Life is More Than an Artificial Leg:

The Luena/Angola Experience

Medico International is a German non-governmental organization (NGO) that specializes in socio-medical care and advocacy from the onset of an emergency throughout the rehabilitation and reintegration process.

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The Mine Action Program in Luena, Moxico, Angola

Moxico is the largest province of Angola, thinly populated with approximately 350,000 people, and about 100,000 who fled to Zambia during almost 40 years of war. Moxico is full of landmines and UXO. They stem from the anti-colonial warfare during Portuguese time and from the ongoing wars since Angola's independence in 1975 —which involved South African and Cuban troops, and mercenaries on the sides of the belligerents, the Angolan Army and UNITA.

Humanitarian demining in Angola started in Luena, the provincial capital, in 1994 at the time of the signing of the Lusaka Protocol, which brought a fragile peace that lasted until 1998. Medico International and the Vietnam Veterans of America Foundation (VVAF) joined Mines Advisory Group (MAG) in 1996 on the ground in order to start a comprehensive integrated mine action program.[1] Medico International is a German NGO founded in 1968 that works in the field of socio-medical care and advocacy from emergency to development. The three NGOs have been close partners in the steering committee of the International Campaign to Ban Landmines (ICBL) from the beginning.

Humanitarian demining in Moxico had to stop from 1998–2000, but it recommenced by mid-2000 in and around Luena in order to assist more than 100,000 internally displaced persons (IDPs). Those internally displaced had fled the Moxico countryside and the neighboring provinces during the fighting so they could reach Luena. In order to assist this new wave of IDPs, Medico took over the management of the mine awareness teams in 1998, including the monitoring of accidents. By the end of 2000, the management responsibility was handed back to MAG.

■ An Angolan woman walks past a minefield on her way home. *c/o AP*

Mine Action Programs in Luena

1. **Survey, marking, clearance and mine awareness**: Community liaison is the basis used to give priorities to tasks in the interest of common people.

2. **First aid and hospital care, including psychosocial care**: In general, 30–50 percent of mine victims die before or after surgery because of distance, lack of transport or wrongly applied first aid. In the last few years, a Norwegian NGO, Trauma Care, has been training locals in first aid. Psychosocial care by social workers starts in the hospital.

3. **Physical rehabilitation including physiotherapy**: A VVAF regional rehabilitation center has fitted over 1,000 persons with prostheses and crutches.

4. **Socio-economic rehabilitation, including community development**: Because communities are traumatized by years of war, repression and fear, social workers provide victims with psychosocial counseling, and community therapy works to improve their common plight while contributing to the healing of a shattered social fabric.

5. **Campaigning and advocacy in order to gather and disseminate information**: Activities include campaigning for the ban on landmines (which Angola has finally ratified in 2002); informing the local, national and international public about landmine victim statistics in Moxico; and organizing an International Day of the Disabled on the 3rd of December. Unfortunately, in 2000, activities were limited to a range of only five km because of the threat of war and mines to NGOs. With the opening of the last Peace Accord in 2001 to mid 2002, the range expanded to about 20–30 km around Luena.

Other NGOs working with IDPs in food-aid programs and with agricultural programs are closely linked with mine awareness/risk education and referring persons with an amputation to the rehab centre. Some simple polio cases can also be helped. Lutheran World Federation has begun to provide funds for mine clearance as well. Projects covering all of these sectors have been active in Luena since 1996. They were implemented by an informal group of international NGOs including affected associations, churches and community based organizations (CBOs) in collaboration with authorities from the national, provincial and local levels. Donors are diverse and have been changing over time.[2] The level of integration and cooperation between involved actors is varied, and not all see themselves as part of a concerted program. From the beginning, Medico International has been struggling for a common understanding, a common approach, and a stronger tangible integration.

NGOs that work in close cooperation with Medico International are VVAF and MAG. Collaborating on the international funding level are the Jesuit Refugee Service (JRS) and Norwegian Peoples Aid. The Medico project focuses on psychosocial victim assistance and advocacy. There are three teams of 15 community workers trained in various related sectors such as pedagogics, agriculture, physical education and social work, as well as a few mine survivors themselves. Although the program was started by Medico, four years into it a regional NGO, Support Center for the Promotion and Development of Communities (CAPDC), was formed, and it has taken on the responsibility of running the entire project itself—with promising success.

Recommendations in Regard to Victims Assistance and Economic Reintegration Through Psychosocial Care

Do:

1. Start by listening: Listen to the individual, understand the family situation, the neighbors' attitudes and the community context. Facilitate a process that will help the client find proper solutions such as participation, ownership and empowerment.

Starting point: Any person who suffered as a direct mine victim, any mine survivors or any person sustaining a family who lost a member due to mine accidents.

Methodology used for community access: Participatory Rural Appraisal (PRA)—also known as Participatory Learning and Action (PLA)—or psychological stress and trauma training sessions with individuals and their communities.

Examples: Participatory study and assessments should come first. Then conduct regular visits to civil and military hospitals to offer psychosocial assistance to mine survivors. This should be more than listening and talking with the victim himself; it is important to talk with others, such as the spouse and children. Once the victim is out of the hospital, follow-up visits by mixed teams (technicians, psycho and social workers and peer groups) should continue during rehabilitation. An important task is also to identify and mobilize clients for physical rehabilitation, especially women, who do not always understand the benefit of a prosthesis. Children of mine survivors should receive encouragement in school.

2. Assess existing potentials for change: Foster opportunities for mine victims and other physically disabled at the community level. Analyze the existing potentials and the challenges people are facing for betterment. Investigate the potential for improvement through the wider community by way of an information center about and access to first aid, demining, psychotherapy, prosthesis production, literacy training, vocational training and job-placement, essential items for those most in need and loan options.

