Assistance to Victims of Landmines and Explosive Remnants of War:

Guidance on Child-focused Victim Assistance

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In addition to the print version, the Guidelines are also available in a range of alternative formats: DAISY; E-Pub and accessible HTML that can be found at www.unicef.org/disabilities.

Cover photo:
Tayyab lost his right foot due to a mine that exploded while he was playing with it. Tayyab's father, a farmer, explains: "My land was flooded, but with the help from my family, I managed to cultivate it again. I was working … when I saw something that looked like a thermos cap. I … put it in my pocket … I gave it to my children to play with. The next morning … I heard a big explosion. It sounded too close. I came out to look and saw Tayyab lying in the pool of blood. I was devastated. I could not go to the hospital that day and just kept crying."
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Acknowledgements

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Mohamed was 13 years old and living in Benghazi, Libya, when he was playing football with his friends in front of his apartment block. He saw a shiny golden metal object and started hitting it against a wall. It was a submunition which exploded, hitting the child in the hand and face. He lost several fingers in the accident.

Survey: Armed Violence & Weapons Child-Focused Victim Assistance

Foreword

FOR me, one incident expresses it all: When 8-year-old Nouay picked up an unusual looking stone, it exploded, leaving him unconscious and bloodied. He said recently, "Every day I used to cry when I looked at my hand." This is one child's reflection on the explosion of a cluster munition in Lao PDR that occurred years after the war ended. Even decades after fighting is over, these small and indiscriminate weapons remain hidden in the ground, just as landmines, ready to explode at the touch of an animal's paw or hoof — or a child's hand or foot. This guidance is important because of a largely invisible group of survivors: children whose lives were altered forever in a split second's explosion of sound and light. Though this manual originated in the global Mine Action community, all those who work with children with disabilities will benefit from this guidance.

While landmines, cluster munitions, Improvised Explosive Devices and other explosive ordnance had been in use for decades, in 1996, the UN Secretary General issued a report, "Impact of armed conflict on children". Its development was led by former Mozambican First Lady Graça Machel, still an activist today for children's rights. That report highlighted systematically the dangers to children posed by landmines and explosive remnants of war and the illicit global flows of small arms and light weapons.

The following year, 1997, saw the adoption of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction. This was followed by other related protocols and conventions, notably the 2006 Convention on the Rights of Persons with Disabilities. You will read about these later in the text. The point here is that when States ratified these international agreements, amongst other provisions, they committed to providing assistance for the care, rehabilitation and reintegration of mine victims and their families. This is as relevant in today's troubled regions as it is in those still contaminated by these "explosive remnants of war".

Implementation by States of the "victim assistance" provisions has been uneven, often left to non-governmental organizations and UN agencies. It has been even more irregular for children, who are too often absent from policy dialogue and programme planning and implementation. Child survivors require more care and attention than adults. Their growing bodies require more frequent access to health, rehabilitation and prosthetic services. The right to education is crucial for supporting the social and economic reintegration of child survivors, yet this right is often in jeopardy if a child has a disability. The psychosocial recovery and wellbeing of child survivors also requires specific considerations appropriate to the survivor's age and phase in the life cycle. Children with disabilities are especially vulnerable to discrimination, marginalization, violence, abuse, exploitation and neglect, requiring pro-active preventative attention through protection services. For those interested in economic measurements, the DALY or Disability Adjusted Life Years lost due to disease or disability is far greater for children than for adults.

This guidance will be a contribution to filling the gap in ensuring that the child survivors of mine and other explosive accidents receive the immediate and long-term support required for their physical and psychosocial wellbeing. It is also applicable for those who work to end the havoc wreaked by guns and other light weapons and, indeed, other forms of violence against children.

Let us know how you have been able to use it and good luck with your important work.

Susan Bissell
Associate Director, Child Protection
Programme Division
UNICEF New York

Acronyms

AIDS	acquired immune deficiency syndrome
APMBC	Anti-Personnel Mine Ban Convention
C4D	Communication for Development
CBR	community-based rehabilitation
CCM	Convention on Cluster Munitions
CCW	Convention on Certain Conventional Weapons
CDC	Centers for Disease Control and Prevention
CMC	Cluster Munition Coalition
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DFID	Department for International Development, Government of the United Kingdom of Great Britain and Northern Ireland
DPO	disabled people's organization
ERW	explosive remnants of war
GA	General Assembly (of the UN)
GICHD	Geneva International Centre for Humanitarian Demining
GMAP	Gender Mine Action Programme (A Swiss NGO)
HI	Handicap International
HIV	human immunodeficiency virus
ICBL	International Campaign to Ban Landmines
IDP	internally displaced persons
IED	improvised explosive device
IMAS	International Mine Action Standards
IMSMA	Information Management System for Mine Action
ISPO	International Society for Prosthetics and Orthotics
ISU	Implementation Support Unit (of the APMBC)
MA	mine action
MRE	mine risk education
NGO	non-governmental organization
NSA	non-state actor
PDR	People's Democratic Republic (as in Lao PDR)
PFA	psychological first aid

P&O	prosthetics and orthotics
UN	United Nations
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNMAS	United Nations Mine Action Service
UXO	unexploded ordnance
VA	victim assistance
WASH	water and sanitation and hygiene
WHO	World Health Organization

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Amadou, in Timbuktu, Mali, had an arm and a leg amputated following the explosion of a grenade that killed the other two children he was with.

Chapter 1
Introduction: The Need for Child-focused Victim Assistance

The Need for Child-Focused Victim Assistance

BETWEEN 1999 and 2012, 88,331 people living in some 60 countries are known to have been killed or injured by landmines or explosive remnants of war (ERW). Of these, at least 15,868 were under the age of 18 at the time of the accident.[1] Although significant progress has been made in reducing the threat of unexploded ordnance worldwide, some 1,000 children – 90 per cent of them boys or young male adolescents[2] – are still killed or injured annually. Cluster munition remnants and improvised explosive devices (IEDs) are particularly deadly for children. Blast and fragmentation injuries often cause long-lasting impairments including limb amputations, loss of eyesight and hearing, severe injuries to genitals, internal organs, face and chest, brain damage and spinal cord damage.

These physical injuries are aggravated by the psychosocial, socio-economic and protection consequences of the traumatic event of a blast accident as the survivors confront lifelong difficulties accessing education, livelihood opportunities and, like many vulnerable children with disabilities, are subject to violence, abuse and exploitation. Children who lose a family member as a result of a mine/ERW blast, or who are living in a family with an adult survivor, also face considerable challenges from the loss or impairment of a care giver or the household breadwinner. Educational opportunities may be lost due to the burden of school fees or the child's need to work to support family income.

Not all deaths and injuries are recorded and not all highly impacted countries disaggregate data by age. Nonetheless, available data on 1,466 child victims collected from 2009 to 2012 show that children from 12 to 17 years old are most at risk and those under 5 the least (See Box 1).

More in-depth research is required to better understand the causes that lead to accidents and the associated risk-taking age groups. However, it is crucial to distinguish between those who accidentally set them off, intentionally tamper with a device, and the bystanders. Those causing the explosion may be adults with their children either helping or simply standing by at the moment of the explosion. Table 1 shows the activities by age group that resulted in ERW/mine accidents in Cambodia from 2008 through 2012.

It reveals that the youngest children hurt or killed were more often observers rather than active participants, while adolescents were far more likely to be handling the object when it exploded. Regardless of the causes, child and adolescent casualties of ERW/mine accidents need assistance from all stakeholders if more deaths and injuries are to be prevented.

A focus group discussion with male Cambodian landmine/ERW survivors to learn about available victim assistance services and to hear personal accounts as to what has been the most important support for them.

Box 1: Age-groups Among Child Casualties Globally (2009-2012)

From 2009-2012, the Landmine and Cluster Munition Monitor recorded 1,705 child victims globally whose sex and age were known, including children killed and children injured. Of these, 1,218 (71%) were boys and 248 (29%) were girls. For the other 239 children, either the age or sex were unknown). (Many media report on 'children' in general; if they differentiate the sex, most provide details only about girls. *Therefore, for the known sex and age casualties, it is likely that girls are slightly over-represented in this dataset*).

In order to undertake an analysis by age-groups, key life cycle segments are considered. The following four main groups are suggested: 0-5, 6-11, 12-14, and 15-17 years of age. By combining the two sub-groups comprising adolescents (12-17), equal age-brackets of 6 years each can be compared.

Children from 12-17 are most at risk from mines/ERW (49%) compared to the two younger age groups. Children aged 12-14 are particularly at risk, comprising nearly one third of reported fatalities and injuries. Those under 6 are least at risk as they are most likely by-standers and too young to actively manipulate the explosive device (see also Box 7 on Cambodia data analysis by age-groups in Section 5.1 "Data collection and analysis").

All Children

Boys

Girls
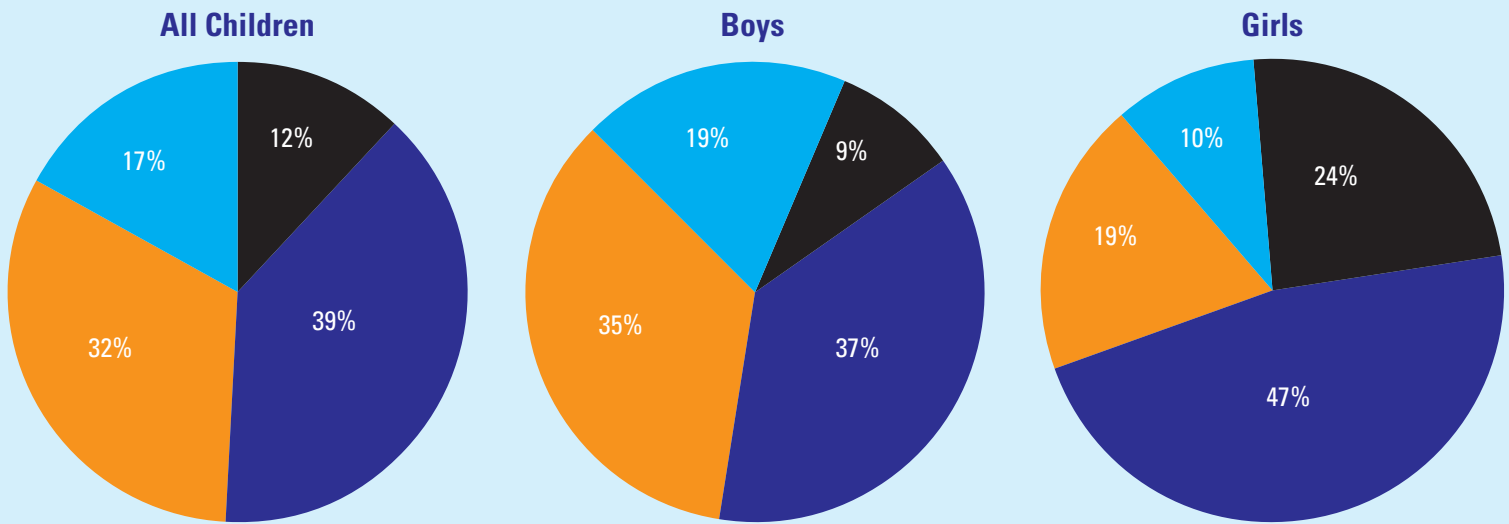
Figure A: Mine/ERW Child casualties (2009-2012) (n=1,491; of 1,705 total casualties, 214 did not report age or sex)

Figure B: Mine/ERW boy casualties (2009-2012) (n=1,218)

Figure C: Mine/ERW girl casualties (2009-2012) (n=248)

Legend: 0-5 | 6-11 | 12-14 | 15-17

Accounting for 71% of reported child victims, boys are clearly much more at risk from ERW and mines than girls. Comparing boys and girls by age-group reveals stark differences though:

- In the 12-17 age group, 54% of the victims of ERW and mines are boys, with 29% adolescent girls.
- Girls aged 6-11 comprise the largest segment of victims among female age groups – by 10% higher than the corresponding boys' segment.
- Surprisingly, girls under 6 years of age are apparently at considerably higher risk than boys in that age group.

Source: Data provided by Landmine & Cluster Munition Monitor (LCM) team for global data (February 2014), Cambodia Mine/ERW Victim Information System (CMVIS) for Cambodia data (February 2014).

Table 1: Activity at Time of ERW/Mine Accident among Children in Cambodia (2008-2012)

Age Group	Activity at the Time of Accident	Devices ERW	Mine	Total
0-5	Bystander	21	9	30
	Handling Mine/ERW	2	1	3
	Making fire	1		1
	Traveling		9	9
0-5 Years of Age: Total		24	19	43
6-11	Bystander	60	3	63
	Farming		1	1
	Handling Mine/ERW	39	5	44
	Making fire	1		1
	Traveling		5	5
6-11 Years of Age: Total		100	14	114
12-14	Bystander	38	8	46
	Clearing new land	1		1
	Collecting food	1	1	2
	Farming		3	3
	Handling Mine/ERW	40	1	41
	Herding	1	1	2
	Other	2		2
	Traveling		3	3
12-14 Years of Age: Total		83	17	100
15-17	Bystander	32	7	39
	Clearing new land	3	2	5
	Collecting wood		2	2
	Construction		1	1
	Farming	1	5	6
	Handling Mine/ERW	33	2	35
	Herding	2	1	3
	Making fire	2		2
	Other	1		1
	Traveling		14	14
15-17 Years of Age: Total		74	34	108
Grand Total		281	84	365

Source: Data provided by Landmine & Cluster Munition Monitor (LCM) team for global data (February 2014), Cambodia Mine/ERW Victim Information System (CMVIS) for Cambodia data (February 2014).

Resources Chapter 1 "Introduction: The Need for Child-focused Victim Assistance Guidance"

Landmine & Cluster Munition Monitor. *The Impact of Mines/ERW on Children.* Fact Sheet. December 2013. [Since 2009 annually.] http://www.the-monitor.org/

Landmine & Cluster Munition Monitor. *Landmine Monitor Report 2013.* [Particularly Section 'Casualties and Victim Assistance'] http://www.the-monitor.org/

Liban lost his leg in a bomb blast in Mogadishu, Somalia, after arriving from the city of Baidoa as an internally displaced person.

Chapter 2
Mine Action, UNICEF and Guidance on Child Victim Assistance

Mine Action, UNICEF and Guidance on Child Victim Assistance

MINE Action (MA) is comprised of five pillars:
- Demining,
- Stockpile destruction,
- Mine risk education (MRE),
- Victim assistance (VA), and
- Advocacy for accession and adherence to the Anti-Personnel Mine Ban Convention (APMBC).

MRE and advocacy, particularly advocacy for the Convention on the Rights of Persons with Disabilities (CRPD), are closely linked to VA. Demining and clearance of landmines and explosive remnants of war (ERW) in affected communities is also fundamental to VA in order to reduce accidents, improve socio-economic recovery and enable life without fear from mines and ERW. Injury prevention (lethal and non-lethal), including the prevention of impairments, is primarily addressed by MRE, demining and advocacy.

The United Nations Mine Action Service (UNMAS), United Nations Development Programme (UNDP), UNICEF and World Health Organization (WHO) have been engaged in VA over the past 15 years. UNICEF contributes to MA through its support of MRE, VA and advocacy. Although the 2011 General Assembly (GA) mandated evaluation of the United Nations (UN) work in MA specifically recommended appointing a VA focal point in the UN system, as of mid-2014, this was not the case; nor is there a UN disability focal point.

UNICEF supports survivors and victims of landmines and ERW as part of its comprehensive support to children affected by armed conflict and to children with disabilities. UNICEF advocates for implementation of the Anti-Personnel Mine Ban Convention (APMBC), the Convention on Cluster Munitions (CCM) and Protocol V on ERW of the UN Convention on Certain Conventional Weapons (CCW), three conventions that integrate needs of victims into disarmament treaties and reinforce their rights. It also supports the Optional Protocol to the UN Convention on the Rights of the Child (CRC) on Children and Armed Conflict and the UN Convention on the Rights of Persons with Disabilities (CRPD), among other legal instruments. UNICEF supports the APMBC Standing Committee on Victim Assistance and Socio-Economic Reintegration in their efforts to strengthen age and gender-appropriate VA for children. In supporting efforts to implement the relevant instruments of international humanitarian law, mine action actors address all types of explosive devices including landmines, ERW and cluster munitions.

Children with Disabilities

The term, 'children with disabilities' refers to persons up to the age of 18 who have 'long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'

Convention on the Rights of Persons with Disabilities, Article 1

The noted gap of the inability of armed non-state actors (NSAs), many of which use indiscriminate weapons, to sign on to international law has been addressed through the work of the Swiss Non-governmental organization (NGO) *Geneva Call* which has for many years successfully lobbied NSAs to sign a 'Deed of Commitment' similar to the APMBC. As of mid-2014, 45 NSAs agreed to ban landmines and to broadly undertake mine action, including limited VA. UNICEF supports or has supported civilians living in areas controlled by NSAs in some countries/areas.

States Parties to the Mine Ban Convention have acknowledged victim assistance to be a core pillar of Mine Action and States Parties to the Convention on Cluster Munitions have agreed to VA as an obligation with its own article whereby States Parties must adequately provide age-sensitive assistance. High Contracting Parties to the Convention on Certain Conventional Weapons that signed Protocol V on ERW also incorporated VA requirements.

All States Parties repeatedly called for such assistance to be age and gender-appropriate, noting that survivors and other victims may need to access various components of VA at different points in their life-cycle, depending on individual circumstances. This life cycle approach is particularly relevant for child survivors who require tailored assistance at various stages throughout their lives. Their initial needs also vary greatly depending on whether they were under six, school age or adolescents at the time of injury.

Various victim assistance and disability stakeholders, including treaty-related bodies, have developed guiding principles and policies on victim assistance. The UN Mine Action Strategy 2013-2018, for example, includes comprehensive support to victims as the second of four strategic objectives and calls for the provision of age- and

gender-sensitive assistance. The *Landmine & Cluster Munition Monitor* has compiled and reported the limited information that is available on child victims and on victim assistance annually since 2009, with the support of UNICEF. While most such strategies acknowledge the need to provide age- and gender-sensitive assistance, they provide no detail on how to do so. In recent years, there has been increasing anecdotal evidence and acknowledgement of a considerable gap in age- and gender-sensitive VA. A comprehensive mapping of VA-related literature and programming undertaken by UNICEF confirmed what was suspected: age-sensitive assistance remains among the least considered aspects of victim assistance provisions. There is a scarcity of child-specific literature, recommendations, good practices and analysis with the notable exception of the Save the Children publication *Child Landmine Survivors: An Inclusive Approach to Policy and Practice,* published in 2000.

While data and analysis on how children are impacted have been used as a primary advocacy and fundraising tool by the MA and VA community, existing guidelines, tools, studies or programme evaluations barely address their specific needs. Although some information can be gleaned from gender guidelines and studies undertaken with a deliberate gender focus, these fail to recognize that the needs of boys and girls of different ages vary greatly from those of adults, and that girls', let alone boys', needs cannot be adequately or appropriately met through strategies and approaches that target only women.

In response to this gap and to increased demand from UNICEF Country Offices for guidance in this area, UNICEF established an international resource group made up of victim experts involved in treaty-related processes, global policy and advocacy and direct programme implementation to oversee the development of a new guide. This group included landmine survivors. The process of development included:

- Comprehensive desk and literature review;
- Comprehensive mapping of victim assistance programmes;
- The development, dissemination and analysis of a survey on child-centred victim assistance to UNICEF Country Offices in 53 mine/ERW affected countries and areas;
- Missions to Mozambique and Cambodia, which included focus group discussions conducted with landmine/ERW survivors including children and family members of landmine/ERW victims;
- Participation and presentation of concepts and preliminary findings during side meetings of the APMBC Intersessional Meeting 2013 and the Meeting of States Parties 2013 organized by the Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration (Austria and Colombia); and
- A final draft review by an editorial group.

Child-focused VA is about children and their families

A child survivor who lost a limb or the eyesight is the most visible victim. But to ensure the rights of all child victims, we must also support adult mine/ERW survivors and families who have lost someone due to a blast.

How can victim assistance be provided to best benefit children affected by landmines/ERW?

This is the core question.

This guidance is intended to support UNICEF staff and other MA, VA and children with disabilities practitioners engaged in planning and implementing victim assistance to apply human rights, child and gender-based approaches. The goal is to improve the well-being of children directly or indirectly affected by landmines and ERW, as well as children living with disabilities overall.

Overall objectives of the guidance

- To provide guidance on how to develop or adapt policies and programmes that assist child mine/ERW victims that are age- and gender-appropriate and promote the rights of children and young people with disabilities.
- To promote access for children directly and indirectly affected by landmines and ERW to comprehensive support in emergency situations, directly or through their families, communities and service providers.
- To promote programming for mine/ERW injured children that is mainstreamed into wider disability, economic and social development, and poverty reduction efforts.
- To support stakeholders to meet the needs and enhance the quality of life of children and their families affected by landmines and ERW by advocating for and facilitating access to affordable health care, rehabilitation, psychosocial support, social and economic inclusion (education, livelihood support and social assistance, etc.).
- To encourage stakeholders to facilitate the empowerment and participation of children affected by armed conflict and of children with disabilities.

Target audiences of the guidance

The primary audiences for this guidance are:

- UNICEF programme and policy staff at country,

Monica and Luis Alberto, both 14 years old, during a weekend retreat for children with disabilities, run by the NGO CIREC (the Colombian Integral Rehabilitation Centre), outside Bogotá, Colombia. Monica lost one foot when her younger cousin brought a grenade home, not knowing its danger. It exploded, killing the cousin and injuring Monica and her brother Jonathan, both of whom required lower leg amputations. Luis Alberto left home at the age of 11. He says he was born without one foot, but social workers suspect it was amputated following a war-related injury. CIREC promotes an integrated recovery approach, especially for children, combining physical and play therapy, counselling and empowerment training. It also trains clients to advocate against stereotypes affecting people with disabilities.

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regional and headquarters levels;
- Governmental and non-governmental entities and international organizations, including UN actors, providing services for survivors and victims of landmines/ERW and persons with disabilities;
- Government, UN, NGO and other relevant stakeholders influencing policy and budgeting related to mine action, persons with disabilities, and/or child rights and protection.

The secondary audiences of the child-focused VA guidance are:
- Child Protection practitioners focusing on children affected by armed conflict and disaster management;
- Mine Action actors;
- Protection, Child Protection, Education, Health, WASH (Water, Sanitation and Hygiene) and other relevant sectors;
- Personnel from service providers, development organizations, non-governmental organizations (NGOs), disabled people's organizations (DPOs) including landmine/ERW survivor organizations working to strengthen respect for human rights and access to health, education, social and livelihood services;
- Children and people with disabilities, their family members and other care givers;
- Victims and survivors of armed conflict, including children and adolescents;
- Researchers and academics.

The Guidance has seven major parts, including an introduction with justification of the need for a child-centred guide, a section on key stakeholders and standards that govern mine action and in particular victim assistance and a summary of the key principles and cross-cutting issues critical to effective VA.

The core of the Guidance is Chapter 5, which has six sections describing the full spectrum of holistic and integrated interventions required for effective victim assistance for children directly and indirectly affected by landmines and explosive remnants of war. Each section contains an introduction, goals, role of the respective child-focused VA, key concepts, desirable outcomes, and suggested activities. The six sections are:

5.1 Data collection and analysis
5.2 Emergency and continuing medical care
5.3 Rehabilitation
5.4 Psychological and psychosocial support
5.5 Social and economic inclusion
5.6 Laws and policies

The six components are in line with the current understanding on VA applied by States Parties to the relevant conventions (APMBC, CCM, Protocol V of CCW). They are also accepted by many States that have yet to join these conventions. The first and sixth elements — data collection and analysis, and laws and policies — serve as the foundation to any efforts on behalf of child survivors and victims. All six components are inter-related and based on the premise that victim assistance must be undertaken as an integrated process through which a person can access all the services required throughout their lifetime rather than as a series of separate actions.

Finally, when using the term "access to", this Guidance adopts the six criteria that underlie the concept of *access* as proposed by Handicap International (HI):
1. availability,
2. accessibility,
3. acceptability,
4. affordability,
5. accountability,
6. good technical quality.

Resources Chapter 2 "Mine Action, UNICEF and Guidance on Child Victim Assistance"

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Ahmed lives in the village of Khan Arnaba, Syria, 10 km from Quneitra, where he was severely injured by a landmine. Ahmed lost vision in both eyes. Quneitra is close to the Golan Heights in southwestern Quneitra Governorate. UNICEF supported a mine risk education campaign and constructed seven safe playgrounds.

Chapter 3

Victim Assistance: Stakeholders and International Standards

Stakeholders

NATIONAL governments are the primary stakeholders responsible for ensuring that the rights and needs of landmine/ERW survivors in their territory are met. States, however, are not expected to do so on their own and treaty language clearly stipulates that "States *in a position to do so*" (emphasis added) are obliged to assist. This assistance may be provided through a variety of means, including through "the United Nations system, international, regional or national organizations or institutions, the International Committee of the Red Cross, and national Red Cross and Red Crescent societies and their International Federation, non-governmental organizations, or on a bilateral basis."

A number of key international agencies and non-governmental actors have historically engaged in the development of VA guidance and in the implementation of assistance to victims. These include the International Committee of the Red Cross (ICRC) and its related national organizations, and international and national NGOs and disabled people's organizations (DPOs) including those comprising the International Campaign to Ban Landmines (ICBL) and the Cluster Munition Coalition (CMC). Key organizations involved in VA programming at global and regional levels include but are not limited to: Handicap International and the ICRC; Clear Path International, Jesuit Refugee Service, and Vietnam Veterans of America Foundation/Veterans International active particularly in Asia; and the Polus Center active particularly in Latin America.

The ICBL-CMC's Survivor Network Project strives to maintain the work begun by the Landmine Survivor Network/Survivor Corps, an influential NGO that ceased to exist in 2010 when its member organizations were integrated into national mine action programmes.

International Standards

While most components of Mine Action are guided by the International Mine Action Standards (IMAS) there is no IMAS for victim assistance.

This is based on the rationale that VA is not a single-sector field expressly dedicated to addressing the impacts of landmines and explosive remnants of war, and that a non-discriminatory approach requires efforts on behalf of survivors of landmines/ERW to be inclusive of all persons with disabilities regardless of cause. Many practitioners therefore agree that a specific IMAS on VA is not required.

Numerous standards and guidelines relevant to components of VA have been developed. These include publications on data collection, emergency first aid and war surgery, the provision of rehabilitation services and on wheelchairs, mental health and psychosocial support, inclusion, community-based rehabilitation, the right to decent work, skills development and gender for mine action programmes.

Box 2 describes Eritrea's comprehensive Victim Assistance programme, which includes a variety of stakeholders and covers several programme sectors.

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Any object can be turned into an Improvised Explosive Device (IED), even a children's toy. This is prohibited by international convention. Though this type of IED was seized in Nepal during the conflict, eight years after the Peace Accord was signed, command-detonated IEDs are still used by various armed groups. Children continue to be victimized by these devices that 'don't look like bombs'.

Box 2: Comprehensive Victim Assistance as Part of Cross-cutting Government Interventions in Eritrea

Eritrea is a State Party to the APMBC and has accepted responsibility for a considerable number of landmine victims. The UNICEF Country Office participated in a VA Survey conducted in August 2013 as part of developing this Guidance.

Eritrea has developed a comprehensive VA programme, engaging in five key programme areas: Protection and Reintegration, Education, Health, Rehabilitation, Social Awareness and Mobilization. National policies and strategies are in place to address children with disabilities and that are inclusive of child mine/ERW survivors.

UNICEF supports the Government in mine action, child protection and disability concerns. In addition, four civil society associations that include persons who are war-disabled, and/or blind, deaf, have Down Syndrome or are autistic operate under the umbrella of the Ministry of Labour and Human Welfare (MoLHW). These organizations actively participate and are consulted for VA related interventions. Moreover, the MoLHW hires and trains persons with disabilities to involve them directly in the implementation of the community-based rehabilitation (CBR) activities. The UN Convention on the Rights of the Child (CRC) periodic reporting mechanism is used to ensure that VA is age and ; UNICEF works with the partners to have disaggregated data from the beginning of any project. The integrated approach is outlined below.

