Voices from the Ground

Landmine and Explosive Remnants of War Survivors Speak Out on Victim Assistance

HANDICAP INTERNATIONAL

September 2009

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When asked if they had a final comment, survivors most often said that this survey was an opportunity to get people to finally…

"Listen to Us"

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Survivors gather in El Salvador to participate in the survey
© Network of Survivors and Persons with Disabilities

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Korab Mula (second from the right) and his family
© Jonuz Kola/ VMA Kukës

"Survivors pledge to… participate in the preparation of National Plans of Action and in formulation of laws, policies and regulations and support that State Parties include the issues of landmine survivors in their Plans… [and] to never forget the world's promise to assist the survivors of landmines…" Survivor Summit Declaration, Nairobi, 28 November 2004.

Introduction

Korab Mula (27) from Albania lost his two arms and injured both legs when he stepped on a mine and then fell on another one in June 2000. With international assistance, he was fitted with conventional prosthetic arms, but they give him problems and he cannot use them which has caused him to feel dejected and depressed. Only with more advanced electronic prostheses, which are not available in Albania, does Korab stand a realistic chance to train up for a job, and even get married. "I want to live with hope," Korab says, "I believe that I have a chance for a normal life, I wish to fulfill my dreams and obligations like all my village friends."

The Mine Ban Treaty (MBT) is the first international disarmament accord requiring the international community to help Korab Mula and the hundreds of thousands of survivors like him – a concept known as 'victim assistance' (VA).[1] Hailed as "a historic victory for the weak and vulnerable of our world," the MBT represented a vital promise to those who have suffered at the hands of these indiscriminate weapons.[2]

Despite this solemn commitment, survivors are still too often left to do just that – survive – on the margins of society, when they should be helped to rebuild their lives and thrive in the heart of their communities. This is because they are often among the poorest in some of the world's poorest countries and live in places that lack even the most basic services. Their governments often cannot afford to help them, and sometimes do not care to, and donors are blind to their suffering or have other priorities. But their governments and the international community have both a legal and moral obligation to treat and reintegrate survivors into society.

In 2004, at a special Survivor Summit, survivors recognized that improvements in VA in certain countries had occurred, but they also expressed their concern that VA was not a priority and that countries needed to improve their commitments. The summit's declaration emphasized the responsibilities of affected states as well as non-affected states to "set standards, dedicate more long-term resources to reach those standards, and improve the quality and sustainability of victim assistance."[3]

For the first time, this report assesses the situation of survivors in the 26 countries which reported responsibility for significant numbers of survivors, commending successes but, more importantly, highlighting the gaps that need to be filled.

VA partnerships

Since 1999, when the MBT entered into force, VA has gradually evolved away from assistance carried out by international organizations with international funding and towards local ownership in partnership with donor partners.

However, few of the affected states understood the extent of the challenge they were facing or had plans and strategies to address it.[4] Even fewer states had VA/disability focal points or coordinating mechanisms, or included survivors in policy-making, implementation and monitoring. As a result, survivors and their representative organizations had little means to hold governments accountable to the imprecise and broad obligation contained in the MBT.

To remedy this, the so-called 2005-2009 Nairobi Action Plan set 11 concrete actions to enhance service provision for survivors (and other persons with disabilities), data collection and management, planning and coordination, as well as input from survivors and VA experts. It also underscored the role of the international community in providing technical and financial assistance. Importantly, one action (#37), carved out a space "to monitor and promote progress in the achievement of victim assistance goals."[5]

Affected countries were also asked to set their own agendas and plans for 2005-2009. They were to articulate what they thought they could achieve by the end of 2009, make plans to achieve these objectives, and find the necessary resources. This more focused approach aimed to prevent countries from "setting themselves up for failure."[6]

This approach considerably raised the bar for VA by stimulating national ownership and (inter-ministerial) coordination. These changes have also had wider benefits, as the lessons learnt from the vague VA provisions in the MBT were instrumental in forging the strong VA language in the Convention on Cluster Munitions. The more concrete roadmap and the tireless efforts of advocates from affected communities and their supporters also resulted in VA rising up government agendas.

Survival strategies

But how has all of this actually improved the day-to-day lives of survivors?

First and foremost, the affected states have to show how they have enhanced VA by providing the kinds of services that effectively address the needs of survivors.

In all of this, affected countries were called upon to "ensure effective integration of mine victims in the work of the convention,"[7] and yet, the voices of survivors were rarely heard giving the official report on the state of play in their country.[8]

In the run-up to the Second Review Conference of the Mine Ban Treaty in November-December 2009, several organizations or individuals were concerned that no systematic efforts were being taken to seek substantial input from mine/ERW survivors in the 26 countries with significant numbers of survivors. Based on this, Handicap International (HI) and its partners decided to embark on the publication of *Voices from the Ground* to ensure that those directly experiencing the human consequences of mines every day are finally given a platform.

Knowing that survivors often live in remote areas with limited infrastructure, HI set a goal of receiving responses from 500 survivors (approximately 25 from each of the 26 relevant countries). Dozens of people – many of them survivors themselves – from the ICBL, the ICRC and its national societies, survivors' organizations and disabled people's organizations volunteered their time to travel far and wide within their own countries to reach out to survivors.

The response was overwhelming. By the end of July 2009, 1,645 survivors in 25 of the 26 countries had been able to complete a questionnaire. This is more than three times the expected total. One national survivors' organization alone reached out to more than 200 survivors, in a bid to provide as many as possible with their own direct voice in shaping the policies that would affect their lives. Other individual survivors contacted HI directly, having heard of the study and wanting the opportunity to be included.

Several interviewers were moved by the experience. In one case, an interviewer felt that the survivors were "all very isolated" and "badly need to be listened to." Interviews often went on for hours because respondents cherished the opportunity to talk. In many cases, survey respondents indicated that this was the first time they were asked their views.[9]

HI acknowledges that it was not possible to reach every survivor, his or her family and community and to do justice to the many more unheard voices. However, this has been the only effort to provide a significant number of survivors from the relevant 26 countries alike with a platform to voice their own needs and priorities for a better future. Most importantly, the general consistency of responses goes beyond country borders and provides an important snapshot of the situation as seen in 2009 by those who know best… the survivors themselves.

As we celebrate the 10th anniversary of the entry into force of the MBT, these previously unheard voices tell us whether or not survivors believe that the fundamental promise to improve their lives has been kept. Have Korab Mula and the hundreds of thousands like him across the world received the assistance that is their right?

Katleen Maes
Brussels, 2 September 2009

ICBL VA focal point conducting an interview
© Patrizia Pompili, Handicap International

Team and methodology

Handicap International (HI) utilized its extensive field and research experience in the area of victim assistance (VA) and data collection, as well as its extensive contacts among survivors and organizations working with survivors, to collect a significant number of opinions and experiences of survivors. Opinions from practitioners working with survivors were also collected.

The research team fully acknowledges that mine/ERW survivors are an integral part of a larger group of persons with disabilities, and that the families of mine/ERW casualties and their communities are also 'victims' of mines and ERW. The situation of persons with disabilities in general – and of their families and of people living in affected communities – has been included extensively in the country chapters. However, since the Nairobi Action Plan emphasizes "first and foremost" assistance to those directly suffering an incident, this progress review also limited its direct sample size to those directly affected.

Survivors were asked to assess what happened in the lives of survivors in the last five years (2005-2009) and what could be improved for the next five years (2010-2014). Survivors were encouraged to start by thinking about their own situation in 2005, and that of other survivors living in their area, and how it had improved, or worsened, since then. A standard questionnaire was developed based on the Nairobi Action Plan under which States Parties committed to "do their utmost" to enhance care, rehabilitation and reintegration efforts for survivors during 2005-2009 by undertaking 11 specific actions.[1] Survivors were asked if, *overall*, the situation or services for the VA actions in the Nairobi Action Plan, including data collection, emergency and continuing medical care, physical rehabilitation, psychological support and social reintegration, economic reintegration, laws and public policy, as well as inclusion and coordination aspects, had improved, stayed the same or become worse. For each of these components, survivors were also asked to give an evaluation of statements describing specific areas in which services might have improved or where there might continue to be obstacles to comprehensive assistance. These questions were a mix of closed and multiple-choice questions.

The questionnaire also contained open questions in which survivors could freely express their opinions on achievements in VA in the last five years and the most pressing priorities for the next five years. To better understand the actual situation of respondents, they were also asked a range of questions about their age, gender, socio-economic situation, their landmine/ERW incident and the types of services they had received since 2005. Questionnaires were available in 10 languages.[2] All respondents were guaranteed anonymity to enable them to provide frank input.

Given the challenge of identifying and reaching survivors, as well as the study's interest in providing as many survivors as possible with the opportunity to voice their views, survey participants were selected using the 'snowball sampling' method. As such, the research sample was selected by having survivors or practitioners known to researchers ('data collectors') recruit additional subjects through their network, usually through survivors' or disabled people's organizations (DPO). From an initial small set of subjects (approximately 100 contacts), the sample size grew to 1,645 survivor respondents and 1,561 responses which fit completeness and eligibility criteria were used.

Data collectors received detailed data collection guidelines, interview techniques and online training support. They were asked to reach out to mine/ERW survivors who were:

- Injured before 2005.
- The most representative for the situation of survivors in that country (casualty profiles were made available as needed).
- Representative of a mix of people who might have varying experiences, for example to include women, even if most survivors are men, and survivors who might not belong to a survivor association, DPO or be beneficiaries of an NGO.
- People living in rural and urban areas.
- People with varying socio-economic situations.
- Data collectors were encouraged to interview both civilian and military survivors (assuming this would not put them in any danger).
- Victims of small arms/lights weapons and persons with disabilities from any other cause were excluded from the survey.

Some questionnaires were completed individually, directly by survivors. In cases where survivors needed additional assistance, questionnaires were completed through an oral interview in the native language of the survivor. Guidelines for data collection did not allow for the completion of individual questionnaires in groups; though some survivors were gathered in groups and then interviewed individually. Data collectors also gathered photos and personal testimonies from those survivors who provided explicit approval. This information has been used to share more in-depth insights about the life experiences of one or more survivor in the country chapters.

These survivor responses make up the core of this progress review. Additional input was sought from non-governmental practitioners or implementing organizations working with survivors, donor states and affected states. As with survivors, all these respondents were offered total confidentiality. More than 500 practitioners were sent a separate practitioner questionnaire, also based on the Nairobi Action Plan and available in three languages. Additionally, the ICRC circulated the practitioner questionnaire to its relevant delegations. In total, 133 practitioners working in 20 of the 26 relevant countries responded to questions on the areas of VA in which they had direct knowledge, and all responded to questions on coordination, national ownership and sustainability.

Additionally, 29 states known to be donors of overseas development assistance were sent a separate one-page questionnaire asking about national and international trends in financial support for VA. Through oral interviews and/or email, representatives of the relevant affected states were asked to respond to preliminary survey findings. They were also asked to give an indication of their expectations and experiences in implementing the informal, more measurable VA process they had been involved in between 2005 and 2009.

Questionnaire responses were processed by a data management specialist to ensure that they met minimum standards. Data was entered in country databases, verified and given another quality check before being provided to researchers on a country-by-country basis in a format allowing for the analysis of results according to a wide range of demographic and socio-economic indicators. A summarized version of all survivor, practitioner and government responses serves as the basis for the country chapters. More detailed information can be made available upon request. The country data was merged into a global database to enable general conclusions and trends.

To provide additional context to survivor, practitioner and government responses, researchers also conducted an extensive review of government statements and reports on VA since 2005 and of civil society assessments of VA activities. A list of reference materials used can be found in the selected bibliography.

Based on these findings, the research team drew country-by-country conclusions on progress since 2005 and added some selected suggestions with the aim of assisting actions towards meeting survivors' priorities in the next five years. A concrete set of more global

policy suggestions in preparation for the Second Review Conference in November-December 2009 is also included.

While the sample size by no means constitutes a systematic survey and the results expressed are the personal opinions and views of the respondents, the research team and the selected international and in-country experts the team shared its preliminary finding with, consider the results consistent with the situation in the countries in question. Nevertheless, the authors acknowledge that many more voices and opinions have not been heard and continue to welcome responses from survivors and other interested parties so as to ensure the constant improvement of the understanding of the scope of the issue, the progress made and challenges faced as voiced from the ground by those most affected.

Research team

Handicap International

- **Stan Brabant** (Head of Policy Unit, Belgium): assisted in aspects of the report's production and oversaw its outreach strategy and launch.
- **Megan Burke** (Victim Assistance Specialist, Nicaragua): conducted country-specific research and writing, provided Spanish translation, and coordinated input from donor states.
- **Stéphanie Castanié** (Ban Advocates Project Officer/Administrator, Belgium): provided administrative support and budget follow-up.
- **Hugh Hosman** (Casualty Data Manager, Vietnam): managed and verified casualty data for all country reports.
- **Katleen Maes** (Research Coordinator, Belgium): was the final editor and general coordinator of the report. She developed the study concept and research methodology; conducted country-specific research and writing; and contributed in-depth knowledge for all countries based on more than five years experience monitoring VA progress.
- **Loren Persi** (Victim Assistance Specialist, Serbia): conducted country-specific research and writing. He contributed to the questionnaire design and research methodology.
- **Patrizia Pompili** (Research Officer, Belgium): provided crucial organizational support, assisted with French translation, and liaised with the printer.
- **Mia Madsen** (Supporting Officer, Finland): conducted fact checks on country reports and supported questionnaire data entry and management.

Data management and data entry staff

- **Stéphane De Greef** (Data Management Expert, Belgium): was in charge of database design and database training; oversaw data input and data verification; and provided researchers with the means to analyze data and produce charts.
- **Moeen Gama Ali** (Yemen): data entry.
- **Sébastien Grolet** (Belgium): data entry and analysis.
- **Karin Krslovic** (US): data entry.
- **Juan Ordoñez** (Nicaragua): data entry.
- **Nsimba Paxe** (Angola): data entry.
- **Hassan al-Qatrawi** (Jordan): data entry.
- **Anna Roughley** (UK): data entry.
- **Ruba Salkham** (Jordan): data entry.
- **Kim Ang Tan** (Cambodia): data entry and analysis.

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- **Firoz Ali Alizada** (Treaty Implementation Officer, Switzerland): supported the research team in coordinating with the ICBL VA focal points. He provided input on questionnaire development and on the Afghanistan chapter.