Examples: Access to land and access to NGOs in the agricultural field was facilitated for national associations of the disabled, but also for individuals, access to tools and seeds was provided. Mine survivors who had been fitted with a prosthesis were placed in carpentry training offered by JRS, but in general, existing opportunities are rather scarce in Luena.

3. If opportunities do not exist: Try to use the best resources available.

Starting point: Start in the community.

Participatory methodology: Use simple yearly evaluations of the community. Assess whether or not things have changed and what factors could have influenced that change. In order to come up with concrete recommendations for the community, use Strength, Weaknesses, Opportunities, Threats (SWOT) analyses.

Examples: Start informal agriculture programs with specific emphasis on mine survivors, train community leaders and community mobilizers, run a community health post, rehabilitate schools, train teachers, run a community kitchen during emergencies, promote and teach literacy—specifically for women—and teach micro-credit schemes to women.

4. Network: Promote the sharing of information among those involved in the field.

Examples: Social workers need to understand how a prosthesis is made and what role psychotherapy plays in mobilizing clients for rehabilitation or to understand complaints about the prosthesis during follow-up visits. Technicians and gate trainers need to

understand how to interact with amputees in a respectful way. Also, it is necessary to have a basic understanding of how a traumatized person "ticks." Agricultural extensionists need to have a wide-based knowledge of mine awareness, what should be done when an unknown device is detected or what should be done in case of an explosion. A surgeon should not only analyze the stump, but also be able to see that a woman is pregnant and anemic.

5. **Specific care:** Actively motivate clients to go for physical rehabilitation, pay specific attention to gender issues, and look for specific needs of other groups such as children, the elderly and those most vulnerable—for example, people with little or no family support.

6. **Sport and culture:** Life is not only about survival. Offer activities for sport, leisure and culture. Sports should include modalities in mixed groups to improve acceptance and integration.

7. **Strengthen local organizations:** Promote organizations for the disabled, human rights, community development, health improvement and community organizations. Include a flexible tool for funding community initiatives or the single needs of most vulnerable cases. We call this tool an "Open Fund for Community Support," which serves to support local development activities that are not an integral part of Medico, such as a mobile clinic, community theatre groups, an association of sports for the physically disabled, literacy training and more. The aim is to create a network for development-oriented activities of local initiatives.

8. **Promote monitoring of the impact:** Monitoring needs to cover all aspects of the mine action program. Monitoring psychosocial improvement is quite complex, especially at the client level. Indicators measuring improvement in self-confidence and self-esteem of clients needs to be agreed upon. An outcome of such monitoring is a necessary follow-up of the more vulnerable clients.

Do Not:

1. **Do not exclusively help mine survivors:** This only leads to more isolation. Houses built by the government for disabled only, kindergarten for disabled only, and agriculture for amputees only address the physically disabled discriminately. Opt for inclusion approaches to community development with a focus on persons with disabilities. The aim of programs for the general community with a special focus on mine survivors is twofold: to improve living conditions for clients and to fight prejudice and stigmatization by creating a better understanding within the community of persons with disabilities.

2. **Do not rely on professionals from only one field:** At a glance, it seems obvious: demining is a job for military persons; medical care is provided by doctors; rehabilitation centers are run by certified prosthetists and orthotists, traumatized persons need to see a psychiatrist. However, this is only a part of the picture. As the Luena experience exemplifies, different expertise is used to offer the best services in each field of mine action. But if we put people first, then we need a proper understanding of the people and their culture; we need to be able to use participatory tools in order to reach them—with respect. For this, social workers, community liaison persons and community mobilizers are a prerequisite in any field.

In regards to the traumatized person who needs to see a psychiatrist, we do not think this to be appropriate for the conditions of Luena and the cultural context. We did not bring in psychologists with clinical training (only once, and with too little impact). We do, however, know that the psychosocial approach outlined above has helped some seriously traumatized (direct) landmine survivors tremendously, others to a lesser extent, and has led to a higher awareness and acceptance of survivors at community and neighborhood level.

Instead of a Summary: A Best Case

Let me finish with one of our best examples: Mr. Lino is a man in his early 40s. He made his living by driving mini-buses as public transport. One day, he drove over a mine 30 km outside Luena, and it exploded right between his legs. He received help and made it to the hospital but both legs had to be amputated, one above the knee and one below the knee. Mr. Lino did not want to live any more. He did not know how he would support his wife and children ever again. The family of his wife advised her to leave this man since he had become "useless." Our social workers intervened; they listened and talked to everyone involved, and eventually the family stayed intact. After both stumps healed, Mr. Lino received prostheses and bravely learned to walk again. He was able to buy a tricycle. Now he could go long distances with the tricycle and walk the shorter distances. But survival? With some help he got a plot of land and started to cultivate his field. Nowadays, his neighbors, "complete" ones, envy him for the good crop he yields. ■

References

1.To promote this comprehenseve development-oriented approach the Bad Honnef Framework was designed by Medico in conjunction with many international experts in the field of HMA in 1997, the framework can be retrieved in German, English, French, Portuguese, Spanish, Russian, Chinese and Arabic under: www.landmine.de.

2. MI received funds for the first three years from the German Government. In 1999 and in 2000 very little funding could be secured, only from Oct. 2001 for three years the Diana, Princess of Wales Foundation (DMF) has agreed to fund ca. US $150,000. MAG has received funding to relaunch their activities from the German Federal Office via Medico since October 2000.

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