Protection and Reintegration
- The MoLHW in collaboration with UNICEF promotes Community-Based Rehabilitation (CBR) programmes at national level. Children with disabilities are protected under government policy through awareness creation, early intervention, medical services (health for all), education, sports and culture, vocational training, and CBR.
- Provision of Integrated Social and Economic Assistance to Children and Families at Risk support annually the placement of orphans and children separated from their primary care givers in foster families and communities with focus on completion of basic education; provide social and economic support for disadvantaged households.
- The national war-disabled association provides support specifically to ex-combatants who were injured during their army service with physical recovery and rehabilitation, psychosocial support and socio-economic reintegration.
- The MoLHW provides socio-economic reintegration and psychosocial support for vulnerable children, child mine/ERW victims/survivors and their families
- UNICEF supports victims through research on situation and profile of children with disabilities and through procuring prosthetics and other mobility aids including donkeys (see Education) and specialized learning materials to reintegrate children with disabilities into the community.
- MRE and other awareness sessions and workshops have been organized in all 6 zobas [provinces] for community-based social workers and community volunteers. Risk reduction and prevention of child injuries, violence and disabilities are addressed.

Education
- Government policy states, "The government shall guarantee equal access for all to a single system of education that will cater for the needs of all learners within an inclusive environment which is pedagogically sound, psychologically acceptable and socially valid".
- To promote access to basic education, UNICEF provided donkeys for 1,000 children with disabilities living in the most remote communities, to serve as means of transport from home to school. Priority was given to girls with disabilities.
- UNICEF procured specialized learning materials to reintegrate children with disabilities into the community in collaboration with Ministry of Education (MOE) and three associations of persons with disabilities.
- UNICEF supported the Education Management Information System (EMIS) in integrating mine/ERW victim surveillance, including training of MOE personnel on data collection and integration of child injuries in the EMIS in collaboration with basic education.
- MRE is conducted by the Eritrean Demining Authority at community level. MRE materials were provided to in and out-of-school children in landmine/ERW impacted areas across all six zobas. Assisted MOE in training teachers in landmine impacted areas on MRE.
- Street children are supported with school materials, cash assistance for uniforms and skill/vocational training for school dropouts.

Health

- The Ministry of Health (MoH) provides emergency medical support for mine/ERW victims. It provides free medical service for victims of mines/ERW.
- MoH extended first aid response in remote war-impacted communities through providing first aid toolkits and training for community-based health promoters, health focal teachers and community focal points. UNICEF procured first aid tool kits and distributed them along with risk prevention materials. The first aid response aims to reduce death before reaching main hospitals, which normally takes hours or days.
- For Community Health Promotion, an integrated community health manual on prevention of child injuries across the six zobas was produced and is in use.
- On-the-job training of social workers and group home care givers on effective utilization and delivery of available social services has been provided.
- The Health Management Information System (HMIS) and Injury Surveillance System (ISS) integrated mine/ERW victim data. The ISS collects data of all types of injuries including weapons related injury used to initiate referrals.
- In collaboration with MoH, three civic associations (War-Disabled, Associations of Blind, Deaf, and Persons with Down Syndrome & Autism) provide medical support for children with disabilities and psychosocial support and rehabilitation services.

Rehabilitation

- The MoLHW with UNICEF support provides mobility devices (prosthetic legs, wheelchairs, crutches and other devices) for child mine/ERW victims/survivors through the referral system of the CBR programme.
- Access to rehabilitation services for children with disabilities promoted through a case management system through building the capacity of physiotherapy centres.
- Development of Child Friendly Spaces which are inclusive of children with disabilities.
- Establishment of Child Resource Centre, promoting friendly services/ environment for children with disabilities.

Social Awareness, Mobilization and Advocacy

The CBR programme run by community-based social workers and volunteers conducts social awareness, community education and mobilization and advocacy to avoid stigmatization as well as over-protection of children with disabilities practiced by families and communities. Key measures include:

- Community-based child wellbeing committees established;
- Promoting child justice and child rights system which is inclusive of children with disabilities;
- Positive parenting for home safety - parents and caregivers sensitized on promoting safer environment for children and prevention of child injuries, violence and early detection of child disabilities;
- Community forums held in all six zobas and on-going community-based injury surveillance for mine/ERW victims;
- Training of social workers on the prevention of child injury and violence;
- Inclusion of children with specific needs and engagement with children during: (i) December 8, International Children's Day and (ii) December 3, International Day of Persons with Disabilities; and
- Finalization and dissemination of a national comprehensive policy on persons with disabilities and a community awareness campaign through media and seminars.

Six Best Practices:

1. Involve victims, families and communities fully in designing and implementing victim support
2. Promote psychosocial support and socio-economic reintegration for child mine/ERW victims/survivors
3. Facilitate educational access for child mine/ERW victims/survivors
4. Promote child/disability friendly environment, including access to physical environment
5. Community education and awareness raising activities at the community level to avoid social stigma and negative attitude
6. Build government capacity and advocacy to domesticate international frameworks, policies into the local context

Source: UNICEF Survey on Child-focused Victim Assistance, August 2013

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The Centre for the Rehabilitation of the Paralyzed in Sava, Bangladesh, has centres throughout Bangladesh that provide rehabilitation services, psychological support, economic services and support for inclusion of children with disabilities into schools and neighbourhoods.

Chapter 4
Principles, Coordination and Cross-cutting Aspects of Victim Assistance

THE following victim assistance (VA) principles are generally agreed amongst the global Mine Action community. They resonate with Article 3 of the Convention on the Rights of Persons with Disabilities (CRPD).

1. Non-discrimination

VA-related projects and policies should not discriminate against or amongst victims of landmines and explosive remnants of war (ERW), other war-victims, or other persons with disabilities who have similar needs. Programmes should be designed for persons with disabilities more generally, while ensuring that the specific needs and rights of landmine/ERW victims are also met. Creating a group entitled to preferential treatment must be avoided.

Inclusion of persons with disabilities should be an integral component of all development strategies and programmes. Bearing in mind that persons with disabilities often face multiple discrimination (for example, because of their gender or their minority status), specific measures should be taken to ensure that programmes targeting other vulnerable populations (such as persons at risk of HIV or pregnant women) are also accessible for persons with disabilities. Programmes specifically designed to assist victims of armed conflict must also ensure that they reach and are accessible to survivors and victims of landmines and ERW.

2. Age and gender sensitivity

Providers of VA must take an individual and tailored approach that considers and responds to the capacities, needs and vulnerabilities of each specific person and affected community. Programmes must take into account the differing capacities, needs and vulnerabilities of boys and girls as well as their changing needs throughout the course of the life cycle from childhood to adolescence into adulthood.

The Inter-Agency Coordination Group on Mine Action produced gender guidelines in 2010, which notes that while boys and men may form the largest groups of mine/ERW survivors, girls and women often experience greater difficulties in getting the necessary medical and psychosocial care. For example, VA strategies should ensure that provisions are made for girls and women to be transported for emergency and rehabilitative care, which may mean covering the transport costs of men who accompany them. In schools, girl survivors may require private toilet and hygiene facilities.

Ensuring age-sensitivity for child victims of landmines/

Victim Assistance

"Each State Party with respect to cluster munition victims in areas under its jurisdiction or control shall, adequately provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support, as well as provide for their social and economic inclusion. …"

Convention on Cluster Munitions, Article 5

ERW requires a focus on children directly and indirectly affected. When a family member or caregiver has been killed or injured, girls and boys indirectly affected require support in order to address the psychological, social, socio-economic, and protection impacts of death or injury within the family. See Box 3 for suggestions on age groups and the risks and opportunities by each group.

3. Participation and Empowerment: Nothing about Us without Us

Mine Action Programmes require the appropriate involvement of those affected, at all levels and through all the stages of the programme cycle from assessment to monitoring and evaluation. Survivors of mines/ERW have played a key role in global and local advocacy on mine action and the rights of persons with disabilities. The movement of persons with disabilities has long advocated full participation under the slogan "Nothing about us without us". The concept of inclusion of persons with disabilities has broadened significantly beyond integration and now includes not only inclusive education but social inclusion – the right to participation in community life – and economic inclusion – the right to work. This all-encompassing approach is of particular relevance to children because they are particularly prone to exclusion.

Children and adolescents with disabilities need to be involved in making decisions that affect them. They can be key agents of change within their families and communities.

Communication for Development (C4D) strategies stress two-way communication, dialogue, participation and empowerment, complemented by policy and advocacy (See Box 4).

Box 3: The Life Cycle Concept

The concept of the "life cycle" refers to the division of individual lives into a series of sequential stages. Each stage is defined in terms of three distinct conceptual components: biological, psychological, and social. The contemporary notion of adolescence, for example, consists of a biological component involving pubertal physical changes, rapid physiological growth, and sexual maturation; a psychological component involving drastic mood swings, inner turmoil, generational conflict, and a quest for identity; and a social component (which involves the shifting social experience, institutional treatment, and cultural definition of adolescence).

Source: Mintz, Steven et al., 'Life Stages', Paper submitted to the "Re-Staging Childhood" Conference, 6-10 August 2009, Bear Lake, Utah <www.usu.edu/anthro/childhoodconference/reading%20material/life_stages.doc>

Early years 0-5	- Risk from explosive devices overwhelmingly as a by-stander (e.g. infant on mother's back), not by actively coming into contact with the device and triggering the explosion - High risk of death or severe impairment due to small body size - Require regular medical, nutritional and rehabilitation services due to growing body - High dependency: risk from loss of parent/care giver, including resulting high risk of being institutionalized - Risk of acquiring secondary disabilities through lack of adequate care, particularly due to neglect, as well as discrimination of girls - Good possibility of strong positive psychosocial recovery in a caring environment
Children 6-11	- Risk of not attending school because of lack of access or inadequate schooling (not inclusive; poor WASH facilities) - Risk of not receiving risk education, particularly children out of school - Require regular medical, nutritional and rehabilitation services due to growing body; children with disabilities require sex education as anyone else does - Dependency: risk from loss of parent/care giver - Risk of not attending school because of domestic or income-earning responsibilities or lack of household income to pay for school related costs and for medical costs related to the accident - Particular issues for girls: not prioritized for investment in education/domestic responsibilities - Vulnerability to sexual exploitation and other forms of abuse when attending schools and institutions - In an inclusive environment and with supportive care givers, strong psychosocial recovery and growing up to full potential is possible
Adoles-cents 12-17	- High risk of deliberate tampering with explosive devices, especially among boys from 12-14; girls tend to be more mature and are less prone to deliberate risk taking than boys - Vulnerability of (especially girl) children to early withdrawal from school due to lack of parents/family income/additional costs due to landmine accident - Impact of triple burden of work, unpaid care and schooling - Risks from early marriage and child-bearing - Lack of access to training/formal employment leading to entry into high risk employment - categories - Increased risk of HIV and AIDS infection as individuals become sexually active - Increasing vulnerability of girls due to gender-based violence - Vulnerability to exploitation, violence and abuse
Note: These three categories of age groups were developed specifically for this context. Each comprises the same age-bracket of 6 years, thus allowing comparison by risk-taking and other factors. For a more refined approach, the adolescent group may be further divided into two brackets (12-14 and 15-17). See also Emma Cain, 'Social Protection and Vulnerability, Risk and Exclusion Across the Life-Cycle'. HelpAge International, UK. <http://www.oecd.org/dac/povertyreduction/43280790.pdf>.	

Box 4: Communication for Development

Communication for Development (C4D) is a cross-cutting practice that contributes to positive social change, including improved outcomes for children and their families. In UNICEF, C4D is defined as "a systematic, planned and evidence-based strategic process to promote positive and measurable behaviour and social change that is an integral part of programmes and humanitarian actions". C4D is not public relations or corporate communications. It involves engaging children, their families and communities in *dialogue, consultation and participation* in issues and decisions of relevance to their lives and based on an understanding of their local context and realities.

Building on the human rights-based approach to programming and the rights to information, communication and participation as enshrined in the Convention on the Rights of the Child (Articles 12, 13 and 17), C4D aims to:

- Facilitate enabling environments that create spaces for a plurality of voices and the narratives of the community. It encourages listening, dialogue, debate and consultation;
- Seek the active and meaningful participation of children and youth, from the research and planning phases through implementation and into the evaluation phases of programmes;
- Reflect the principles of inclusion, self-determination, participation and respect by ensuring that marginalized groups including indigenous populations and people with disabilities are prioritized and given high visibility and voice;
- Link community perspectives with subnational and national policy dialogue;
- Start early and address the whole child, including the physical, cognitive, emotional, social and spiritual aspects;
- Ensure that children are reflected as agents of change and as a primary participant group, starting from the early childhood years; and
- Build the self-esteem and confidence of care providers and children.

In UNICEF, the C4D process takes a holistic view of a social system, referred to as the Social Ecological Model (SEM). The SEM focuses on the complex interplay of systemic factors such as national and international policy, legislation and norms that impact individuals and societies, as well as inter- and intra-personal factors such as relationships, attitudes and individual beliefs. All these influence sustained behaviour and social change. The Social Ecological Model and the corresponding C4D approaches appropriate to each level are shown in the chart.
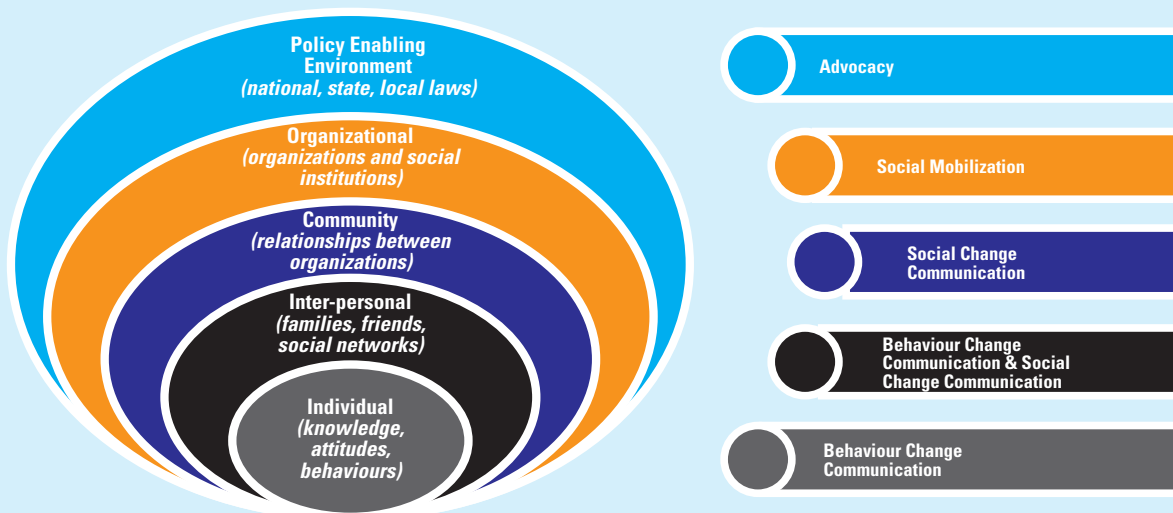
To strengthen victim assistance programming, C4D approaches can be used to:

- garner political support to shape and implement inclusive policies and legislation, and ensure adequate allocation of resources for victim assistance and rehabilitation, by amplifying the views of child survivors and their families, and connecting them to upstream policy advocacy;

- motivate and mobilize civil society, local organizations and social networks to support affected groups including children with disabilities, to claim their rights to information, services and supplies;
- facilitate mine risk education;
- address harmful social norms, stigma and discrimination against those affected;
- promote desired practices to help develop the skills and confidence of individuals and groups including stakeholders and service providers; and
- cultivate positive attitudes and empower households and communities to demand accountability and good governance at local, provincial/state and national levels.

C4D specialists know how to involve children and adults in determining the right mix of communication channels – face-to-face discussions, TV, radio, cell phones and many others – and the most effective messages and talking points for victim assistance programming.

Source: UNICEF New York, C4D Team, January 2014

4. Comprehensiveness - a holistic and integrated approach

The Mine Action sector benefits from working across agencies, professional fields, cultures (civilian and military) and programming contexts (humanitarian to development). A comprehensive approach requires collaboration, coordination and coherence. Inclusion of people with disabilities touches all aspects of life, not only health and rehabilitation, but also education, livelihoods, and justice. Because VA covers a broad variety of fields, coordination is key from the community level up and from national focal points down (see also Principle 6).

All sectors need to work closely together to support inclusive development, including Child Protection (specifically the role of the social welfare sector and social work/case management for vulnerable children, and psychosocial support), Education (with a focus on Inclusive Education to support social and economic inclusion), as well as Health, Rehabilitation, Nutrition and Water and Sanitation and Hygiene (WASH) sectors. Meanwhile, Communication for Development strategies that focus on the use of strategic media and communication methods and technologies to facilitate behaviour and social change among stakeholders and affected groups, including raising awareness and the demand for services, can be used to create an enabling environment for the above.

5. Twin-track approach towards inclusive development

The CRPD calls for a twin-track approach in promoting the inclusion of persons with disabilities:
1. Improving a person's capacities and abilities at the personal and collective level through empowerment;
2. Reducing the physical, communication and attitudinal barriers that society erects towards persons with disabilities to ensure they can participate and access services on an equal basis with everyone else.

This acknowledges that efforts must be made to both ensure and promote the inclusion of persons with disabilities in mainstream service provision, programmes and opportunities. Likewise, targeted efforts must be made to address the specific needs of persons with disabilities. For example, children with limb loss regularly need new prostheses; children with visual impairment will need specific support to fulfil their right to education (training of teachers, training in Braille, provision of material in Braille, etc.); building codes need to be improved and enforced to guarantee physical access to schools.

National Implementation and Monitoring

States Parties … shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels.

Article 33, Convention on the Rights of Persons with Disabilities

6. Coordination of stakeholders and collaboration amongst them

In the early days of mine action, participants debated whether VA should be a specific component of mine action, since it is part of broader sectors such as public health and social affairs. Few agencies and persons involved in mine action were specialized in disability and/or community development. VA requires multi-stakeholder and inter-ministerial involvement and the responsibility to coordinate VA lies with a designated government body with the capacity to do so.

A female facilitator of mine risk reduction sessions talks with children at the Adi-kieh Elementary School in rural Eritrea. Women, men, girls and boys are often trained to facilitate such sessions in their schools and communities.

The VA focal point can be, for example, a ministry mandated to address the needs of persons with disabilities (usually the Ministry of Social Affairs and/or Health). Collaboration extends, however, to the Ministries of Education, Labour, Public Works, Transport, Information, Defence and others – many of which may have their own disability focal point. Some countries may have ministries that separately address children and youth, as well as women. Coordination across ministries is therefore critical.

For child-centred VA, all these government stakeholders, as well as relevant civil society organizations – Survivor and DPOs and associations of parents/ guardians – must be engaged. While in some countries the Mine Action Centre or Authority may take the temporary lead on victim assistance as a first step in raising awareness and building capacities of the relevant ministries and stakeholders, as well as to collect data and mobilize resources, it is important that one designated ministry takes on the role of coordinating VA and engages all relevant actors.

The ultimate responsibility for VA lies with the State. However, as stated in Article 6.3 of the Anti-Personnel Mine Ban Convention (APMBC), Article 8.2 of Prot. V to the Convention on Certain Conventional Weapons (CCW), and Article 6.7 of the Cluster Munition Convention (CCM), there is no expectation that States must do this on their own. "States in a position to do so" are obliged to assist. This assistance may be provided through a variety of means, including through "the United Nations system, international, regional or national organizations or institutions, the International Committee of the Red Cross, and national Red Cross and Red Crescent societies and their International Federation, non-governmental organizations, or on a bilateral basis."

Beyond coordination among relevant government stakeholders, coordination and collaboration with other development and humanitarian sectors is also relevant. Four of these are summarized below.

VA and disarmament: Disarmament circles have come to accept VA as a treaty obligation in arms-related conventions. The unique collaboration among the International Campaign to Ban Landmines, the Cluster Munition Coalition, the International Committee of the Red Cross, the United Nations, governments and donors that exists for the APMBC and CCM is seen as an example for other treaties. Including survivors in meetings, consulting survivors and, to a lesser extent, the affected family members, is a key lesson that other disarmament initiatives are starting to replicate. While continuing to strengthen the linkages and synergies among VA efforts under the various Landmines and ERW Treaty-related processes, cooperation can be increased with other Armed Violence actors including those on Small Arms and Light Weapons and armed violence.

VA and humanitarian crises: While noting the considerable challenges and constraints in humanitarian contexts, it is important that actors provide a broad spectrum of services, including first aid, emergency and longer-term medical and surgical care, physiotherapy and early access to rehabilitation, and psychological and psychosocial support, in order to prevent impairments through a reduction of the physical and psychological consequences of war-related injuries.

While the initial focus is on life-saving measures, addressing the long-term physical, psychosocial and socio-economic impacts through early recovery and development-oriented measures should be considered from its inception. For example, when setting up or improving rehabilitation services, these efforts should be linked from the outset with the wider health sector and social protection sector for socio-economic inclusion purposes. Emergency psychosocial care should be a standard component of the response in all these sectors. Likewise, in humanitarian crises, disability-inclusive planning must become the norm. For example, when setting

up camps for internally displaced persons (IDP) or refugees, or establishing and running children's centres, schools and vocational learning facilities, the transition from humanitarian to sustainable development should be considered. This applies to health facilities, water and sanitation facilities and others as well.

VA and development: There are a number of intersections between victim assistance and development work. Those specific to children include poverty reduction and development efforts to strengthen the health, education and child protection sectors. The majority of survivors and their family members see economic inclusion as their highest priority. Not only are persons with disabilities often the poorest in society, the poor are also the most exposed and susceptible to the threat of landmines and ERW. They have fewer alternatives to generate income or to move to safer surroundings when living in contaminated areas. Families and children who lack meaningful livelihood opportunities may opt to search for scrap metal to sell, to cultivate contaminated land, or to traverse dangerous areas to fetch water, wood, or for herding, despite awareness that these activities pose a lethal risk. Integrating VA and disability-responses into poverty reduction and development programmes and policies is the only long-term sustainable approach towards inclusive development.

Strengthening health and child protection systems as part of post-conflict reconstruction and development programmes should integrate specific considerations for child survivors of landmines/ERW and children. In child protection, this includes strengthening the legal and policy frameworks for children with disabilities, and ensuring that the social welfare sector, including social work, case management, and social protection, is responsive to the needs of both survivors and victims. Health sector interventions should build national capacity to adequately provide emergency and long-term specialized medical and surgical care, physiotherapy, and the production, distribution and repair of mobility devices to support the rehabilitation process of child survivors.

All sectors should endeavour to integrate 'reasonable accommodation' and 'universal design' into their work. *Universal design* means designing products, environments, programmes and services to be usable by all people, both with and without disabilities. *Reasonable accommodation* means "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms".[24]

VA and human rights: From the beginning, VA has been influenced by the human-rights-based approach. Service providers and activists have been strong advocates for the weapons-related conventions (less so regarding Prot. V

Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD provides the international legal framework to guarantee the rights of all persons with disabilities, including children with disabilities (Art.7).

The Convention establishes disability as a human rights and development issue, and calls upon States Parties to address disability not as a supplementary issue of "charity", but as an integral part of human rights guarantees.

The CRPD does not introduce additional rights, but imposes additional obligations on Governments to take action to remove the barriers preventing persons with disabilities from realizing their human rights on an equal basis with others.

<http://www.un.org/disabilities/>

of the Convention on Certain Conventional Weapons) and for the CRPD. The 1989 Convention on the Rights of the Child, which includes Article 23 on children with disabilities, provides a critical human rights framework for child survivors of landmines/ERW. As noted by UNICEF, "Landmines and explosive remnants of war violate nearly all the articles of the Convention on the Rights of the Child: a child's right to life, to a safe environment in which to play, to health, clean water, sanitary conditions and adequate education."[25]

VA is a strong advocacy tool for survivors and for the rights of all persons with disabilities. Before the CRPD, VA in many countries was a primary entry point to bring attention to the rights of persons with disabilities more generally. This was the case, for example, in Afghanistan, Angola and Eritrea. VA has in turn greatly benefited from the disability movement and the CRPD by linking the disarmament, disability and human rights movements. However, approaching VA only from the disability angle is not enough: it is important to remember that there are also specific obligations for those *indirectly* affected by landmines/ERW. These include the families, including children of those killed or injured by mines/ERW, as well as mine/ERW-affected communities more generally. Child survivors often quit school, as do children whose parents died or were severely injured, often due to the need to support family income. Girl and boy survivors, like all children with disabilities, are also at particular risk of violence, abuse and/or exploitation.

In the early years of efforts to implement the APMBC, VA overwhelmingly focused on first aid and rehabilitation. Actors in mine action led the formulation of international guidance in the rehabilitation sector, endorsed by the International

Society for Prosthetics and Orthotics (ISPO). These early efforts often overlooked less visible impairments such as loss of hearing and eyesight. They also did not understand that the provision of medical and rehabilitation service alone did not suffice in enabling a survivor to participate in community, school or work life.

Increased appreciation for the need to adopt a more comprehensive approach beyond the 'physical' rehabilitation needs of survivors is now mainstream. Although links to organizations providing psychosocial/psychological care still remain weak, there has been considerable positive experience through peer-to-peer support among survivors in a number of countries. While inclusive education has been overlooked in many programmes to assist victims there is a wealth of experience in the fields of social and economic inclusion and of community-based rehabilitation. Nonetheless, few of these programmes have been adapted to the specific needs of boys, girls and male and female adolescents.

Cross-cutting Aspects of Victim Assistance

Some stakeholders in mine action and development identify specific cross-cutting functions that should be integrated into VA programming. The United Nations Mine Action Strategy 2013-2018 includes **four cross-cutting functions**: (i) Coordination, (ii) Capacity development, (iii) Data collection and analysis, and (iv) Advocacy.

Coordination is addressed at the beginning of this Chapter as an overarching principle. *Data collection and analysis* is addressed in Chapter 5.1 on "Data collection and analysis". *Advocacy* is addressed in Chapter 5.6, "Laws and policies", because of its essential role in shaping national laws and policies relevant for VA. Good advocacy also supports effective mobilization of funds and contributes to changes in attitudes by top decision-makers and community members.

Capacity building is interwoven throughout but merits extra attention, especially in child-focused VA. Programmes serving women, children and the elderly should have staff trained and enabled to understand the unique issues found within each of these groups. This is particularly true for the individual survivor, who needs to understand the problems caused by the blast injury to support healing, regain mobility, and better interact with the family and the community to become fully included and as independent as possible. Family and community members also need to learn how best to interact with people with disabilities, at home, in school or at the work-place. And of course policy makers, service providers and aid agencies need to understand not only the challenges posed but also the capacities and potentials already existing to improve the lives of victims and survivors and communities affected by landmines and ERW.

Finally, other enabling factors relevant for VA programming are continued engagement/ownership and results-based management. **Continued engagement** or commitment recognizes the need for clear **ownership** of the programme from its inception onwards. Ownership requires involvement by national and sub-national governments, civil society, donors and aid agencies. Engagement, ownership and participation are similar notions that are easy to say but more difficult to realize. Through ongoing consultations with as many stakeholders as possible, victim assistance programmes will be more integrated and, ultimately, more successful.

Results-based management (RBM) focuses on 'results' rather than 'activities' and was adopted by the UN system in the late 1990s to improve effectiveness and accountability. RBM helps UN agencies to articulate better their vision and their support for expected results, through the development of theories of change which clearly articulate how lower level inputs and activities converge to arrive at higher level outcomes. RBM methodology monitors progress using well defined and agreed baselines, indicators and targets. Results-based reporting helps the organization(s), stakeholders and funders to understand the impact that a given programme or project is having on the target population.

Box 5: Suggested Activities to Improve Capacity Building in Child-focused VA

- Ensure that training curricula, for example in the health and education sectors, include injury prevention, psychosocial care and disability-relevant topics taking age and gender considerations into account.
- Train service providers in communication skills to inform, dialogue and communicate with victims/ survivors and affected families/communities.
- Pursue participatory baseline research and ongoing monitoring, including children and adolescents with a disability.
- Consult children/youth in planning and decision making processes, and during monitoring and evaluation of VA programmes.
- Present research results to and with children and adolescents in a child-friendly way, for example, through drawings, role plays or discussion groups.