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Afghanistan

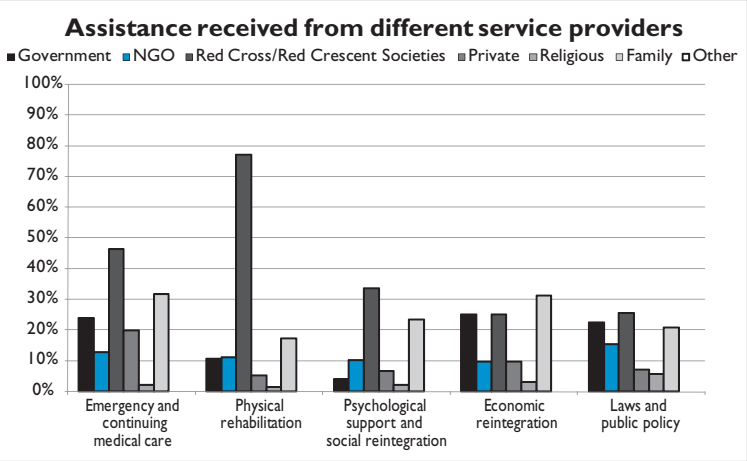
Country indicators

- *Conflict period and mine/ERW use:* Mine, cluster submunition and ERW contamination dates back from the 1979-1989 Soviet invasion and, subsequently, from use by the Taliban/Northern Alliance (1992-2000), the US (2001-2002), and Taliban and other opposition forces in 2002-2009.[1]
- *Estimated contamination:* Remaining contamination was 722.3km^2 as of July 2008, estimated to affect more than 4 million people.[2]
- *Human development index:* Unknown; but the last known value was estimated at 0.345 in 2007. This would rank Afghanistan lower than all but one country (Sierra Leone ranked 179th in 2008).[3]
- *Gross national income (Atlas method):* Unknown (US$237 in 2004).[4]
- *Unemployment rate:* 40% in 2008 (unknown in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 20.1% (compared to 5.9% in 2004).[6]
- *Number of healthcare professionals:* Seven per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* A budget of unknown size provided largely by international sources exists. Some 210,000 persons with disabilities received pensions of US$6-US$10 per month.[9]
- *Measures of poverty and development:* Afghanistan is an extremely poor country, devastated by decades of conflict. Half of the population lives below the poverty line and 20% is at risk of falling into poverty. Average life expectancy is less than 45. Afghanistan is highly dependent on foreign aid and this will continue in the mid to long term.[10]

VA country summary

Total mine/ERW casualties since 1980: Unknown – at least 52,000-60,000 survivors			
Year	Total	Killed	Injured
2004	911	140	771
2005	1,122	195	927
2006	906	138	768
2007	842	217	625
2008	992	266	726
Grand total	**4,773**	**956**	**3,817**

- *Estimated number of mine/ERW survivors:* 52,000-60,000.[11]
- *VA/disability coordinating body/focal point:* The Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD) is the lead ministry through its deputy minister and the Disability Stakeholder Coordination Group. Several other coordination mechanisms exist.
- *VA/disability plan:* The Afghanistan National Disability Action Plan 2008-2011 (ANDAP), developed under the Mine Ban Treaty framework, became the *de facto* work plan for the entire disability sector.
- *VA/disability profile:* Access to services for the entire population of Afghanistan is hampered by a severe lack of services, poor to non-existent infrastructure, ongoing conflict and poverty. Between 2005 and 2009, Afghanistan made progress in VA/disability issues, but the general state of the country meant overall service quantity and quality remained low and significant international funds were needed for improvement. Most services are urban-based, and most are run with the support of international organizations. Movement restrictions because of conflict, a lack of roads and the cost of transport are further obstacles. Access to services for women was even more problematic due to cultural barriers. Throughout 2005-2009, a lack of awareness and professionalism, poverty, ethnic and political divisions and prejudice against disability were also obstacles. While geographic coverage of healthcare expanded, only basic assistance was available in rural areas and emergency care was dependent on the location of an incident. Physical rehabilitation coverage was insufficient throughout 2005-2009 and services were (almost) entirely operated by international NGOs and the ICRC. Psychosocial support was almost non-existent, as were peer support groups. Some self-help groups existed through the community-based rehabilitation (CBR) network. However, the network needed to expand its geographical coverage. CBR also needed strengthening and improved coordination, which started to happen in 2008. Economic reintegration projects were limited and carried out



mostly by NGOs, while ministries paid some disability pensions and ran some vocational training. Increased attention started to be paid to inclusive education, but still most persons with disabilities did not have access to schools or vocational training. Disability legislation had been developed but not approved as of August 2009. Ministries have shown more ownership and integrated disability more in their policies over the years. National NGOs and DPOs also became increasingly active, and were included more often in VA/disability planning. However, DPO and ministry capacity remained weak.[12]

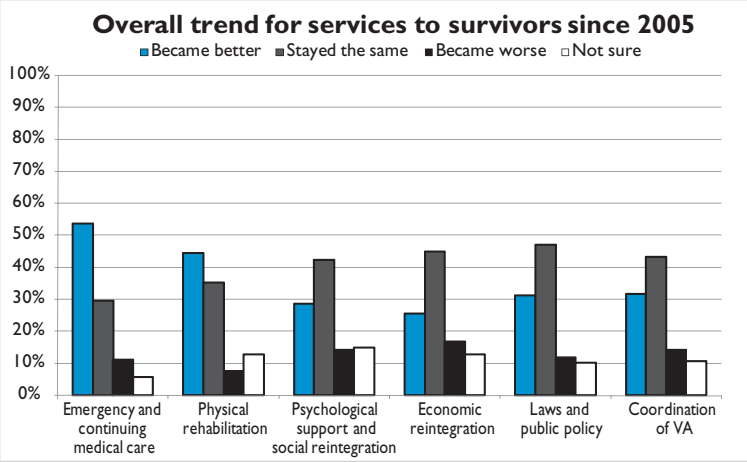
VA progress on the ground

Respondent profile

By July 2009, 196 survivors aged between 15 and 70 responded to a questionnaire about VA/disability progress in Afghanistan since 2005: 178 men, 11 women, four boys and three girls. Half of the respondents were between 18 and 35. Most (70%) were heads of households (no women) and 38% owned property. In total, 45% of respondents had not received any formal education (71% of women) and 11% of respondents had completed secondary education or higher. Some 43% of people lived in villages with limited services; 7% in remote areas without services; 24% in the capital Kabul; and 22% in large cities with a variety of services.[13] For 22% of respondents, their household income was sufficient; 9% of respondents were unemployed before the incident and another 2% were beggars. This increased to 20% (and another 2% beggars) after the incident and the vast majority of people changed jobs. For women, the percentage of unemployed decreased from 29% to 7%. In reality, figures are thought to be higher. The respondent profile corresponds with casualty information indicating that the vast majority of casualties are young males (mostly boys) with low education levels, usually injured by ERW during their daily activities. A significant number of people were also injured while traveling. Several respondents, who had incidents in remote areas, moved to less remote areas to obtain services.

General findings

Overall, survivors noted improvements in all areas of VA/disability service provision, but mostly in medical care and much less so in psychosocial support and economic reintegration. Some 36% of respondents thought that they received more services in 2009 than in 2005 and 38% thought that services were now better. Practitioners' responses often mirrored survivor responses. The areas where opinions converged the least were physical rehabilitation and economic reintegration, where practitioners were more positive than survivors. It should be noted that, while some progress was seen, services in Afghanistan are still among the least developed in the world, hampered by conflict and a lack of infrastructure. Some 39% of people thought that women received services "equal" to those available to men; 22% thought they were "a bit worse"; 16% said "absent" and 10% said "better". Women reacted more negatively: 21% said services were equal; 29% said services were absent and all the others said services were worse. This confirms reports throughout 2005-2009 that women systematically received fewer services due to cultural barriers and a lack of skilled female professionals. Some 44% of respondents said that services for children were "never" or "almost never" adapted to their age, a finding that should be accurate, as most respondents were young when they experienced their incident.



Most survivors (69%) had not been surveyed by NGOs or the government in the last five years and 16% had been surveyed three or more times. Of those surveyed (57 people), 53% felt more listened to; 44% said it had resulted in more information about services; and 32% found that they had received more services as a result. Some 28% of respondents had been able to explain their needs to the government in the last five years and 26% had participated in workshops about VA. Most practitioners felt survivors did not receive more services as a result of survey activity (86%). These results sound rather negative, but are not, because of the sheer number of survivors to be reached (up to 60,000) in Afghanistan. Considering the terrain and security circumstances in Afghanistan, data collection has been relatively good and a significant number of people would have had their incident data collected. Additionally, since 2006 Afghanistan has exerted considerable effort to include DPOs and survivors in VA/disability workshops and planning.

Emergency and continuing medical care

More than half of survivors (54%) found that, overall, healthcare had improved since 2005 and 30% believed it had remained unchanged. One-third of respondents thought that survivors "sometimes" received the medical care they needed; the second largest group (18%) said this was "never" the case. Most advances were seen in the fact that there were more centers (65%) and better facilities (64%). Respondents saw less progress in the availability of emergency transport and follow-ups (40%); affordability and capacity to carry out complex procedures (41%) and the availability of equipment and supplies (42%). Least progress was seen in increased government support (36%). Practitioners were in complete agreement with survivors, with 55% reporting progress. They saw the least progress in the availability of supplies/equipment (27%); and no one saw progress in emergency transport or the capacity to carry out complex procedures. The areas where practitioners saw progress were also those where they thought that the government had increased its efforts.

The survivor and practitioner responses confirm the government's efforts to increase the geographic coverage of basic health services, which has gone up from 9% coverage in 2002 to 77% in 2006 to 85% in 2008. Many of these services are still run in cooperation with or by NGOs. The number of disability services in this Basic Package of Health Services was also increased. In 2008-2009, an increasing number of people did not have access to healthcare due to conflict (600,000 in 2009 and 360,000 in 2008).[14] Complex procedures are only available in major cities, and mostly only at one NGO-run hospital in Kabul, which is struggling to find funding.[15] The cost of continued medical care and transport, as well as of medication and accommodation, is often prohibitive. In 2008, the government also reported that it would take five to 10 years to train enough medical staff, many of whom might not want to work in rural areas. Emergency transport and first response remained problematic and could still take up to three days. Many hospitals suffer from shortages of supplies, water and electricity.[16]

Physical rehabilitation

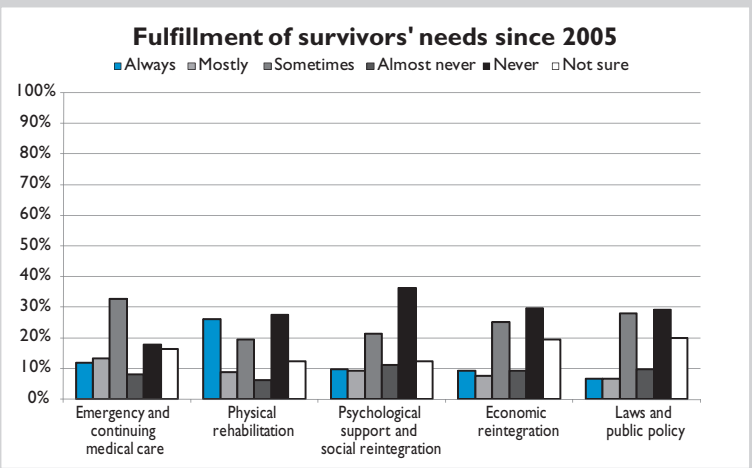
Some 44% of respondents believed that, overall, physical rehabilitation services had improved since 2005 and 35% said they remained the same. However, the largest group of respondents (28%) thought that survivors "never" received the physical rehabilitation they needed, closely followed by people saying the needed services were "always" received

(26%). Interestingly, in villages and remote areas the responses were 50-50, but most negative responses were received from the capital. This is probably due to the over-concentration of persons with disabilities living in the capital. The largest percentages of survivors saw progress in the quality of mobility devices (52%), the availability of free repairs and better-trained staff (51% each). Least progress was seen in the availability of mobile workshops (20% saw progress), an increased number of centers (29%) or services closer to home (35%). Only 18% of respondents thought that the government increased its support for physical rehabilitation. Among practitioners a markedly higher percentage (64%) saw progress, but their insider perspective might have led them to witness more advances first-hand. Practitioners saw the most progress in the availability of more types of devices and of free repairs, better quality services and better infrastructure. The least progress was noted in the number of centers. Practitioners found that the government had increased its efforts most in staff training, but in many areas, such as number of centers and more types of and better devices, they noted the government "did nothing."

The responses confirm the situation in Afghanistan, where all but one physical rehabilitation center are run by NGOs or international organizations (mainly the ICRC), and it has been reported that the government was reluctant to take on more responsibility.[17] NGOs also carried out most of the community-based and mobile services, as well as covering transport, treatment and accommodation costs, and providing training for staff. Service providers have reported throughout 2005-2009 that there were only centers in 10 provinces and physical therapy services in 19. In 2005, Afghanistan reported that rehabilitation centers were needed in at least 30 of 34 provinces.[18] The Ministry of Public Health (MoPH) acknowledged in 2009 that service provision in the 15 uncovered provinces remained problematic.[19] Two main international rehabilitation providers noted in 2009 that no end dates were envisioned for their support, because the government or local organizations were not in a position to take over services.[20] While access to services improved from 1% in 2004 to some 40% in 2006, operators still noted that the rehabilitation needs of survivors were seldom met. In late 2007 and in 2008, progress was made on capacity building, awareness raising and the regulation of the sector through the integration of physiotherapy in health packages, staff training, and the development of guidelines and training curricula in close cooperation with the government. These measures would have contributed to the practitioners' sense of improvement but might have been too recent for survivors to see.

Psychological support and social reintegration

Just over 42% of respondents found that, overall, psychological support and social reintegration services had remained the same since 2005, while 29% saw progress. By far the largest group of respondents (36%) said that survivors "never" received the psychosocial assistance they needed and an additional 11% said the needed services were "almost never" received. Survivors saw most advances in feeling more empowered (49%) and in their own involvement in community activities (50%). Some 35% thought that survivors were considered to be "charity cases" less often. But 30% or fewer saw improvement in the creation of peer support groups, the number of social workers, awareness about the importance of psychosocial services, opportunities to get services and assistance closer to home. Just 10% thought that the government provided more support to psychosocial services. Practitioners agreed with survivors: 45% said psychosocial support remained



the same and 30% or less saw progress in specific areas, such as staff training, reduced stigma or more services. Most progress was noted in the involvement of survivors in psychosocial services (45%).

