuing medical care

Some 48% of respondents said healthcare had improved, while 42% thought it had stayed the same since 2005. However, a majority (60%) also indicated that survivors only “sometimes” received the care they needed; 16% thought this was “never” or “almost never” the case. When looking at specific areas of progress, 68% of survivors found it easier to obtain referrals; 62% thought the government provided more support for healthcare; and 58% could get services closer to home. Half of all respondents reported there were more first aid workers, but just 34% also thought there was more emergency transport. The areas where the least progress was perceived were better supplies and equipment (28% saw improvement) or the availability of medication or more complete teams (24% respectively). Among practitioners, 43% reported medical care had improved. They also found the main progress to have been in the number of health centers operating and in improved health infrastructure. No improvement was reported by practitioners in making healthcare more affordable and few saw increased government efforts on healthcare.

These findings correspond to the areas in which the authorities reported increasing their efforts, mainly through the Health Sector Development Program (HSDP) Phase III (2005-2010), which is part of a 20-year health sector reform plan started in 1997. The plan aimed to expand coverage, increase staff, and improve emergency response. These efforts would first be noticed in the capital (where the respondents live) and were far more limited in the rural areas. In 2006-2007, it was reported that only about 50% of the population had access to healthcare and that most people had to walk at least two hours to reach a medical center.¹⁴ Overall, shortages in medicine, supplies and staff, as well as high staff turn-over, persisted. In part this is due to a focus on quantity rather than quality in the program.¹⁵

Physical rehabilitation

Half of all respondents believed that, overall, physical rehabilitation services had remained the same since 2005, while 38% saw improvement. Nevertheless, most respondents (54%) thought survivors only “sometimes” received the physical rehabilitation services they needed; 14% said this was “never” the case; and just 4% thought survivors “always” received needed services. The most progress was reported in better-trained rehabilitation staff (38% saw improvement), more complete rehabilitation teams and improved physical access to rehabilitation centers (32% respectively). Just one-quarter of respondents believed the quality of physical therapy and mobility devices has improved, and just 22% found physical rehabilitation to be more affordable or more supported by the government. Over 70% of practitioner responses indicated that physical rehabilitation services had improved, particularly noting more centers increasingly providing free-of-charge repairs and less difficulty in obtaining replacement devices. They also said the government had maintained and in some areas increased its efforts with respect to physical rehabilitation. However, it must be taken into account that the majority of responses were received from rehabilitation practitioners who would, therefore, have experienced these improvements first-hand. More rehabilitation centers do exist in 2009 than in 2005. They have been opened through

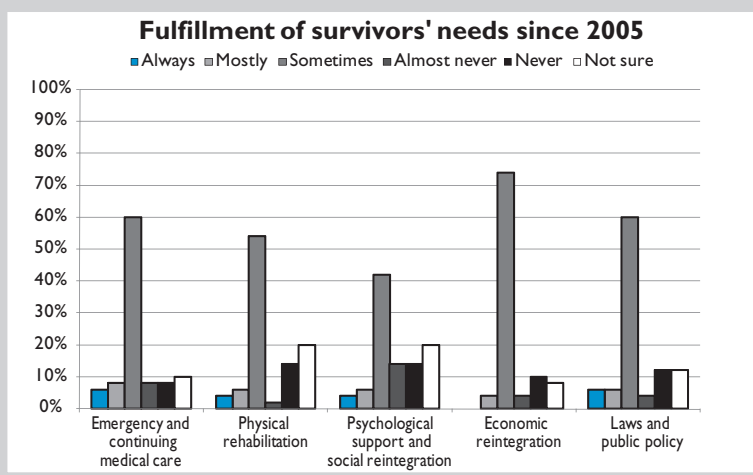
the Emergency Demobilization and Reintegration Project (with a World Bank loan) and one center (Bahir Dar) has been moved to a more accessible location. However, the ICRC continued to report throughout the period that the number of centers was insufficient to meet the need, and that access was limited because most persons with disabilities could not afford transportation or accommodation.¹⁶ Respondents from the capital would have seen more improvement, as Addis Ababa houses the largest rehabilitation center in the country and saw the opening of the National Orthopedic Center in October 2007, even though the latter was not fully operational during the first half of 2008. In mine-affected areas, rehabilitation centers run by BoLSA and NGOs lack staff, capacity, and depend on external support. The ICRC increased its coverage after several other international NGOs left the country. It was also noted that geographic coverage is unequal, with more facilities along the old frontlines and very few services in isolated mine-affected areas, such as the Somali and Afar regions. Community-based rehabilitation services (CBR) provided by some local NGOs are not always considered to be of sufficient quality or quantity.¹⁷