Box 6: Suggested Activities to Apply Results-based and Evidence-based Management in Child-focused Victim Assistance

- Use and promote disability-specific budgeting, whereby a government or an institution sets specific goals for all children with disabilities and allocates a sufficient portion of resources for them.
- Incorporate a child rights and child development perspective into all programming for children affected by landmines and ERW. Advocate and support age and gender specific considerations and ensure that the needs of child survivors and victims of mines/ERW are integrated within the Economic Recovery, Education and Health Sectors.
- Be aware that mine/ERW survivors and victims may be at particular risk of violence, abuse, exploitation, harmful practices and exclusion – survivors because of the heightened risks faced by children with disabilities, and victims as a result of the loss or disability of a care giver or family bread winner. Social norms with regard to children or persons with disabilities may further exacerbate risks.
- Age- and gender-sensitive VA-related programming needs to consider child-friendly and accessible institutions (hospitals, rehabilitation centres, schools, sports facilities) but also has to provide access for mothers or other female guardians (female staff, separate areas depending on the cultural context, child care).
- Include victim assistance/disability projects in tools that could serve resource mobilization, such as the Strategic Response Plans or the Portfolio of Mine Action projects.

Evidence-based management relies on solid **monitoring and evaluation (M&E)**. M&E should ensure both situation monitoring – needed to understand what the problem is – and performance monitoring that allows for real-time, evidence-based decision-making. Developing solid indicators, using appropriate monitoring methodologies and adequate resourcing of monitoring efforts allow for course corrections to be taken during programme implementation. It also helps to assess changes in attitudes and practices over time.

Conclusion

In summary, victim assistance and, more generally, disability support entails many diverse factors and demands the engagement of a greater variety of stakeholders that few other issues demand. It requires sustained political will across several fields of government to effectively bring about change for affected people and communities.

From a practical point of view, there is consensus that

national mine action authorities should play a supportive and not an implementing role in VA. But ensuring that the State's obligations enshrined in the weapons-related conventions, including to victims indirectly affected, are met has proven to be a challenge. Some of the most affected States have not yet joined the relevant conventions but are willing to comply with the provisions. Given the specific mandate and focus of national mine action actors, few have the capacity to implement VA programmes in a non-discriminatory manner, that is, ensuring assistance not only to mine/ERW survivors and victims, but also to all persons with disabilities. As of 2012, 12 of 30 States Parties that have accepted special responsibility for a significant number of landmine/ERW survivors[26] had allocated the role of VA focal point to disability-responsible actors. When disability responsible actors have engaged in VA, the programmes increasingly benefit persons with disabilities equally in terms of numbers of beneficiaries.

Resources Chapter 4 "Principles, Coordination and Cross-cutting Aspects of Victim Assistance"

APMBC Implementation Support Unit [ISU]. *Five key examples of the role of mine action in integrating victim assistance into broader frameworks.* Sheree Bailey. Geneva 2014. <http://reliefweb.int/sites/reliefweb.int/files/resources/Five_Key_Examples_of_the_Role_of_Mine_Action.pdf>

APMBC ISU. *Assisting Landmine and other ERW Survivors in the Context of Disarmament, Disability and Development.* Sheree Bailey. Geneva 2011. <http://www.apminebanconvention.org/fileadmin/GICHD-resources/rec-documents/Brochure-Assisting-Survivors-June2011.pdf>

Convention on Cluster Munitions/Governments of Spain and Mexico. *FROM WORDS TO ACTION. Catalogue of Best Practices on Cooperation and Assistance for the Convention on Cluster Munitions.* Madrid 2012. <http://www.clusterconvention.org/files/2012/11/FROM-WORDS-TO-ACTION-COOP-and-Assistance-kopi.pdf>

Handicap International. 'Victim Assistance Issue Briefs: How to ensure survivors and other people with disabilities benefit from, and participate in, disability-inclusive development', Lyon 2014. <http://www.handicapinternational.be/en/publications/victim-assistance-disability-inclusive%20development>

United Nations Development Group. *Results-Based Management Handbook, Strengthening RBM harmonization for improved development results.* Clean Draft Version. New York 2010. <http://www.undg.org/docs/12316/UNDG-RBM%20Handbook-2012.pdf>

UNICEF. *It's About Ability. An explanation of the Convention on the Rights of Persons with Disabilities [to children].* Available in English, French and Spanish. New York 2008. <http://www.unicef.org/publications/index_43893.html>

Please see also Chapter 6 for further resources.

Endnotes

1   Data provided by the Landmine & Cluster Munition Monitor team. See also *Landmine Monitor Report 2013*.

2   Landmine & Cluster Munition Monitor (2013), *Fact Sheet Children & Landmines*, full source see References. These are reported casualties; the actual figure may be higher. Landmines are explosive devices. However, as conventions and protocols address landmines and ERW separately, the two are listed separately henceforth. Protocol V of the Convention on Certain Conventional Weapons defines ERW as unexploded and abandoned explosive ordnance. The data include casualties from remnants of cluster munitions, a specific type of ERW.

3   The UN Mine Action Strategy 2001-2005 (see UN General Assembly document A/56/448/Add.1) lists "five complementary core components"; in a previous UN GA document from 1998 (A/53/496), four components were listed (not listing stockpile destruction).

4   UN, Joint Inspection Unit, *Evaluation of the scope, organization, effectiveness and approach of the work of the United Nations in mine action,* JIU/REP/2011/11, Geneva 2011, <https://www.unjiu.org/en/reports-notes/JIU%20Products/JIU_REP_2011_11_English.pdf>; Recommendation 1. The recommendation was welcomed by UN agencies, see UN General Assembly 2013, Note by the Secretary-General, A/68/63/Add.1; <https://www.unjiu.org/en/reports-notes/CEB%20and%20organisation%20documents/A_68_63_Add.1.pdf>.

5   The full title of the APMBC is "Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction", also commonly referred to as Ottawa Convention; <http://www.apminebanconvention.org/>.

6   The full title of this UN convention is "Convention on Prohibitions or Restrictions on the Use of Certain Conventional Weapons Which May Be Deemed to Be Excessively Injurious or to Have Indiscriminate Effects"; <http://www.unog.ch/disarmament>.

7   <http://www.genevacall.org/what-we-do/landmine-ban/>

8   CCW Prot. V on ERW refers more generally to "care and rehabilitation and social and economic reintegration of victims of explosive remnants of war."

9   Another notable exception is a psychosocial study from 2004 undertaken in Lao People's Democratic Republic (PDR): HI (Belgium)/Lao Youth Union/UNICEF (2004), *Life After the Bomb: A Psychosocial Study of Child Survivors of UXO Accidents in Lao PDR,* Vientiane.

10   While writing the Guidance the following article was published: "Masculinity: The Unseen Barrier in Survivor Assistance", by Duprat, Anne-Sophie and Lusia Peçak (Gender in Mine Action Program) (2013), *The Journal of ERW and Mine Action,* Vol.17.3, Fall 2013, Harrisonburg, VA, pp. 18-21, <http://www.jmu.edu/cisr/journal/17.3/173.pdf>.

11   Forty of the 53 UNICEF offices responded to the survey. For more detail on the survey and the countries from which information was collected, see Chapter 5, Section 5.6, "Laws and Policies".

12   At the time of writing, Colombia and Austria, the Co-Chairs of the APMBC Standing Committee on VA and Socio-economic Reintegration, were also preparing a guidance document particularly aimed at the States Parties to improve child-focused VA. A Working Paper titled "Strengthening the Assistance to Child Victims" was shared at the 13th Meeting of the States Parties to the APMBC in December 2013; <http://www.maputoreviewconference.org/fileadmin/APMBC-RC3/3RC-Austria-Colombia-Paper.pdf>. It directs recommendations at three levels: i) the international and regional level, ii) the national level and iii) the community level. The "Guide for Comprehensive Assistance to Boys, Girls and Adolescent Landmine Victims" was released at the third Review conference of the APMBC in Maputo in 2014. It focuses its recommendations on four 'dimensions': "Boys, Girls and Adolescents; The Family; The Community, The State";<http://www.maputoreviewconference.org/fileadmin/APMBC-RC3/3RC-Colombia-Paper.pdf>.

13   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

14   This structure follows the Community-Based Rehabilitation Guidelines, see WHO/UNESCO/ILO/IDDC (2010), *Community-Based Rehabilitation: CBR Guidelines,* Geneva.

15   Handicap International in August 2013 published a set of 12 *Victim Assistance Factsheets. How to implement victim assistance obligations?* <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>.

16   References to all Conventions can be found in Chapter 6, *Resources – Literature and websites*.

17   Handicap International in August 2013 published a set of 12 *Victim Assistance Factsheets. How to implement victim assistance obligations?* <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>.

18   This is an incomplete list aiming to highlight key VA providers. UN agencies, GICHD, ISU, GMAP and other NGOs not listed have played and are playing an important role in developing guidance. The remaining LSN branches were nationalized and are supported by the ICBL-CMC survivor network project.

19   <http://www.mineactionstandards.org/>

20   Afghanistan developed a National Mine Action Standard on VA: <http://www.macca.org.af/macca/afghanistan-mine-action-standards/>.

21   Guidelines are listed under Resources at the end of each Component, i.e. Chapter 5.1, 5.2 etc. Please see also *Resources – Literature and websites.*

22   Among the 10 programme areas proposed throughout the UNICEF VA survey these five were most prevalent.

23   <http://www.mineaction.org/sites/default/files/publications/MA-Guidelines-WEB.pdf>. See especially Chapter 3, pages 35-46 for additional guidance and suggestions.

24   <http://www.un.org/disabilities/convention/conventionfull.shtml>. See Article 2.

25   UNICEF, *Children and Landmines: A Deadly Legacy,* Leaflet, New York (undated but circa 2009).

26   *Landmine Monitor Report 2013,* Section 'Casualties and Victim Assistance', <http://www.the-monitor.org/index.php/publications/display?url=lm/2013/sub/Casualties_and_Victim_Assistance.html>.

Salim was collecting firewood along with two other boys in central Tajikistan when they found a cluster munition. Another boy hit it with an axe and it exploded. During data collection, Salim points out which device they had found.

Chapter 5
Child-focused Victim Assistance

Section 5.1
Data collection and analysis

5.1 Data Collection and Analysis

Introduction

IF we do not know the dimension of a problem, and understand the many complexities, we cannot respond effectively.

Systematic data collection is fundamental to Victim Assistance (VA) to ensure that decision makers and service providers are informed by a sound evidence base on the demographic profiles of affected persons. Practitioners need to know what, where, how and why injuries occurred and to be assured that they are reaching victims/survivors of accidents, while not fostering preferential access to services specifically for survivors of landmines and explosive remnants of war (ERW). Data should enable States Parties to monitor and report regularly on the progress of their legal obligations to address the needs of mine/ERW victims and survivors. Despite broad acceptance that it is critical to have comprehensive data, most of the 60 plus countries affected by landmines and ERW do not have complete and updated data or information on landmine/ERW casualties (the term casualty includes those killed as well as those injured) or on the services they or their family members have received.

The availability of data and information on mines/ERW may start with a media report about an accident. Because they are prepared for a different purpose, media reports are often incomplete and insufficient to inform programming. Few, for example, mention the age or sex of the victims. To ensure effective child-focused victim assistance, it is critical to systematically collect, verify, manage, and analyse sex and age-disaggregated landmine and ERW casualty data.

Most mine-affected countries that collect and manage this information use the Information Management System for Mine Action (IMSMA) or other injury surveillance systems. Even seemingly complete casualty data, however, often provides only a snap shot. Available data is usually limited to information on what happened from the time of the accident until the admission to hospital. Data collection usually stops once a survivor is released from emergency medical care. VA actors rarely know whether he or she benefited from services, what kinds of assistance and support have been provided (e.g. continuing medical care, prosthesis or hearing aid, school reintegration, job placement or livelihood support), and their life situations post-accident (e.g. whether they have been able to return to school or, for adults to found a family and have children, whether they are employed and so forth).[3] Generally, information is not collected on the family members of survivors or those who have been killed, including on how the death or injury of an adult affected their children and family.

Gathering accurate information on the specific impact of landmines and ERW is challenging. Data from hospitals or from rehabilitation centres often do not specify the cause of the amputation, spinal cord injury, loss of eye sight or other injury. National censuses and other data collection methods for conflict victims or persons with disabilities may not specifically identify the cause of the injury. Collecting data on war-related injury, particularly on children, during conflict or in a volatile post-conflict situation can be perceived by the government as very sensitive and caution may be required.

Goal

Stakeholders have access to reliable age and gender disaggregated data on landmine/ERW victims (including survivors, families and the mine/ERW affected communities) to plan, implement, monitor and report on victim assistance.

The role of data and information in child-focused victim assistance

The role of data and information in child-focused victim assistance is to ensure that:

- Sex and age disaggregated data is collected on mine/ERW casualties and their families;
- Sex and age disaggregated data is collected on type of impairment of mine/ERW survivors;
- Data is collected on existing services;
- Sex and age disaggregated data is collected on specific needs and services received by survivors and victims;
- Sex and age disaggregated data is collected on self-

Box 7: Cambodia Mine/ERW Victim Information System (CMVIS)

The Cambodia Mine/ERW Victim Information System (CMVIS) was established in 1994 by the Cambodian Red Cross (CRC) with technical and financial support from Handicap International Belgium and UNICEF to provide systematic collection, analysis, interpretation and dissemination of information about civilian and military casualties of landmines and explosive remnants of war. By 2013, more than 64,400 casualties had been recorded.

In 2009, CRC handed over management of the CMVIS to the Cambodian Mine Action and Victim Assistance Authority (CMAA). All CMVIS staff became government staff. In 2013, CMVIS deployed 15 full-time data gatherers at district and provincial levels who cover 24 municipalities with the support of volunteers.

Main tasks include:

Mine/ERW casualty and accident data collection: On a daily basis, CMVIS data gatherers look actively for mine/ERW casualties and incidents by visiting communities and collecting information from different institutions.

Data Follow-up: Ensure the accuracy of data collected by CMVIS data gatherers by regularly checking with casualties, their families, local authorities, and other relevant people. Data follow-up also includes spot-checking, verifying information sources and cross-checking with other data sources.

Mine/ERW Casualty Database: The database has been regularly updated and developed to reflect the evolution of mine action and expectations of end-users. It was integrated into IMSMA New Generation software.

Information Analysis and Reporting: The mine/ERW casualty situation is analysed and reports are prepared monthly, annually and customized or ad-hoc and disseminated to all concerned mine action stakeholders and other agencies nationally and internationally to assist their planning and monitoring.

Explosive Ordnance Reporting: Information on the location of explosive ordnance is collected on a daily basis from community members. The information is passed on to mine action agencies for removal and destruction.

Victim assistance and risk education: VA referrals are provided for new mine/ERW casualties to guide them towards appropriate resources. Disability awareness messages are shared with mine/ERW casualties in communities in order to encourage them and to improve their living conditions. Mine Risk Education (MRE) began in 2006 in order to reduce the number of accidents occurring in vulnerable communities. CMVIS field staff provides MRE briefings when traveling through affected communities.

Source: CMAA, CMVIS, see <http://www.cmaa.gov.kh>

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perception of psychosocial well-being of survivors;

- Information that is relevant to families and communities should be included in the collection and analysis system, in addition to data for national database and reporting;
- The voices of boy and girl survivors and indirect victims (i.e. family members of people injured and killed) are heard and reported in needs assessments and in monitoring and evaluation exercises;
- Collected data is consolidated and safety and confidentially managed;
- Collected data is systematically verified, analysed and shared;

- Evidence based data is used for informed action in planning, implementing, monitoring and evaluating delivery of services, and for reporting and advocacy.

Key concepts

Data collection and analysis

Data collection and analysis, and corresponding information management systems, are a core component of victim assistance. Good data leads to effective assessment and situation analysis, incident reporting and surveillance, the establishment of referral mechanisms, case management, and monitoring and evaluation of programmes.

Data collection is the process of gathering and measuring information on identified variables of interest. This should be done in an established systematic fashion that enables specific questions (e.g. whether the needs of a particular group are being adequately met) to be answered and hypotheses to be tested (e.g. assumptions based on media coverage that one group or area is more severely impacted than another). It also allows for quality monitoring and evaluation of outcomes. While methods vary by discipline, an emphasis on ensuring accurate and honest data collection is common to all data collection efforts.

Data analysis is the process of systematically applying statistical and/or logical techniques to interpret, describe and illustrate, condense and recap, and evaluate data. *Information management* is the process of consolidating, analysing, summarizing, sharing and using information and data to inform programmatic decisions. Databases are used as the primary tools to support this process.

To ensure VA-related services are responsive to the specific needs of boys and girls of different ages, data must be disaggregated by age and gender. A simple disaggregation between children (those under 18) and adults (those 18 and above) is insufficient to ensure that assistance is responsive to specific stages of the life cycle (see Box 3 in Chapter 4 for suggested age categories). If the exact age is not known, it is better to put an estimated age category rather than 'unknown'. At a minimum, it is important to indicate that the victim was a child and not an adult, thus capturing at least a minimal age disaggregation.

Key considerations for data collection also include *how, by and from whom, where and when* data is collected. Several questions should be answered to ensure the most complete methodology or methodologies for collecting data. *Who* is conducting the data collection or discussions? Have they been adequately trained? *How* do we ensure that persons with different types of impairments (physical, sensory, mental, intellectual, multiple) are equally represented in the data collection? Is it adequate to use a questionnaire for interviews or focus group discussions? Is it appropriate to audio-record interviews? Are other people around when data is being collected and is their presence appropriate? Is a mechanism in place to ensure informed consent and the privacy of those providing information? Are there risks to collecting data? How do we ensure those already marginalized in society will be given a voice? *When* is the best time to reach women, girls, boys and men, male or female adolescents? Should meetings be held separately according to age and gender? *Where* are we going to obtain the information, as part of house-to-house visits or in 'neutral' communal spaces? Are we able to access and reach those who are marginalized in society and those living in remote affected areas?

Many quantitative and qualitative methodologies exist for collecting data; ensuring the collection of qualitative information is equally important in a victim assistance strategy. Likewise, cell phones and other technologies can be used to collect data even in remote areas.

The make-up of teams collecting data is an important consideration – for example, forming and training a survey team with gender balance, or which includes representation of marginalized groups, to obtain optimal data from the spectrum of those affected. Data collection teams should strive to include survivors, victims and other persons with disabilities. It is essential to build trust with the community members prior to collecting detailed information, particularly in situations where this information is deemed sensitive.

Data is not useful in and of itself. Once collected it must be consolidated, analysed, interpreted and disseminated in order to inform a response. Analysis can be facilitated through tables and charts that demonstrate what the data 'shows us'. Interpretation should be undertaken by those who are familiar with the context and issue and are able to 'tell the story' of what the data shows. Interpretation should avoid over-generalization, and assumptions and the limitations of the data should be clearly spelled out.

The data, analysis and interpretation should then be translated and disseminated through reports, presentations and other manners for specific groups based on their role in VA. For example, information required by donors is different from that required by actors implementing VA programmes and providing services. Communities, including boys and girls, should also be given the opportunity to review the data and analysis so they contribute to refining actions that will help fulfil their rights.

Needs assessments and situation analyses

A needs assessment aims to document the impact of a particular crisis and to identify the needs of an affected population. Needs assessments are undertaken prior to the development of a programme or an action plan. *Situation analyses* which contextualize needs assessments are undertaken periodically, usually as a mechanism to update initial needs assessments and to measure changes over time. (In UNICEF's programme planning process, a comprehensive national-level Situation Analysis is undertaken with the Government at the beginning of the programme planning cycle. Smaller ones may be undertaken more frequently.) In the VA context, both processes systematically collect and analyse data and information in order to identify *who* is in need of services, *where*, *why*, and *what* is being done to respond. They should be undertaken in close collaboration and shared with all relevant stakeholders, including with affected individuals, families and communities.

Psychological and psychosocial needs are often expressed less well by the victims, especially children. This may be due to feelings of shame, because such needs are not always conscious or because the level of trust between the survivor and the counsellor is not yet high enough. In many instances,

time for trust-building may be required until the full story emerges. Use of painting or drawing or other art therapy methods can be applied but this requires prior training. Too often, no or little data is collected on the strengths and capacities of the people, although this should be an integral part of any needs assessment.

After the initial assessment and situation analysis are finished, it is important to update and reassess them continually in order to ensure that programmes remain responsive to changes and shifts in the situation of children over time. While this can be done by undertaking situation assessment periodically, a better approach is to support the establishment, make use of and analyse data and information available through other institutionalized victim assistance, disability- or mine action related information management processes. For example, existing incident reporting, injury surveillance or case management systems that collect information on an ongoing basis should be utilized. Such systems enable programmes that are responsive to shifts in situations as and when they occur are more sustainable and represent a more cost-effective use of limited resources.

Incident reporting and injury surveillance

Surveillance in epidemiology refers to a systematic monitoring mechanism that provides data on the scope and distribution of a health problem. As blast injuries are a form of violence that are addressed by the health sector, epidemiological approaches can be used to monitor incidents and ensure more responsive and up-to-date information on the situation.

In epidemiology, the terms *active* and *passive surveillance* are used. Health care facilities typically undertake *passive surveillance.* That is, they routinely report on the cases of diseases/injury that reach their facilities, but cases that are not treated are missed. A passive system therefore misses those who are killed prior to reaching hospitals, or those who are unable to access medical facilities due to transportation challenges or other causes. Injury surveillance is also usually set up at a central level hospital that is equipped to deal with severe injuries, and is based on a few selected 'sentinel' sites. As a result, many persons with minor injuries are also likely to be missed.

Active surveillance involves an effort to pro-actively identify and document all incidents regardless of their severity and whether or not the casualties reach a health facility. Usually undertaken by community members or networks, mine action centres, mine risk education teams, Red Cross or Red Crescent volunteers, or human rights activists, cases of blast incidents are reported and then followed-up on to determine whether the accident was related to a landmine or ERW. If so, detailed information is collected on the incident and person(s) impacted. If the situation permits, active surveillance can greatly benefit from civilian data collectors establishing close collaboration and case reporting and referral pathways with law enforcement agents and security forces.

✓ Box 8: Nine Steps of Nepal's Surveillance System

Step 1: Explosive device detonates and injures or kills one or more individuals.

Step 2: A partner organization of the national human rights non-governmental organization (NGO) Informal Sector Service Centre (INSEC) or other entity notifies INSEC. Injured individuals, family or community members, police and INSEC's partner organizations inform INSEC officials. INSEC officials may also become aware of an incident through the media. If INSEC central office personnel receive such a report, they contact the appropriate INSEC district representative (DR) and INSEC regional offices follow up with DRs to ensure prompt data collection.

Step 3: INSEC DR investigates the incident and collects data. DRs gather information from injured individuals, relatives, incident witnesses, police, hospital personnel, teachers, and members of community-based organizations. DR goes to the incident site if possible. He/she records the data in a standardized form and when possible also includes case studies with photographs of the injured individual(s). The DR then sends the information to regional and central offices, mostly via Google Forms. If required, the DR also refers injured individuals and their families for victim assistance services.

Step 4: INSEC regional office reviews data. Each office has a documentation officer (DO). DO reviews forms sent by DR before forwarding them to the central office. Regional office personnel can assist DR with victim assistance referral as required.

Step 5: INSEC central office reviews data. The focal person reviews forms sent by regional offices.

Step 6: INSEC central office translates data and enters them into database. The focal person for mine action checks data for consistency and enters them into a database. All data are translated from Nepali to English upon entry into the database, so that international use may also be made of this important information.

Step 7: INSEC central office cleans and analyses data. The project coordinator cleans and analyses data in Microsoft Excel on a monthly basis and prepares a flash report.

Step 8: INSEC central office publishes and disseminates data in mine action reports and the Human Rights Yearbook.

Step 9: Partners use data for mine action interventions.

1 Explosive device detonates and injures one or more individuals	

Referral of injured individual(s) to services

Quality control

| **2** INSEC partner or other entity notifies INSEC | **3** INSEC district representative investigates incident and collects data | **4** INSEC regional office reviews data | **5** INSEC central office reviews data |

Quality control

INSEC central office updates human rights reporting at www.inseconline.org twice daily

6 INSEC central office translates data and enters them into database

Quality control

| **9** Partners use data to inform mine action activities | **8** INSEC central office publishes and disseminates data in mine action reports and the Human Rights Yearbook | **7** INSEC central office cleans and analyzes data |

Advantages: The surveillance system is operational in all 75 districts of Nepal.

INSEC district representatives from all 75 districts have been trained in data collection on incidents, identification of explosive devices, interview techniques, safe behaviour and referral of survivors. The system continuously generates quality data which has been used to plan mine action activities (including emergency response) such as selection and prioritization of communities for MRE; referral of injured individuals to victim assistance-related services; marking and fencing of areas in which incidents occur; prioritization of clearance activities; advocacy for the acknowledgement of the explosive device problem in Nepal and raising funds for the mine action programme.

Limitation: There is a risk of under-reporting especially if an incident occurs in a remote area, unnoticed by media or INSEC's extended network of partner organizations. Because it is not state-funded, the system depends on the financial and managerial viability of the NGO INSEC.

Source: UNICEF Nepal, <www.inseconline.org>

Case and other information management systems

In a number of mine-affected countries, information management systems have been established to collect information on survivors and to support case management. With regard to child-centred victim assistance, case management for children may be undertaken through VA programmes or through child protection/social welfare case management systems that support the provision of social supports for vulnerable children. The utility of these systems is sometimes perceived to be limited to their use as a tool purely to facilitate the provision of assistance to individuals who have been affected. It is important to bear in mind that these systems, if the information is amalgamated, analysed and interpreted, can also provide a wealth of information to provide a more complete 'picture' and enable more general situational monitoring of the impacts of landmines/ERW on affected populations and on children specifically.

Whether from needs assessments or situation analysis undertaken by different actors, from passive or active surveillance systems, or from case management systems, collected information should be consolidated into a single centralized database or mechanism to enable systematic management of the information. Once analysed, interpreted and disseminated, this should be used to inform improved targeting and quality of programming, by enabling:

- Evidence-based identification of programme priorities;
- Improved targeting and adaptation of programmes to the needs and profiles of those most affected (e.g. children versus adults; girls versus boys; types of injuries; etc.);
- Improved targeting and evidence-based resource allocation for geographic areas most affected (e.g. where survivors and victims may be concentrated);
- The development of evidence-based policies and strategies to respond to risks and impacts;
- Evidence-based advocacy.

Finally, consideration should be given to what institution(s) and organizations may contribute to the database and where the database will ultimately reside. Cost considerations are important, as the software used must be accessible and affordable for end users and for the entity that will be responsible for updating and sharing the information over time. Resources are wasted if the database set up is too expensive or complex for the sometimes under-resourced government entity that may ultimately "own" it. Make sure that data collection and analysis systems, an invaluable resource when done correctly, will endure because the information can be regularly updated by partners.

Ethics and data collection

The collection of information from affected populations, especially children, is unethical in the absence of concrete and specific plans for how this information will be used to benefit affected populations. Such plans should be shared and feedback invited in order to ensure realistic management of the expectations of those providing information. Many individuals and communities in mine/ERW affected communities feel 'over-surveyed', which can lead to 'survey' or 'assessment fatigue ', especially when people do not see a tangible benefit to their participation in such processes. The dignity and best interests of those interviewed must be a primary consideration, and potential risks to those providing information must be identified and mitigated.

These considerations are of particular concern when interviewing and collecting information from children due to their more limited maturity and heightened vulnerability to violence, abuse and exploitation. Specific considerations for children that must be addressed include:

- Before information is collected, there must be informed consent of children and/or their care givers, including clear and understandable information on the purpose of data collection and to ensure realistic expectation of how data collection will benefit the child. Asking questions on a child's situation and the assistance he or she requires often raises expectations;
- Children's privacy and anonymity has to be guaranteed and the confidentiality of the interview as well as the management of the information collected has to be ensured. Personal or other information on specific cases of children should not be shared with any other actors except on a strict need-to-know basis and only if the child's guardian has provided specific consent to do so;
- The safety and security of children must be a primary consideration. If providing information can put the child or their family at risk, the information should not be collected or safeguard measures applied that are trusted by all;
- Leading questions should be avoided, i.e. those 'suggesting' an answer. Questions should be adapted to ensure that they are appropriate to the maturity level and situation of the child. Children should not be pushed to discuss issues that cause them distress;
- Feedback should be provided, and findings shared if possible;
- Duplication of survey/assessment/surveillance efforts should be avoided at all costs — victims/survivors should not be subjected to multiple interviews conducted by various organizations collecting the same data;
- All persons interviewing and collecting information from children must be trained on how to do this in a safe, ethical and age- and gender-appropriate manner.[4]

Victim Assistance Officer from Tajikistan Mine Action Centre, Reykhan Muminova, collects casualty data during a field visit. Saygufron signs the IMSMA form to confirm that the data are correct. At the age of 10, he lost both hands from a cluster munition incident during the Civil War in 1996.