Although conflict-related trauma is common in Afghanistan, psychosocial services remained limited, as was the awareness of their importance. Since 2008, just one DPO has provided peer support and systematic counseling to new survivors in Kabul. The CBR network provided some unsystematic services. Other one-off projects or peer support on the work floor in organizations where significant numbers of persons with disabilities work also existed. Services were uncoordinated and largely confined to Kabul. There is no formal training for social workers. However, the government has started to acknowledge the problem by including it more in its basic health package and some training has been started. A mental health unit was started at the MoPH in 2008 and the ministry also started to raise awareness, but due to a lack of actual service implementation, survivors would not have benefited from these recent changes.[21]

Economic reintegration

Nearly half of survivors (45%) felt that, overall, economic reintegration opportunities had remained the same since 2005 and 26% saw improvement. But the largest group of respondents (30%) said that survivors "never" received the economic reintegration they needed. Some 77% said that unemployment was so high that survivors were the last to be chosen for a job. This is a lower percentage than other countries, maybe because quite a few respondents were employed in the VA/disability sector. Most progress was seen on decreased educational and professional discrimination (44%) and increased pensions (42%). In the employment sphere, progress was low: only 21% said it was easier to get a bank loan; and 22% thought that employment quotas were better enforced. Just 17% thought that the government increased its support for economic reintegration.

Some 55% of practitioners found that economic reintegration opportunities had improved. Areas of most progress for practitioners were: availability of vocational training (64% compared to 37% of survivors) and of teacher awareness (55% compared to 27% of survivors). Areas of least progress according to practitioners were: job placement and vocational training meeting market demand. Overall, practitioners thought that the government had maintained its efforts.

The government acknowledged that economic reintegration of mine/ERW survivors and persons with disabilities remained a challenge and that high general unemployment and stigma severely limited economic opportunities.[22] More than 70% of persons with disabilities were unemployed and 73% did not have access to education. Government vocational training programs existed but were of variable quality due to capacity gaps and because of the lack of employment opportunities afterwards. Most projects were carried out by NGOs, but were not able to reach sufficient numbers of survivors. Women were particularly hard to target as they were often not allowed to study or work. In 2008, employment of persons with disabilities even decreased slightly compared to previous years.[23] During the period under review, pensions did indeed double, as noted by survivors, but the amount was still insufficient and many survivors were not registered.[24]

Laws and public policy

Almost 47% of survivors thought that, overall, the protection of their rights had remained the same since 2005 and 31% saw an improvement. Some 29% said that the rights of survivors were "never" respected; another 10% said this was "almost never" the case and 28% said rights were "sometimes" protected. Most improvement was seen in the decreased use of negative terms about persons with disabilities (53%) and in decreased discrimination (49%). Fewer people thought that legislation relevant to survivors had been developed (38%) or that legislation was increasingly enforced (34%). Some 76% did not think that the rights of survivors were a government priority. Some 55% of practitioners

saw improvements in the rights of survivors, but they remarked that the improvements were in the development (64%) not the implementation of legislation (9%).

Survivor responses partly confirm the situation in Afghanistan where disability legislation has been developed but not approved as of August 2009. Developing legislation was a slow process, due to institutional problems: inactive government disability coordination (2002-2005), weak coordination (2005-2007), because of ministerial rearrangements as well as an ineffectual UNDP supporting program (the National Programme for Action on Disability, NPAD) in 2005-March 2008. Another obstacle was that, initially, DPOs and civil society were not involved. The situation was the same for the disability policy developed in 2003, which was said to have been poorly understood and, therefore, not implemented.[25] Afghanistan also has not signed the UNCRPD, while NGOs and DPOs saw the UNCRPD as an opportunity to put pressure on the government to support the disability sector. They also noted that the rights of persons with disabilities were generally not ensured due to the lack of a legislative framework. A disability terminology guide was developed and circulated. It was noted that the disability movement was in its "infancy" and that DPOs still did not have enough capacity to effectively lobby for the rights of survivors.[26]

When asked to respond preliminary survey findings, one government representative said that changes have been made but that survivors do not care about policy developments as long as no real steps on the ground follow. A UN representative agreed with this and added that rural Afghanistan had seen little change in access or additional service provision. All representatives noted that awareness had been raised,[27] disability had become more of a priority, and coordination mechanisms had been established at ministries. Several representatives noted that this should further improve services in the future as disability/VA was a long-term issue in a country with many other challenges.

VA process achievements

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

Note: In 2008 a mine survivor working for the UN participated and, at four meetings, a Deputy Minister was the VA/disability expert.

Afghanistan, as one of the 26 countries with the greatest number of survivors, and, therefore, "the greatest responsibility to act, but also the greatest needs and expectations for assistance," has made strides in implementing the 2005-2009 Nairobi Action Plan. National ownership increased, policy frameworks were improved, coordination mechanisms were set up and functioning, and NGOs and survivors were more included in coordination. But the very low development level, intensified conflict, many competing challenges, the overall weak government capacity, and frequent political infighting have been severe complications to rapid progress. It was rightly noted throughout 2005-2009 that progress in Afghanistan should be measured in decades. Nevertheless, in many cases, real-life change for survivors was lagging.

One representative added that, at first, Afghanistan did not have clear ideas of what to expect of and did not understand the so-called VA26 process. All representatives noted that through the process they had expected to draw the international community's attention more towards the mine problem in Afghanistan. While Afghanistan received significant mine action support in 2005-2009, only a small percentage went to VA. DPOs

confirmed low donor interest in disability, and said that this led to a lack of progress in services.

However, most of the benefits of the VA26 process – even if not coined as such – have been seen nationally. Several representatives stated that Afghanistan and its VA/disability sector had benefited a great deal in that disability has been raised to a higher level of awareness thanks to mine action and Mine Ban Treaty obligations. Under the impetus of what essentially is a disarmament process, the "doors were opened" to the disability actors and VA planning resulted in an integrated approach to disability. A UN representative hoped that this would also result in increased donor funding for something that is "far more sustainable" than traditional mine action.

As one of the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration in 2005-2006, Afghanistan said it aimed to "lead by example to show other affected States what can be achieved with political will and commitment from all actors…" and focused on inter-ministerial coordination.[28]

The Deputy Minister for Disability Affairs stated that "some of the most significant achievements have been in the transition of responsibility for victim assistance from the UN to the Government of Afghanistan."[29] MoLSAMD is the lead ministry for disability, but coordination with the disability/VA sector in Afghanistan is carried out through various coordinating bodies at the relevant ministries. All are functioning relatively well and have been strengthened or given a stronger mandate throughout 2005-2009. Disability has been integrated into the work of the ministries, but all ministries still needed to build a lot of capacity and had little or no national budgets, making them dependent on external funding, and suffered from constant internal changes (for political reasons). For example, MoLSAMD had little funding for anything but paying out disability pensions and could do little more than keep disability on the radar of other ministries. Survivor responses also reflected this, as 72% said the government lacked resources.

The government has needed significant technical support from the Mine Action Coordination Center of Afghanistan (MACCA) and other UN bodies. Where the disability initiatives under the UN, such as NPAD, were not able to create momentum, MACCA's support and interest in the VA26 process managed to give the necessary impetus.

As part of its implementation of the Nairobi Action Plan, Afghanistan developed its 2005-2009 objectives, and revised them several times which fed into the Afghanistan National Disability Action Plan 2008-2011 (ANDAP), which was approved by the government in the second half of 2008. Two components, inclusive education and CBR, were added. Compared to the preceding objectives, ANDAP in places was made "less ambitious to take into account the particular challenges faced by the disability sector."[30] ANDAP is linked to other relevant strategies, such as the Afghanistan National Development Strategy.[31] A complex monitoring system for ANDAP was developed but MoLSAMD did not yet have the capacity to implement it; ANDAP was monitored through indicators of the development strategy.

Owing to the late approval of the plan and delays in its translation, most stakeholders conducted their activities without it. But since many stakeholders, including survivors and DPOs, had been involved in the plan's development, their activities were in line with and contributed to fulfillment of the plan. Implementation of ANDAP has been left to mainly international non-governmental operators, but national NGOs and DPOs were gradually taking on more substantial roles.

Most stakeholders saw the development of the plan itself as a major success. But implementation is still in its early stages and success continues to be very dependent on existing NGO capacity and fluctuating government involvement and capabilities. The

weakest component of ANDAP is economic reintegration – the area where survivor respondents were also least optimistic. In many ways survivors do not appear to have experienced ANDAP yet. Just 39% said the government had become more involved and 29% found that the needs of survivors were taken into account when developing VA priorities. Practitioners – all involved in the planning process – were much more positive with 82% believing that the needs of survivors had been taken into account. While overall confirming increased government responsibility (55%) and improved coordination particularly with NGOs and the broader disability sector (82%), few practitioners thought that this had already led to implementation improvements.

UN and government representatives highlighted the increased participation of persons with disabilities and their organizations in planning. Consistent efforts have been made to involve at least some of the large number of survivors and DPOs. But practitioners noted markedly less improvement (45%) in government coordination with DPOs and survivors than in other areas of coordination. This corresponds with DPOs and survivor organizations' remarks that coordination with the ministries remained challenging, as in some cases the government was reluctant to involve "the more activist disability organizations" in its activities. Some of this is reflected in survivor responses to the survey. Just 37% knew who was in charge of VA/disability coordination; 23% received information on VA progress; 24% thought that survivors were involved in coordination; and 28% thought that survivors and representatives were involved in planning.

DPOs also added that, in real life, survivors were not usually included in social, political, cultural issues and that negative attitudes persisted. This might confirm the government and UN representatives' statements that the foundations had been laid and that awareness had been raised but that improvements might not have reached much farther than the major cities. An issue that was also raised in a European Union evaluation of the mine action program said that VA "seemed overly focused" on policy and awareness raising and that "for mine survivors it is unlikely that such initiatives will generate much in the way of tangible benefits in the short term."[32]

Conclusions

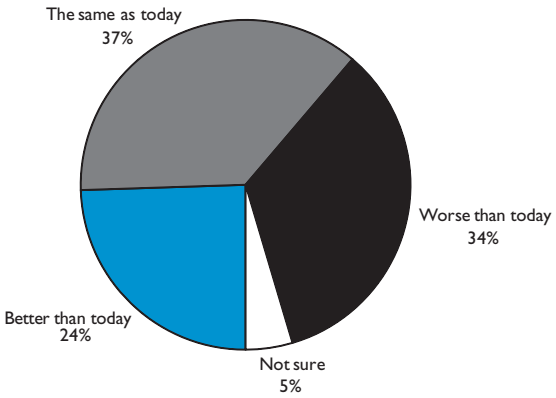
- VA/disability service provision remained severely hampered by generally poor security and development conditions.
- Despite increased national involvement, most services depended heavily on international support and will continue to do so in the medium to long term.
- Economic reintegration and psychosocial support services were the most lacking.
- Government efforts in increasing health coverage in cooperation with civil society registered high on the improvement scale; the government's lack of commitment in the physical rehabilitation sector resulted in more negative survey responses.
- Mine Ban Treaty efforts and the continuous support of the MACCA resulted in the prioritization of disability issues.
- Opening up to the broader disability sector and its actors gave the VA process a much-needed impetus and a variety of resources.
- Significant coordination and policy framework progress was made and experienced as such by the government and practitioners, but much less by survivors and their representatives.
- National NGOs and DPOs as well as ministries became more involved, but all continued to face significant capacity and funding problems.
- Despite efforts to involve survivors in planning and coordination, many DPOs and survivors still felt excluded or not treated equally.
- Disability legislation was still pending as of August 2009.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 37% of survivors felt that it would be the same as today; 34% thought it would be worse; and 24% thought it would be better.[33] To assist in a better future ahead the following suggestions may be taken into account:

- Continue to rigorously implement and revise ANDAP as needed, particularly reinforcing economic reintegration.
- Develop peer support mechanisms as part of government policy and further strengthen community-based initiatives.
- Expand physical rehabilitation services to achieve adequate geographical coverage by increasing government involvement, replicating lessons learned from healthcare expansion where appropriate.
- Maintain and improve coordination mechanisms as necessary, and assist the MoLSAMD in diversifying its mandate to cover a broader package, including comprehensive coordination and guidance of other ministries, implementation and monitoring.
- Ensure that the technical advisors to ministries (provided by the MACCA) can remain in place and, in the near future, become integrated long-term ministry staff.
- Put structures in place at ministries that can withstand political infighting and changes.
- Increase capacity building among DPOs and survivor organizations, particularly through NGOs who, in some cases, have worked with these local partners for significant periods of time but have not always included capacity building.
- Continue to increase survivor and DPO involvement in all parts of the country, even if DPOs and survivors are critical, perceived as activist or not well-organized.
- Start monitoring ANDAP, with a monitoring mechanism more suitable for the Afghan context if needed.
- Urgently adopt and implement pending disability legislation, and sign and ratify the UNCRPD.
- Ensure that women and children with disabilities receive equal services.

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



Rahmatullah Ghulam Reza (right) interviewing another survivor
© Afghan Landmine Survivors' Organization

In their own words…

Survivors described themselves as: hard-working, incomplete, disabled, unlucky, good, a servant, speechless, honest, confident, unemployed, a beggar, peace-loving, unhappy…

In their own words…

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

- Vocational training.
- Professional training centers.
- Schools for survivors' children.
- Protecting the rights of survivors and raising their awareness of their rights.
- Job creation schemes.
- Creating alternative, less physical work for survivors in villages.
- Appointing trusted NGOs to distribute aid to civilians.
- Capacity building for survivors through education, vocational training and micro-credit.
- Higher pensions.
- Mobile workshops.

In their own words…

If countries really cared about survivors they would:

- Find them employment.
- Provide more clinics and hospitals, as well as other facilities.
- Provide us with complete support, from healthcare and psychological assistance to vocational training and employment.
- Create opportunities for survivors.
- Support survivors by passing new disability laws.
- Raise people's awareness of the situation of survivors.
- Give survivors justice.
- Not forget us like this.
- Appoint survivor representatives in every region.

In his own words: the life experience of Rahmatullah Ghulam Reza

Rahmatullah Ghulam Reza (23) from Panjshir Province stepped on a mine on the way to school 14 years ago and lost both legs. He was in hospital for five months and underwent seven operations. With the help of his family, he received further treatment and his first prosthetic legs in Germany. After a year, Reza came back to Afghanistan but had to face a whole different set of problems. He says, "I was not so happy to go out and back to school, I was not able to play or run, like other children."