Psychological support and social reintegration

More than half of all respondents (54%) believed psychological support and social reintegration activities had improved since 2005; 38% said they remained unchanged. However, 42% said survivors only “sometimes” received the psychosocial support they needed; 28% said this was “never” or “almost never” the case; and just 4% said it was “always” the case. Just 22% thought psychosocial support is a government priority. The most progress was registered on the personal level, such as feeling more involved in community activities (76%), feeling more empowered (72%), and becoming involved in support activities for others (68%). Over half of all respondents noted that peer support groups had been created (56%) and that there were more sports activities (54%). These results were to a large extent echoed by practitioners, where 54% saw improvement of services, mostly in reduced stigma around seeking psychosocial support (50%). Practitioners saw much less advancement in the number or quality of services. They noted, for the most part, that the government had maintained its efforts to provide psychosocial support services

The survivor responses need to be taken with caution, as they are strongly influenced by the fact that these urban-based respondents were contacted by a peer-run VA NGO offering psychosocial support. Also, the NGO began its activities in 2000, which means most respondents have most likely been experiencing progress since before 2005.¹⁸ Therefore, the outcomes do not correspond with what has been reported throughout 2005-2009; in 2008 the government acknowledged psychosocial support activities were limited and mostly carried out by NGOs. This is best reflected by the fact that only 36% of survivor respondents thought survivors were seen as “charity cases” less often. The government added that the capacity of DPOs was too weak to be effective. It also noted in 2008 that children with disabilities had extremely limited access to education and that a needs

assessment, more awareness, resources and better coordination are needed to improve inclusive education.¹⁹ However, the survivor responses are a positive indication of the effectiveness these types of activities can have for survivors.



Economic reintegration

Again, more than half of all respondents (54%) said economic reintegration opportunities had improved since 2005 and 36% found the situation unchanged. Nearly three-quarters of respondents said survivors “sometimes” received the economic reintegration support they needed; 14% found this “never” or “almost never” to be the case; and 4% said this was “mostly” the case. Some 60% of survivors said economic reintegration was not a government priority; 84% said unemployment was so high survivors were the last to be chosen for a job. Less than a third of respondents (30%) believed employment opportunities for survivors had increased, while 20% indicated there were more job placement services than before. Just 8% said employment quotas were better enforced. Respondents did, however, see the most progress in the availability of micro-credit and small business loans specifically for survivors (70% saw improvement), and 58% also believed survivors had better access to programs not designed specifically for them. Just over half of practitioners also saw advances in economic reintegration for survivors, mostly in the availability of micro-credit and loans. Practitioners did not see increased government efforts towards economic reintegration.

These responses should be put into context, as many respondents accessed economic reintegration opportunities through the peer support NGO or were referred to other services by it. Also, there are more employment opportunities in Addis Ababa and provisions for veterans are generally better than for civilians. This situation should not be seen as representative of survivors throughout Ethiopia, where economic reintegration activities are limited and are exacerbated by very high general unemployment, large numbers of people in extreme poverty surviving on subsistence farming, and inaccessible terrain in many mine-affected areas. Additionally, strict eligibility criteria for vocational training or micro-credit and high interest rates (for the latter) further limit access. Pensions are also subject to very strict eligibility conditions and are set at just 30% of the salary last earned, which for many survivors would amount to very little.²⁰

Laws and public policy

Just 2% of respondents thought the protection of their rights was worse now than in 2005; 62% saw progress. However, the majority (60%) still said the rights of survivors were only “sometimes” ensured and 16% thought this was “never” or “almost never” the case. When looking at specific areas, the most progress was noted in increased awareness about the rights of survivors (80%), decreased discrimination (74%), and less use of negative terms about persons with disabilities (72% saw improvement). While 80% of people thought there was more legislation, just 20% thought these laws were enforced better; 24% believed persons with disabilities had more representation in government. Like the survivor responses, some 60% of practitioners reported improvements in laws and public policies, more specifically in the development of legislation and access to information about rights. Most thought the authorities had increased efforts.