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Desirable outcomes[5]

- All actors have a sound evidence base on the profiles of landmine/ERW survivors and victims, how they are affected, and where they live in order to inform VA-related programmes and services;
- Affected individuals and communities have sufficient information on availability and access to the spectrum of services, including hospitals, rehabilitation centres, psychosocial support, inclusive education facilities, vocational training opportunities, and so forth;
- Data is available to identify and address gaps in the delivery of services, including for people of different ages, impact of services on the quality of life, geographic coverage, and so forth;
- Advocacy is informed by and resources are mobilized based on sound evidence.

Suggested activities

1. Identify landmine/ERW casualties

In most countries with existing injury or incident surveillance systems, the 'case definition' of who is a mine/ERW victim has not been universally defined. Are we collecting information only on survivors, or also on those killed? Are we collecting information and data on those indirectly affected? Without a specific case definition that is disseminated and understood by all those collecting data and a standardized data collection form to ensure that those in different areas are collecting the same information, the systematic consolidation, analysis and interpretation of data is not possible.

- ✓ Agree on a definition of a "landmine/ERW victim". Definitions may differ from country to country. Sri Lanka, for example, includes persons injured/killed by a "trap gun", an improvised explosive device that is victim-activated and therefore indiscriminate in nature. Even in countries where surveillance on landmines/ERW is undertaken within systems for more general

injury surveillance or where information collection on landmines/ERW survivors and victims may be integrated within data and information systems for persons with disabilities more generally, or child protection more specifically, it is important to specifically define what we mean by a 'victim', with inclusive and exclusive criteria.

- ✓ Agree on whether and how to include family members of those killed and injured. Given the specific vulnerabilities and needs of children, the collection of information on children indirectly affected is particularly relevant for child-centred VA.
- ✓ Collect casualty data on victims from landmine and ERW including on cluster munition accidents. Ensure they are age- and sex-disaggregated.
- ✓ Identify all stakeholders who already collect data to ensure coordination and to avoid overlap.
- ✓ Specify mines/ERW as a specific cause under Killing and Maiming of Children within Child Protection monitoring systems, including Security Council Resolution 1612 Monitoring and Reporting Mechanism.

2. Train stakeholders in data collection and management and establish information security protocols

Working level stakeholders involved in data collection and information management for VA must be technically trained. They should have a sound understanding of such processes, both in terms of the establishment of data and information management systems and also in appropriate collection of data from children. In order to ensure the safety and confidentiality of informants, as well as the security of information, specific data storage and data-sharing protocols should also be developed and put in place. See also Box 23 in Section 5.6 "Laws and Policies" for principles to observe when dealing with children.

- ✓ Develop or enhance injury surveillance systems that include landmine/ERW injury. UNICEF and the US-based Centers for Disease Control and Prevention (CDC) have trained dozens of mine action staff in Field Epidemiology for Mine Action Courses (FEMAC).

  More recently, based on the FEMAC, a course focused on the technical aspects of establishing or strengthening surveillance of weapons-related injury, and more broadly, on injury related to violence against children, has been developed and is being implemented.[6]
- ✓ Ensure that those who are collecting information from children and their families or who have a role in managing such information are trained on ethical and safe child interviewing, data collection and management procedures.
- ✓ Train information management personnel on data management, analysis, interpretation, reporting and dissemination.
- ✓ Train staff in health, social protection or other ministries to monitor child injury and to develop comprehensive prevention programmes.
- ✓ Include child survivors/victims and/or their parents in the design and implementation of data collection

  This involves costs, but survivor involvement in data collection has been shown to have additional benefits, such as opportunities to provide informal peer support, while also making people more comfortable in responding to questions.
- ✓ Establish specific protocols and standard operating procedures to ensure data security and the privacy, confidentiality and safety of those providing information, including specific measures for the informed consent and protection of children.

3. Identify both needs and potentials

In collecting data, the survivors/victims should not be disempowered; while they may have specific needs, they also have potentials and capacities like everybody else.
- ✓ Make use of existing data before collecting additional data. Include situation assessments of children in general, not just of children with disabilities or child survivors of victims of landmines/ERW. What sources of data on landmine victims, survivors and persons with disabilities are already available? What information do they provide? How can different sources of data be integrated? Once such questions are answered, then the need for additional information can be determined.
- ✓ Identify needs and potentials of child survivors and of children of injured or killed victims. Pursue child-informed research including on children and

adolescents with disabilities. Ensure the family and community context is also assessed.
- ✓ Focus on mine-ERW affected areas including those already cleared where victims remain but be aware that some victims and their families may have moved to the provincial or national capital or even abroad in search of services.

Not everyone who is a mine/ERW victim will necessarily need support, but their situation should be documented and their views should be heard.

4. Collect data on VA-related service provision
- ✓ Collect data on the services that landmine/ERW victims receive. Ensure data is age- and sex-disaggregated.
- ✓ Map referral mechanisms including through case and social work information management systems.

  A referral pathway and standard operating procedures can only be created with a full and regularly updated picture. Mapping also helps identify gaps in the provision of child-centred services (e.g. lack of prosthetic workshops that serve children), in reaching certain groups of children, and in response capacities (e.g. lack of same-sex staff in prosthetic workshops). For referral systems to work, referral handbooks and mappings must be updated regularly.
- ✓ Analyse the capacity of existing organizations to ascertain whether they address the needs of child survivors and victims of mines/ERW.

5. Mainstream the databases
Data including those on children with disabilities are often collected by various sources and kept in different formats at local, district, provincial and national levels. A centralized database is an ideal to be sought for.
- ✓ Analyse what data collection mechanisms already exist and agree on one that can be adapted to meet the needs of those providing services to survivors, other persons with disabilities and the broader group of indirect victims.
- ✓ Governments should coordinate among relevant institutions to collect data and use coherent categories and definitions; coordinate with initiatives for child protection, social work and case management, and children with disabilities including parents' initiatives.
- ✓ Stakeholders should assist each other in data verification and ideally agree on one central data base focal point.
- ✓ When an unambiguous definition of mine/ERW victim has been agreed upon, all stakeholders should use this category when collecting data.

✓ Existing databases such as those for registration of children, on family reunification, and other protection issues should include the category "landmine/ERW victim" to support mainstreaming.

✓ Include mine action actors involved in incident surveillance in Child Protection information management-related training to ensure that they are able to take the protection of children into consideration in their work.

Box 9: "I am happy I am alive!" – Village-focused Needs Assessment Paired with Advocacy by Landmine Survivors in Cambodia

'I am happy I am alive!', a Cambodia Survivor Network Project report, presents findings of a low-cost needs assessment undertaken by Cambodia's Campaign to Ban Landmines & Cluster Bombs (CCBL) and the Jesuit Refugee Service (JRS) in 393 villages in 21 provinces from June 2012 to May 2013.

This research showed that many people with disabilities are happy and well-adjusted, helping their communities ensure sure their rights are upheld. But it also had some sobering news:

1) 41 per cent of people with disabilities have identity cards
2) 39 per cent have land titles
3) 56 per cent can read and write, though for women, the figure is 39 per cent
4) 51 per cent have enough food to eat
5) Few say they have enough income to live in dignity.

The study did not compare people living with disabilities to those with no disabilities.

This village-focused approach was undertaken by landmine/ERW survivors. Not only did they come up with a wealth of data, they also connected local authorities with persons with disabilities from their own community and advocated for fulfilling their rights, discussed the Convention on the Rights of Persons with Disabilities and the local law on persons with disabilities. The report aims to improve the quality of life of people with disabilities at the village level through emergency response (by taking people to the hospital) and through rehabilitation (by providing crutches and wheelchairs or by linking people to income generating activities).

Among the 3,448 participants in the assessment, 276 (8%) were 15 years old or younger and 168 (5%) between 16 and 20. This is a notable exception to other studies that rarely reach out to children/young people. It is noteworthy that 1,523 (44%) respondents had children going to school. Of the 276 children under 16, 103 were girls and 173 were boys. The majority of this group answered 'bad' to the statement 'I feel healthy'.

The needs assessment was not representative of all persons with disabilities but it did reach out to other persons with disabilities. Nearly 50% of those who provided information on the cause of the disability were mine/ERW survivors (1,215 mines and 417 ERW).

The study noted that more research is needed on "quality of life", especially for children. Future research should take into account children's psycho-social health, family relations, and access to food.

Source: CCBL/CMAA/JRS (2013), *I am happy I am alive! A practical approach. Towards a dignified quality of life for people with disability in Cambodia,* From the Survivor Network Project. Siem Reap/Phnom Penh <http://www.jrscambodia.org/publication/Iamhappy.jpg>

Technical Resources

Documents are listed in ***inverse chronological order***, starting with the most recent ones.

Data collection and analysis

De Santis, Angela and Daniel Eriksson (GICHD) (2013), 'The New IMSMA and Victim Assistance', *The Journal of ERW and Mine Action,* V.17.3, Fall 2013, Harrisonburg, VA, [Only online: <http://www.jmu.edu/cisr/journal/17.3/focus/desantis.shtml>.]

Handicap International (HI) (2013), *Victim Assistance Factsheets,* Lyon; here Factsheet 10 'Data Collection', <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>

ICRC (2013), *Professional Standards for Protection Work Professional carried out by humanitarian and human rights actors in armed conflict,* 2013 Edition, Geneva, <http://www.icrc.org/eng/assets/files/other/icrc-002-0999.pdf>

Child Protection Working Group (CPWG) (2012), *Minimum standards for child protection in humanitarian action;* here Standard 5 'Information Management', <http://cpwg.net/minimum-standards/>

Mine Action Information Center (2008), *Landmine Casualty Data: Best Practices Guidebook* [Author: Suzanne Fiederlein], James Madison University, Harrisonburg VA, <http://www.jmu.edu/cisr/research/links/guidebook/download.htm>

GICHD (2008), *IMSMA User Manual,* Geneva [The Information Management System for Mine Action is good for casualty data management; the latest version developed in 2013 allows to manage VA service delivery data. See article by De Santis and Eriksson 2013.] <http://www.gichd.org/mine-action-resources/documents/detail/publication/imsma-user-manual/#.U-8OEmNW62o>

UNICEF and GICHD (2005), *IMAS Best Practice Guidebook 1, An Introduction to Mine Risk Education. Best Practice Guidebook 2, Data Collection and Needs Assessment,* Geneva, <http://www.gichd.org/fileadmin/GICHD-resources/rec-documents/IMAS-MRE-Guidebooks-2005-complete-en.pdf>

Anderson, Mark and Michael L. Gerber (2004), 'Applying epidemiology to the field of mine action.' Centers for Disease Control and Prevention (CDC). *US Foreign Policy Agenda* V.9(1) 2004:11-13, See also <http://www.cdc.gov/globalhealth/healthprotection/errb/publications/warrelatedinjuries.htm>

WHO (2001), *Injury surveillance guidelines,* Holder Y, Peden M, Krug E et al. (eds.), Geneva, <http://www.who.int/violence_injury_prevention/publications/surveillance/surveillance_guidelines/en/>

Physicians for Human Rights (2000), *Measuring Landmine Incidents & Injuries and the Capacity to Provide Care: A Guide to Assist Governments and Non-governmental Organizations in Collecting Data about Landmine Victims, Hospitals and Orthopaedic Centers.* Boston, MA, <http://physiciansforhumanrights.org/library/reports/measuring-landmine-incidents-guide-2000.html>

Endnotes

1   Landmine & Cluster Munition Monitor (2013), Fact Sheet Children & Landmines, full source see References. These are reported casualties; the actual figure may be higher. Landmines are explosive devices. However, as conventions and protocols address landmines and ERW separately, the two are listed separately henceforth. Protocol V of the Convention on Certain Conventional Weapons defines ERW as unexploded and abandoned explosive ordnance. The data include casualties from remnants of cluster munitions, a specific type of ERW.

2   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

3   Often it is very difficult to locate victims and/or their families, for example, when attempting to survey victims. To address this, the government of Sri Lanka is suggesting that a specific code be introduced for people with disabilities so that they can be identified by this code in any data base. UNICEF is also working with the Non-Communicable Disease Unit of the Ministry of Health in establishing an injury surveillance system to strengthen the knowledge base.

4   For more information and guidance on safe and ethical data collection and management related to children and protection (including during armed conflict), see 'Standard 5: Information Management' and 'Standard 6: Child Protection Monitoring' of the Minimum standards for child protection in humanitarian action and 'Chapter 5: Managing Sensitive Protection Information' of the ICRC Professional Standards for Protection Work.

5   "Outcome   The intended or achieved short-term and medium-term effects of an intervention's outputs, responding to national priorities and local needs and UNDAF [UN Development Assistance Framework] outcomes. Outcomes represent changes in development conditions that occur between the completion of outputs and the achievement of impact." United Nations Development Group (UNDG) 2010, Results-Based Management Handbook, Strengthening RBM harmonization for improved development results. Clean Draft Version. New York 2010. <http://www.undg.org/docs/12316/UNDG-RBM%20Handbook-2012.pdf>.

6   For more information on this work, see <http://www.cdc.gov/globalhealth/healthprotection/errb/training/femac.htm>.

A Tajik surgeon reviews the stump of this young man's right leg. Medical personnel must be properly trained to avoid complications, reduce pain and allow best fitting of the prosthetic limb.

Chapter 5
Child-focused Victim Assistance

Section 5.2
Emergency and continuing medical care

5.2 Emergency and continuing medical care

Introduction

BLAST injuries from landmines and explosive remnants of war (ERW) cause particularly severe effects in young children because the vital organs of their smaller bodies are closer to the centre of the blast, resulting in the increased likelihood of death. For children who survive, injuries include limb loss, spinal cord injury, fractures, burns and fragmentation injury, shrapnel remaining in the body, injury to the genitals, impairments of eye-sight and hearing, as well as head and brain injury. Psychological trauma is another major consequence of a blast accident. (See also Section 5.4, "Psychological and psychosocial care") Mortality rates differ greatly, based on the types of explosive devices typically encountered in a country, ease of access to adequate emergency first aid and other conditions.

The first objective of emergency medical care is to keep the victim alive, thus reducing the number of preventable deaths, and to take measures as early as possible to prevent longer-term impairment. Most affected countries do not have appropriate pre-hospital emergency medical care to save children's lives. First responders are often not adequately trained to stop severe bleeding, whether in adults or in children. Weapon-contaminated areas are often in remote areas, far away from better equipped medical services and transport from the accident site to the nearest available first aid (pre-hospital care) is particularly challenging.

Emergency care continues at the hospital: those directly affected from the explosive blast usually require lifesaving trauma care, including amputations (of lower limbs from a typical blast mine, of upper limbs from tampering with mines and unexploded ordnance and fragmentation injury from fragmentation mines or hand grenades). Many blast injury victims sustain multiple injuries and require a range of surgical interventions.

Post-operative care is oftentimes lengthy after a severe traumatic injury. Mine/ERW casualties typically require further medical care to allow healing of wounds and burns and physiotherapy. Physiotherapy is essential for persons who underwent amputations in order to avoid secondary complications and impairments and to facilitate the fitting of prosthetic limbs and gait training.

This initial period following the explosion is also the first and truly difficult phase of psychological trauma. Both the survivor and family members go through phases of shock and despair as they try to accept a new reality. Many survivors with limb loss or facing blindness or deafness report that they had thought of ending their lives while in hospital, a despair for which care givers must remain alert.

Finally, children may need ongoing medical interventions after the initial treatment of the physical trauma for corrective surgery, for pain treatment and physiotherapy or for the removal of shrapnel. Families of child survivors oftentimes struggle to afford medical and rehabilitative care. For cultural reasons, in countries where there are challenges of discrimination against women, boys and men are more likely than girls and women to receive high-cost medical attention and transport, as well as longer-term support for their inclusion in education, family, social and economically productive lives.

In armed conflict scenarios the available spectrum of service may be extremely limited and even sometimes non-existent when access is blocked.

Terminology matters

IMPAIRMENT is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual when involved in daily life situations.

DISABILITY is an evolving concept, resulting from the interaction between people with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. *Convention on the Rights of Persons with Disabilities*

INJURY is the damage to the physical body of a person, resulting from an event (not from a disease or long-term process). It can result from various causes such as violence (for example, the immediate consequence of war, such as gunshot, shrapnel or torture), accidents, consequence of birth, attempted suicide etc.

HelpAge International/Handicap International (2014), Hidden victims of the Syrian crisis: disabled, injured and older refugees, *London/Lyon*

Box 10: Mortality and Morbidity among Child Survivors by Age Group, Cambodia (2008-2012)

Over the five-year period from 2008 to 2012 the Cambodia Mine/ERW Victim Information System (CMVIS) registered details on 365 mine/ERW child casualties: 81 (22 per cent) died and 284 (78 per cent) were injured. (For information on CMVIS, see Box 7 in Section 5.1, "Data collection and analysis".) Boys comprise 79 per cent of all child casualties, girls 21 per cent. Boys were more likely to be killed (24 per cent) than girls (16 per cent).

When analysing mortality and morbidity (the latter term in epidemiology describes the rate at which an illness occurs in a particular area or population) among four age groups, the general pattern for Cambodia was the same as the global pattern: adolescents (groups 12-14 and 15-17) make up the highest percentage, 57 per cent, followed by children aged 6-11 (31 per cent). The youngest children, aged 0-5, account for 12 per cent. (See Table 1 in the Introduction.)

Comparing mortality and morbidity of boys and girls among the age groups does not reveal large differences, except to note that girls are killed less often than their male peers once they are older than 5.

Of 355 child survivors whose injuries were recorded, 255 (72 per cent) sustained wounds. Of those wounded, 42 (12 per cent) required amputations (some may have lost one or more limbs), and 26 (7 per cent) suffered burns; 20 (6 per cent) partially or fully lost their eye sight, 11 (3 per cent) have partially or fully impaired hearing and one adolescent remained paralyzed as a consequence of the blast injury. The nature of ten injuries was unknown.

Analysis of injuries by age groups reveals 1 child aged 0-5 years out of 36 in that age group who sustained an amputation. Of children aged 6-11 years, in total 95, 14 had amputations, 7 remained blind and 2 remained deaf as a consequence of the explosion. Adolescents aged 12-17 comprised the largest group of 198 survivors, 27 of whom underwent amputations, 1 was paralyzed, 13 remained blind and 9 remained deaf. Wounds make up the highest number and need to be further analysed as most may fully heal but some, for example shrapnel wounds, may cause long-term pain and complications. Similarly, burns can be severe and cause lifelong consequences.

Further analysis by sex and severity of injuries would be needed to provide a deeper understanding of the consequences of blast injuries to boys and girls by age group. (For further details on the activities that led to the accidents and the device type for the same group of Cambodian child survivors, see Table 1 in Chapter 1 "Introduction".

Figure: Mortality and Morbidity among Child Survivors by Age Group, Cambodia (2008-2012)
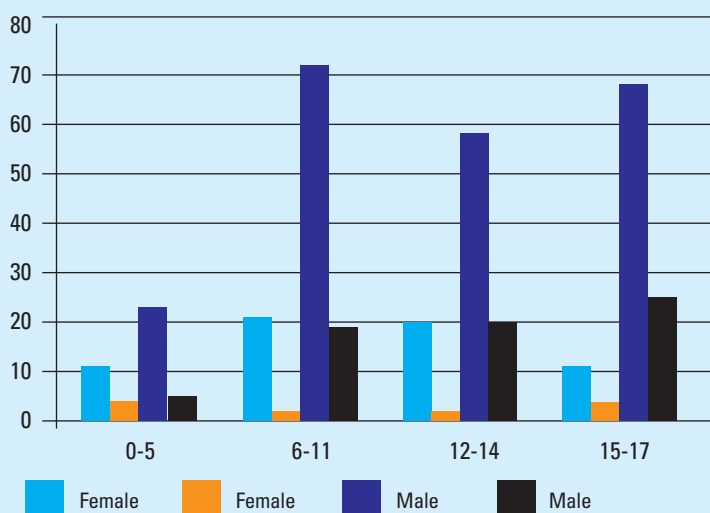
Note: Here, the adolescents (12-17) are split in two sub-groups of 3-year brackets. If there were three same size age-groups depicted, the column for adolescents among those injured or killed would exceed the others by far.

Figure: Injuries by Age Group, Cambodia (2008-2012)
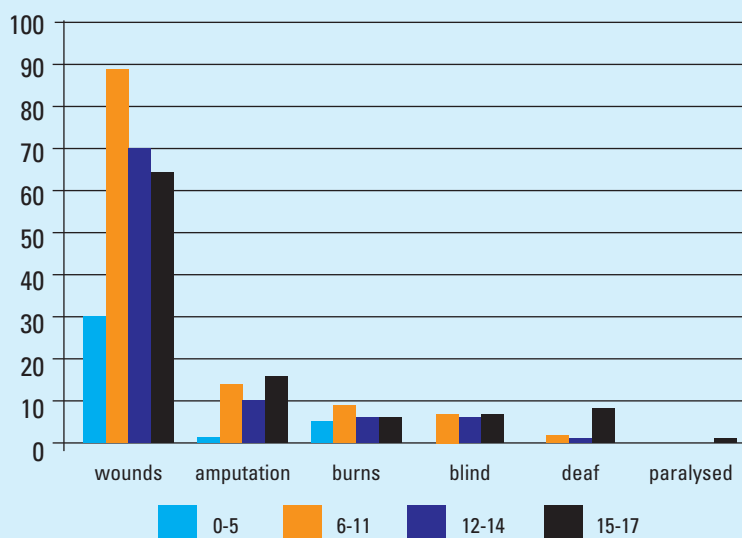
Note: Adolescents (12-17) are split in two sub-groups of 3-year brackets each. See Note to previous figure as well.

Source: Analysis by the author based on data provided by Cambodia Mine/ERW Victim Information System (CMVIS), February 2014

Goals

Improved first aid results in fewer children who die or sustain long-term impairments as a consequence of a blast injury. That they receive optimal emergency and continual hospital care, as needed, that facilitates rehabilitation and allows for full recovery. That child survivors and their caretakers receive psychosocial care and support as an integrated component of health care.

The role of emergency and continued medical care in child-focused victim assistance

The role of emergency and continued medical care in child-focused victim assistance is to ensure that:

- Medical practitioners, including emergency, continual and surgical care practitioners, are trained and have the capacity to address the specific complexities of child traumatic injury;
- First aid and emergency trauma care are adapted to the specific needs of children; and are available and accessible, with the objective of saving lives and preventing impairment and facilitating rehabilitation to the extent possible;
- Boys and girls are able to access age- and gender-appropriate medical care throughout their life-cycle, at the level and frequency that they require for optimal recovery and to facilitate rehabilitation;
- Health care practitioners are aware of potential gender-bias and discrimination in the demand and provision of emergency and continued medical care, and are sensitized and enabled to promote equal access and attention for girls and boys;
- Health care practitioners are aware and able to maintain family ties and prevent the separation of children from their families during medical evacuation or hospitalization;
- Child victims and their family members receive adequate psychosocial care by trained medical staff or social workers and peer-supporters (see below for further detail).

Key concepts

Emergency medical care for mine/ERW victims

The goal of emergency care is to provide acute trauma care including first aid, blood transfusions, and other immediate measures that prevent death and permanent impairments as much as possible.

Saving lives and limbs is a slogan commonly articulated as a key objective of mine action, often with respect to demining but which is equally relevant as a key objective of victim assistance. We know that fast and appropriate first aid, including specific skills required to treat children, not only saves lives but also limbs. For example, whether a first aid

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<div style="background: orange; color: white;">

War Surgery – Field Manual
The injured child

Children are not small adults!

In particular, children are different in the way they react to blood loss.

Yet the basic rules for examination and treatment are the same as in adults: First airway, then breathing, and then blood circulation.

The normal values [of breathing rate, heart rate, approximate blood volume, etc.] for children are different from those for adults. You must know what is normal when you examine an injured child. [Tables are provided with normal values of breathing rate/minute, heart rate/minute, approximate blood volume, etc. for children age 1-2 years, 5-7 years, and 10-12 years]

Airways: Small children breathe through the nose, not by the mouth. If the nose is blocked they may become desperate …

Husum, Hans et al. 2011, War Surgery, *p.406*

</div>

provider stops the bleeding by applying pressure dressing or by using a tourniquet will have a significant impact. Above the knee amputation can be avoided if the first rather than second approach is used.

Beyond first aid, adequate trauma care and surgery by medical staff specially trained in treating injuries to children is required. Medical practitioners must bear in mind that, "[A]ll children are extremely afraid after an accident – especially if they have trouble in breathing." The field manual on war surgery identifies three age categories for children in determining treatment: Age 1-2 years, 5-7 years, and 10-12 years.[3]

Continuing medical care for mine/ERW survivors

The goal of continuing medical care is to promote the person's full recovery with measures such as corrective surgery as children grow and pain management. Many persons that have undergone limb amputations suffer from phantom limb pain.

Barriers to emergency and continuing medical care for mine/ERW victims

In the provision of VA for children, one of the critical gaps is a general lack of trained first aid providers at the village level. First aid providers, often lay persons or local health care workers, need specialized training on what techniques to use to save children, especially in less-resourced settings.

At the hospital level, surgeons often lack training in adequate amputation techniques and eyesight-saving measures required to treat children.

Inadequate transport is another serious barrier. No or inadequate transport leads to critical delay in getting first responders to the accident scene as well as getting the victim(s) to the nearest adequate medical facility. Long journeys, at times taking several days, may result in serious infections that eventually lead to death. Barriers to affordable transport also affect continuing medical care as child survivors with limb loss may need repeated adaptive surgery due to the continuous bone growth. Similarly children with eye or head injuries may require several surgeries.

In humanitarian settings, the issue of denied humanitarian access might also be a serious barrier.

Inclusive health

"Inclusive health means that all individuals can access health care irrespective of impairment, gender, age, colour, race, religion and socioeconomic status. To ensure this, health-care service providers need to have positive attitudes towards disability and people with disabilities and have appropriate skills, e.g. communication skills to accommodate the needs of people with different impairments. The whole environment needs to change so that nobody is actively, or passively, discriminated against; one way of achieving this is by ensuring that people with disabilities and disabled people's organizations (DPOs) are active participants in the planning and strengthening of health-care and rehabilitation services."[4] Disability issues should be further incorporated in training and policy guidelines for health workers. Deliberate efforts should be made to generate data on access to health care for people with disabilities to inform positive changes in inclusive health care delivery. CRPD Article 25 describes the rights to health services for all persons with disabilities.

Nutrition

Nutrition is important for the development of all children including children with disabilities and child victims in general. While malnutrition can be a cause of disability, it can also be a consequence. Malnutrition is very closely linked to poor hygiene and poor sanitation. Poor nutrition in early childhood can result in poor cognitive and educational performance. Specifically for survivors, adequate nutrition plays an essential role in children's healing and recovery, and caloric needs of children may need to be revised based on the impacts of injury (e.g. for children with amputations). Considerations for the impacts of injuries on the digestive system, including ability to eat due to injuries to the hands or mouth, should also be borne in mind, both in terms of medical attention as well as during the physical rehabilitation phase. UNICEF globally addresses Vitamin A deficiency, which, according to the World Health Organization (WHO), is the leading cause of preventable blindness in children and increases the risk of disease and death from severe infections. Children with disabilities should be included in all public health nutrition considerations.

Desirable outcomes

- Landmine and ERW casualties including children have access to specialized first aid within the critical first hour following the accident.
- First aid responders are adequately trained to save lives and limbs of severely injured children.
- Child deaths from a mine/ERW-accident are reduced and prevented thanks to improved access to and quality of first aid and emergency trauma care adapted to the specific needs of children.
- Long-term physical impairment and disability of children is prevented or reduced through appropriate emergency and longer-term medical and surgical care.
- Children who sustain severe blast injuries receive adequate medical care over their lifetime.
- Women and girls have equal access to medical services as men and boys.
- Injured persons and their family members understand the role and purpose of medical care, receive accurate information about the treatment available and participate in the decisions regarding their treatment.

Sony Kinyera, 17 years, is walking back from school in Gulu district, Northern Uganda. He lost his right leg after stepping on a landmine.

- Children who are medically evacuated or hospitalized maintain family ties and are not separated from their caregivers.
- Medical services and other related providers promote the psychosocial recovery and wellbeing of children and their families.
- Medical services and the access to specialized services are affordable.