In high school, he had some difficulties with the attitudes of his fellow students. But Reza adds, "I said to myself I am an able person and I can do anything I want." He also figured out he had a real talent for languages. So he decided to take matters into his own hands. In addition to his regular schooling, he took English and IT courses. When he graduated, he became a teacher himself.

Reza also started working as a peer supporter at the Afghan Landmine Survivors' Organization (ALSO). He says that a person who has to experience the limitations and barriers imposed upon him by the community really feels disabled. But one does not need to rely on others one's entire life, and should strive to be self-reliant. Reza assisted in conducting interviews for this report.

Albania

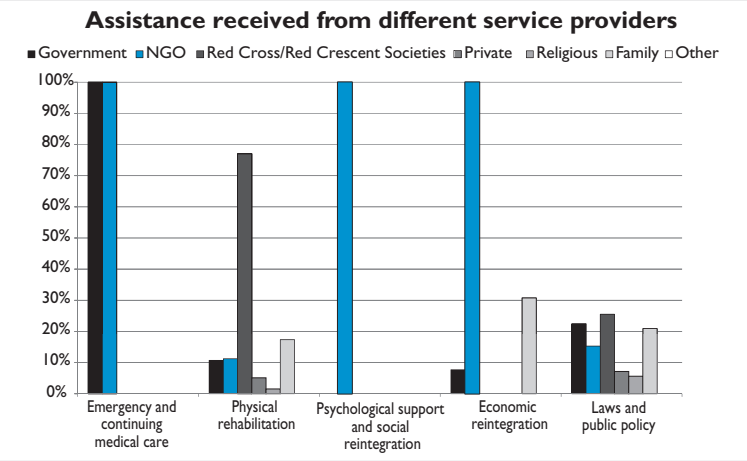
Country indicators

- *Conflict period and mine/ERW use:* Mines/ERW contamination from the 1998-1999 Kosovo crisis is found in the north-eastern border districts of Kukës, Has, and Tropojë. Forces of the former Federal Republic of Yugoslavia (FRY) laid minefields; both FRY forces and NATO used cluster munitions which spilled into Albania. Civil unrest in 1997 included looting from military depots and subsequent abandoned explosive ordnance (AXO) contamination throughout the country, which is ongoing due to the intermittent abandonment of illicitly possessed weapons caches.[1]
- *Estimated contamination:* As of 2008, in northeastern Albania, 43 suspected hazardous areas cover 1.6 km^2 and unquantifiable levels of AXO contaminate most other regions. The affected population is unknown, but incidents have occurred in all regions.[2]
- *Human development index:* 68th of 179 countries, medium human development (compared to 65th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$3,840 - 113th of 210 countries/areas (compared to US$ 2,389 in 2004).[4]
- *Unemployment rate:* 12.5% official rate; this may exceed 30% due to preponderance of near-subsistence farming (compared to 15.8% official rate; actual rate 30% in 2004).[5]
- *External resources for healthcare as a percentage of total expenditure:* 3.7% (compared to 2.4% in 2004).[6]
- *Number of healthcare professionals:* 53 per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* No budget was allocated for the National Disability Strategy.
- *Measures of poverty and development:* Poverty in the mine/ERW-affected rural mountain areas remained higher than the national average (26.6% compared to 13%) and relatively constant, whereas the national average decreased. It is possible that this ongoing disparity will result in "the creation of a poverty trap" in the mountain areas.[9]

VA country summary

Total casualties in mine/ERW-affected areas since 1999: 272			
Year	Total	Killed	Injured
2004	25	6	19
2005	2	0	2
2006	0	0	0
2007	0	0	0
2008	0	0	0
Grand total	**27**	**6**	**21**
Total recorded casualties in AXO-affected areas since 1997: 489			
Year	Total	Killed	Injured
2004	21	3	18
2005	23	1	22
2006	1	0	1
2007	18	2	16
2008	0	0	0
Grand total	**63**	**6**	**57**

- *Estimated number of mine/ERW survivors:* Approximately 738 (238 mine/ERW survivors in northeastern Albania and an estimated 500 AXO survivors elsewhere).[10]
- *VA coordinating body/focal point:* The Albanian Mine Action Executive (AMAE) is the coordinating body; its VA officer (a medical doctor) is the focal point and has actively engaged all relevant actors.
- *VA plan:* The National Victim Assistance Plan of 2003 was incorporated into the 2005-2009 VA objectives and plan. Since 2005, these have been used actively and revised as needed.
- *VA profile:* While immediately after the 1998-1999 conflict there was a significant international presence in northeast Albania, most organizations had pulled out by 2004. They left behind an insufficiently state-funded infrastructure, which subsequently reduced VA capacity. Nevertheless, Albania has made strides in developing all VA components in the northeast since the introduction of an initial VA plan in 2003. Extensive data collection used for program design and information-sharing contributed to the success of the regional VA program in 2005-2009. Needs-based and comprehensive community-based programming, as well as linkages to broader development strategies, also contributed to progress. Between 2005 and 2009, only one national NGO (VMA Kukës) provided direct VA in Kukës, with the support of AMAE. Initially, progress was most prominent in the areas of medical care, employment and economic support in the northeast, but expanded to all service types through the involvement of the local VA NGO and increasingly with the support of the local health institutions. In



2009, economic assistance continued with international funding, but there were few opportunities for employment in the area. Psychological support was not readily obtainable other than through limited peer support. At the national level, efforts were also made to grasp the extent of AXO casualties and the regional VA program facilitated access to prosthetic assistance for AXO survivors, but with less success, as a comprehensive national data collection system was still lacking in 2009 and requires a commitment of additional resources. Also nationally, the conditions at the National Orthotic-Prosthetic Center have been deteriorating since 2005. By 2009, the center was operating at its lowest level since 2004, despite receiving international support since 1998. Laws do not effectively address the needs of people with disabilities, including mine/ERW survivors. The AMAE VA program contributed to the development and fulfillment of the National Strategy for People with Disabilities, but there is no national budget for the strategy and political will is lacking. The mine action program was scheduled to be completed in 2010. In the absence of a fully-functioning disability strategy, the future prospects for survivors are uncertain. [11]

VA progress on the ground

Respondent profile

By July 2009, 26 survivors had responded to a questionnaire on VA progress in Albania: 20 were men, four were women, and two were boys. Seventeen people had a primary-school level of education, including all of the women; eight others had a secondary-school degree (one person did not answer). Eight men and one woman were heads of household. Only six respondents did not own property and 12 felt their income is sufficient. All survivors were from the Kukës region, and the majority described themselves as living in a village with some services (14); eight said they lived in a remote area without services; and four said they lived in a city with a variety of services.

General findings

Overall, survivors saw progress in all areas of VA since 2005. In many cases, all respondents agreed the situation in a specific area had become better. This is obviously in part due to the small survey sample (26 of 238 total survivors) conducted in a small region under the mandate of the VA program. It also is an indication of the impact a well-functioning, specific VA program can have on a small target group. All respondents found the government was more involved, but also noted it still lacked sufficient resources and political will. This is explained by the clear distinction the survivors appear to be making between the local/national authorities and the AMAE VA program.

All respondents reported services for child survivors were "sometimes" adapted to the requirements of their age levels. Services for female survivors, when compared to male survivors, were reported to be either "absent" (27%) or "equal" (26%); some 15% said such services are "better" and another 8% said they were "much better". [12] Two women responded that services are "absent", one said they were "equal" and one said they are "better".

All of the survivors had been surveyed more than four times in the past five years. They all said this had resulted in their receiving more services; 25 also felt listened-to. All

survivors said they had received the opportunity to explain their needs to government representatives. Most had done so two times during the past five years (54%).

Emergency and continuing medical care

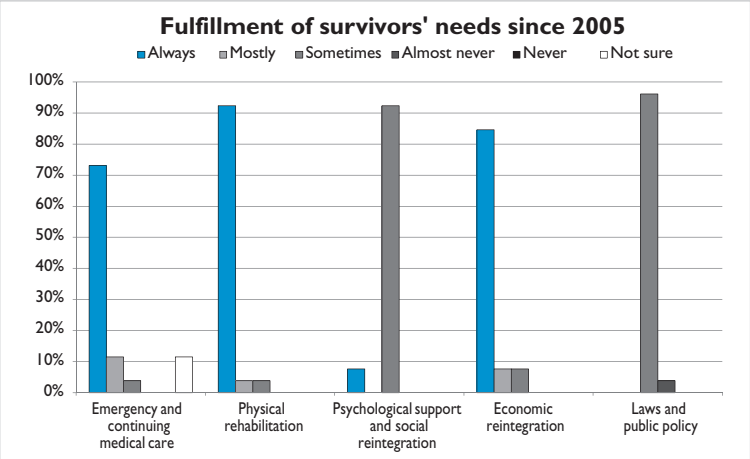
All respondents (100%) reported healthcare had improved. Nearly three-quarters (73%) said survivors "always" receive the healthcare they need. The greatest progress was reported in improved training of health staff (96%) and teams with a more complete range of skills (92%). The fewest respondents saw progress in increased availability of medication (only 21%), and all who responded (13 total) noted that centers were not better-equipped. Almost no one (96%) found it easier to obtain referrals for specialized or follow-up services, and no one felt there were more health centers in the region than in 2005.

These answers, which at first sight seem mutually contradictory, must be seen in light of the effectiveness of the VA program on the one hand, and the overall poverty in the area and poor state of the healthcare system on the other hand. Medical facilities in the mine-affected areas often still have either archaic equipment or almost no equipment. The VA program has regularly found donors for medical equipment,[13] but this may not have been apparent to survivors visiting medical facilities that are still run-down and under-funded, nor would it be apparent to those visited by community nurses. The increased satisfaction with medical staff is due not only to the existence of the network of community nurses/social workers, but also to sufficient staff capacity during the period under review. The existence of this NGO-supported network likely created a bias in the responses. However, it is interesting that this did not result in most people also answering that medical care is available closer to home (most people did not answer this question). This is likely because the nurses only provide first aid, among a wide variety of tasks, and also because survivors still have to travel considerable distances to one of the three regional hospitals or to the capital Tirana to get medical treatment.

Physical rehabilitation

All respondents said that, overall, physical rehabilitation had improved since 2005. The great majority of responses (92%) indicated survivors received all the physical rehabilitation they required (4% responded "mostly" and another 4% "sometimes"). Areas of most improvement included the quality of physical therapy, the quality of prosthetic and other devices, and better-trained staff (92%). All respondents said a larger variety of devices is available and that repairs are available free of charge. However, respondents overwhelmingly (92%) felt physical rehabilitation was not a government priority, and they did not report more centers in their area.

This last response is surprising, given the opening of the Kukës Prosthetics Workshop and Rehabilitation Department in late 2007/early 2008. Possibly those surveyed had not made use of the center yet or still found the distance to Kukës considerable. The Prosthetics Repair Workshop, which has existed since 2005, has been upgraded to full production capability. However, some people were likely to have still been referred to the capital during the past five years. With international support, extensive training has been provided both to prosthetic/orthotic technicians and to physiotherapists.[14] While considerable improvements have been made to the mostly government-



run, but internationally funded, physical rehabilitation sector in northeastern Albania under the stimulus of the VA program, survivors likely see these services as being delivered or supported by local systems, rather than by the state. The complex relationship between AMAE, NGOs and state support for the sector may not be apparent to survivors receiving services.

Psychological support and social reintegration

The respondents were much less positive on progress in psychological support and social reintegration over the last five years, with some 88% saying the situation has remained the same (12% saw improvement). Almost all (92%) also said survivors only "sometimes" received the psychosocial support they needed (8% said "always") – a more positive response than in other countries. Nearly 81% said the government did not provide more support for psychosocial support, and 92% did not see quality improvements. Only half of those answering the question (8 of 16) said there were more opportunities for formal psychological counseling. However, on the positive side, all survivors noted that peer support groups had been created, that they had become more involved in psychosocial support activities for others, and that they were also more involved in community activities in general.

Psychosocial support is only provided by the local VA NGO (VMA Kukës), and responses show both the value-added and the limitations of the service provision. As counseling services are neither widely available nor socially accepted, most survivors would not have received psychosocial support without the NGO and its network of nurses/social workers. The NGO's community-based activities have stimulated peer support and increased community involvement. However, the NGO lacks staff and capacity. While training has been provided to the network, infrequent funding for this activity has resulted in the departure of some of its most experienced social workers/nurses.[15] Government (including AMAE) activities and objectives were among the weakest of the VA program and were limited to awareness raising and facilitation.[16]

Economic reintegration

Overall, 92% of survivors responded that economic reintegration has improved since 2005, and 85% said survivors "always" receive the economic reintegration they need. However, the responses to more specific questions clearly indicate that while there has been some progress in implementing programs for survivors, the economic situation in the region and the country is extremely disadvantageous. All survivors noted there were more educational and economic opportunities in their areas. At the same time, they all also felt there was not less discrimination in education and employment, that employment opportunities for survivors had not increased, and that it had not become easier to access programs not specifically designed for survivors. However, they all said economic opportunities, including micro-credits and other loans through programs specifically designed for survivors, had increased (100%). The respondents also noted increased pensions.

This clearly indicates that without the existence of a specific VA program in the northeast, there would be little or no opportunity for the economic improvement of the lives of survivors in one of the poorest regions in Europe. It was estimated that some 80% of survivors have received economic reintegration assistance through the program. The government is also perceived as having provided more support for economic reintegration. This is, in part, because of improved pensions and because of projects undertaken by local authorities through the regional development strategy and the regional poverty reduction strategy, which have both incorporated activities to reduce the impact of mines/ERW.[17] At national level, the dichotomy in other sectors also persists with respect to economic reintegration, as most people (85%) still say economic reintegration of survivors is not a government priority.

Laws and public policy

Almost all respondents (96%) noted that the rights situation of survivors had remained the same since 2005, and that these rights were only "sometimes" respected or implemented. However, all survivors noted that new policies and legislation had been developed. Of those responding (14), 93% also said there is more awareness about disability among the general public, and that discrimination had decreased (67% of 15 responses).