These results are interesting because Ethiopia has actually reviewed very few of its existing disability laws, apart from employment legislation, which has been under review since 2008. Reports of discrimination, particularly in rural areas, are common and existing legislation was considered to be inadequate and in need of review. Ethiopia subscribed to several disability initiatives, such as the African Decade of Persons with Disabilities (2009-2010) and has signed the UNCRPD, but little implementation has ensued. However, awareness-raising efforts have increased. UNICEF was commissioned to conduct a review of disability legislation, and a Disability Council for UNCRPD implementation was created in 2008. While these efforts are just preparatory steps, survivors in the capital would have been more aware of these efforts, particularly since some NGOs organized workshops to promote the UNCRPD in 2008.²¹

The government was unavailable to comment on preliminary findings.

VA process achievements

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

Note: Ethiopia only submitted its initial Article 7 transparency report in July 2008, while it was due by 25 November 2005.

After announcing its ratification of the Mine Ban Treaty at the First Review Conference in Nairobi in December 2004, Ethiopia became the 24th State Party to join the group of countries with significant numbers of survivors and the greatest responsibility to act, but also the greatest needs and expectations for assistance (now informally referred to as the VA26).²² Throughout 2005-2009, Ethiopia does not appear to have participated actively in the so-called VA26 process, either nationally or internationally. While efforts were undertaken by individuals in MoLSA and by international organizations to make progress, mostly in late 2006-2007, these efforts were unsystematic and do not appear to have received broader government support. It was noted in 2007-2008 that VA/disability was not a government priority.²³

In 2005, Ethiopia did not provide an overview of the status of its services as a benchmark against which progress could be measured; it did provide some detail on legislation and data collection. In 2008, Ethiopia finally presented its status report. Also in 2005, it presented some vague objectives, which have not been reviewed since.²⁴ Plans have not been developed, although this was recommended in 2006-2007 workshops and round-table discussions (two organized by the government with support from the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration and one by the ICRC).²⁵ As of August 2009, while progress was made on some objectives, which are largely immeasurable, this was done in broader healthcare or development programs, rather than stimulated by the VA process and dependent on international support. For example, health sector reform and support to the rehabilitation sector was funded by two World Bank loans/grants, disability legislation initiatives by UNICEF, economic opportunities by the International Labour Organization, and CBR by the World Health Organization.²⁶ Persons with disabilities (particularly veterans) have been integrated as one of the priority vulnerable groups in post-conflict and development projects on a regular basis.

A lack of a clear focal point might have hampered achievements. MoLSA was responsible for disability in general, but did not undertake specific action on VA until it decided to host a VA workshop in November 2006. In 2007, it was again recommended that a VA/UNCRPD focal point be appointed. Only in 2008 did the MoLSA representative report that MoLSA was responsible for VA, but in that same year the MoH claimed the same. The Ethiopian Mine Action Office (EMAO) does not include VA in its mandate. Even though it was supposedly responsible for casualty data collection, EMAO noted it would only start doing so “when the government decides it is a priority worthy of scarce funds.”²⁷ Ethiopia acknowledged that a lack of inter-ministerial coordination was one of the main obstacles, as well as a lack of funding and human resource capacity.²⁸ The establishment of the inter-ministerial Disability Council for the implementation of the UNCRPD under the Prime Minister, in 2008, might advance coordination.

The lack of coordination is reflected in survivor responses; just 34% thought they knew who was responsible for coordinating VA and the same percentage thought there was better coordination with the disability sector. Just over one-quarter (26%) thought survivors were included in coordination and just 4% thought the government allocated more funds to VA/disability than in 2005. Some 36% felt the needs of survivors were taken into account while developing plans, which most likely means the peer support NGO was relatively successful in conveying survivors’ priorities to the government level. However, only 12% of survivors said they received regular information on VA achievements.