Suggested activities

Strengthen first aid for children
- ✓ Increase disability prevention and child injury treatment capacity of 'first responders' (men and women) mainly in the pre-hospital phase of care primarily through training villagers and community volunteers with no medical background.
- ✓ Provide sufficient basic supplies to pharmacies and first aid responders at the community level.
- ✓ Integrate first aid training with other sector actors, including disaster risk management and school safety. Consider training mine risk education-providers as first aid trainers.
- ✓ Increase psychological first aid capacity.
- ✓ Ensure that children are not separated from their caregivers/families during emergency medical evacuations.
- ✓ Train drivers of formal and informal ambulances as first aid responders.

Facilitate access to first aid responders
- ✓ Address communication challenges regarding how to reach first aid responders and how to arrange transport for emergency evacuations. Pay attention to cost recovery issues.

Ensure access to appropriate medical and nutritional care
- ✓ Inform child victims/survivors, their caretakers and community members about existing services and how to access them.
- ✓ Assist with transport cost to reach adequate medical and nutritional care.
- ✓ Organize adequate referrals from primary care to higher level care.
- ✓ Ensure that social or case workers are kept informed and document and ensure information management of medical-related referrals.
- ✓ Aim at professional assessment of all possible medical and nutritional effects resulting from the blast accident; agree on a routine medical protocol if not existing; ensure child-specific medical care is incorporated.
- ✓ Aim at adequate and safe accommodation for children and their caregivers while receiving medical treatment.
- ✓ Ensure that children are not separated from their care givers or families when they are referred to required medical services.

Box 11: Training of First Responders Reduces Mortality Rates

In post-conflict, landmine-ridden rural areas of Cambodia and Iraq, there were no formal emergency medical services. An innovative programme by Trauma Care Foundation, Norway, from 1997-1999 created a two-tier network of village 'first responders' (villagers who had completed a two-day basic first aid course) and paramedics (trained on a 450-hour course). Each paramedic trained at least 50 first responders between each stage of their own training. At the end of the five-year intervention, 5,200 first responders had been trained in the villages. An additional, explicit aim of the training programme was to rebuild trust and repair broken social networks in these remote, rural areas.

At the end of the first five years, an in-depth assessment was conducted. A total of 1,061 trauma victims had been managed, most of them with severe injuries. The mean response time from injury to first medical contact was reduced from 2.9 hours in 1997 to 1.8 hours in 2001. Given the remote areas in which the work was conducted, the mean pre-hospital transit time did not change and remained 5.7 hours. Mortality among injured people declined dramatically, from 40 per cent to 9 per cent. This programme supplied training and basic equipment, but no ambulances or other vehicles. Over time, the systems in both countries grew and adapted to a changing epidemiological pattern, caring for increasing numbers of road traffic crash victims and other medical emergencies.

Source: World Health Organization (2010), *Strengthening care for the injured: success stories and lessons learned from around the world, Geneva*, pp. 3-7; see also Handicap International (2013), Victim Assistance Factsheet 1, Medical Care, Lyon

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Continuing medical care for mine/ERW victims

- ✓ Provide training to medical staff on surgery, advanced trauma care and on psychological first aid and psychosocial support for children with severe injury and disability, including on the prevention/reduction of impairment. This training needs to address specific requirements when assisting children of various age-groups with traumatic injuries.
- ✓ Provide training to nutrition staff on specific nutritional needs of child survivors.
- ✓ Provide free or affordable medical and nutritional care to the highest attainable levels.
- ✓ Support healing, e.g. with the right nutrition, community-based sanitation and hygiene, follow-up care, psychosocial support for survivors, family members/care givers and medical staff.
- ✓ Provide child-friendly care, respecting privacy especially for girls and female caregivers.
- ✓ Ensure referrals to rehabilitation services, the provision of assistive devices and to (continued) psychosocial and nutritional care.
- ✓ Provide access especially for child survivors for continued specific medical care; several corrective surgeries may be needed throughout their childhood/adolescence due to continuous bone growth. (Programme budgets should include transport and other costs as required on an ongoing basis for families with low income).

Help to prevent secondary conditions

- ✓ Provide health promotion as early as possible after the accident on how to prevent secondary infections and joint contractions through physiotherapy and, ideally, occupational therapy.
- ✓ Provide psychosocial and where required more specialized psychological support to prevent depression, to reduce trauma and to minimize phantom limb pain.
- ✓ Provide specialized nutritional support to enhance healing and recovery.

Ensure access to healthcare services (inclusive health)

- ✓ Ensure access to standard medical and nutritional care for all children with disabilities as part of inclusive health provision.
- ✓ Provide access to general medical and nutritional care for survivors, families and their communities. Health services that are particularly necessary for children, adolescents and women, including victims and those with disabilities, include vaccinations, nutrition advice, early detection of impairments, contraception, HIV prevention and maternal and child care.
- ✓ Provide these health services as close as possible to people's own communities, including in rural areas.

Technical Resources

Documents are listed in ***inverse chronological order***, starting with the most recent ones.

Emergency and continuing medical care

Meddings, David (2013), 'Child Injury Prevention: An Overlooked Challenge for Child Survival', *International Journal of Environmental Research and Public Health* 2013 Vol. 10, pp. 568-570, <http://www.thehealthwell.info/journal/ijerph-vol-10-pages-568-570-child-injury-prevention-overlooked-challenge-child-survival-0?&content=journal_article&member=none&catalogue=none&collection=none&tokens_complete=true>

Handicap International (HI) (2013), *Victim Assistance Factsheets,* Lyon; here Factsheet 1 'Medical Care', <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>

Husum, Hans, Ang, Swee Chai & Fosse, Erik (2011), *War Surgery, Field Manual,* Third World Network, Trauma Care Foundation, 2nd revised edition, Penang [Chapter 19 is on 'Injuries to children and old people'], <http://traumacare.no/warsurgery-online/>

WHO/UNESCO/ILO/IDDC (2010), 'Health component', *Community-Based Rehabilitation: CBR Guidelines,* Geneva [Also: 'CBR and HIV/AIDS', In 'Supplementary booklet', pp. 21-32] <http://www.who.int/disabilities/cbr/guidelines/en/>

World Health Organization (2010), *Strengthening care for the injured: success stories and lessons learned from around the world,* Geneva, <http://whqlibdoc.who.int/publications/2010/9789241563963_eng.pdf>

Watts, Hugh G. (2009), 'The consequences for children of explosive remnants of war: Land mines, unexploded ordnance, improvised explosive devices and cluster bombs.' *Journal of Pediatric Rehabilitation Medicine: An Interdisciplinary Approach,* 2009, Vol. 2, pp. 217-227, <http://iospress.metapress.com/content/jp375t0l812026g4/>

WHO (2007), *Integrated Management for Emergency and Essential Surgical Care (IMEESC) e-learning tool kit,* Geneva, <http://www.who.int/surgery/publications/imeesc/en/>

International Committee of the Red Cross (2006), *First Aid in Armed Conflicts and Other Situations of Violence,* Geneva, <http://www.icrc.org/eng/assets/files/other/icrc-002-0870.pdf>

WHO (2005), *Prehospital trauma care systems,* Geneva, <http://whqlibdoc.who.int/publications/2005/924159294x.pdf>

WHO (2004), *Guidelines for essential trauma care,* Injuries and Violence Prevention Department, WHO and the International Association for the Surgery of Trauma and Surgical Intensive Care (IATSIC), Geneva, <http://www.who.int/violence_injury_prevention/publications/services/guidelines_traumacare/en/>

Husum, Hans, Gilbert M. & Wiborg T. (2000), *Save Lives, Save Limbs, Life support for victims of mines, wars, and accidents. A handbook for medics and medical teachers.* Penang (Third World Network), <http://traumacare.no/publications/>

ICRC (1998), *Surgery for victims of war,* Third Edition, Geneva, <http://www.icrc.org/eng/resources/documents/publication/p0446.htm>

Endnotes

1   Landmine & Cluster Munition Monitor (2013), *Fact Sheet Children & Landmines*, full source see References. These are reported casualties; the actual figure may be higher. Landmines are explosive devices. However, as conventions and protocols address landmines and ERW separately, the two are listed separately henceforth. Protocol V of the Convention on Certain Conventional Weapons defines ERW as unexploded and abandoned explosive ordnance. The data include casualties from remnants of cluster munitions, a specific type of ERW.

2   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

3   Husum, Hans, Ang, Swee Chai & Fosse, Erik, *War Surgery, Field Manual,* 2nd revised edition, Penang 2011, p. 406; Chapter 19 is on 'Injuries to children and old people'. See <http://traumacare.no/warsurgery-online/>.

4   WHO/UNESCO/ILO/IDDC (2010), *Community-Based Rehabilitation: CBR Guidelines,* 'Health component', p. 7.

At a rehabilitation centre in Battambang, Cambodia, children with different physical impairments learn to walk. The girl in front on the left is wearing an orthosis.

Chapter 5
Child-focused Victim Assistance

Section 5.3
Rehabilitation

5.3 Rehabilitation

Introduction

REHABILITATION is a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environment. Although the concept of rehabilitation is broad, not everything to do with disability can be included in the term. In line with the CRPD, the term *rehabilitation* is preferred to the term *physical rehabilitation* as it is more comprehensive and less medically oriented.

Rehabilitation targets improvements in individual functioning – for example by improving a person's ability to eat and drink independently. Rehabilitation also includes making changes to the individual's environment, for example, by installing a handrail. Barrier removal initiatives at societal level, such as fitting a ramp to a public building, are commonly not considered rehabilitation. A key aspect of rehabilitation is the psychosocial dimension. For example, getting a prosthesis, trying it out and learning to live with it in the longer term, or learning to live without or partial eye-sight or hearing, involves complicated psychological mechanisms, which need to be acknowledged, supported and dealt with, from the beginning onwards. (This aspect is addressed in Section 5.4, "Psychological and Psychosocial Support".)

Rehabilitation services range from the basic to the specialized and are provided in many different locations, e.g. hospitals, prosthetic workshops, homes and community environments – at times by mobile units in order to reach remote areas. Rehabilitation is initiated by the health sector but requires collaboration among all sectors, particularly Social Protection.

One core task of the specialized services is to produce assistive devices. An assistive device is a device that has been designed, made or adapted to assist a person with an impairment to perform a particular task. Many people with disabilities benefit from the use of one or more assistive devices. Common types of assistive devices include mobility devices (e.g. crutches, prostheses, wheelchairs and tricycles), visual devices (e.g. glasses, white canes) and hearing devices/aids. To ensure that assistive devices are used effectively, important aspects of their provision include user education, follow-up, repair, replacement, access to appropriate therapy and environmental adaptations in the home and community.

Between 5 per cent and 15 per cent of persons living in low- and middle-income countries who require assistive devices and

> "I got a new prosthesis and I got rid of my crutches. I am ready to live a new life. I can go to the hospital by myself.... I can walk five to seven kilometers.... It is an amazing feeling when someone who has lost a leg—who was not even sure that he would still live, who did not see any light in the tunnel—gets a prosthesis and starts a life as a person and starts thinking about the future."
> — A landmine survivor

Sperber Richie, Beth, et al (2002), *Paths to Recovery: Coordinated and Comprehensive Care for Landmine Survivors*

technologies have access to them. Less than 3 per cent of the hearing aids needs are met in developing countries. Mobility devices are of particular importance for landmine and explosive remnants of war (ERW) survivors and other amputees. Children's artificial limbs need to be replaced every 6-12 months due to their growing body and bones. A ten-year old child with a lower limb amputation, for example, is likely to need 25 prostheses in the course of his or her life. Appropriate child wheelchairs also need to be adapted often as children grow.

For cultural reasons, in some countries, girls and women may not be able to access medical or rehabilitation services if only male practitioners are available. Or, they may not be able to travel to available services without a male escort.

Goal

Landmine/ERW survivors including children have access to rehabilitation services which contribute to their overall well-being, inclusion and participation; they have access to appropriate assistive devices of good quality, which enable them to participate in life at home, school, work (when age-appropriate) and in the community.

The role of rehabilitation in child-focused victim assistance

The role of rehabilitation in child-focused victim assistance is to promote child-friendly rehabilitation services and to ensure that institution-based rehabilitation is complemented by community-based rehabilitation.

Two years after the end of the civil war in Sri Lanka, a war-injured boy receives prosthetic care in the Meththa Foundation Physical Rehabilitation Centre, Mannar, Sri Lanka.

Key concepts

Rehabilitation

There are three goals in rehabilitation: healing, improving functioning and inclusion in the community of both the injured person and his/her family. This section focuses on the second aspect, improving functioning, to encourage functional independence. For a child who lost a lower limb, this requires a prosthesis that fits well. Prosthetic and orthotic (P&O) services should start early after amputation with tight wrapping of the stump and regular exercise through physiotherapy to ensure optimal results. After receiving the prosthesis, the girl or boy needs to learn how to walk through gait training so that she or he can move around freely without having to use crutches. Children with spinal injuries may have to learn how to use a wheelchair. Children who have received injuries to the digestive system, the hands or the face may have difficulties maintaining their nutrition wellbeing. All survivors, irrespective of their specific injuries, will need to re-learn how to do daily activities like washing, dressing, using the toilet, eating independently to the extent possible. All this requires occupational therapy. Children and young adults with amputations can greatly enhance mobility by learning

how to ride a bicycle or a tricycle to cover longer distances. Rehabilitation should also include speech therapy to address communication disorders.

Parents should be educated on the benefits of various rehabilitation services. For low-income families the rights and needs of persons with disabilities are often not considered a priority. Family members must learn how best to support a person with limb loss or other types of impairments. This training can be provided by community-based rehabilitation (CBR) workers who might also assist in maintaining the assistive devices when it is time to seek modifications or a replacement – or to apply low-cost and low-tech solutions for adaptations at home, for example to adapt a toilet so that it can be easily used by child survivors. See Box 12 for several types of assistive devices that should be considered for a child survivor.

The right to maximum independence

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilation and rehabilitation.

Article 26, Convention on the Rights of Persons with Disabilities

Box 12: Assistive Technology Devices for Children with Disabilities

Category	Examples of products
Mobility	• Walking stick, crutch, walking frame, manual and powered wheelchair, tricycle • Artificial leg or hand, caliper, hand splint, club foot brace • Corner chair, special seat, standing frame • Adapted cutlery and cooking utensils, dressing stick, shower seat, toilet seat, toilet frame, feeding robot
Vision	• Eyeglasses, magnifier, magnifying software for computer • White cane, GPS-based navigation device • Braille systems for reading and writing, screen reader for computer, talking book player, audio recorder and player • Braille chess, balls that emit sound
Hearing	• Headphone, hearing aid • Amplified telephone, hearing loop
Communication	• Communication cards with texts, communication board with letters, symbols or pictures • Electronic communication device with recorded or synthetic speech
Cognition	• Task lists, picture schedule and calendar, picture-based instructions • Timer, manual or automatic reminder, smartphone with adapted task lists, schedules, calendars and audio recorder • Adapted toys and games

Source: UNICEF. The State of the World's Children 2013. Children with Disabilities. New York 2013. <http://www.unicef.org/sowc2013/report.html>

Institutional and community-based care

Rehabilitation services can be provided in a variety of settings. Most common are institutional settings such as hospitals or separate rehabilitation clinics. Basic services can be provided by trained Community-based Rehabilitation (CBR)-staff at the community level, such as when CBR workers train family and community members to improve care or to initiate simple improvements at home. CBR workers can also link children with broader mainstream services available for children and communities more generally. At the institutional level, many facilities are run by governments with International Committee of the Red Cross or NGO-support or as non-profit or private enterprises. Not all services follow standards as defined by the International Society for Prosthetics and Orthotics (ISPO) and the World Health Organization (WHO) and many do not have staff trained to ISPO/WHO norms. Sub-standard devices that cause medical complications often lead disappointed users, including children and adolescents, to abandon the prosthesis and lose out on the potential benefits good rehabilitation services can provide at an affordable cost.

Mobility device service providers often find it difficult to recruit local and well trained physiotherapists, occupational therapists and social workers or persons trained in providing psychosocial care. Few service providers provide outreach work to the communities or actively link to CBR networks where they exist. Self-help groups at the community level can provide basic services to their members and beyond and are often promoted by CBR-workers. Many of these groups also demand access to adequate care and services from the government.

Countries with high numbers of military casualties tend to have their own rehabilitation services for injured soldiers and war veterans with disabilities. These services should be opened for all citizens instead of developing and maintaining a parallel civilian rehabilitation sector.

Highest attainable standards

High quality artificial limbs can be produced using an appropriate technology at a fairly low cost but even this cost is often too high for low-income families. Assistance to victims of conflict (and for other persons with disabilities) is free in many countries – at least officially – but someone in the end has to pay the bill for running mobility device services. While some specialists in the field may advocate for or promote the use of locally available (and sometimes lower quality) materials, this should be accepted only if these materials meet the minimum standards stipulated by the ISPO. Article 25 of the CRPD clearly calls for achieving the highest attainable standards.

Box 13: Community-based Rehabilitation in Iran (Islamic Republic of)

The CBR programme in the Islamic Republic of Iran encourages village health workers and CBR personnel to identify people with disabilities early and refer them to the primary health-care services in the community. Following referral, a mobile team of rehabilitation personnel visit the home to provide home-based rehabilitation. If specialized interventions are required, referral is made to a tertiary-level care centre, usually in the provincial headquarters or capital city. Following rehabilitation at a specialized centre, people are referred back to the primary health-care services, which work with the CBR programme to ensure that rehabilitation activities are continued, if necessary. The mobile team provides follow-up to monitor progress and provide further assistance when required.

Source: WHO/UNESCO/ILO/IDDC (2010), CBR Guidelines, 'Health component', p. 52

Desirable outcomes

- Child survivors receive individual assessments and jointly with their caregivers are involved in the development of rehabilitation plans outlining the services they will receive. Where they exist, individual assessments should be undertaken as a component of social work/case management systems.
- People with disabilities and their family members understand the role and purpose of rehabilitation and receive accurate information about the services available.
- Specialized rehabilitation services are available with affordable transport to access these services; decentralized maintenance and repair workshops for prostheses , orthoses , wheelchairs and assistive devices are available; children and their care givers are trained in care and maintenance of assistive devices at home.
- Basic rehabilitation services are available at the community-level; community-based rehabilitation (CBR) personnel receive appropriate training, education and support to enable them to undertake rehabilitation activities with children.
- Special efforts are made to reach those in need of rehabilitation services in hard-to-reach locations. Mobile rehabilitation teams deployed if no local services available.
- Special efforts are made to reach women and girls in need of rehabilitation services.
- Care givers, families and children themselves have access to information, knowledge and support to strengthen the psychosocial resilience and recovery of child survivors and victims.
- Rehabilitation workers are adequately trained in psychosocial care tailored to meet the needs of children and adolescents.

Suggested activities

Promote specialized rehabilitation and production of assistive devices according to international standards and best practice

- ✓ Support the Government body responsible for addressing the needs of persons with disabilities – often the Ministry of Health and the Ministry of Social Affairs or Social Welfare – to develop a comprehensive rehabilitation strategy and action plan. Develop this plan jointly with rehabilitation providers, Disabled People's Organizations and people with disabilities and agree on the appropriate P&O technology, address the training needs of rehabilitation staff *(not forgetting the need to have female professionals)* and advocate for a specific national budget line. Update the existing strategy and plan if necessary.
- ✓ Support rehabilitation services for civilians living in areas not under government control in cases of armed conflict, where possible.
- ✓ Educate parents, teachers, social workers, local leaders and decision making persons of any rank including medical and protection staff about the potential that results from good rehabilitation.
- ✓ Provide child-friendly rehabilitation, including occupational and speech therapy, services to the highest attainable levels.
- ✓ Respect privacy especially for girls and female caregivers in sex-segregated areas.
- ✓ Provide and equip areas designated as child-friendly spaces.
- ✓ Undertake mapping of rehabilitation services available for children and strengthen referral mechanisms to these.
- ✓ Train rehabilitation workers in psychosocial support and referral to other services as required, including in interpersonal skills that stress respect for all clients and understanding signs of distress caused by the

traumatic event of a mine/ERW explosion and listening for those signs. Workers should understand that their clients are not 'patients' who are sick. Training should be age-appropriate and tailored to meet the needs of each age group with traumatic injuries.

✓ Promote a team approach comprising the client (including the child if feasible), caregivers, family, P&O professionals, physiotherapists, occupational therapists, (psycho) social workers and others.

✓ Promote community outreach to identify and follow up on clients. Too often people who get a prosthetic limb stop using it because of pain or other trouble.

✓ Promote psychosocial care as an integral part of rehabilitation, e.g. by promoting peer-to-peer support at both the institutional and the community level. Involve family members and other caregivers.

✓ Promote sport and leisure activities at the rehabilitation facility as well as back in the home community. Include persons without disabilities.

✓ Ensure referrals as needed, for example, to medical care (for corrective surgery if needed), physiotherapy prior to fitting, the provision of assistive devices, to (continued) psychosocial care, nutritional support when required, and so forth. Address specific needs of persons with spinal cord injuries, digestive system injuries, those in need of hearing aids and other special needs.

✓ Ensure accessible, timely and affordable maintenance, repair and replacement of prostheses, orthoses and assistive devices.

✓ Monitor and evaluate the effectiveness, quality and acceptance of mobility device service providers by their clients.

Promote access to mobility device services

✓ Locate mobility device service providers as close as possible to where survivors/child survivors live.

✓ Ensure effective referral for children to child-friendly rehabilitation services.

✓ Ensure that providers are following appropriate service provision standards.

✓ Provide for free or affordable transport to mobility device service providers including physiotherapy.

✓ Provide acceptable accommodation for clients staying overnight and for longer rehabilitation periods.

✓ Support mothers seeking mobility devices services for themselves or one of their children for child care for their other children both in their communities and/or at the rehabilitation facility.

✓ Ensure that protocols are in place to prevent the separation of children from their families when children or their care givers receive specialized rehabilitation services.

Figure 1: Model for Integrated Community-based Rehabilitation Approach
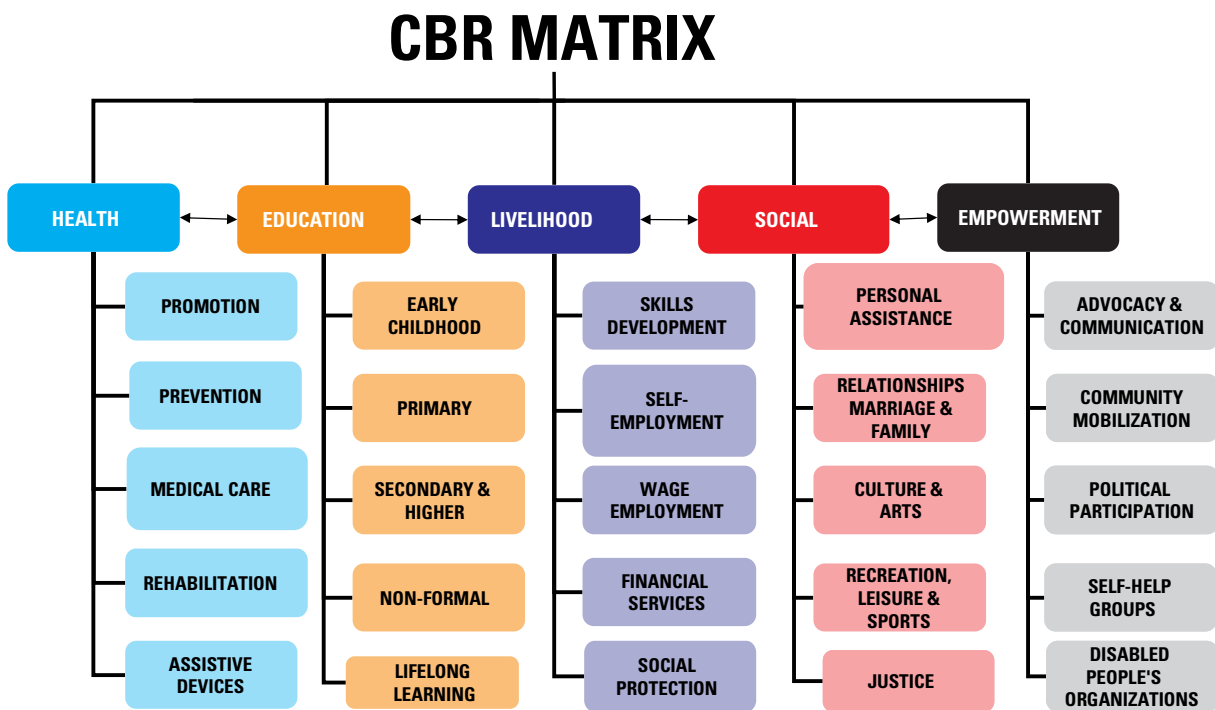
Source: WHO/UNESCO/ILO/IDDC (2010), CBR Guidelines

Promote community-based rehabilitation

- ✓ Train community-based rehabilitation workers who can support landmine/ERW survivors when returning to their families and to their community after discharge from hospital. CBR workers may assist with adequate wrapping and with exercises to strengthen the body prior to fitting a prosthesis, identify and refer children in need of nutritional support. CBR workers may provide important support during periods of transition, such as when a child starts school or an adolescent starts work.

- ✓ Ensure that children with disabilities and their family members are involved when developing an individual rehabilitation plan. (Case management approach, see Section 5.5 on "Social and Economic Inclusion".)
- ✓ Ensure close links to specialized care to allow optimal medical care, especially for children as they may require repeat surgeries and regular replacements of P&O devices and other follow-up.

Box 14: Being Able to Work Again – Nepal

Community Based Rehabilitation Biratnagar (CBRB) is a nongovernmental organization that has been working in the eastern region of Nepal since 1990. Currently it is working in 41 villages of the Morang District and in Biratnagar Submunicipality, providing rehabilitation services to more than 3,000 children and adults with disabilities.

In 1997, CBRB started a small orthopaedic workshop to carry out minor repairs of assistive devices, as many people with disabilities had to travel to the capital or neighbouring India for repairs. Over time, CBRB worked towards establishing a fully equipped orthopaedic workshop. Working in partnership with Handicap International (Nepal), they developed a comprehensive service that included the fabrication, provision and repair of assistive devices.

CBRB provides quality orthoses (e.g. callipers, braces, splints), prostheses (e.g. artificial legs and hands) and mobility devices (e.g. crutches, tricycles, wheelchairs) to people living with disabilities in 16 districts of eastern Nepal. CBR personnel, therapists and workshop technicians work hand-in-hand to enhance the quality of life of people with disabilities.

Chandeswar has benefited from the orthopaedic workshop. He is a rickshaw-puller who suffered an injury and had his left leg amputated. He lost his income because he was no longer able to work as a rickshaw-puller and he lost his savings because he needed to pay for his medical care. Chandeswar was identified by the CBRB team working in his village, who fitted him with a below-knee prosthesis and provided rehabilitation to ensure he was able to walk well with his artificial leg and learn how to pedal his rickshaw again. Once again, Chandeswar is pedalling his rickshaw around the busy streets of Biratnagar and making a reasonable living.

Seeing the benefit to people like Chandeswar, the President of CBRB says: "We were carrying out CBR for many years but since we started providing quality assistive devices, we have become more effective, our credibility has gone up and now we have a great acceptance in the community".

Source: WHO/UNESCO/ILO/IDDC (2010), CBR Guidelines, Health Component, p. 58

Technical Resources

Documents are listed in *inverse chronological order*, starting with the most recent ones.