The survivors' responses corroborate Albania's efforts to increase levels of awareness raising and develop a national disability policy, as well as the efforts of the AMAE to obtain equal rights for mine survivors through mine action legislation. However, government coordination is lacking on disability issues; the enhancement of legislation is still pending and national disability policy is largely unimplemented.[18]

When asked what they would say should the majority of survivors report the situation has stayed the same over the last five years, the VA focal point correctly doubted that any respondents would say this. Furthermore, he offered that if anyone expressed such a concern they would be addressed and assisted individually. The focal point also said VA improvements in the northeast are apparent since the 2004 Review Conference, particularly when compared to the services received by AXO survivors not under AMAE mandate. He also said the prioritizing of infrastructure developments in the area is a sign of the "positive discrimination" of government efforts towards mine/ERW affected communities and survivors.

VA process achievements

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

Throughout 2005-2009, Albania demonstrated significant dedication to implementing the Nairobi Action Plan and has made good use of the tools put at the disposal of the 26 countries with significant numbers of survivors and the greatest responsibility to act, but also the greatest needs and expectations for assistance. Albania used the so-called VA26 process to build on its existing VA plan. When going into the VA26 process in 2004-2005, Albania saw it as a confirmation of its obligation to fulfill its responsibilities to assist survivors, rather than as an opportunity for increased international funding. However, being part of the process did help focus attention on VA in Albania, particularly among donor countries. While the scope of the problem is limited, the VA program is focused on one region and future sustainability is not ensured, Albania has been very successful in achieving the goals it set for itself between 2005 and 2009.

In 2005, Albania presented SMART objectives and revised them in 2006 to make them more suitable and realistic. These objectives were developed with the input of survivors as well as governmental and NGO stakeholders, and were coherent with what had begun in the 2003 VA plan. Throughout the process, needs identified by survivors were prioritized, and this is confirmed by the survivor responses, which unanimously say survivors were included in the development of national action plans and that there is better coordination with the disability sector. The 2005-2009 objectives and the actions to achieve them became the *de facto* work plan for all stakeholders. Planning was developed and improved through the process. Budget allocations were made or projected and progress against the objectives was monitored and reported systematically.

While development and implementation of the objectives was mostly a bottom-up process, AMAE coordination and the role of its VA focal point were pivotal. The focal point liaised systematically with service providers and state representatives and worked with donors to help link donor resources to service providers and to projects planned to fulfill objectives. The continuity in the position, the focal point's experience with the existing medical system, and his ability to work both nationally and internationally for coordination and resources proved vital.[19] This was also reflected in survivors' responses, all of whom know who is in charge of VA coordination. However, it is unclear whether sufficient coordination capacity has been built in the event of the departure of the current focal point.

Through its consistent progress reporting, detailing both achievements and set-backs, AMAE has demonstrated its commitment to the Nairobi Action Plan and made an evaluation of its progress possible. Several objectives have been delayed and timeframes were set back when Albania revised its plans due to some initial hold-ups in establishing programs. Subsequently, most of these revised objectives have either been achieved or have made substantial progress by deadline. Where appropriate, activities were continued past the stated deadline and exceeded the initial target. That the objectives correspond to the needs of survivors is evidenced not only by survivor inclusion in the development of priorities, but also by their responses.

Progress was to a certain extent dependent on available resources and the level of cooperation of the implementing partners. However, given that by early 2009 most of the plans had been achieved, the budget and capacity estimates in the plan appear to have been realistic. The least progress was made when the VA program had to work with the national level, particularly for physical rehabilitation and disability rights. However, the AMAE has successfully lobbied for improvements at the national level, such as better premises and a state budget for the national rehabilitation center, to which the Ministry of Health committed in 2009 after four years of AMAE facilitation.[20]

Internationally, the Albanian VA program has benefited from participating actively in Mine Ban Treaty meetings and has been able to demonstrate the consistency of its program. Albania's example and its lessons learned under the VA26 process could be very useful to other states in the process.

Due to its accomplishments, some might say Albania no longer needs to be one of the VA26 group with "the greatest needs and expectations for assistance." However, further assistance is required to solve the country's precarious economic and social situation. Albania does not yet have adequate resources to do this and will need further international assistance. The lessons learned and the capacities from the AMAE program should be expanded to cover the needs of all survivors in AXO-affected areas and for survivors of other traumatic injuries.

Additionally, the long-term viability of VA in Albania relies on the implementation of the National Strategy on People with Disabilities. The disability strategy's second implementation report, based on survey data from six regions (including several AXO affected areas), was issued in October 2008 and found no progress in some 40% of the measures. Only 2% of the measures were accomplished on schedule.[21] The disability strategy has a long way to go before it can address the needs of survivors, particularly in the northeast.

Conclusions

- The AMAE VA program has significantly improved services and opportunities for survivors in the northeast and, to a certain extent, for ERW survivors throughout the country.
- Survivors were involved in VA planning and implementation, resulting in services appropriate to their needs.
- Psychological support has improved but required continued capacity building.
- Most survivors from the northeast continued to be dependent on AMAE and the VA NGO to access the now-improved services in the region because they live in isolated rural areas.
- Significant effort put into economic reintegration activities for survivors has resulted, to some extent, in "positive discrimination" in an area with high general unemployment.
- Considerable contributions have been made toward bringing medical capacity close to survivors, but their impact may have been lessened by the generally poor state of services in the region.
- Sustainability of VA relies on sufficient national capacity and on the implementation of the national disability strategy. It would not be effective to continue specialized programs for survivors, but general disability initiatives, thus far, have been ineffective.

Suggestions for the way forward

When asked how they saw their situation in five years, all survivors thought it would be better. To assist in a better future ahead, the following suggestions may be taken into account:

- Ensure that VA lasts beyond the end of the mine action program in 2010 by increasing national funding for the disability strategy and involving appropriate international partners.
- Continue mainstreaming of VA into disability, but remain mindful of the slow progress in implementing disability plans and ensuring protection of rights, as well as the lack of budget for implementation of these plans.
- Use AMAE and NGO VA expertise for service provision for AXO survivors and others disabled by explosive or traumatic injury elsewhere in the country, advance inter-ministerial coordination and support capacity building in related fields.
- Continued resources are needed to maintain the peer support and assistance activities of the VA NGO in Kukës and to improve psychosocial support capacities.
- Increase general poverty-reduction efforts in the northeast in order to sustain economic opportunities for survivors and continue to link rural infrastructure projects to VA.
- Redefine survivor participation to ensure that the advancements by AMAE in the past five years are maintained and to include survivors in plans for disability and AXO survivors.
- Draw lessons for the VA26 process in general and for the Cartagena Action Plan from the Albanian VA planning progress, as it has demonstrated that plans linked to survivors' needs and community requests can have more impact than general integration of activities into disability plans, which might not respond sufficiently or rapidly enough to survivors' needs.

Izet Ademi at work
© Jonuz Kola/ VMA Kukës

In his own words: the life experience of Izet Ademi

Izet Ademi, born in 1969, lives in a village in northeastern Albania and is the father of three children. He was a good student, but his family did not have the means to send him to university. Izet thus became a border policeman. He was about 1km from the border, in a location where children and other villagers often grazed animals in summer and gathered wood in winter, when he lost his right leg in a mine incident.

Izet recounts: "I lost my mind. I was in immediate agony. When I regained consciousness, I felt that something was missing from my body… I tried to touch my legs but everything seemed wrong." First aid was given in the Italian Field Hospital near Kukës, and Izet was then transported by NATO/UNHCR helicopter to the military hospital in Tirana. After he received his prosthetic leg he returned home to start a new life, feeling isolated and alone. His only concerns were his children's future and his wife, who had no income.

When the local VA NGO (VMA Kukës) knocked on his door in 2001 he was very skeptical, because other organizations had approached him only to take pictures and then disappear. When Izet found out this local organization was trying to protect the rights and opportunities of mine/ERW survivors, he was convinced. He even joined the association, and nowadays everyone calls him the "happy villager." He is a positive, cheerful role model, ready to help survivors. He travels every day to assist survivors with their rehabilitation needs and to give them hope.

In their own words…

Survivors described themselves as: optimistic for a better future, hopeful for the future, happy father, enthusiastic, pessimistic, persistent, unlucky, desperate housewife, happy villager, very active woman, getting older, grandmother in retirement.

In their own words…

When asked about the main priority for VA in the next five years, almost all respondents said it should be improved psychosocial support and rights enjoyment.

In their own words…

If people really cared about survivors they would: Know them as a group with disabilities.

Both of these responses can be explained by the fact that all of the survivors have received assistance from the only VA NGO in Kukës and form a relatively close-knit group in which members influence one other.

Angola

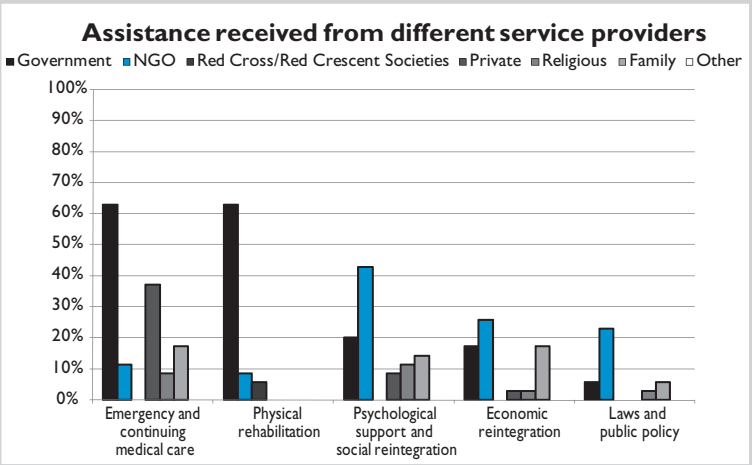
Country indicators

- *Conflict period and mine/ERW use:* Angola is heavily contaminated by mines and ERW. Mines have been used in great numbers by warring parties since the start of the war of independence in 1961 until the end of the conflict in 2002.[1]
- *Estimated contamination:* According to the 2007 Landmine Impact Survey (LIS), 8% of communities in all provinces were mine/ERW-impacted, affecting 2.4 million people. This number is probably higher as some areas were inaccessible to survey teams.[2]
- *Human development index:* 162nd of 179 countries, low human development (compared to 166th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$3,450 – 120th of 210 countries/areas (compared to US$1,106 in 2004).[4]
- *Unemployment rate:* N/A (more than 50% un- and underemployment).[5]
- *External resources for healthcare as a percentage of total expenditure:* 7% (compared to 9% in 2004).[6]
- *Number of healthcare professionals:* 15 per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Angola has a high economic growth rate driven by the oil sector resulting in a reconstruction boom after four decades of war. However, corruption is high and most of the population still needs to live off subsistence farming activities. Nearly 70% of the population lives under the poverty line and average life expectancy is less than 39, among the lowest in the world.[9]

VA country summary

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

- *Estimated number of mine/ERW survivors:* Unknown, unreliable estimates ranging between 23,000 and 80,000.[10]
- *VA coordinating body/focal point:* Officially, the Inter-sectoral Commission on Demining and Humanitarian Assistance (CNIDAH, Comissão Nacional Intersectoral de Desminagem e Assistancia Humanitaria) coordinates VA, and the ministries of health and social assistance and reintegration implement disability activities. But CNIDAH does not have the authority or capacity to direct the relevant ministries.
- *VA plan:* The National Plan for Integrated Action on Victim Assistance 2007-2011 was developed, but largely unimplemented.
- *VA profile:* In 2005, NGOs noted that CNIDAH had become more actively involved in VA and that the government had pledged that VA would become stronger.[11] Angola has significant oil revenues to invest in reconstruction and development. International donor assistance, also for VA/disability, has, therefore, gradually decreased. Amid the many reconstruction, demobilization and resettlement projects since the end of the conflict, disability was not a priority. Governmental health and social services were severely damaged as a result of decades of conflict and remained limited as of 2009. Private services were unaffordable for most mine/ERW survivors and supporting NGOs focused mainly on physical rehabilitation throughout 2005-2009. The absence of decentralized services and the cost of transport and services were serious obstacles to most survivors and persons with disabilities. Costs were not always covered by service providers. Access to healthcare improved due to (re)construction, facility upgrades and an improved road network, but overall it remained limited especially for those in rural areas. Physical rehabilitation provisions have declined since 2005 due to the failed nationalization process of the sector and the departure of all supporting international organizations as of 2009. None of the centers functioning in 2005 were fully operational as of August 2009, staff salaries were not paid and materials not available. Psychosocial support was only provided by local NGOs and disabled people's organizations (DPO) at



community level, but in many cases they also suffered from the decreasing international support. As in 2005, formal counseling structures did not exist and there was insufficient trained staff. Economic reintegration opportunities were also limited due to the poor economic situation overall and a lack of awareness among survivors of existing services. Most initiatives were carried out by NGOs but government vocational training and economic aid programs existed. Various legislations covering the rights of persons with disabilities existed but none of them were comprehensive and draft legislation pending since 2000 had not been approved as of 2009. Plans to systematically collect and analyze data about survivors and their needs had not been achieved, and accurate information about their needs or the services received was unavailable.[12]

VA progress on the ground

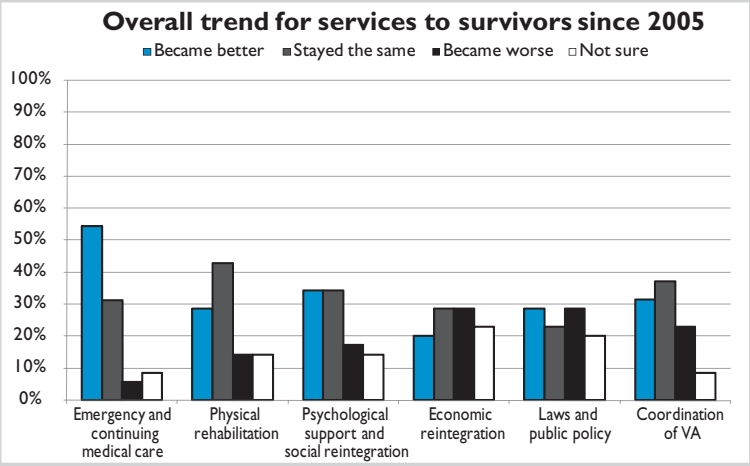
Respondent profile

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

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

General findings

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



Most people (71%) had been surveyed by NGOs or the government at least once in the last five years. More than half of respondents (54%) said that as a result of the survey they had received more information about services; 37% also said they had received more services; 23% felt listened to; and 20% said they had fewer difficulties with bureaucracy. Some 46% of survivors had had a chance to explain their needs to the government. These responses might be slightly too positive, as most respondents were contacted through a network of disability organizations and through rehabilitation centers in relatively accessible areas. However, the responses also confirm the involvement of local authorities, mine action operators, local disability organizations and, to a lesser extent, CNIDAH in collecting casualty and survivor information. Additionally, the LIS and a CNIDAH assessment started in 2009 might also have covered the same target areas. Unfortunately this information has not been unified, verified or organized for use.[15]