Conclusions

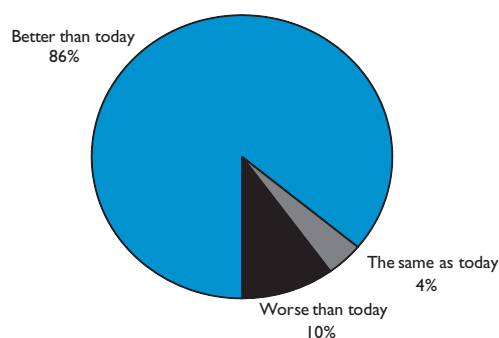
- Despite survey sample bias, service provision appears to have improved in the capital, but this situation is not representative for the vast majority of survivors in rural areas.
- Where progress in VA was made, it was either through major development projects or the work of local and international NGOs.
- Measurable improvements in VA/disability coordination or importance were not indicated.
- Under international encouragement, the VA26 process generated some *ad hoc* efforts, but national authorities were neither willing nor able to sustain them.

Suggestions for the way forward

The vast majority of respondents (86%) thought their situation in five years would be better than it is now; 10% believed it would be worse; and 4% said it would stay the same. To assist in a better future ahead, the following suggestions may be taken into account:

- Increase services and access to them in mine-affected and rural areas; focus in particular on the under-served areas in Afar and Somali province.
- Increase Ethiopia's engagement on VA in the Mine Ban Treaty framework.
- Clarify who the focal point is for VA/disability, clarify relations between ministries, and clarify relations with the new disability council in order to improve coordination and harmonize VA and UNCRPD implementation.
- Work on elevating the status of disability issues within the government, particularly as disabled persons and their families constitute a significant percentage of the population.
- Substantially increase the equal involvement of survivors and both national and international NGOs in the planning and monitoring of VA/disability activities; build DPO capacity.
- Develop a VA/disability action plan that links to existing poverty reduction, health and development strategies.

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



- Allocate sufficient funds (nationally and internationally) to VA/disability implementation and capacity building.
- Review legislation to bring it in line with the UNCRPD and ratify the UNCRPD.



Aynalem Zenebe doing a crossword puzzle

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In their own words...

Respondents described themselves as: brave, challenger, efficient, hopeful, hot-tempered, self-confident, courageous, gentle, industrious, optimistic, hardworking, communicator, happy, committed, innocent, positive, strong, smiling, and tolerant.

In their own words...

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

- Physical rehabilitation and devices.
- Improving enforcement of legislation and policies.
- Economic reintegration.
- Properly made devices.
- Respect for persons with disabilities.
- Affirmative action for women.
- Creating job opportunities.
- Accessibility of infrastructure.
- Equal opportunities to work.
- Awareness among the public through the mass media.

In her own words: the life experience of Aynalem Zenebe

Aynalem, from Mekelle (northern Ethiopia), was only seven years old when she was injured by a cluster submunition while returning from school in 1998. Her younger brother and two older sisters were also hurt, but Aynalem was the most seriously injured. She lost consciousness and later awoke in hospital in Mekelle, where she spent five months before being transferred to Addis Ababa.

One of Aynalem's legs was amputated; since 1998 she has had nine prosthetic legs. "At first I was too young to realize the consequences of my disability, but I understood when it was not possible to go play football with the other children anymore," she says. Aynalem, now 18, studies business at a vocational school. While she and her family still do not talk about that dark day back in 1998, she has accepted her disability. She says she does tell her friends at school or people who ask about her disability because she does not want the same thing to happen to other people.

Aynalem realizes she received assistance because of the NGOs working in mine-affected areas and she knows that mines, just like the cluster submunition that injured her, are indiscriminate weapons. She, therefore, became one of Handicap International's "Ban Advocates", survivors active in campaigning for their rights and against indiscriminate weapons of war. Like antipersonnel mines, cluster submunitions have now been banned under international law. Cluster submunition survivors often require the same services and assistance and live in the same affected communities as other mine/ERW survivors. During her training, Aynalem learned that VA was first included in the Mine Ban Treaty; she also learned about the VA provisions of the Nairobi Action Plan, which do not discriminate between survivors from antipersonnel mines and ERW (or other persons with disabilities). The recent Convention on Cluster Munitions drew heavily on the lessons of the Mine Ban Treaty and the Nairobi Action Plan for its VA provisions.