Rehabilitation

Handicap International (2013), *Victim Assistance Factsheets,* Lyon; here Factsheet 2 *Rehabilitation,* <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>

International Committee of the Red Cross [ICRC] (2013), *Physical Rehabilitation Programme, Annual Report,* Geneva 2013 [and earlier years, see also regular *Mid-term Reports.* See info on "Services for mine/ERW survivors", p. 13] <http://www.icrc.org/eng/resources/documents/publication/p4160.htm>

ICRC Special Fund for the Disabled (SFD) (2013), *Annual Report 2013,* Geneva [and earlier years, see also regular *Mid-term Reports*] <http://www.icrc.org/Web/doc/sitesfd0.nsf/htmlall/6HWVXE/$FILE/SFD_AnnualReport2014_LR%5B1%5D.pdf?OpenElement>

WHO/UNESCO/ILO/IDDC (2010), *Health Component* [and other Components], *Community-Based Rehabilitation: CBR Guidelines,* Geneva, <http://www.who.int/disabilities/cbr/guidelines/en/>

Werner, David (2009), *Disabled Village Children: A guide for community health workers, rehabilitation workers and families,* 2nd Edition. Hesperian, Palo Alto, <http://hesperian.org/wp-content/uploads/pdf/en_dvc_2009/en_dvc_2009_fm.pdf>

WHO (2008), *Guidelines on the provision of manual wheelchairs in less-resourced settings,* Geneva, <http://www.ncbi.nlm.nih.gov/books/NBK143778/pdf/TOC.pdf>

Prosthetics and Orthotics Programme Guide, Implementing P&O Services in Low-Income Settings (2006), A guide for planners and providers of services for persons in need of orthopaedic devices, …, Endorsed by The International Society for Prosthetics and Orthotics [ISPO], … Geneva, <http://www.ispoint.org/sites/default/files/img/programme_guide_final_version.pdf>

Prosthetics and Orthotics Project Guide: Supporting P&O Services in Low-Income Settings (2006), Endorsed by ISPO, Geneva, <http://www.usispo.org/assets/pdf/Project_Guide_Final_Version.pdf>

Hobbs, Liz, McDonough, Susan and O'Callaghan, Ann (2002), *Life after injury, A rehabilitation manual for the injured and their helpers,* Third World Network, Penang, <http://www.twnside.org.sg/title/injury.htm>

Endnotes

1   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

2   "A system providing proper fit and alignment based on sound biomechanical principles [that] suits the needs of the individual and can be sustained by the country at the most economical and affordable price." Day, H.J.B., J. Hughes & N. Jacobs (eds.), *Report of ISPO Consensus Conference on Appropriate Orthopaedic Technology for Developing Countries*, ISPO, Phnom Penh, Cambodia, 5-10 June 1995, ISPO/USAID/WHO, Brussels 1996.

3   Prosthesis - 'an artificial device that is used to replace a part of the body that is missing, such as an arm, leg, or joint'.

4   Orthosis - 'An external orthopaedic appliance, for example, a brace or splint that prevents or assists movement of the spine or the limbs.'

In a summer camp for child mine/ERW survivors, a psychosocial support session is facilitated by a psychologist, Davlatov Mahmadullo, who lives with a physical disability himself.

Chapter 5
Child-focused Victim Assistance

Section 5.4
Psychological and psychosocial support

5.4 Psychological and psychosocial support

Introduction

PSYCHOLOGICAL care aims to prevent or treat mental disorder while *psychosocial support* has been defined as any type of local or outside support that aims to protect or promote psychosocial well-being. 'Psycho' refers to the psyche or the 'soul' of a person. It has to do with the inner world – with feelings, thoughts, desires, beliefs and values and how we perceive ourselves and others. 'Social' refers to the relationships and environment of an individual. It includes not only the material world but also the social and cultural context in which people live, ranging from the intricate network of their relationships to manifold cultural expressions to the community and the state. The inner world (psycho) and the outer world (social) influence each other. In short, 'psychosocial' deals with the well-being of individuals in relation to their environment.[3]

People who experience a violent injury from a blast explosion suffer a trauma, which is a Greek word that means wound. Survivors may suffer a *physical trauma* – an amputation of a limb or limbs, blindness or deafness – as well as a *mental trauma*. A landmine or explosive remnant of war (ERW) accident is traumatic both for those who are injured and for those who witness it but are left unharmed. Although everyone is affected in some way, individual reactions vary greatly. Many people may feel overwhelmed, confused, guilty and very uncertain about what is happening, especially children. Some feel very fearful or anxious; others display numbness and detachment. Some people may have mild reactions, whereas others may have more severe reactions. How someone reacts depends on many factors including age – and children of different age groups react differently.

Traumatic processes change not only the individuals directly affected, but also their environs. Living as a person with a disability often creates additional stress resulting from discrimination, mockery and bullying, but also from over-protection and pity instead of empathy. Prejudice against and stigmatization of persons with disabilities may lead to exclusion and a low self-esteem in children and adults. Women and girls with disabilities can face greater discrimination within their communities. Exclusion from school, from play, from community and for adolescents from economic life has particularly dire consequences for the recovery of children and young people. Many young people with disabilities are often incorrectly believed to be sexually inactive, unlikely to use substances and at less risk of violence and abuse than their peers without disabilities.

An indicator of the high level of anxiety felt by child survivors is seen in their strong attachment to their parents. The majority of child survivors say they are afraid to be without their parents. Several parents also mentioned over-attachment immediately after the accident.

"After coming back from the hospital, he could not be separated from me for 3 months: he was afraid to be alone."

Handicap International/Lao Youth Union/UNICEF (2004), Life after the Bomb: A Psychosocial Study of Child Survivors of UXO Accidents in Lao PDR*, Vientiane, p. 13*

Psychosocial support must address both the direct victims and their families and close friends. Loved ones, be they spouse or parents, brothers and sisters or close friends usually are the first ones who have to come to terms with how best to deal with this difficult and stressful situation. They can play a very important support role but they may also 'panic' and make the coping process more difficult. Too often, the new realities of life after such a trauma result in the break-up of marriages or long-term relationships as people with disabilities often confront discrimination.

The first year after the accident is often described as the most difficult: suicidal intentions, anger, grief, deep sadness, anxiety, guilt, and psychosomatic illnesses are common. Leaving the 'safe environment' of the hospital, sometimes months after the incident, is a difficult step in the adaptation process to learn to accept the new reality of being a person with a disability. The survivors return to their home (unless their family has become displaced in the meantime) and face their friends, neighbours, other relatives, and school mates.

In the immediate aftermath of the traumatizing event, psychosocial attention has to focus on the suffering and shock (traumatic reaction). Long term psychosocial approaches should focus on the coping mechanisms and strengthening the resilience of the individual and the surrounding family and community (traumatic process). Everyone has experienced more or less traumatizing events in his/her lifetime and developed coping mechanisms. These need to be identified and understood. What has helped in the past can also help in the present.

Goal

Landmine/ERW victims and survivors including children have access to psychological and psychosocial support that allows them to better understand and cope with the consequences of the traumatic accident.

The role of psychological and psychosocial support in child-focused victim assistance

The role of psychological and psychosocial support in child-focused victim assistance is to promote the mental health and the psychosocial well-being of child survivors and family members of injured or killed children and adults.

Key concepts

Psychosocial support

Psychosocial support addresses the psychological and emotional well-being of persons directly and indirectly affected from traumatic events and circumstances. These events include violent deaths or injuries from conflict-related events such as landmine/ERW accidents and from torture, sexual violence, trafficking, and natural disasters such as earthquakes or landslides. How a person reacts to such a distressing event differs widely and is associated to his or her individual resilience, which often depends on previous traumatic experiences, their social support structures, and coping mechanisms. The process of the trauma continues in a healing or destructive way after the war, direct violence and persecution have come to an end. It is usually not difficult to determine when a traumatic process began, but often difficult to know when it has stopped.

From a psychosocial perspective, three key social processes correspond to certain mental processes: threat and fear; destruction and trauma; loss and grief. Landmines were designed to create a threat and to leave soldiers and civilians in constant fear of getting maimed or killed. The victims thus do not only have to deal with their own fear reaction to their terrible experience, but also with being a symbol of the destructive power of the mines and therefore potentially being rejected or marginalized by others. Destruction and trauma are always present for the victims, many of whom experience feelings of total helplessness and the terrible images of destruction that, like a nightmare, stay in the vivid memory and are difficult to overcome. Finally, the experiences always imply loss – the violent injury of a blast explosion implies death or the loss of one or several limbs, eyesight or hearing. Assisting others to grieve, to mourn, is a key component of psychosocial support. Loss of loved ones and the difficulties of grieving during acute conflict are evident. One amputee in Angola said he wished he could have buried his leg that had been cut off but that it had been dumped in the hospital garbage. Burying the remains of his leg would have been one way for him to grieve.[4]

Medical staff, preoccupied with treating physical trauma, are often not sensitive to survivors' psychological needs. A comprehensive psychosocial approach should address the fundamental needs of an affected person, usually through psychological first aid or professional counselling if available. Only in rare cases is it necessary to refer a survivor to clinical management of severe mental conditions. Psychosocial support needs to be specific to the stage of the child's life cycle, for example, to address the anxiety of female adolescents about their suitability for marriage or the fears of adolescent boys who sustained injuries to their genital area. It is equally critical for young children, especially those under five, whose communication skills are less developed.
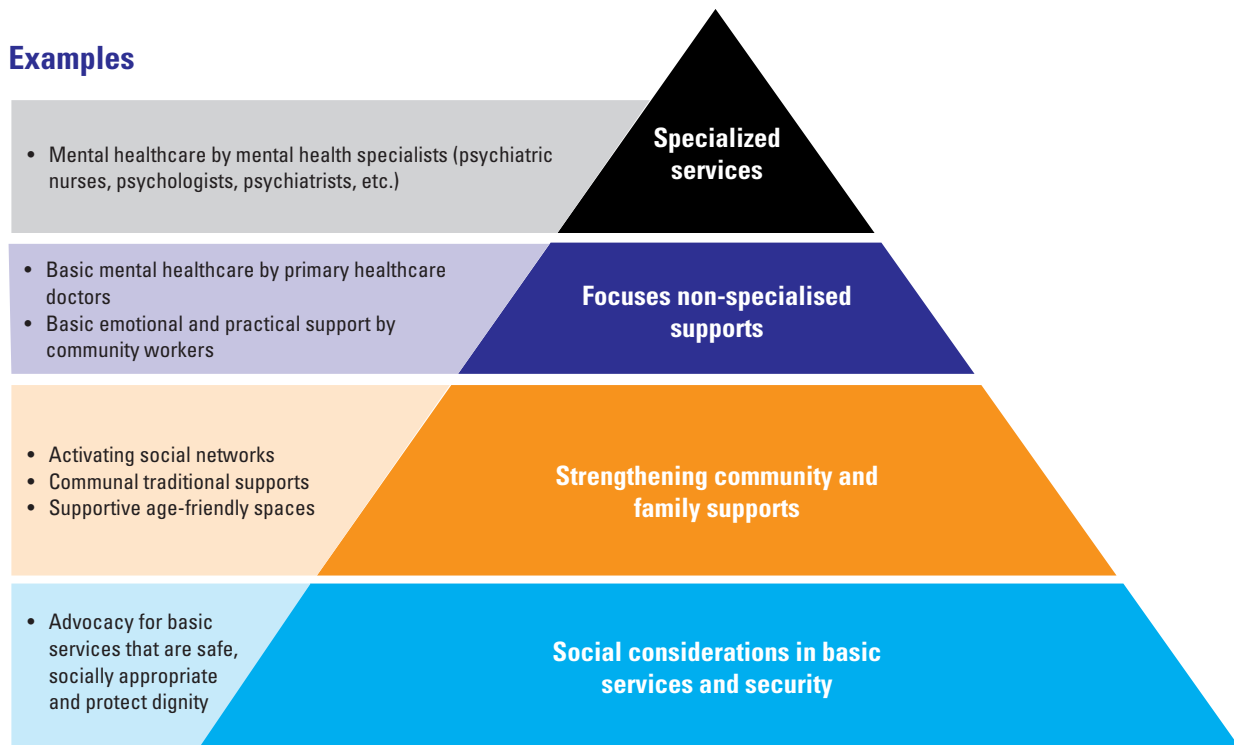
Psychosocial support includes ensuring access to shelter, food, health, water, sanitation, hygiene, and safety and offering these services in a way that respects the dignity of the people affected. It includes organizing support from family and neighbours. It encompasses organizing support from persons trained in basic psychosocial support, such as community workers, child protection and health care staff, and if needed, referral to clinical specialists. Meeting basic needs can go a long way in allaying anxiety. Building supportive networks helps to build individual resilience and to reweave the broken social fabric.

Mental health

Mental health is a state of well-being in which a person realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community. The term 'Mental health' is also used when referring to the work of specialists and includes psychological and psychosocial support. These terms are therefore often used interchangeably. Mental health specialists are usually asked to intervene for patients diagnosed with a severe mental disorder, usually not more than 3-5 per cent out of a group that is faced by severely distressing events (See Figure 2, The Intervention Pyramid).

Mental health is among the least understood areas among the VA components: Trauma is sometimes perceived as an illness that needs to be 'overcome'[5] or 'cured'. It is helpful to understand the experience of trauma, as a process that may manifest itself from time to time, sometimes triggered years after the initial most violent traumatic event. Trauma goes through different stages, in which the immediate

Figure 2: Mental Health and Psychosocial Support, the Intervention Pyramid

Examples

- Mental healthcare by mental health specialists (psychiatric nurses, psychologists, psychiatrists, etc.)

Specialized services

- Basic mental healthcare by primary healthcare doctors
- Basic emotional and practical support by community workers

Focuses non-specialised supports

- Activating social networks
- Communal traditional supports
- Supportive age-friendly spaces

Strengthening community and family supports

- Advocacy for basic services that are safe, socially appropriate and protect dignity

Social considerations in basic services and security

Note: This Intervention Pyramid shows four main types of mental health/psychosocial support interventions to a population under distress. The pyramid resembles the total group requiring multi-layered support. The smallest group, at the top of the pyramid requires support by mental health specialists while the largest group gets the highest mental relief from living in security and safety and by having basic services guaranteed. All layers of the pyramid are important and should ideally be implemented at the same time.

Source: Minimum standards in child protection (2012), after Inter-Agency Standing Committee (IASC) (2007), Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Geneva

environment of the survivors plays an important role. The initial traumatic shock reaction often subsides rather quickly, but then begins the long phase of getting used to the new life, of facing difficulties and experiencing social rejection, of anger, pain and depression. In order to mobilize their strength and resilience, victims need to come to terms with loss and the adverse life changes they experience. By identifying and addressing feelings of helplessness and despair, survivors and victims can develop their resilience and make better use of their own capacities and resources. Furthermore, whether traumatic symptoms appear or reappear will depend in large part on how the social environment reacts to the issue, not only in the immediate aftermath but also many years later.

Barriers to psychosocial support

Psychosocial support in child-focused VA needs to address the needs of both children and their care givers. The capacities of parents, caregivers and other members of the family should be recognized and strengthened to provide emotional support for survivors and victims. Interviews with parents of child survivors indicate that parents also experience stress, anxiety and depression, which can reduce their capacity to provide care and support. Family members and caregivers of persons with disabilities must also be provided with psychosocial support and ways to provide adequate support to their child.

In some cases, the family can be an obstacle to inclusion because family members are ashamed, because they want to overprotect the child, or they do not have enough information or understanding to be inclusive. The stigma of having a family member with a disability is often a source of fear and pain for family members. This may lead parents to keep these children, especially daughters, out of sight. Girl survivors in some cultural contexts are seen as 'useless' by their parents because they assume the girl cannot contribute to the household and cannot get married. A child with disability may be seen as an additional 'burden' that increases the cost of living and leads to lost income-earning opportunities as a result of time spent for specific care. It is essential to create a supporting environment within the family first, and to do so through a contextual approach that builds on and respects positive cultural traditions and coping mechanisms.

Box 15: Life After the Bomb: A Psychosocial Study of Child Survivors of Unexploded Ordnance Accidents in Lao People's Democratic Republic

A total of 162 child survivors in 23 districts were interviewed using a questionnaire and an additional 24 children participated in open interviews. Boys made up 76 per cent of child survivors interviewed. A total of 158 parents of child survivors were interviewed, the overwhelming majority of whom were rural farmers.

Very few child survivors had received specialist medical care after the accident. About one in ten had accessed rehabilitation services at the National Rehabilitation Centre in Vientiane.

Despite frequent vision and hearing impairments, none reported undergoing medical examinations to ascertain whether or not treatment, surgery or special rehabilitation aids such as eye glasses or hearing aids could improve their remaining vision or hearing. Most child survivors and their families were not aware that specialist services exist.

The cost of medical treatment for child survivors ranged widely. Some families spent the equivalent of a few US dollars, while several paid more than US$1,000. A significant proportion of health care expenditure is accounted for by the cost of transportation to hospital. The mean average expenditure on transport to hospital was US$43, but in some cases transport to hospital cost families a few hundred dollars.

None of the child survivors had received psychological support. The small Mental Health Unit located in Mahasot Hospital in Vientiane provides the only psychological care and support service in the country. There are no mental health services at the provincial or district level, nor any community-based mental health care services.

Traditional healing practices were often sought. They are not limited to the treatment of physical injury and pain, but also address emotional suffering. This is significant given the total lack of mental health services outside the capital city. Traditional healing practices therefore have an essential role in the psychological rehabilitation of child survivors and their families. Healing practices also have a broader therapeutic function. By bringing together the injured child, parents, the extended family and other members of the community, they serve to reinforce social relationships, help to re-integrate the child into the community and provide an opportunity for family and community members to provide moral and material support. The overwhelming majority of parents (88 per cent) said that their child's recovery was assisted by a ceremony of some sort. The most common healing ceremonies involved calling and strengthening souls. Ceremonies involving offerings to spirits and at the temple were less common. Suk Khouane (soul strengthening) and Ern Khouane (soul calling) ceremonies are deemed necessary in light of the force of a UXO explosion, the resulting pain and the strong emotional impact which can severely weaken a person's soul and may even cause one or more souls to become detached from the body [One person has multiple souls according to local beliefs]. Recovery is considered to be impossible without a full complement of strong souls.

Source: Handicap International (Belgium), Lao Youth Union, UNICEF (2004), *Life After the Bomb*, … Vientiane, pp. 16-19

Peer support

Peer support refers to support from a person who has knowledge of a condition drawn from their own experiences. For victim assistance, peer support typically comes from a landmine or ERW survivor.[6] Meeting people who face the same problems as I do helps to realize that I am not alone and that there are solutions that might also work for me. Peer support reduces isolation and can lead to providing longer term mutual support, for example in self-help groups or in Disabled People's Organizations. 'If they can, so can I' is a powerful motivator. The turning point in recovery for many is seeing other survivors leading productive, fulfilling lives. Peer counsellors need to be trained both in trauma recovery and confidence building as well as in socio-economic

> **"After I returned from hospital we went back to the site of the accident to call back the souls that I lost … Not all the souls have come back yet."**
> — *Child landmine survivor from Lao PDR*

empowerment through referrals and advocacy.

Peer support extends also to mixed groups of persons with and without disabilities. Peer support of classmates for fellow students with disabilities has shown very successful results. Seeing the capacities of persons with disabilities changes the prevailing perceptions among persons without disabilities. (See Box 16 on Peer Support in El Salvador.)

Social exclusion

Social exclusion is the process of being shut out from the social, economic, political and cultural systems that contribute to the inclusion of a person into the community. Exclusion of persons with disabilities in conflict or post-conflict societies is also an expression of the fragmentation and destruction of the collective social structure, of the social fabric. Without addressing the past and without addressing the context in which most mine/ERW victims live – in poverty where social injustice is common – progress to improve individuals' and communities' mental health may be modest. Stigma against people with disabilities is widespread regardless of whether it is a congenital or acquired disability. Family members are also subject to limited understanding, prejudiced attitudes and discriminatory behaviour. Stigmatization may lead to self-stigma, internalizing negative attitudes, leading to self-blame, a low self-image and low self-esteem.

Empowerment

Empowerment is at the core of the psychosocial approach. It includes empowerment of the individual, including improved self-esteem, and empowerment of marginalized communities by overcoming social injustice and seeking inclusive development. To seek empowerment, we need to understand the factors that result in disempowerment.[7] One of these factors is pity. While feeling empathy is good, pity implies labelling the other as deficient. Also, with children, it is important to understand that they may be angry and frustrated with their situation, and that anger in this context is not only a difficulty but may actually be a positive yet temporary force that helps them survive and struggle for a better life. Many mine/ERW casualties in children are the result of their natural and healthy curiosity, which should not be destroyed in the aftermath of the experience of destruction.

Desirable outcomes

- Landmine and ERW victims including children have access to psychological and to psychosocial support.
- Mental health workers, community workers, teachers and other education professionals, peer-supporters and others who work with children, are adequately trained in psychosocial support including on specificities regarding both female and male children and adolescents.
- Families, caregivers and communities are trained and mobilized to provide support to children and their families or care takers.
- Child survivors and children with disabilities are valued as members of their families. They are encouraged and supported to contribute their

Minimum standards for child protection in humanitarian action:

Standard 7: Dangers and Injuries

Girls and boys are protected against harm, injury and disability caused by physical dangers in their environment, and the physical and psychosocial needs of injured children are responded to in a timely and efficient way

Child Protection Working Group, Minimum standards for child protection in humanitarian action, 2012, p. 79

skills and resources to the development of their communities.
- Sport and leisure activities provide an opportunity for boys and girls to better accept their changed bodies and to be included in school and the community.
- Awareness campaigns and social mobilization promote positive knowledge, attitudes and practices to help reduce stigma and discrimination towards people with disabilities and alleviate mental health problems. Bullying of children with disabilities in schools is reduced.
- People with disabilities and conflict victims make their own decisions and take responsibilities for changing their lives and improving their communities.

Suggested activities

In general, activities intended to provide direct and indirect psychosocial support should reconnect children with family members, friends and neighbours. They should foster social connections and interactions especially in situations where children are separated from their family or community of origin. Activities should normalize daily life; promote a sense of competence and restoration of control over one's life; and build on and encourage children's and community's innate resilience to crisis. Finally, they should provide for identifying, referring and treating children with severe mental conditions. Specific activities may include the following:

Promote psychosocial support

✓ Promote training in psychosocial support that addresses the specific needs of children. Include mine action actors in training opportunities in psychological first aid. (Psychological first aid or PFA, despite its name, covers both social and psychological support.)
✓ Be aware that all staff, not only 'professionals', dealing with mine/ERW victims need special psychosocial

Chan, 17 years old, lost three friends in an ERW incident that left him blind in one eye and caused his right arm to be amputated. To help defray the high expenses of his treatment, he dropped out of school and is working as a car washer. His two younger sisters also dropped out of school and work in Thailand in the garment industry.

training in order to manage their own difficulties and potential hate that can result from fear, helplessness, and difficulties in accepting that victims do not need to be grateful for the help they are getting.
- ✓ Create opportunities for 'non-focused specialized care' (such as PFA) for child survivors and victims of mines/ERW.
- ✓ Value and incorporate traditional medicine and local ceremonies offering support for acceptance of a traumatic event or change in life.
- ✓ Merge mine/ERW risk education messages and Child Protection psychosocial support messages in awareness-raising campaigns.
- ✓ A risk education session provided to a community recently traumatized by a victim-activated explosion can be considered both as a psychosocial intervention and a prevention strategy (e.g. to discuss the accident and to identify ways to prevent future accidents).

Promote mental health
- ✓ Train and build the capacity of psychosocial and mental health care providers to identify children who may require more specialized psychosocial or mental health care/attention.
- ✓ Promote clinical mental health providers to be able to provide psychiatric care to treat severe mental conditions, including to children, when required.
- ✓ Train clinical mental health providers in the psychosocial approach.

Overcome stigma and discrimination
- ✓ Support awareness campaigns and long-term values-based communication efforts to promote positive attitudes and social norms to overcome stigma and discrimination.
- ✓ Address common myths, prejudices and discrimination at family and at community levels (for example, through schools/parents committees, religious leaders, community-based organizations, village committees and in the workplace).
- ✓ Mobilize community support groups of children, adolescents, women and men.
- ✓ Develop the capacity of mine action staff, Child Protection staff, Community-based Rehabilitation (CBR)-workers and others on disability issues and services and how to undertake awareness campaigns/Communication for Development strategies.
- ✓ Promote activities that foster mutual support, such as peer support and self-help groups, for both children and their parents/family members.

Support the recovery process
- ✓ Facilitate access to appropriate medical care, to social support, to livelihood opportunities, to community life, and to psychological support as needed.

Support family members

- ✓ Promote assistance to the caregivers of survivors (mostly for mothers and/or eldest sisters), including education on proper health care and health promotion and the psychosocial impact of trauma.
- ✓ Provide life skills training for parents and other caregivers.

Contribute to the empowerment process

- ✓ Ensure that child survivors and victims of mines/ERW are able to access and participate in support activities for children in the community.
- ✓ Promote art, sport and leisure activities both as

activities for people with disabilities only (amputee football, wheelchair basketball, cycling, swimming, athletics, etc.) and as inclusive events. Sport and leisure activities can help survivors accept the new body image and improve self-esteem. Invite parents to design sports and cultural programmes that include children with disabilities, especially girls.

- ✓ Provide support to caregivers to better care for child survivors of mines/ERW, to deal with their own distress and to link them to basic services.
- ✓ Include support for child survivors and victims of mines/ERW in work to strengthen pre-existing community networks to provide psychosocial support to children and their families.

Box 16: Peer-to-peer Support in El Salvador

To address issues of social exclusion and extreme poverty of persons with disabilities and their families, including survivors of armed conflict, the *Fundación Red de Sobrevivientes y Personas con Discapacidad* (Foundation Network of Survivors and Persons with Disabilities) developed a peer-to-peer support programme.

Its three major components are:

1. **Access to Health:** promotion of mental health (self-esteem and self-management), rehabilitation (mobility devices), and prevention (nutrition, preventing infectious disease);
2. **Support for Decent Work:** business training and seed capital;
3. **Promotion of Social Empowerment:** training on disability and human rights, leadership, advocacy and legal frameworks; strengthening of community-based organizations and awareness-raising at national level.

The Red has a team of field workers with disabilities who visit other persons with disabilities to understand their needs and define a personal plan of action in accordance with the person's priorities, potential and environment.

The Red notes that although peer-to-peer support contributes to improving mental health, it should not be seen as a substitute for professional psychological support.

About 700 persons with disabilities have been trained annually by peers on health, human rights and business management. Another 100 persons with disabilities received support to start self-employment projects. In 2012, 160 persons received mobility devices. Evidence indicates that a larger number actually benefits from support provided to persons with disabilities, including their family members and friends.

This peer-to-peer model has been successful in improving psychological and socio-economic wellbeing. It promotes sustainability in three ways:

1. Persons with disabilities themselves are trained and improve their own knowledge and capacities, and share them with their peers;
2. Persons with disabilities can use peer-to-peer support with the main goal of promoting self-esteem and psychological well-being, and also as a methodology to provide support in a specific sector (e.g. employment or health);
3. Collective empowerment is strengthened via local associations of persons with disabilities for advocacy and awareness campaigns.

Donors to this programme are the Government of Norway, InterAmerican Foundations and Provictimis Foundation.
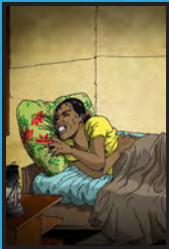
Source: Handicap International (2013), VA Factsheet 'Psychological & Psycho-social Support'

Poster and leaflet used during joint UXO Risk Education-psychosocial support activities in Mpila, Brazzaville.

On 4 March 2012, ammunition stores exploded in the neighbourhood of Mpila, in Brazzaville, the capital of the Republic of the Congo. The blast killed at least 300 persons and injured another 2,500. It destroyed homes and buildings, including public infrastructures. It forced 200,000 citizens to live in camps or with friends or families. After this tragedy, many people, mostly children and adults living around the epicentre of the explosion, were traumatized. Some lost relatives, many lost their homes and belongings and some of them believed they would die.

In response, the UNICEF Country Office developed several activities. In the camps, Child Friendly Spaces were established and recreational activities organized. Teams of psychologists were deployed to alert the public and take care of traumatized people. Unexploded Ordnance (UXO) risk education activities were developed and implemented inside and outside the camps. (Indeed, a large perimeter around the epicentre of the blast had been contaminated by potentially dangerous devices.) Scouts undertook door-to-door awareness, supported by the association Tchikaya U'Tamsi which staged plays about the risk education. Communication supports, such as flyers, were disseminated all over the city. The Scouts and members of Tchikaya U'Tamsi learned how to recognize the signs of a traumatized person: being afraid to be hurt or to die (for oneself or family), inability to attend or participate in favourite activities, feelings of guilt, feeling to be a burden for the family, feeling of being isolated and detached from social activities. If a person exhibited some of these symptoms, teams in the field or relatives were asked to refer him or her to psychologists in spaces established to provide psychosocial support and trauma counselling.

This approach proved to be successful. As of early 2014, UNICEF and its partners are pursuing risk education activities in Pointe-Noire and Brazzaville, reaching out to teachers, youth representatives, military and police. The psychological approach has been integrated with the risk education component, which includes a specific component on the psychological impacts after an exposure to an explosion caused by ammunitions.