Emergency and continuing medical care

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

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

Physical rehabilitation

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

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

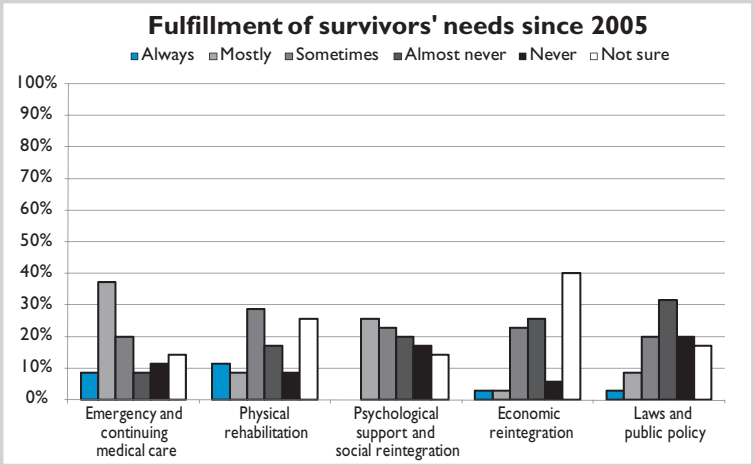
A lack of political will and MoH involvement was often cited among rehabilitation personnel and supporting organizations for the failed sustainability of the PNR. One practitioner working in the sector also noted that NGOs had pulled out of the sector without ensuring that sustainable alternatives were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

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

Psychological support and social reintegration

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

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



Economic reintegration

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

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

their economic reintegration activities since 2005.[24] DPOs and local NGOs gained more capacity in the area (often still with international support). But high general unemployment rates, a large number of persons of working age with disabilities, their high illiteracy rates and concentration in urban areas were considered to be serious obstacles throughout 2005-2009. Fewer services were available in rural areas than in urban areas.[25]

Laws and public policy

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

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

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

VA process achievements

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

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

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

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

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

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

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

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

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

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

Conclusions

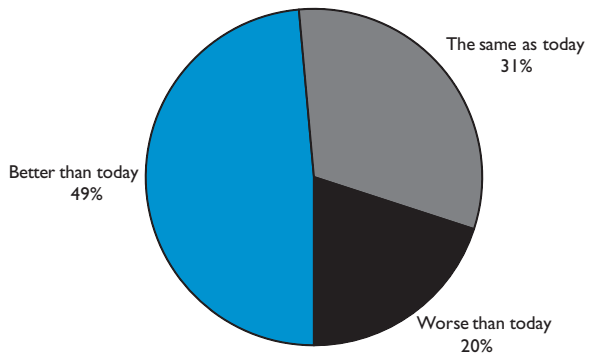
- Areas where survivors saw most improvement were also those highlighted by CNIDAH, particularly medical care. Overall, however, services remained limited particularly in rural areas.
- The negative consequences of the increased malfunctioning of the PNR for physical rehabilitation were not yet felt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

Suggestions for the way forward

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

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

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



Palmira Vanala in her shop
© Handicap International

In their own words…

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

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

In their own words…

If countries really cared about survivors they would:

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

In her own words: the life experience of Palmira Vanala

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

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

Bosnia and Herzegovina (BiH)

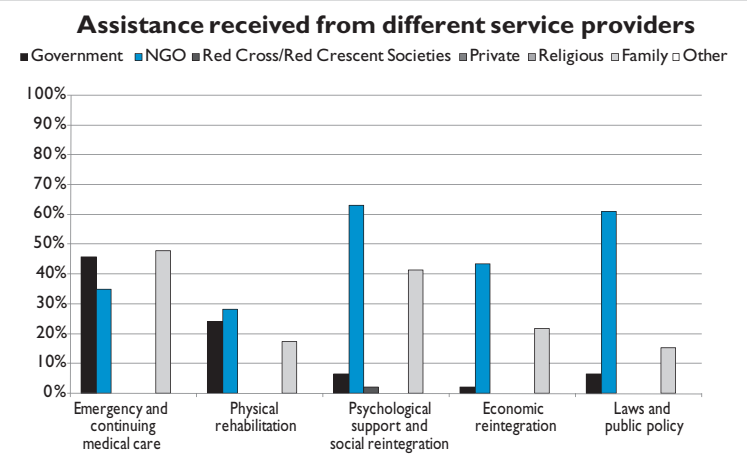
Country indicators

- *Conflict period and mine/ERW use:* Contamination is primarily a result of the 1992-1995 conflict related to the break-up of the Socialist Federal Republic of Yugoslavia.[1]
- *Estimated contamination:* Contamination is estimated at 1,738km^2; affecting some 921,513 people.[2]
- *Human development index:* 66th of 179 countries, medium human development (compared to 66th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$4,510 – 106th of 210 countries/areas (compared to US$2,692 in 2004).[4]
- *Unemployment rate:* 29% (compared to 40% in 2004).[5]
- *External resources for healthcare as a percentage of total expenditure:* 1% (compared to 1.1% in 2004).[6]
- *Number of healthcare professionals:* 61 per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* The conflict in BiH (1992-1995) caused economic output to drop by 80% and resulted in high unemployment. Although the situation has improved, unemployment and reliance on imported goods remains high. Some 25% of the population lives below the poverty line, which as in other "transition" countries, has resulted in social exclusion and a lack of access to an adequate standard of living. A significant portion of the population suffers from low incomes, poor diet, and few employment opportunities, and more people are vulnerable to falling into a cycle of poverty.[9]

VA country summary

Total mine/ERW casualties since 1992: Unknown – up to 7,300			
Year	Total	Killed	Injured
2004	24	13	11
2005	25	15	10
2006	35	18	17
2007	30	8	22
2008	39	19	20
Grand total	**153**	**73**	**80**

- *Estimated number of mine/ERW survivors:* Unknown, but approximately 3,919.[10]
- *VA coordinating body/focal point:* BiH Mine Action Center (BHMAC) was mandated by the Council of Ministers to coordinate VA. An IT/data expert at BHMAC did most of the coordination, rather than a VA officer. Occasionally, an assistant Minister of Health (a medical doctor) of the Federation of BiH has represented BiH at international meetings.
- *VA plan:* VA is a sub-strategy of the 2005-2009 Mine Action Strategy; it remains mostly unimplemented. For 2009-2019, approval is pending on a new sub-strategy.
- *VA profile:* From 1999-2004, most of the direct VA services were provided by international NGOs, often resulting in unsystematic service provision. As post-conflict funding for NGO efforts began to wane after 2004, so did international capacity for VA. Nevertheless, VA efforts continued to rely significantly on international contributions between 2005 and 2009. Regulations and benefits for persons with disabilities differ between entities[11] and even between cantons, but several state-run services are free of charge for some groups, including military disabled and people with insurance. In general, services for disabled military and pensions are better than civilian services and pensions. In 2009, both medical care and physical rehabilitation were deemed sufficient to meet the needs. Medical assistance has been adequate since 2004, despite a dependence on international aid as a result of the conflict. Improvements have mainly been made in emergency response services, again due to international donor contributions. Physical rehabilitation services remain variable in 2009, but overall, the quality is satisfactory, despite a lack of personnel trained to international standards, incomplete rehabilitation teams, and a complex bureaucracy. Government capacity to finance rehabilitation services has improved since 2004. State-run social centers and a network of community-based rehabilitation (CBR) centers – created in 1998 – provide psychosocial support, but continued to suffer from a lack of capacity and awareness throughout



2005-2009. NGOs also provided this type of support. Persistent gaps in economic reintegration remained during the entire period, partly due to high general unemployment. Almost all of the economic reintegration activities were carried out by NGOs, but in 2007-2008 one such activity did receive some co-financing from an entity. Disability legislation does exist but is not enforced sufficiently. Additionally, the inequality of access and the gaps between rural and urban services have increased. From 2005-2009, data on survivors and casualties remained incomplete and unusable for VA planning.

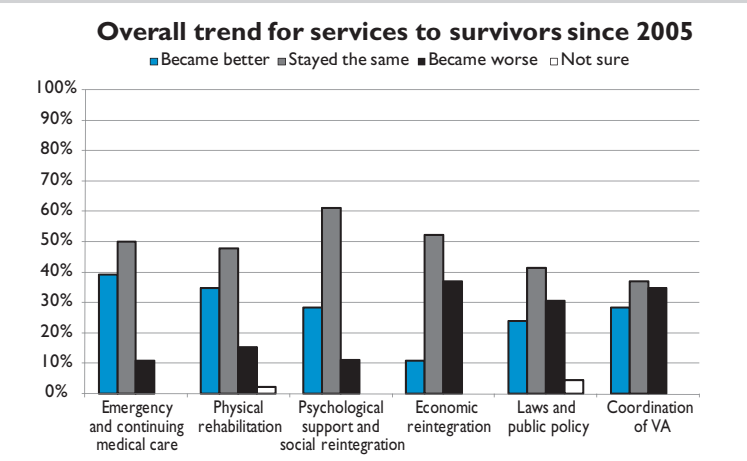
VA progress on the ground

Respondent profile

For BiH, 46 responses were received by July 2009: 44 (96%) were men and two were women. All were between 26 and 78 years old, with 78% between the ages of 35 and 49. The largest group of respondents (43%) lived in villages with some services, followed by people living in large cities with a variety of services (30%), people living in remote areas without services (13%), and people from the capital (7%).[12] Some 72% of respondents had completed at least secondary education. Some 89% were the heads of their household and 72% owned their own property. Almost half of the respondents (48%) were unemployed at the time of survey, although at least 86% of them worked prior to their incident (most of whom had been mobilized as soldiers for the conflict at the time of the incident, but might have left regular jobs to join the army). The vast majority (89%) did not find their household income sufficient. Over three-quarters of respondents (78%) were soldiers at the time of the incident. Most incidents occurred during or shortly after the conflict period (91%). This corresponds with what limited casualty data is available, which indicates some 88% of casualties occurred during the conflict and immediately following it (1992-1996) and that most casualties were men, often military personnel.[13]

General findings[14]

The majority of respondents felt that, overall, services had remained the same since 2005; 70% did not feel they now received more services than in 2005 and 74% did not think services were better. Respondents from rural environments, where services were most needed, reported less improvement than urban respondents. The two female respondents reported the situation was "worse" or "much worse" for women; 52% of all respondents confirmed that services for female survivors were worse or entirely absent. Most people (59%) did not know whether services for child survivors were adapted to their age level, but 26% felt this was "almost never" the case, 4% believed it was "never" the case, and 11% believed it was "sometimes" the case. This response probably reflects a steady decrease in child casualties since 2004.[15]



Most respondents (76%) had been surveyed by authorities or NGOs more than three times since 2005, but 11% had never been surveyed. The majority of respondents (65%) said participation had resulted in increased information about services, but just 39% said they had received more services as a result; 65% of all respondents had the opportunity to explain their needs to government representatives, including 37% who had done so four or more times.

Emergency and continuing medical care

Respondents said that, overall, healthcare services had stayed the same (50%) or improved (39%) since 2005; 11% said the situation has worsened. Most (63%) believe survivors only "sometimes" receive the healthcare they need but 15% said this "almost never" happens. Respondents saw the most improvements in the availability of medication (67%), increased emergency transport (63%), better supplies and equipment in facilities (63%), increased affordability (61%), and easier referral for specialized or follow-up services (61%). The least progress was noted on the availability of services closer to home (39%) and in the number of health centers (37%) − the majority of those seeing improvement in these areas lived in a large city or the capital. Similarly, just 39% of respondents said health staff are better trained or saw quality improvements in healthcare. Less than 25% said the government provided more support for healthcare (24%).

BiH has reported since 2005 that the country has a rather good healthcare network with free services for those with insurance or life-threatening conditions, adequately trained personnel, and sufficient equipment. This may help explain why survivors did not note significant improvements (even though many people still lack health insurance). Since many respondents are military they benefit from automatic insurance. The main areas where progress was needed were emergency transport and faster emergency medical interventions, and these were improved in 2006 with international funding for activities not connected to VA planning.[16]

Physical rehabilitation

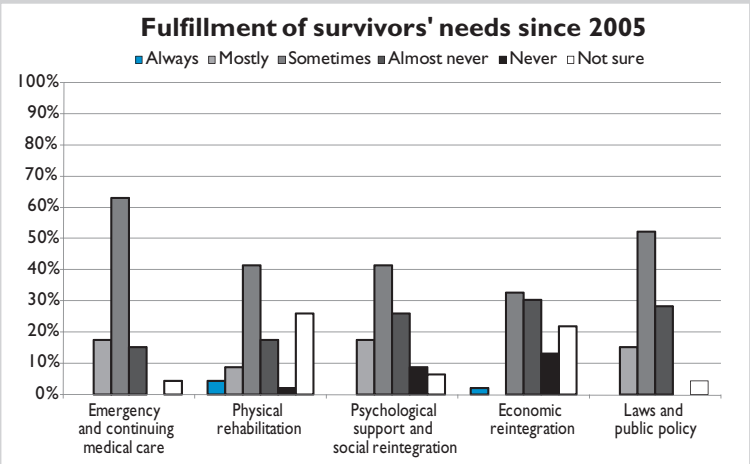
About 35% of respondents noticed an overall improvement in physical rehabilitation since 2005; 48% perceived no change, and 15% thought the situation had actually declined.[17] However, survivors' needs do not appear to have been met, with 41% of respondents saying survivors only "sometimes" receive the physical rehabilitation they need and 17% saying this is "almost never" the case (9% "mostly", 4% "always", 3% "never", and 26% "unsure"). Just 4% believe survivors' physical rehabilitation needs are always met. Areas of most progress were: the quality of devices (54%) and increased physical rehabilitation in hospitals soon after medical interventions (50%). Just under half of all respondents reported that rehabilitation teams were more complete and that more types of prosthetics and other auxiliary devices were available (48%). On the whole, responses indicated mediocre progress, particularly concerning better quality of physical therapy (46%), staff training (43%), buildings (43%), and physical accessibility (41%). Only 20% believed the government had provided more support for physical rehabilitation.