Source: UNICEF Brazzaville, Congo, January 2014

Technical Resources

Documents are listed in *inverse chronological order*, starting with the most recent ones.

Psychological and psychosocial support

Rutherford, Ken and Cameron Macauley (CISR) (2013), 'The Power of Peers: Rethinking Victim Assistance', *The Journal of ERW and Mine* Action, V.17.3, Fall 2013 [Focus Survivor Assistance]. Harrisonburg, VA, pp. 6-9, <http://www.jmu.edu/cisr/journal/17.3/173.pdf>

Child Protection Working Group (2012), 'Standard 10 Psychosocial distress and mental disorders', in *Minimum standards for child protection in humanitarian action,* pp. 97-102, <http://cpwg.net/minimum-standards/>

WHO/War Trauma Foundation/World Vision International (2011), *Psychological first aid: Guide for field workers,* Geneva, <http://www.who.int/mental_health/publications/guide_field_workers/en/>

WHO/UNESCO/ILO/IDDC (2010), 'CBR and mental health', in 'Supplementary booklet', *Community-Based Rehabilitation: CBR Guidelines,* Geneva, pp. 3-20 [see also 'Empowerment component' and 'Social component'] <http://www.who.int/disabilities/cbr/guidelines/en/>

International Federation of Red Cross and Red Crescent Societies (2009), *Psychosocial interventions: A handbook,* IFRC Reference Centre for Psychosocial Support, Copenhagen [Note: the 'Psychosocial Centre' states that it collaborates with UNICEF, WHO etc., <http://psp.drk.dk/sw2955.asp>, <http://www.medbox.org/preview/5255d859-89d8-4908-b860-15880e695ecc/doc.pdf>

Inter-Agency Standing Committee (IASC) (2007), *Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* Geneva, <http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/>

Becker, David and Weyermann, Barbara (2006), *Gender, Conflict Transformation & the Psychosocial Approach, Toolkit,* SDC Bern, <http://www.deza.admin.ch/ressources/resource_en_91135.pdf>

UNICEF East Asia and Pacific Regional Office/Regional Emergency Psychosocial Support Network (2004), *Handbook on Psychosocial Assessment of Children and Communities in Emergencies,* Bangkok, Quezon City, <http://www.unicef.org/eapro/Handbook.pdf>

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Walsh, Nicolas E. and Walsh, Wendy S. (2003), 'Rehabilitation of landmine victims – the ultimate challenge', *Bulletin of the World Health Organization* 2003, 81 (9), pp. 665-670, <http://www.who.int/bulletin/volumes/81/9/Walsh.pdf>

Endnotes

1   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

2   "A system providing proper fit and alignment based on sound biomechanical principles [that] suits the needs of the individual and can be sustained by the country at the most economical and affordable price." Day, H.J.B., J. Hughes & N. Jacobs (eds.), *Report of ISPO Consensus Conference on Appropriate Orthopaedic Technology for Developing Countries*, ISPO, Phnom Penh, Cambodia, 5-10 June 1995, ISPO/USAID/WHO, Brussels 1996.

3   Becker, David and Weyermann, Barbara (2006), *Gender, Conflict Transformation & the Psychosocial Approach, Toolkit,* SDC Bern; here: Work Sheet 2, *The psychosocial approach: conceptual framework*. <http://www.deza.admin.ch/ressources/resource_en_91135.pdf>

4   As recounted to the author by a survivor in Luena, Angola.

5   For example: "[T]he States Parties have increased their understanding of the importance and cross-cutting nature of psychological support, including peer support, and the need to raise the profile of this component to assist mine survivors and the families of those killed or injured **to overcome the psychological trauma** of a landmine explosion and promote their social well-being." (Highlighted by the author). APMBC (2010), 'Part II: Review of the operation and status of the Convention on the prohibition of the use, stockpiling, production and transfer of anti-personnel mines and on their destruction: 2005-2009', Cartagena, in Final Report of the Second Review Conference, APLC/CONF/2009/9, 17 June 2010, p. 49, para 119.

Rahmatuallah, 14 years old, writes on a white board during a training workshop for electricians at a UNICEF-assisted reintegration and rehabilitation centre for war-affected children in the southern city of Kandahar, Afghanistan.

Chapter 5
Child-focused Victim Assistance

Section 5.5
Social and economic inclusion

5.5 Social and economic inclusion

Introduction

THE 1997 Anti-Personnel Mine Ban Convention refers to *socio-economic reintegration,* but with the evolution of the Convention on the Rights of Persons with Disabilities (CRPD), *inclusion* became the preferred term.[3] Integration usually means the adaption of a person to fit into the dominant norms of a society. Inclusion means that the society and environment must adapt to include all persons, without discrimination. Inclusion in the victim assistance (VA) context covers social inclusion including inclusive education and economic inclusion.

An inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. To be fully included in society children, both boys and girls, need to be able to access education. Accessible and inclusive education is one key element of this victim assistance component and of child-focused VA as a whole. It is estimated that over 90 per cent of children with disabilities in low-income countries do not attend school. Of the 75 million children of primary school age who are out of school, one third are children with disabilities.[4] To achieve an inclusive society a two-pronged approach is needed: (i) Focus on the society to remove the barriers that exclude (mainstreaming); (ii) Focus on the groups of those excluded to improve their capacity for full inclusion and support their lobbying efforts for inclusion.[5]

Handicap International (HI) defines *economic inclusion* as an adequate standard of living through waged and self-employment as well as through social protection.[6] It means that all persons, without discrimination, can benefit from, participate in, and contribute to, the economic development of their family and community. *Economic exclusion*, on the other hand, has been defined as lack of access to and participation in the economy. In addition to salaried and self-employment, social protection also contributes to economic inclusion.

Children with disabilities can live a full life and be fully included in education and social opportunities if they have access to assistive aids, inclusive education systems with trained teachers and a supportive family and community. For adolescents with disabilities, opportunities to continue their formal education should be a priority. They should also have access to vocational training and support to ensure the right to decent work, decent income and social protection. Care must be given to ensuring that girls have the same opportunities as boys.

"I was fifteen when I walked on the plank that had an anti-personnel mine buried under it. I am 33 now, yet I cannot forget the trauma I went through. I was angry all the time after the accident. Although they never said much to my face, I knew they used to talk of my condition behind my back. They thought I was no good anymore for I couldn't help them bring income in the household."
—*Sri Kea*

Handicap International US, <http://www.handicap-international.us/cambodia_victim_assistance>. Article on the launch of the study: HI (2011), *Victim assistance in Cambodia: The Human Face of Survivors and Their Needs for Assistance.*

Fundamentals of Inclusion

The Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD) challenge charitable approaches that regard children with disabilities as passive recipients of care and protection. Instead, the Conventions demand recognition of each child as a full member of her or his family, community and society. This entails a focus not on traditional notions of 'rescuing' the child, but on investment in removing the physical, cultural, economic, communication, mobility and attitudinal barriers that impede the realization of the child's rights – including the child's right to active involvement in the making of decisions that affect children's daily lives.

UNICEF, The State of the World's Children 2013, p. 11

Social inclusion is closely linked to psychosocial care and empowerment. People who are or feel included in society are encouraged to participate in common events, e.g. religious or political gatherings, school events, weddings and other festivities, sports and leisure activities and meetings of self-help groups or Disabled People's Organizations (DPOs). To overcome exclusion, the family and community play important roles. Peer support by other persons with disabilities or, for

Box 18: Increased Independence in Afghanistan

Afghan Amputee Bicyclists for Rehabilitation and Recreation (AABRAR) is a local non-government organization working for the rehabilitation and socio-economic integration of people with disabilities and other vulnerable groups into the community.

At its inception in 1992, AABRAR began a bicycle-training programme for amputees to improve mobility and increase their independence, enabling them to travel to and from work, and save on transportations costs. Since then, AABRAR has expanded its activities.

Sixteen year old Muhammad Fahim from Pacher-O-Agam District, Nangarhar Province, was four years old when both of his legs were affected by polio. He says, "It was the worst incident of my life and I cannot ever forget that. But still I am grateful to *Almighty Allah* that he gave me opportunities for living a better life." He received a wheelchair from AABRAR that enables him to move around and saves money on transportation.

Muhammad also participates in AABRAR's wheelchair basketball training programme, in which 23 athletes receive sports basketball wheelchairs and daily training by a professional coach. The team participated in a tournament in Kandahar province and played against professional basketball wheelchair teams of Herat and Kabul. Muhammad adds, "Beside this, we several times received physiotherapy sessions of AABRAR here in Jalalabad."

Source: AABRAR Jalalabad, Afghanistan, November 2013

example, by a father or mother of a child who died, can play an important role (On peer support see Box 16 in Section 5.4, "Psychological and psychosocial support").

In crises, during war, in an IDP or refugee camp, spaces for children of both sexes should be created that allow for "normal" daily routine activities such as learning, playing or sports for everyone. UNICEF with its partners is experienced in providing education in emergencies and post-conflict settings, including temporary learning spaces, child-friendly spaces for playing and learning, accelerated learning for ex-child soldiers and for other children who have missed out on learning. Specific efforts need to ensure that all children with disabilities are included, integrating mine/ERW survivors as well.

Goal

Assistance for Landmine/ERW victims and survivors includes children's access to education and lifelong learning; ensuring that they have meaningful social roles in their families and communities; they have access to social protection measures; that adolescents of working-age and adults gain a livelihood allowing them to lead dignified lives and to contribute to their families and communities.

Education

4. … States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

Extract from Article 24, Convention on the Rights of Persons with Disabilities

The role of social and economic inclusion in child-focused victim assistance

The role of social and economic inclusion in child-focused victim assistance is to:

- Facilitate access for child landmine/ERW survivors and the children of mine/ERW victims to inclusive education and lifelong learning,
- Ensure their full participation in the social life of their families and communities,
- Include child survivors/victims and children with disabilities, their caregivers and family members in case management programming and other social protection mechanisms (see also Box 19),
- Ensure that survivors acquire skills and livelihood opportunities as equal members of society.

Key concepts

Inclusive education

Inclusive education is the process of addressing and responding to the diversity of needs of all learners. Inclusive education involves the provision of education at all levels including early childhood, primary and secondary education as well as adults' education in inclusive settings. Article 24 of the CRPD mandates the provision of education to children with disabilities on an equal basis with other children, within an inclusive education system. Article 23 of the Convention on the Rights of the Child (CRC) articulates the right of children with disabilities to assistance to ensure their access to education in a manner that promotes their social inclusion.

Inclusive education entails providing meaningful learning opportunities for all students within the mainstream school system. It allows children with and without disabilities to attend the same classes at the local school, with additional, individually tailored support as needed. It requires physical accommodation, for example, ramps instead of stairs and doorways wide enough for wheelchair users. A child-centred curriculum will include representations of the full spectrum of people found in society (not just persons with disabilities) and reflect the rights of all children. In an inclusive school, students are taught in small classes in which they collaborate and support one another rather than compete. Children with disabilities are not segregated in the classroom, at lunchtime or on the playground.

Poverty, marginalization and discrimination are the main barriers to inclusive education. Children with disabilities are often placed in specialized institutions – either because they are not deemed fit or because they are supposed to be "made fit" for general schools. The concept of inclusive education tries to alter the dominant approach of "changing the student to fit the system" to one of "changing the system to fit the student". Instead of focusing on impairments (medical model), the aim is to

remove barriers in society to ensure children and other people with disabilities are given the same opportunities as others (social model of disability). The main premise of the social model of disability is that disability results not from the impairment itself but from an interaction of the impairment with barriers in the society whether physical, communicational, informational or attitudinal.

Integration is not the same as inclusion. *Integrated* education focuses on improving the functional capacities of the child to bring him/her into existing general schooling, or the placement of a child with disability within the mainstream setting without necessary accommodations having been made in the general education setting to make it inclusive. *Inclusive* education, on the other hand, focuses as much on providing necessary impairment-specific support as on improving the school and the community, so they are accessible to the child.

Social protection

Social protection is a set of public actions which address not only low income, poverty and economic shocks, but also social vulnerability, thus taking into account the inter-relationship between exclusion and poverty. Through income or in-kind support and programmes designed to increase access to services (such as health, education and nutrition), social protection helps realize the human rights of children and families.

Special education or special needs education is also used in the context of education for children with disabilities, at times inferring that 'children with special needs' have learning difficulties. Children without a disability also encounter learning difficulties. With good child-centred teaching techniques, essential resources and an inclusive environment, all children can learn. While disability-specific courses and schools have a role to play, they need to be linked with regular schools and their expertise applied with an aim towards supporting inclusion. Centres, schools and associations that teach Braille language or sign language, for instance, are important in providing the necessary impairment-specific training and support needed for inclusion within the general education system.

Child protection includes measures to prevent and respond to violence, abuse, exploitation and neglect of children. The field addresses social norms, policies, standards, guidelines and procedures to prevent and protect children from intentional and unintentional harm. Some girls and boys are particularly vulnerable, including those affected by conflict, children with disabilities, children separated from their families or who are orphaned, children who live in institutions, and children who are displaced within their country's borders or who are refugees outside their countries.

Children of a mine/ERW survivor or victim are at risk of being taken out of school in order to support the family. They are more likely to be forced into child labour, and they may be at increased risk of forced migration and trafficking. In families where the breadwinning parent died or was injured in a mine/ERW accident, children may suddenly have to fill the role of breadwinner. A mine/ERW explosion can lead to the break-up of families as children are sent to live with relatives or are placed in institutional care. VA-related activities should therefore consider the needs of the victim's spouse and children to ensure long-term support for the family's socio-economic development.

UNICEF's child protection strategy provides a framework that guides interventions on behalf of child victims of landmines/ERW and all children with disabilities. Pillars of the strategy relevant to VA include:

- Building a national child protection system, ensuring that laws, policies and other normative frameworks are protective of children. It means providing protection services for children when they do become victims of violations. It helps strengthen and build the capacity of child protection institutions to respond (including the social welfare sector, justice for children, and alternative care for children without parental care).
- Supporting positive behaviour and social change, by addressing harmful social and cultural norms and practices, combating stigma, and mobilizing and building the capacity and resilience of families, communities, and children to prevent, mitigate and address violence, abuse and exploitation. Using

"Girls and boys are protected from abuse, violence, exploitation and neglect through community-based mechanisms and processes."

Inter-Agency Minimum Standards for Child Protection in Humanitarian Action, Standard 16: Community-based mechanisms

Communication for Development strategies supports this change process.

- Strengthening child protection in armed conflict and natural disaster including through the application of the above two approaches across the emergency continuum of preparedness, response and recovery.

Livelihood and economic inclusion

A *livelihood* comprises the capabilities, material and social resource assets and activities required to make a living. A livelihood is sustainable when it can cope with and recover from stress and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base. The Sustainable Livelihoods Framework, developed by the UK's Department for International Development (DFID) provides a way to understand: (i) the assets people draw upon, (ii) the strategies they develop to make a living, (iii) the context within which a livelihood is developed and (iv) factors that make a livelihood more or less vulnerable to shocks and stresses.

The livelihood component in the *Community-Based Rehabilitation (CBR) Guide* addresses five key elements: Skills development, financial services, self-employment, waged employment and social protection. Support to access employment and livelihood services, such as financial services, should target family members rather than children. Nevertheless, adolescents can participate in age-appropriate vocational training, money management training and other skills development programmes. In addition to wage or self-employment, the family of a child survivor should be supported to access social protection schemes that may provide additional income to ensure children remain in school. The financial burden in the aftermath of an accident can lead some families to resort to harmful practices as coping mechanisms. For example, they may arrange early marriage for daughters with the intention of providing for them or of enhancing the family's economic situation. Or they may take children out of school and make them work, putting them at additional risks associated to child labour, trafficking and abuse.

Desirable outcomes

- Child survivors have access to local schools which are equipped (disability-friendly infrastructure and teachers trained on inclusive education) to include children with disabilities so that they can learn and play along with their peers. Child survivors and victims have access to skills development and lifelong learning opportunities.
- The rate of children of landmine/ERW victims dropping out of school is significantly lowered.
- Parents of children with disabilities advocate for access to education, skill development and lifelong learning opportunities.
- Water, sanitation and hygiene facilities at home, in schools and elsewhere are inclusive and can be used with dignity.
- Child survivors are valued within their families and are encouraged and supported to contribute their skills to the development of their communities.
- People with disabilities have access to all services they need to improve their economic situation, including skills development, finance, social protection, and waged or self-employment.
- Women and girls with disabilities have equal opportunities for education, work and employment as do men and boys.
- Family members of mine/ERW victims are included in efforts to promote the quality of life of families affected by mines and ERW.
- Community leaders are convinced that social and economic inclusion of survivors strengthens the cohesion of the whole group.

Suggested activities

Inclusive education[7]

- ✓ Support families to facilitate access to education for survivors and/or the children of those killed or injured in a landmine/ERW explosion in general inclusive education settings.
- ✓ Prevent children from dropping out of school after a mine/ERW accident; e.g. by providing psycho-social support to the child and the family/care giver and providing income-generating support.
- ✓ Promote inclusive education at all levels, i.e. early childhood, primary, secondary and higher education, non-formal education and lifelong learning. This involves bringing domestic laws and education policies into harmony with Article 24 of the CRPD.
- ✓ Creation of an inclusive education setting entails removal of barriers (physical, informational, communicational and attitudinal). In schools, this

Participation in cultural life, recreation, leisure and sport

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:

(a) Enjoy access to cultural materials in accessible formats;
(b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;
(c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.

2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society. …

5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:

(a) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
(b) To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities …; …
(d) To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system; …

Article 30, Convention on the Rights of Persons with Disabilities

means ensuring access to the school and access within the school premises including accessible classroom and WASH facilities (Water, Sanitation and Hygiene). It also means providing training in braille and or sign language for students with sensory disabilities as well as provision of necessary assistive devices and technology.
- ✓ Discrimination on grounds of disability often arises

Box 19: Case Management System for Victims/Survivors of Landmines/ERW in Sri Lanka

UNICEF with its partner agencies in Sri Lanka is practicing a case management system in response to the needs of persons with disabilities with a focus on mine/ERW victims and survivors. The main objectives of this system are to

- Ensure each child's individual needs are identified and that assistance is adapted and responsive to the specific needs of each child;
- Ensure multi-sector participation and consultation in decision making process;
- Avoid duplication in terms of services to mine/ERW victims;
- Provide continuous follow-up through Social Service Officers and Mine Risk Education (MRE) agencies.

In 2012, 119 total cases were discussed and 86 supported. Of the 86 cases, 45 were mines/ERW related and 41 cases were other persons with disabilities. Twenty-five cases were children (19 boys, all mines/ERW-related and 6 girls, including 1 related to mines/ERW).

The case management system works in the following manner:

- MRE agencies identify mine/ERW/war victims in need of assistance during their visits to villages;
- MRE facilitator fills the victim assessment form;
- The completed victim assessment form is submitted along with the case history of the individual for discussion during case management sessions;
- The Case Management team discusses the status of the victim and identifies assistance required to respond to the specific needs of the victims or survivor in a holistic manner by different stakeholders;
- The Case Management process is documented, including recommended response to victims, and goes to the Divisional Secretary or the Government for endorsement.

Based on the number of cases and urgency in responding to the need of the victims, case management meetings are organized on an as-needed basis. MRE agencies submit their request along with supporting documents to the Social Service officer in Divisional Secretariat to call for case management action.

Members of Case Management System

- Social Services Officer
- MRE agencies
- Grama Sevaka [Lowest administrative unit of Local Government]
- Victim assistance agencies – agencies providing support related to physical rehabilitation, psychosocial support, social and economic inclusion
- Members of Rural Development Society (RDS), Women Rural Development Societies (WRDS) or Village Mine Action committees
- School teachers or principals if the case is related to a child
- Any other relevant officers based on the nature of the case

MRE agencies/Social Service Officers continuously follow up the supported/referred cases and document the progress.

Source: UNICEF Country Office, Sri Lanka, November 2013

from ignorance about disability. Thus, it is important to raise awareness and ensure training on disability rights as well as inclusive education techniques and methodologies for all educational staff, teachers and parents. Teacher training in inclusive education, both pre-service and ongoing in-service, is most effective when it is hands on and teachers are provided with

follow up guidance and mentoring support and are monitored.

✓ Some child survivors spend months in hospital and rehabilitation and lose out on schooling. Many have problems with concentration and thus fall behind. Where necessary additional support and bridge programmes as well as itinerant support may need to

be provided to ensure continuation of education.

- ✓ Support parents' groups of children with disabilities. Parents need support from local schools, teachers and possibly from parents' associations to assist their children who may be survivors or children of those killed or injured in a landmine/ERW explosion.
- ✓ Support inclusive after-school child and youth clubs to break down attitudinal barriers and create necessary social networks and support systems.
- ✓ Support the development of multi-sectoral approaches where health, WASH, education, rehabilitation, transport and social protection services can be provided in a synergistic manner.
- ✓ Incorporate the "lifelong learning approach" stipulated in the CRPD and the CBR Guidelines into VA-related policies and services. Lifelong learning refers to all types of learning that promotes personal development and participation in society including the skills and knowledge needed for employment as well as for early childhood education.

Social inclusion

- ✓ Ensure that family ties are maintained if/when children are evacuated/hospitalized, and strive to reunite as quickly as possible child survivors of mines/ERW who have been separated from their families; facilitate support particularly for young children (0-8 years) and their care-givers. Family Tracing and Reunification efforts should take into consideration needs of children who may have recently acquired impairments and of children who have family members with disabilities.
- ✓ Include mines/ERW in the identification of risk scenarios for boys and girls in emergency situations, as well as in the development and implementation of community preparedness and response plans.
- ✓ Consider that child survivors of mines/ERW may be at particular risk of separation from their families (including institutionalization) because children with disabilities or those whose family has lost a bread winner may be considered a "burden"; and support families to maintain family unity.
- ✓ Assess and ensure that the specific needs of child survivors of mines/ERW who may be associated with armed forces, including those with disabilities, are taken into consideration in the release and reintegration of children associated with armed forces or armed groups.
- ✓ Ensure that 'Child-friendly spaces' (CFS) are accessible to children with disabilities; ensure that child victims participate equally in CFS activities; fully involve boys, girls, women and men in the community who are affected by mines/ERW in developing and supporting CFS activities; include mine/ERW survivors and victims

in the recruitment of animators from the community; include the integration of specific considerations for mine/ERW victims and survivors in the training, coaching and follow-up support for animators; integrate mine/ERW risk education into CFS activities.

- ✓ Assess and ensure that the specific needs of child survivors of mines/ERW who are unaccompanied/separated from their care givers are taken into consideration in the identification, registration, interim/alternative care, development of care plans, tracing, assessment, reunification and follow-up.
- ✓ Promote 'case management' for child survivors and victims of mines/ERW as a core component of integrated and holistic supports and services. Case management is the process of helping individual children and families through direct social work-type support and managing information well (see also #15 of the Minimum Standards for Child Protection in Humanitarian Action).
- ✓ Build capacity of government, community-based organizations (including community-based child protection networks) and NGOs on collecting information and case management for child survivors and victims of mines/ERW; include child survivors of mines/ERW in the defining and sharing of criteria on who is a vulnerable child, building on definitions that already exist (including community-based definitions); in conjunction with MA and other relevant actors, develop standard operating procedures on addressing child survivors and victims of mines/ERW by defining criteria and processes for registration, referral and follow-up linked to best interest; work closely with community-based child protection mechanisms and networks to identify girls, boys and families who are mine/ERW victims and who have or are vulnerable to child protection risks for referral to the case management system, to encourage community support, and to provide ongoing monitoring.
- ✓ Support community-based child protection mechanisms and promote safety nets
  - * Include services, mechanisms and support for mine/ERW survivors in the mapping and capacity building of local formal and informal supports, service providers and support mechanisms for child protection.
  - * Include mine/ERW survivors in the selection, recruitment and training of volunteers from the community for community-based child protection networks to protect children from, and support child survivors of, abuse, violence, exploitation and neglect.
  - * Mobilize and strengthen peer-to-peer supports for child victims/survivors of mines/ERW.
- ✓ Facilitate access for child survivors and victims of

mines/ERW to participate in social life of families and communities.

✓ Incorporate the approaches stipulated in the Social Component of CBR, addressing five elements (Personal assistance; relationships, marriage and family; culture and arts; recreation, leisure and sports; and justice) into VA-related policies and services.

Economic inclusion

✓ Facilitate access to age-appropriate livelihood, vocational training, income-generation etc. opportunities. These opportunities have to be viable in terms of income-generation in the specific context where the victims live. A particular focus should be given to children/adolescents who drop out of school and to those who finish school without the necessary skills to earn an income.

✓ Inform survivors, victims and their families about existing social protection measures (such as cash transfer schemes, school stipends, social pensions, food vouchers, food transfers, user fee exemptions for health care, WASH, education or subsidized services), and support families to access them.

✓ Support the families of child survivors to start/continue/improve their livelihood activities, to help children maintain and improve their quality of life.

✓ When a person with disability is not directly in charge of a livelihood activity, ensure that he/she actively contributes and participates as much as possible (to avoid him/her being excluded by the family).

✓ Ensure that persons with disabilities have access to existing programmes that promote youth employment.

Box 20: Improving Quality of Life in Cambodia

A holistic and integrated approach towards improving the quality of life of mine/ERW survivors/victims and other persons with disabilities in Cambodia has shown impressive results,

The project "Towards Sustainable Income Generating Activities" is implemented by Handicap International and the local NGO *Opération Enfants du Cambodge* in one of the most mine/ERW affected provinces of Cambodia, Battambang. Since 2008, the project has adopted a comprehensive approach that aims to improve key factors influencing the quality of life of mine/ERW victims as identified by them, rather than focusing on facilitating access to a single service. The project worked on two aspects:

1. Improving access to business-related services (microfinance, in-kind seed capital, vocational training, money management), and
2. Improving access to medical social services (rehabilitation, vaccination and nutrition campaigns, (which have an important impact on children), meetings on prevention of domestic violence and others.

Project team members worked to empower mine/ERW survivors and other persons with disabilities and victims' family members. They also trained mainstream service providers to include persons with disabilities in their work. The evaluation of the first phase of the project (2008-2010) demonstrated that all 560 participants experienced improvements in their quality of life, especially in the household budget and in community participation.

The second phase of the project, currently ongoing, has been expanded to another province. It now includes persons from 16 years of age in vocational and money management training, so that when they are 18 years old they have the necessary skills to start a business.

This approach recognizes that a single organization cannot cover all sectors (livelihoods, health, etc.) but rather that orientation and referral networks should be in place and strengthened to ensure persons can access all the different services they need to improve their lives and those of their families.

Source: Handicap International (2010), Good practices from the project Towards Sustainable Income Generating Activities in Cambodia, Phnom Penh/Lyon, <http://www.hiproweb.org/uploads/tx_hidrtdocs/Good_practices__TIGA.pdf>

Box 21: Persons with Disabilities and HIV-AIDS

Persons with disabilities have a heightened risk to HIV infection compared to persons without disabilities due to limited access to HIV education, information and prevention services; at-risk behaviours leading to HIV infection; and limited access to HIV treatment, care and support. They also are more vulnerable to sexual violence; have limited knowledge and capacity of services providers to render inclusive services; and face stigma and discrimination.

This challenges the common misconception that persons with disabilities are sexually inactive and do not require HIV or sexual reproductive health services. Marginalized or stigmatized communities with limited access to basic human rights are frequently at higher risk of HIV infection and feel the impact of HIV and AIDS more significantly. Yet women and men and adolescents with different impairments (physical, sensory and particularly intellectual and mental) have often been ignored in HIV prevention, treatment, care, support and impact mitigation services, along with sexual and reproductive health promotion and gender-based violence protection services.

Handicap International's projects on HIV and AIDS are centred on four key areas of intervention:

- HIV prevention
- Treatment, care and support including different types of rehabilitation services
- Integration with sexual and reproductive health (SRH)
- Integration with gender-based violence (GBV)

Examples from the field:
- 'See It, Sign It, Know It, Share It' project in South Africa, engages young Deaf South Africans in HIV prevention. <http://www.gala.co.za/deaf_programme/hiv_aids_awareness/see_it_know_it_sign_it_share_it.htm>
- See also a detailed video from Handicap International on integrated programming in Cambodia, with a focus on raising awareness about gender-based violence and HIV/AIDS prevention among deaf women. <https://www.youtube.com/watch?gl=FR&v=M_Ar4LSXhgQ>

Source: Handicap International (2012), Inclusive and integrated HIV and AIDS programming, Policy Paper, Muriel Mac-Seing, Lyon

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Endnotes

1   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

2   "A system providing proper fit and alignment based on sound biomechanical principles [that] suits the needs of the individual and can be sustained by the country at the most economical and affordable price." Day, H.J.B., J. Hughes & N. Jacobs (eds.), *Report of ISPO Consensus Conference on Appropriate Orthopaedic Technology for Developing Countries*, ISPO, Phnom Penh, Cambodia, 5-10 June 1995, ISPO/USAID/WHO, Brussels 1996.

3   CRPD Articles 3, 19, 24, 26-27.

4   <http://www.unesco.org/en/education-ar/themes/improving-education-quality/inclusive-education/vulnerable-and-marginalized-groups/children-with-disabilities/>.

5   Stubbs, Sue (no date), Inclusive Development, IDDC Paper [International Disability and Development Consortium], <www.un.org/esa/socdev/enable/rights/ahc5docs/ahc5iddc.doc>.

6   Handicap International, Victim Assistance Factsheets, <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>; here Factsheet 6 'Economic Inclusion'.

7   Education in VA is usually seen as a part of social inclusion but it is of such critical importance for child-focused VA that it is presented separately. This "Social and economic inclusion" chapter covers three of the six CBR components: Education, Livelihood, and Social, while the CBR component "Empowerment" also addresses key concerns relevant for an inclusive development approach.

Boys learn about the dangers of mines and other Explosive Remnants of War during a mine risk education session in Basra, Iraq.

Chapter 5
Child-focused Victim Assistance

Section 5.6
Laws and policies

Introduction

LAWS and policies provide the institutional framework for victim assistance (VA) and all of its elements. Without laws and policies there is no possibility to hold governments legally accountable to their obligation to protect their citizens from discrimination. Nor is there any basis for national ownership or for action plans.

Many States do not have consistent disability laws, policies, strategies or action plans. Not all countries with a significant number of victims from landmines and explosive remnants of war (ERW) have VA Action Plans or disability action plans inclusive of landmine/ERW survivors. Where they exist, they sometimes do not provide for landmine/ERW survivors and for the family members of those who were killed or injured. At times, only members from the armed forces and ex-combatants are included, not civilian conflict victims. For example, veterans with disabilities may benefit from pension funds while civilian survivors do not. Table 2 shows results from a survey of UNICEF Country Offices.

Table 2: Countries with Policies for Children with Disabilities, Inclusive of Child Survivors

APMBC VA Status	Country/Area	GOVERNMENT POLICY STATUS		SECTOR COORDINATION STATUS			NATIONAL PLAN STATUS	
		Address Children with Disabilties	Inclusive of Child Survivors	Mine Action	Child Protection	Persons with Disabilities	Mine Action	Victim Assistance
VA-30	Afghanistan	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Cambodia	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Colombia	Yes	Yes	Yes	No	No	Yes	Yes
	Congo, DR	Yes	Yes	Yes	Yes	No	Yes	Yes
	Eritrea	Yes	Yes	Yes	Yes	Yes	Yes	No
	Jordan	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Nicaragua	Yes	Yes	Yes	No	No	No	No
	Senegal	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	South Sudan	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Tajikistan	Yes	Yes	Yes	No	Yes	Yes	Yes
	Turkey	Yes	Yes	No	Yes	Yes	No	No
	Yemen	Yes	Yes	Yes	Yes	No	Yes	Yes
VA Other	Mali	Yes	Yes	Yes	Yes	Yes	No	No
	Zambia	Yes	Yes	Yes	Yes	Yes	Yes	Yes
NS-9	Azerbaijan	Yes	Yes	No	Yes	Yes	No	No
	Iran	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Lebanon	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Myanmar	Yes	Yes	Yes	Yes	Yes	Yes	No
	Nepal	Yes	Yes	Yes	No	Yes	Yes	No
NS Other	Libya	Yes	Yes	Yes	Yes	No	No	No
Other	Kosovo	Yes	Yes	Yes	No	No	Yes	Yes
	Palestine	Yes	Yes	Yes	Yes	No	Yes	No

This table summarizes findings from 40 UNICEF Country Offices, which in August 2013 completed a VA Survey sent to 53 Country Offices as part of the exercise to develop this guidance on child-focused victim assistance. Of the 40 responses, 24 (60%) were countries that are States Parties to the Anti-Personnel Mine Ban Convention (APMBC); 14 (35%) were Non-Signatory (NS) states and the remaining 2 were from not fully recognized countries (State of Palestine and Kosovo). Of the 24 APMBC States Parties, 21 belong to the VA-30, comprising States that have officially reported significant numbers of mine/ERW-casualties. Of the 14 Non-Signatories, 8 belong to the NS-9, a category created by the Landmine Monitor to describe countries not yet part of the APMBC but with a high number of casualties. This survey was a perception survey and may not fully coincide with the analysis of the respective government, other stakeholders or the Landmine & Cluster Munition Monitor reports.

Where laws and policies exist, bureaucratic procedures and lack of administrative implementation and coordination often result in landmine/ERW survivors not having their rights upheld, or worse, having their rights violated, as in some discriminatory legislation.

Advocacy is a set of planned actions aimed at influencing a target group to make a positive change. Advocacy, including lobbying parliamentarians and government stakeholders, has in the past led to improved legislative frameworks. Concerted efforts by the International Committee of the Red Cross and its national movements, the International Campaign to Ban Landmines, the Cluster Munition Coalition, other non-governmental organizations (NGOs), the UN system and many Governments, succeeded in shaping the Anti-Personnel Mine Ban Convention (APMBC) and the Cluster Munition Convention (CCM). At national level, civil society, particularly Disabled People's Organizations (DPOs) including survivor organizations and NGOs, have played an important role in advocating for their governments to ratify and comply with these international conventions. At an individual level, persons with disabilities have claimed their rights, often successfully, in court or by filing a complaint to an Ombudsman Office or a Children's Ombudsman.[3]

Goals

Conflict victims and people with disabilities including landmine/ERW victims enjoy the same rights and opportunities as all other citizens. Children and adolescents are adequately protected even when they do not have direct access to the court system and legislative decision making.

The role of the laws and policies component in child-focused victim assistance

The role of the laws and policies component in child-focused victim assistance is to promote consideration of and respect for the rights of child survivors and victims, as well as children with disabilities more generally, when developing laws and policies relevant to children, victims of conflict and persons with disabilities.

Key concepts

Access to justice

Access to justice can be defined as the ability to obtain a just and timely remedy for violations of rights as put forth in national and international laws, norms and standards (including the Convention on the Rights of the Child, CRC). Lack of access to justice is a defining attribute of poverty and an impediment to poverty eradication and gender equality. People with disabilities often face barriers to access the legal system, which often treats children in the same ways as adults, with no consideration to their age. The Convention on the Rights of Persons with Disabilities

(CRPD) in Article 13 explicitly addresses access to justice. Using monitoring and reporting mechanisms can be a means by which governments are held accountable to fulfilling their obligations on VA in the APMBC, CCM, Convention on Certain Conventional Weapons (CCW) and on children with disabilities in the CRC, the CRPD and Security Council Resolution 1612 on children affected by armed conflict. Generic human rights reporting through the Periodic Human Rights Framework can be employed as well.

Inclusive development

Like inclusive education, inclusive development is both a process and a goal. It aims to ensure that all marginalized and excluded groups are included in the development process. Many groups are excluded from development because of their gender, ethnicity, religious beliefs, age, sexual orientation, disability or poverty. Inclusive development envisions a society that accommodates differences and values diversity. Disability-inclusive development is founded upon three key principles: participation, non-discrimination and accessibility. It uses a twin-track approach that implies both (i) How to improve a person's capacities and abilities at the personal and collective level through empowerment and (ii) How to reduce the physical, communication and attitudinal barriers that society erects towards persons with disabilities to ensure they can participate and access services on an equal basis with everyone else.

When inclusive development is achieved, the full and effective participation and inclusion of mine survivors and the families of those killed or injured will be a natural result. The positive impact of all girls, women, boys and men being active in the social, cultural, economic and political life of their communities will be felt in the short- and long-term wellbeing of the state.

Participation

"Nothing about us without us." This slogan has been widely used by persons with disabilities in political campaigns and by other marginalized groups. Children, including children with disabilities, also have a right to be heard and should be supported to contribute their own opinions to issues that shape their lives. Through ombudspersons or other channels, their contributions should be channelled into decision making processes. Many communication channels should be used to support participation: from call-in shows on national or local TV or radio to school- and community-based discussion forums to theatre, music and other cultural gatherings and sports events.

Supporting a participatory process takes time, money and hard work, but the investments pay off in an engaged and empowered community. Participation and empowerment strategies that address behavioural and socio-cultural determinants are increasingly built on evidence of what works and what doesn't.

Eight-year-old Marmane, is learning to use a wheelchair at a rehabilitation centre run by the international NGO Médecins Sans Frontières in Port-au-Prince, Haiti. She was struck in the neck by a stray bullet while playing in the schoolyard and is now paralysed from the waist down. She will be released soon but does not want to leave the facility for fear of being teased. She is also afraid to return to the neighbourhood where she lives.

While DPOs and self-help groups strive to be heard in the public debate, in reality few children and adults with disabilities opt to engage or to speak out. Many are never given the opportunity to engage as they cannot, for example, physically access locations of public debates. Also, many may feel ashamed or intimidated in participating publicly, girls and women in particular.

Accessibility, Assistive technology, Universal design

Accessibility is more than just ramps for children using wheelchairs. A barrier-free environment aims at removing all barriers beyond the physical or architectural ones. Accessibility as stipulated by the CRPD (Article 9.1) requires States to ensure access to persons with disabilities, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, in urban and in rural areas.

Assistive technology is important to promote accessibility. In today's world, it includes a wide variety of items and services such as Braille readers, speech recognition software, screen readers, text-to-speech, speech recognition and magnifiers, amongst others. "Assistive devices" include a wide variety of helping aids – from prosthetics and mobility devices to vision and hearing devices. See Section 5.3 "Rehabilitation" for more information on assistive devices.

Universal design means designing products, environments, programmes and services to be usable by all people, both with and without disabilities. One familiar example is the design of door knobs, which are often smooth, round and hard to grasp, rather than as a handle that is easily managed by all persons.

Desirable outcomes

- The national legislation explicitly guarantees that conflict victims and persons with disabilities enjoy equal rights to other citizens, ensuring the fulfillment of these rights for children. Governments recognize landmine/ERW victims as victims of war or conflict even with accidents that occur long after the conflict has ended.
- The Government enacts national legislation including a budget line in support of persons with disabilities.
- Children and adolescents with disabilities and their families are aware of their rights, the respective laws and legal remedies. They are part of an inclusive development and advocacy strategy and actively participate in its planning, implementation, monitoring and evaluation.
- Poverty reduction strategies and programmes include and benefit people with disabilities and landmine/ERW victims.

- A government or publicly-supported entity is responsible for disability and victim assistance issues. It seeks mainstreaming in different ministries and holds them accountable.
- Government authorities adopt and apply policies and measures to improve health, rehabilitation and protection services and to provide psychosocial care accessible to all citizens.
- Government authorities adopt and apply policies and measures to ensure inclusive education, access to work, micro-finance and benefits for people with disabilities.
- Children with disabilities and children of landmine/ERW victims participate in designing, monitoring and revising policies, laws, standards and other measures that address their rights.
- Governments regularly report on victim assistance, including disaggregated data on child survivors, in compliance with international conventions.

Suggested activities

Access to justice

- ✓ Facilitate access to legal support for children and adolescents, particularly at community and district levels, including through DPOs and children's groups.
- ✓ Raise awareness among judges, lawyers and lawmakers of their existing obligations.
- ✓ Support Goverments in aligning existing legislation and the corresponding policies and programmes with the CRPD and the CRC.
- ✓ Support the use of reporting mechanisms to the three weapons-related conventions (APMBC, CCM, CCW) and of human rights monitoring mechanisms to improve the situation of children with disabilties, including child survivors. For example, this includes the CRC review mechanism, CRPD reporting and use of the Optional Protocol, and the Universal Periodic Human Rights Review.

Box 22: Ensuring the Rights of Especially Vulnerable Internally Displaced and Refugee Children

Unaccompanied and separated children who are displaced from their homes by conflict or natural are especially vulnerable to abuse or neglect. This is compounded for children living with disabilities. In a 2013 briefing paper, the Landmine and Cluster Munition Monitor noted that refugees (people who cross the borders of their countries into another country) often lack official recognition from the government in their new country as refugees, war victims, and/or landmine or cluster munition victims. People who are displaced within their own country's borders (Internally Displaced Persons, IDPs) also face legal challenges in addition to basic survival challenges.

The families of refugee and IDP children may not have been able to carry their birth certificates or health cards in the haste to leave their homes, complicating everything from registration in school to immunization to locating family members in the case of separation during the forced migration.

Landmine/ERW victims and other displaced persons with disabilities often face insufficient and unequal access to shelter, education, specialized healthcare and rehabilitation within refugee and IDP camps. This is inconsistent with the commitments of host states and the international community to provide adequate support for victim assistance without discrimination against persons with disabilities. Provisions should be made for children with disabilities to receive specialized health care, to access sanitation and hygiene services and to register for school. School facilities should be accessible to children with disabilities.

The concept of establishing safe "child-friendly spaces", a concept that originated in the late 1990s, is now standard practice in IDP and refugee camps and following natural disasters. UNICEF notes that "Efforts should be undertaken to promote the inclusion and participation of children with disabilities and to assist in accessing equation, health care services, rehabilitation support and recreational activities."

The Inter-Agency Standing Committee states that camps and settlements for displaced or refugee populations should be "be designed so as to maximize the security and protection of displaced persons, including women and others whose physical security is most at risk (e.g. children, older persons, persons with disabilities, single-headed households and members of religious and ethnic minority groups or indigenous peoples)".

Sources: Landmine & Cluster Munition Monitor (2013), *Landmines and Refugees: The Risks and the Responsibilities to Protect and Assist Victims, Briefing Paper, Geneva;* UNICEF (Undated), *A Practical Guide for Developing Child Friendly Spaces,* New York[4]; Inter-Agency Standing Committee (2006), *"Protecting Persons Affected by Natural Disasters: IASC Operational Guidelines on Human Rights and Natural Disasters"*, Geneva[5]

- ✓ Support the development of national legislation in accordance with international standards.
- ✓ Support the development of national plans of action or the update of existing plans to ensure the inclusion of mine/ERW victims and children with disabilities.
- ✓ Promote inclusive media. By including nuanced portrayals of children, adolescents and adults with disabilities, media can send out positive messages about the capacities of persons with disabilities. This will counter misrepresentations and stereotypes that reinforce social prejudices.
- ✓ Advocate for the rights of children with disabilities during conflict; promote the protection of children during and post-conflict, e.g. in their own communities and as IDPs or refugees (see Box 21). Facilitate awareness campaigns on how to seek access to justice for persons with disabilities and conflict victims.

Inclusive development
- ✓ Support Governments in mainstreaming disability in all sectors at the level of policy, planning and delivery. Strive for an institutional arrangement that entails a mainstreaming mandate and has capacity, resources and power. Involve children and adolescents with disabilities in the discussions.
- ✓ Advocate for age- and gender-sensitive VA including to raise awareness and understanding of child-rights based approach in the family and community as well as advocacy on policy levels in local, national, regional and international opportunities.
- ✓ In situations of armed conflict, advocate for a mine action component in the humanitarian and development programming, including victim assistance and risk reduction education, together with other relevant child protection issues
- ✓ Advocate for global and national mine action goals, including for treaty universalization and

Box 23: Principles for Communicating About and Advocating for Children

Humanitarian and development organizations communicate with large audiences all the time using their websites, reports and other documents, their work with the media, and other ways. Text, images and sound that include children can be very effective tools to promote the rights and protection of children. When they understand fully the implications of not acting, decision-makers take quicker steps to tackle child protection issues.

However, poor communication and advocacy can negatively affect the way children are perceived and have the potential to put children and their families in danger. Child survivors on mine/ERW incidents may be especially vulnerable due to the physical and psychological trauma.

Many organizations and agencies have developed principles for reporting on and working with children and representing them online, on TV and radio and in print publications A few principles are provided below, from the global Child Protection Working Group. For UNICEF's set of principles for the media, see <http://www.unicef.org/media/media_tools_guidelines.html>.

- ▪ Always consider whether a publication is in the best interests of the individual child and his or her family;
- ▪ Ensure children, parents and guardians have been properly informed and have signed an informed consent form before using any image, recording or quote of them;
- ▪ Always make sure the stories and images used are accurate and sensitive;
- ▪ Avoid exaggerating the situation of a child and depicting children as powerless;
- ▪ Avoid using images of boys and girls that could be viewed as sexual by others;
- ▪ Avoid exposing children to further harm, for example by maintaining stereotypes;
- ▪ Do not use the real name of the child unless they have asked for this and the parent or guardian has agreed;
- ▪ Never reveal the identity of current or former child combatants, survivors of physical or sexual abuse, perpetrators of abuse or children living with HIV or AIDS;
- ▪ Where possible, give children access to media to express their own opinions;
- ▪ Bring together information provided by different sources;
- ▪ Do not pay children, parents or caregivers for information or materials which will be used;
- ▪ Ensure that children who testify or who give evidence to media are in no way at risk.

Source: CPWG (2012), Standard 3 (Minimum Standards for Child Protection in Humanitarian Action), http://cpwg.net/minimum-standards/

implementation, compliance with international humanitarian law, victim assistance and its integration into disability and development frameworks. Advocate for adequate and reliable funding.

- ✓ Integrate victim assistance into disability and development frameworks and ensure age- and gender-sensitivity.
- ✓ Include risks and impacts of mines/ERW as a key Child Protection issue for communications and advocacy. This should include integrating mine/ERW incidents involving children and their families into findings on Child Protection issues to be shared with stakeholders and highlighting the differential impacts of mines/ERW on girls, boys, women and men.
- ✓ Work with media professionals to ensure respect for child survivors and victims of mines/ERW, for girls' and boys' dignity and for their best interests and safety.

Participation

- ✓ Involve children and adolescents with disabilities and child landmine/ERW victims in decisions that affect them. Solicit the feedback of children with disabilities so that facilities and services can better meet their needs. This takes time but yields more positive and sustainable results.
- ✓ Promote the empowerment of persons with disabilities as stipulated in the CRPD and the CBR Guidelines through advocacy, community mobilization, political participation, self-help groups and Disabled People's Organizations.
- ✓ Promote the use of Communication for Development principles and approaches that address behavioural and social beliefs, norms and practices.

Accessibility, Assistive Technology, Universal Design

- ✓ Dismantle barriers against inclusion so that all children's environments – homes, schools, health facilities, public transport and so on – facilitate access and encourage the participation of children with disabilities alongside their peers.
- ✓ Provide information in accessible formats and technologies appropriate to different kinds of disabilities, without unreasonable delay or additional cost to the child.
- ✓ Facilitate the use of sign language, Braille, augmentative and alternative communication, and modes and formats of communication of their choice.
- ✓ Encourage private entities that provide services, including through the Internet, to provide information and services in accessible and usable formats for children with disabilities at little or no cost.
- ✓ Promote architectural accessibility: Develop, disseminate and monitor the implementation of minimum standards and accessibility guidelines for facilities and services open or provided to the public (including to water, sanitation and hygiene facilities) to guarantee access for women, girls, boys and men with disabilities.

Box 24: Involving Children in Policy Advocacy

The UNICEF programme in Kazakhstan supported a multipronged approach to creating spaces for children and young people to participate in national-level policy debates. Twenty-six young facilitators were trained in participatory techniques and skills and an understanding of core child rights principles and their application. The facilitators then conducted 70 sub-national consultations across the country, supporting more than 2,000 children and young people in identifying issues of importance to them for community and national development.

The consultations included views from boys, girls, and young women and men living in villages, **children with disabilities,** and children living in orphanages. The children were sensitized about the role of the media in the success of a democracy. Young video journalists received training, then documented the entire process and produced documentaries reflecting issues of importance to adolescents in the country. These videos were used as advocacy tools.

The consultations were summarized in a document representing the views and recommendations of the young people. To consolidate the gains from the process, more than 2,500 children and young delegates from various parts of the country were brought together. Known as the Adolescents and Youth Forum, and held in Astana, the event provided the children and young people with a platform to present their perspectives on Kazakhstan's emerging youth policy. This process generated further actions on the involvement of adolescents in policies and actions that affect their lives.

Source: UNICEF (2010), *Advocacy Toolkit, A guide to influencing decisions that improves children's lives*, New York

Box 25: Participation Makes for Successful Survivor Networks

Victims of landmines, cluster munitions and explosive remnants of war have been at the heart of campaign and advocacy efforts since the founding of the International Campaign to Ban Landmines (ICBL) and subsequently, the Cluster Munition Coalition (CMC). At least 25 ICBL-CMC national and local survivor networks are strong advocates for all aspects of the APMBC, the CCM and the CRPD. These networks empower and improve the lives of thousands of survivors and their families through peer support and income-generating projects and by helping them to access other services such as healthcare and physical rehabilitation.

In response to requests from national campaigns to provide targeted financial and technical support to survivor networks, the ICBL-CMC created the Survivor Network Project in 2012 with support from the Government of Norway. Eleven survivor networks received financial support during the first year of the project and are showing impressive results. Some highlights are provided below.

The survivor network of the **Cambodian** Campaign to Ban Landmines visited almost 400 villages to learn first-hand the needs of survivors, and then passed this information directly to the Prime Minister and Defence Ministry with a comprehensive set of national and local recommendations. The Cambodian Campaign also used the village visits to share information about the rights of survivors and other persons with disabilities with local authorities and survivors.

In **Afghanistan** and **Albania**, the Afghan Landmine Survivor Network and the Kukes Survivor Network saw their countries ratify the CRPD following letter writing campaigns, public awareness events and high level lobbying meetings. In **Tajikistan**, the President signed an action plan for CRPD accession following advocacy efforts by the Tajik Survivor Network. The Tajik Survivor Network also successfully lobbied for increased financial resources for victim assistance and increased availability of peer support services for survivors.

The **Senegalese** Association of Landmine Victims (ASVM) and Yitawekilgn Yeakal Gudatagnoch Mehiber, a survivor network in Ethiopia, boosted survivor participation in sporting events for persons with disabilities to encourage social inclusion in their countries. ASVM organized a regional basketball tournament in 2012 bringing together survivors from the Casamance region, the Gambia and Guinea-Bissau. Survivor athletes in **Ethiopia** took home three gold medals and a silver at the Addis Ababa Sports Festival for Persons with Disabilities, also in December 2012, around the International Day of Persons with Disabilities.

In **El Salvador**, survivors monitored the government's implementation of the APMBC and the CRPD. The Network of Survivors, alongside other organizations of persons with disabilities, contributed to the national CRPD alternative report. The report highlights areas where more progress is needed to uphold the rights of survivors and other persons with disabilities and will contribute to the Committee of the CRPD's official recommendations to the government of El Salvador.

The Landmine Survivor Initiative in **Bosnia and Herzegovina** successfully advocated for survivor participation in the drafting of the country's Victim assistance statement for the upcoming Meeting of States Parties to the Cluster Munition Convention.

In **Uganda**, a local survivor group in Pader district created by the Uganda Landmine Survivors Association conducted training on Uganda's obligations and commitments to survivors under the APMBC, CCM and CRPD. Following the training, the group was given official representation on the district council to aid in the design and implementation of local development projects.

"Outputs from the Survivor Network Project members over the past 12 months have shown once again how important and effective it is to engage survivors in the promotion of victim's rights and implementation of the Mine Ban Treaty, the Convention on Cluster Munitions and the Convention on Persons with Disabilities," said Megan Burke, Coordinator of the Survivor Network Project.

Source: Cluster Munition Coalition, 26 August 2013, <http://www.stopclustermunitions.org/news/?id=4351>

Technical Resources

Documents are listed in *inverse chronological order*, starting with the most recent ones.

Laws and Policies [and Advocacy]

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1   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

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Chapter 6
Resources – literature and websites

Resources – literature and websites

International normative and legal frameworks

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Documents are listed in ***inverse chronological order***, starting with the most recent ones. **Only generic documents** are listed here. Specific resources for each of the VA components please refer to the respective section 5.1 to 5.6.

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Yemen

Geneva International Centre for Humanitarian Demining (GICHD) (2006), *Departure of the Devil: Landmines and Livelihoods in Yemen,* Geneva, <http://www.gichd.org/fileadmin/pdf/publications/Socio-eco-Survey-2012/Socio-eco-Survey-2012-Pound-Yemen-Livelihoods-Analysis.pdf>

Web-links

UNICEF <http://www.unicef.org/protection>; <http://www.unicef.org/disabilities>; <http://www.unicef.org/cbsc/> [Communication for Development]; education, nutrition, health, ...

UN Children and Armed Conflict, <http://childrenandarmedconflict.un.org>

APMBC Review Conferences <http://www.nairobisummit.org/>, <http://www.cartagenasummit.org/>, <http://www.maputoreviewconference.org/>

UNHCR, Protection and Children <http://www.refworld.org/children.html>

Mine Action Standards, <www.mineactionstandards.org>

UN Office Geneva, Disarmament <www.unog.ch/disarmament>

<http://www.apminebanconvention.org/resources-for-states-parties/>

<http://www.clusterconvention.org/documents/publications/>

<http://www.mineaction.org/resources> - Website maintained by UNMAS

<http://www.icrc.org/eng/resources/index.jsp> - data in reports on Physical Rehabilitation services distinguish clients who are mine incident survivors

<http://www.icrc.org/fund-disabled> - ICRC Special Fund for the Disabled

<www.victim-assistance.org> – this website is managed by Loren Persi Vicentic, ICBL-CMC/LCM; see especially <http://victim-assistance.org/advocacy/mines-and-children/>

<www.icbl.org> and <www.icbl.org/index.php/icbl/Work/MBT/Victim-Assistance>

<www.the-monitor.org> - Website of the Landmine & Cluster Munition Monitor, ICBL

<http://www.stopclustermunitions.org/> - Website of the Cluster Munition Coalition

<http://www.gichd.org/publications/> - Geneva International Centre for Humanitarian Demining

<http://genevacall.org/resources/resources.htm> - Geneva Call has three thematic areas on its website: landmines, children and gender

<http://www.gmap.ch/> - *Gender & Mine Action Programme*. Swiss NGO. Website in English, French and Spanish

<http://maic.jmu.edu/> - James Madison University, Harrisonburg, VA, United States of America – Various resources, first of all *The Journal on ERW and Mine Action,* Victim Assistance was covered as specific issue from time to time – regularly articles feature VA.

<http://www.handicap-international.org/>

Vietnam Veterans of America Foundation/Veterans International, <http://www.ic-vvaf.org/>

Tromsø Mine Victim Resource Center and Trauma Care Foundation - Norway <www.traumacare.no>

Clear Path International 'Conflict Survivor Assistance', <http://cpi.org/>

Polus Center for Social and Economic Development <http://www.poluscenter.org/>

ITF Enhancing Hauman Security - Slovenia <http://www.itf-fund.si/>

<http://www.makingitwork-crpd.org/> - MIW is a methodology for documenting good practices on inclusion of people with disabilities for evidence-based advocacy.

International Disability and Development Consortium, <http://www.iddcconsortium.net/>

CBM, <http://www.cbm.org>

International Network on Explosive Weapons, <http://www.inew.org/>

Action on Armed Violence, <http://aoav.org.uk/about-aoav/what-do-we-do/supporting-victims/>

<www.article36.org> – NGO working to prevent the unintended, unnecessary or unacceptable harm caused by certain weapons. The name refers to article 36 of the 1977 Additional Protocol I of the Geneva Conventions that requires states to review new weapons, means and methods of warfare.

Mental Health & Psychosocial Support Network, <http://mhpss.net/>

Survivor Networks, groups or associations of survivors of injuries and disability caused by landmines, cluster munition remnants and other explosives left over from armed conflict - http://survivornetworks.wordpress.com/>

One Step Beyond, 'An Art Project by Lukas Einsele, Reporting on landmines and their victims', <http://www.one-step-beyond.de/en/>. Including personal statements by child survivors, their original voice recordings, some drawings, and much more.

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