In 2005 BiH declared that the rehabilitation services available and the quantity of prosthetic-orthopedic workshops were sufficient for the needs of the country. It also reported sufficient numbers of trained personnel.[18] BiH repeated its assertion that quality and standards of prosthetics were adequate in both 2006 and 2007.[19] However, an NGO survey of almost 500 survivors found that quality of services was variable; teams were incomplete; and there was a lack of standardization and quality control of devices and services.[20] Survivor responses indicate that these same concerns about quality and staff persist. More importantly, their general assessment appears to indicate that services fell short of meeting BiH's only 2005-2009 objective for physical rehabilitation, namely, to ensure that "every mine survivor" will be provided with "quality prosthetics and, if needed, rehabilitation."[21] Most prosthetic and orthotic staff in BiH were not trained to international standards in 2009.

Psychological support and social reintegration

Most respondents (61%) consider psychological support and social reintegration services to have remained the same since 2005; 28% saw improvement; and 11% believe the situation has deteriorated. Some 41% added that survivors only "sometimes" receive the psychosocial support they need; 35% said these needs were "never" or "almost never" met, compared with just 17% responding that

survivors "mostly" received the needed services.[22] While most respondents (63%) felt more empowered, many (61%) did not think there has been any improvement in survivors being seen as "charity cases." The stigma connected to seeking psychological counseling largely persisted, with just 33% noticing progress; 35% said it was easier to access formal counseling and 35% said more peer support groups exist. Less than half of the respondents said the quality of services had improved (39%) or that services had increased (37%). On the positive side, 50% felt more involved in community activities, and 48% reported that they personally had become more involved in psychosocial support for other survivors. Just 13% of respondents said the government had increased its contributions for psychosocial support.



These responses appear to be at odds with BiH's reports in 2005 that all mine survivors had access to mental health facilities that deal with post-traumatic stress issues. Indeed, psychological support through social and CBR centers has been available since 1998,[23] and peer support through NGOs was also well-established prior to 2004.[24] The fact that these systems have been in place for a significant period of time may have contributed to the respondents' perceived lack of progress. However, throughout the period there have been reports that state-run centers lacked capacity and funding, and that there was a lack of awareness about the issue. In 2007, BiH confirmed that although the centers for social assistance could in theory provide satisfactory support to survivors, their capacities were limited by economic constraints.[25]

Economic reintegration

Most respondents reported that, overall, economic reintegration opportunities for survivors had stayed the same (52%) or deteriorated (37%) since 2005. Many (43%) added that survivors "never" or "almost never" received the economic reintegration services they needed and 33% found this to "sometimes" be the case. Just 2% believed survivors "always" received the economic reintegration assistance needed (22% did not know). Worryingly, all but one respondent believed unemployment was so high that survivors are the last to be chosen for a job. Fewer than 40% of people saw improvement in any economic progress indicators. The most progress was noted in the areas of better physical accessibility of services (39%), more affordable education and vocational training (35%), and less discrimination (35%). However, only 15% said job training programs better met market demands and the same number of people said they had better access to services not specific for survivors. Just 13% thought there were more job placement services or that employment quotas for persons with disabilities were better-enforced. Less than one-tenth of respondents perceived the government as providing more support for economic reintegration activities (9%).

Few (or no) coordinated government efforts for the economic reintegration of mine survivors were reported at any administrative level in BiH, although BiH recognizes that unemployment is one of the country's biggest problems. State services and quotas exist, but are inadequately implemented, not targeted at survivors, and therefore hard for them to access. Although identified as a priority in 2005, BiH did not report on any government efforts to facilitate vocational training and economic reintegration of survivors or persons with disabilities until 2008, when some co-funding was assigned from an entity for one NGO project.[26] NGOs were the main service providers, but their activities were small-

scale and dependent on funding fluctuations. Additionally, NGOs also appear to have focused more on supporting physical rehabilitation and psychosocial activities.

Laws and public policy

Less than one-quarter of respondents (24%) indicated overall improvement in the rights situation of survivors in the last five years; 41% reported no change and 30% said the situation worsened.[27] More than half of all respondents (52%) believed the rights of survivors were only "sometimes" respected; 29% said "almost never"; 15% said "mostly"; and 4% did not know. Survivors reported the most progress in increased access to legal means for addressing violations of their rights (50%), as well as increased information about rights (46%) and about VA services (36%). Some 35% found discrimination had decreased, but just 20% affirmed that survivors' needs are included in disability legislation. The least progress was measured in the enforcement of legislation and policies that should benefit survivors (13%).

Disability legislation varies between the entities, the self-governing Brčko District, and sometimes even between cantons, but gaps exist everywhere. Despite reports by BiH that existing laws have been "fully implemented,"[28] this is not the case, as reports of discrimination in employment, education, access to healthcare and other services persist. Physical accessibility legislation is not enforced, discrimination between civilian and military survivors persists;[29] and in some entities employment laws are yet to be passed. [30]

No government or BHMAC representative answered our request to respond to preliminary findings from the survivor questionnaires.

VA process achievements

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

BiH has largely relied on NGOs and international support for the implementation of VA. BiH has not stated how it made use of its position as one of the 26 countries with significant numbers of mine survivors and therefore the greatest responsibility to act, but also the greatest needs and expectations for assistance during 2005-2009. VA capacity in BiH was reported to be relatively adequate in 2005, particularly in the field of medical care and physical rehabilitation, and the seeds of functioning mechanisms were in place for other sectors, such as psychosocial support. However, BiH does not appear to have joined forces with well-established NGOs to take advantage of the still-significant international interest to further improve these services or to address the chronic problems of economic reintegration and rights enforcement.

In 2005, BiH presented its objectives for 2005-2009 as part of its commitment to the Nairobi Action Plan, but did not make them SMART. The VA sub-strategy of the mine action plan contained similar general goals, mostly focused on managing coordination and further strategy development. A concrete roadmap for implementing the stated goals was never developed and clear responsibilities were not assigned to relevant stakeholders.

There are, therefore, few concrete goals to monitor. One goal, improved emergency response, was achieved independent of the VA process. The most concrete goal, harmonization of casualty data, has not been completed as of August 2009, resulting in inadequate data for planning purposes. Survivor responses clearly indicate that the goals of providing physical rehabilitation and psychological support to "every mine survivor," to

facilitate economic reintegration, and to enforce existing laws have not been achieved.[31] At the international level, statements made by BiH often repeat information about capacity in place since 2005, particularly concerning the existing CBR network and general healthcare infrastructure.

While BHMAC was assigned to coordinate VA in 2004, it did not have the mandate to manage implementation or to take overall responsibility for the VA situation. BHMAC's VA efforts consist mostly of holding coordination meetings. BiH has often repeated in statements that more inter-ministerial coordination is needed.[32] Coordination is also needed across entities, each of which has its own president, government, and social and healthcare systems, as well as the self-governing district of Brčko. Halfway through the five-year period in 2007, BiH held two national VA workshops in which representatives from entity governments, NGOs and BHMAC participated. Although these meetings were intended to review, revise and enhance BiH's initial VA objectives and allocate responsibility for implementation, this was never achieved. The results of the process were, instead, transferred for inclusion in a strategic plan covering another decade, 2009-2019.[33] The plan has not been approved as of August 2009. Less than one-third of respondents (30%) thought that, due to improvements in coordination, they were receiving more services by 2009 than they had in 2005.

This lack of responsibility for VA and subsequent inactivity is reflected in survivor responses. In addition, only 39% believe they know who is in charge of coordinating VA, and the same number of respondents said there were fewer service gaps due to coordination efforts. Most respondents also felt survivors were excluded from the VA planning process: only 15% believed survivors were included in the development of a national action plan and in coordination meetings, or that their needs were taken into account while developing the plan. Just 9% reported that the government became more involved in VA coordination, or that survivors received regular information about VA achievements. Only 4% found there was more government funding for VA. Survivors from BiH frequently participated in Mine Ban Treaty meetings, usually as part of the civil society delegation.

Conclusions

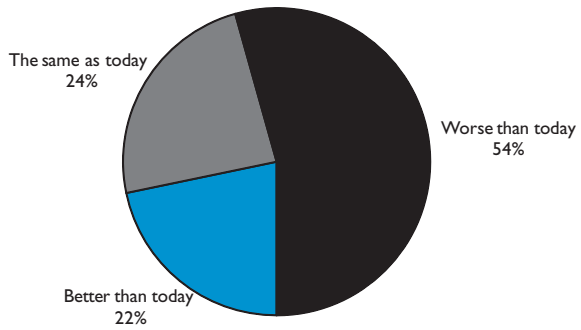
- VA activities were being carried out without taking advantage of BiH's status as one of the 26 countries with significant numbers of survivors and, therefore, the greatest responsibility to act but also the greatest needs and expectations for assistance.
- Complicated state structures may have delayed VA progress, but cannot be seen as the main factor in the lack of progress.
- Survivor satisfaction was the highest in areas where systems were already functioning adequately prior to 2005 and to which few further improvements have been made.
- NGOs continued to be the main providers of economic and psychological support services.
- BiH lacked the political will to coordinate VA and assign responsibilities, resulting in the postponement of any concrete VA plans and activities into the next decade.
- Services and benefits for military disabled were better than for civilians, but both had gaps.

Suggestions for the way forward

When asked about how they saw their situation in five years: 54% of survivors thought it would get worse; 24% thought it would remain the same; and just 22% thought it would be better. To assist in a better future ahead, the following suggestions may be taken into account:

- Immediately start implementation of the already developed 2009-2019 VA strategy by using BiH's position as one of the so-called VA26 to elevate the VA profile and set specific targets for progress.
- Develop coordinated SMART objectives aimed at incremental increases in availability and implementation of services which are achievable throughout the various entities.
- Improve coordination by having a focal point with a clear mandate and expertise that operates across and is inclusive of the different administrative regions of BiH.
- Implement legislation and increase linkages between VA and the broader disability sector.
- Introduce and uphold basic standards for minimum healthcare and physical rehabilitation (including devices) and psychosocial support.
- Increase VA-specific economic reintegration activities and increase access for survivors to broader development programs.

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



Mine/ERW survivors playing volleyball
© ICBL

In their own words…

Respondents described themselves as: free, communicative, integrated (10), nervous, not very open, persistent, satisfied, optimistic.

In their own words…

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

- Improvements in healthcare/rehabilitation.
- Spa treatment.
- Free-of-charge prosthetics.
- Peer support.
- Help with employment and self-employment.
- Development of projects to employ persons with disabilities.
- Education.
- Achievement of rights.
- More engagement of the NGO sector in realizing objectives.
- For the government to pay more attention towards persons with disabilities.
- Accessibility.
- Housing issues.

In their own words…

If countries really care about survivors they would:

- Better implement the laws in practice.
- Allocate more funds for assistance.
- Assist persons with disabilities in all aspects of life, especially education and employment.
- Enact quality laws and provide support to employ persons with disabilities.
- Coordinate between the government and the NGO sector.
- Develop programs for persons with disabilities that will serve their needs and involve organizations that represent them in this process.
- Fully implement laws, especially on education, employment, and accessibility.
- Help us more and not be an obstacle.
- Involve landmine survivors in resolving issues concerning them.
- Forbid discrimination on the basis of disability.
- Create a strategy and action plans.
- Legally address the rights of the disabled and harmonize laws with world standards.
- Pay less attention to bureaucracy and more to inclusion of survivors.
- Sign, ratify and implement the Convention on the Rights of Persons with Disabilities.

In their own words…

A diverse range of opinions were expressed in survey responses and some respondents chose to include comments about services, such as:

One man, who had both legs amputated above the knee after a mine incident some 15 years ago had worked prior to the incident but is now unemployed. He said:
"We have never been asked what we need when it comes to medical treatment… There are no job opportunities for my type of disability."

Another man injured in a mine incident 17 years ago, which resulted in amputation of his right leg and lung damage, said:
"Medical services and production of prosthetics have improved."

One married man, a soldier at the time of his incident, now living in a village and earning a living by cutting wood for others, believes that:
"The future will be better. [Improvements are] due to the fact that the government enacted laws about the right of former soldiers and persons with disabilities to receive physical rehabilitation."

A 40-year-old woman who has had no opportunity for edcuation beyond primary school level due to her financial situation, remarked
"Government and employers do not pay enough attention to employment of landmine survivors and persons with disabilities in general."

A man who has managed to keep his job as a mechanic from before the mine incident, noted:
"The government enacts laws, but those laws do not give results as supposed."

Burundi

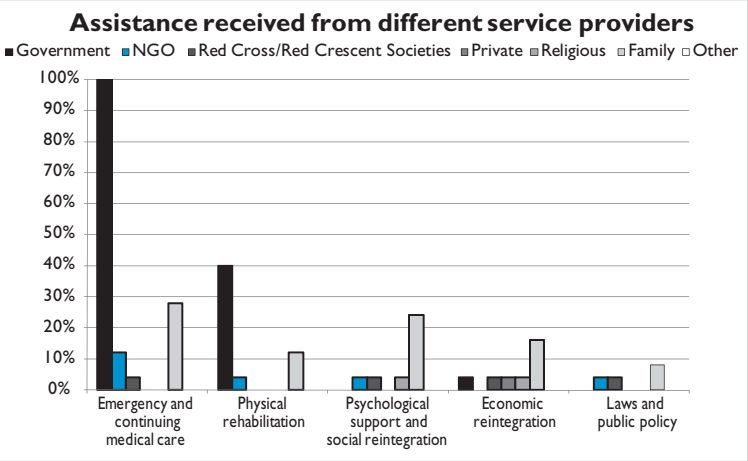
Country indicators

- *Conflict period and mine/ERW use:* Burundi is contaminated with mines/ERW due to use by all parties in the internal conflict, starting in 1993; the first reported government use was in 1996. Use increased in 2002-2003 and there were sporadic reports of ongoing use until 2006.[1]
- *Estimated contamination:* Unknown, but as of May 2009, Burundi said 60 suspected hazard areas remained to be cleared (58 of which needed confirmation).[2]
- *Human development index:* 167th of 179 countries, low human development, (compared to 173rd of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$140 – last of 210 countries/areas (compared to US$86 in 2004).[4]
- *Unemployment rate:* Unknown.[5]
- *External resources for healthcare as percentage of total expenditure:* 13.7% (compared to 13% in 2004).[6]
- *Number of healthcare professionals:* Less than three per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention and its Optional Protocol on 26 April 2007.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Burundi is a country with little resources and has been devastated by years of conflict and instability since independence. More than two-thirds of the population lives below the poverty line, more than 90% must survive from subsistence farming, and HIV/AIDS rates are among the highest in the world. While external assistance and economic activity have increased since the end of the conflict in 2006, further development is hampered by low education levels, a weak legal system, and a lack of the most basic food, water and electricity supplies.[9]

VA country summary

Total mine mine/ERW casualties since 1993: Unknown – at least 1,564				
Year	Total	Killed	Injured	Unknown
2004	320	105	213	2
2005	14	4	10	0
2006	15	10	0	5
2007	8	3	2	3
2008	4	2	2	0
Grand total	**361**	**124**	**227**	**10**

- *Estimated number of mine/ERW survivors:* Unknown, but between 523 and 1,314.[10]
- *VA coordinating body/focal point:* None; the mine action center does not include VA in its mandate. Disability issues are distributed among several ministries without any clear coordination.
- *VA plan:* None, and there is also no disability plan. Persons with disabilities are included in the 2006 poverty reduction strategy, which is largely unimplemented.
- *VA profile:* A UN Mine Action Service (UNMAS) evaluation in November 2004 recommended a comprehensive VA program should be established. Between 2005 and 2009 no such program was established, nor was there any VA/disability coordination. Burundi continued to acknowledge that its VA/disability provisions are weak and, in 2009, it was repeated that much remained to be done.[11] Mine/ERW survivors receive the same treatment as other persons with disabilities, but programs are limited and uncoordinated. Burundi's infrastructure, including basic healthcare and rehabilitation services, has deteriorated as a result of the conflict begun in 1993. Despite large international support projects, health infrastructure remains weak, ill-equipped, and under-staffed; specialized care is confined to the capital Bujumbura. Cost recovery schemes limit access to healthcare for the poor. Although some vulnerable groups, including persons with disabilities, can obtain cards for free services, they are not always honored. In May 2009, Burundi said emergency response can only be carried out by international organizations.[12] The physical rehabilitation sector remains entirely dependent on international NGO financial and capacity support, which has resulted in renovations and quality improvements. These NGOs also cover patients' costs, but overall services are too limited to meet demand. In 2009, as in 2005, psychosocial support was being carried on a small scale by NGOs and disabled people's organizations (DPO). The limited economic reintegration services that exist do not target survivors or persons with disabilities, a serious



obstacle in a country with very poor economic conditions overall. Burundi lacks legislation for persons with disabilities. Draft legislation was introduced in 2004 and 2007, but as of 2009 had not been approved. Since plans to collect and analyze data about survivors and their needs have not been achieved, accurate information about the number of survivors or the services received was unavailable.[13]

VA progress on the ground

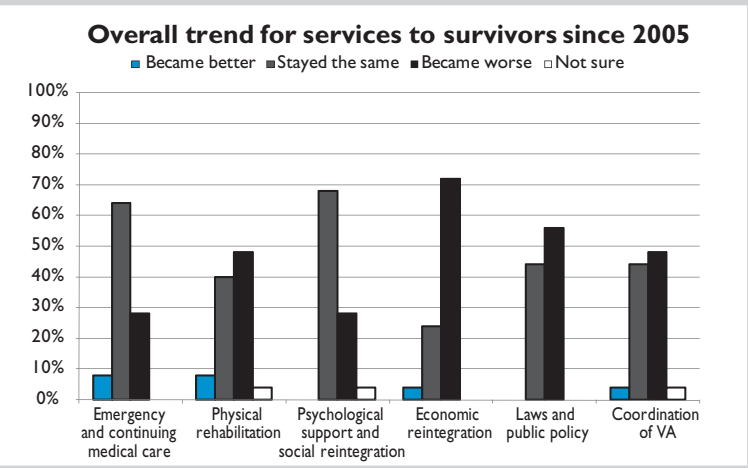
Respondent profile

For Burundi, responses from 25 mine/ERW survivors to a questionnaire about VA progress in since 2005 were used.[14] All respondents were men from Bujumbura between 26 and 45 years old. Some 56% were heads of households and 60% owned property. More than half of respondents (52%) had started secondary school and two people had gone on to further education. Some 84% were unemployed at the time of the survey; all were employed by the military at the time of the incident. More than one-third (36%) did not feel their household income was sufficient (60% did not respond).

It was impossible to survey survivors living outside of Bujumbura or those who were not already members of a particular association due to a lack of in-country capacity, ongoing insecurity, poor infrastructure, and the fact that several NGOs claim mine/ERW survivors are not an issue in Burundi.[15] The profile of the respondents, therefore, does not correspond to the majority of survivors, many of whom are civilians, often from rural areas.[16] However, the consistency of the responses provides a valuable snapshot of the living conditions for some survivors in Burundi.[17]

General findings

The majority of respondents felt VA provisions had remained unchanged over the past five years and economic reintegration opportunities had declined. No respondents said they received more or better services. Although the validity of responses cannot be ascertained due to the lack of female respondents, 52% of people felt services for female survivors were "absent" and another 32% said services for women were worse than those available for men. Also, 72% of respondents thought services for child survivors were "never" or "almost never" adapted to their age levels.



The majority of respondents (64%) had not been surveyed by the government or NGOs since 2005. They had also seen few benefits from such surveys; just 36% said they had received information about services as a result of participation, while 24% reported having fewer problems with bureaucratic procedures as a result.

These results confirm the lack of data collection in Burundi and the fact that NGOs do not distinguish mine/ERW survivors from other war victims.[18]

Emergency and continuing medical care

Nearly two-thirds of respondents (64%) said medical care had remained the same since 2005; 28% saw deterioration. Nearly half (48%) said survivors "sometimes" received the medical care they needed and 24% felt this was "almost never" the case. The vast majority saw no improvements within specific areas, though 12% said facilities had improved and staff was better trained. Just 4% thought there were quality improvements, more emergency transport, and that healthcare was more affordable. None thought the government provided more support to the sector.

These responses confirm persistent reports of a lack of healthcare infrastructure and capacity despite extensive international reconstruction support from, among others, the World Health Organization (WHO) throughout 2005-2009. Health sector improvements were also included in the poverty reduction strategy. Several facilities were renovated and services extended somewhat to rural areas. In 2009, the government reported that emergency care had to be left to NGOs[19] because of a lack of capacity and because NGOs already work in the areas where incidents might occur. Strikes by personnel against low salaries and poor working conditions have further exacerbated services. Specialized assistance is only available in a limited number of hospitals, almost all in Bujumbura. A cost recovery system introduced in 2004 has also made services unaffordable for vulnerable groups, even though they were in principle eligible for free services if they had a special card. Health centers did not always accept this card, nor were all costs covered by it.[20]

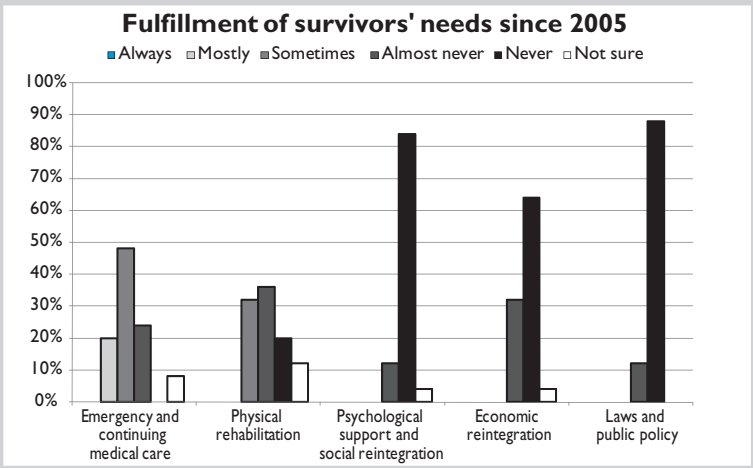
Physical rehabilitation

Nearly half of respondents (48%) felt that, overall, physical rehabilitation services had gotten worse since 2005 and the majority (56%) felt survivors "never" or "almost never" received the physical rehabilitation they needed. Again, few respondents saw advances on any of the progress indicators, with just 12% saying they could get services closer to home and 8% saying transportation and accommodation were increasingly included as part of service. Only 4% found staff better-trained, that rehabilitation centers had more complete teams, or that it was easier to get replacement devices. No one saw improvement in the affordability or quality of services.

Throughout 2005-2009, it was reported that the existing physical rehabilitation services were insufficient and that no prosthetic/orthotic training facility existed. Since 2005, international support has been extended to all orthopedic centers in Burundi, which, as of 2009, needed extensive international financial, material and training support. In May 2009, Burundi reported centers lacked the staff and equipment necessary to meet the needs of survivors. It also reported that just four centers were functioning;[21] whereas in 2004 nine centers were reported open.[22] Burundi also noted in 2009 that 10-20% of patients needed to be sent abroad for treatment.[23] Mobility devices were usually not free (unless covered by a supporting NGO or the card for vulnerable people), waiting lists were long, and referral mechanisms were lacking, which affected the survivors' responses. In rural areas, access was also limited by difficult terrain and climatic circumstances. Responses would also appear to confirm a survey in 2006 by Handicap International (HI) that 71% of persons with disabilities in three southern provinces did not have access to mobility devices.[24]

Psychological support and social reintegration

Most respondents (68%) felt psychological support and social reintegration services had remained unchanged since 2005. Additionally, 84% said survivors "never" received the psychosocial support they needed and 12% said this was "almost never" the case. A very small minority (8%) felt there was less stigma related to seeking psychological counseling and that survivors were no longer considered "charity cases." Just 4% felt empowered, more involved in community activities, or more involved in providing psychosocial support



services to other survivors. No survivors felt peer support groups had been developed or that the government provided more support to the sector. While the respondents were members of an association of former combatants, this association worked mostly on confidence-building and development issues; disability was just one of many issues and did not explicitly include peer support.

Throughout 2005-2009, psychosocial support activities were limited and were mostly carried out by NGOs targeting all war victims, by some DPOs, and by one state hospital outside of Bujumbura. A survivor organization was created in 2004 but it is unknown whether it is still active. Providing psychosocial support to war victims was also one of the goals of Burundi's poverty reduction strategy in 2006.[25] However, it would appear that, as a small group among the many traumatized by war, mine/ERW survivors might not have been able to access what limited opportunities there are.

Economic reintegration

Nearly three-quarters of respondents (72%) felt that, overall, economic reintegration opportunities had deteriorated since 2005 and 4% saw an overall improvement. Again, 64% of respondents felt survivors "never" received the economic reintegration services needed and another 32% said this was "almost never" the case. Just 4% of respondents saw improvement in accessing educational, vocational training, employment or income-generating opportunities. All respondents felt unemployment was so high survivors were the last to be chosen for a job. They commented that a lack of education and vocational training opportunities for survivors meant they did not have the proper schooling to qualify them for employment.

With an 84% unemployment rate among respondents, it is clear that economic opportunities were seriously lacking among this group. Vocational training is organized by the government but it is not targeted at persons with disabilities and is of variable quality. The government's activities specifically for persons with disabilities appear to be limited to tax exemptions for goods used in small income-generating projects. Other economic reintegration activities are either small-scale projects carried out by DPOs, or include persons with disabilities as part of a larger group of vulnerable people. In 2008, Burundi also acknowledged that prejudice and discrimination hamper disabled persons' opportunities[26] and acknowledged that the task of providing economic reintegration to survivors "remains immense."[27] Most persons with disabilities (adults and children) also had limited access to education, especially in rural areas where schools were long distances away. A 2006 HI assessment noted that 53% of persons with disabilities in three southern provinces had never been enrolled in schools,[28] which would confirm the respondents' comments. The bad economic situation and limited job opportunities for all people in Burundi were further obstacles. It was reported in 2004 that disabled military who cannot return to their duties receive pensions,[29] but this was not mentioned by respondents.

Laws and public policy

Most respondents (56%) felt the protection of survivors' rights had worsened and 44% felt it had remained the same since 2005. The vast majority (88%) thought survivors' rights were "never" protected and the remaining 12% said they "almost never" were. Just a very small minority saw improvements in some specific areas: 8% said survivors had increased access to legal action when their rights were violated. However, no respondents saw

decreases in discrimination, or in the use of negative terms about persons with disabilities, nor did they see increased disability awareness among the general public. All respondents felt disability was a stigma and that they had no voice in government.

As of July 2009, Burundi had no specific disability legislation. Draft laws developed in cooperation with the disabled persons' union and introduced in 2004 and 2007 remained pending. Some awareness raising has been carried out, but in November 2008 Burundi acknowledged that disability legislation and ratification of the UNCRPD were among its greatest challenges.[30]

When asked to respond to preliminary findings, a government representative acknowledged that not all survivors had been assisted and that while "we try to assist as many people as possible, we don't have the financial means to reach everyone." However, the representative added that the government was interested in trying to improve survivors' lives.

VA process achievements

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

Note: Burundi only reported one sentence on casualty data in its 2008 Article 7 Report.

Since 2004, Burundi has acknowledged that, of all its Mine Ban Treaty obligations, VA is "the weakest link in the chain" and that "everything remains to be done."[31] In 2009, one government official said the situation remained much the same, stating that VA efforts were still weak and calling for increased international assistance. Devastated by decades of conflict and one of the poorest countries in the world, Burundi is heavily dependent on the international community for the provision of most basic services. Any progress made relevant to VA/disability is being achieved through post-conflict reconstruction efforts. While disability was included in several reconstruction and poverty reduction efforts, there is no coordination of VA/disability.

UNMAS saw the need for a comprehensive VA program in 2004. After stakeholder consultation, UNMAS proposed a draft strategy in 2005 calling for comprehensive assistance through existing programs, establishment of a coordination mechanism, casualty data collection, promotion of survivors' employment, and increased resource mobilization.[32] As of May 2009, Burundi had not formally presented any 2005-2009 objectives or plans to implement the Nairobi Action Plan. As one of the 26 countries declaring responsibility for the greatest numbers of survivors, but also the greatest needs and expectations for assistance, Burundi committed to defining its own SMART objectives, developing plans to achieve these objectives, implementing the plans, and monitoring and reporting regularly on progress.[33]

However, Burundi has on various occasions in 2005-2009 presented what it calls its "coherent victim assistance program" which identifies the need to strengthen healthcare and establish community-based rehabilitation, as well as to develop a disability strategy and recognize the rights of persons with disabilities. Most tasks in the program would be carried out by NGOs and DPOs in cooperation with ministries.[34] However, the program does not include specific targets or timeframes and there is no evidence that implementation is underway.

One of the main obstacles is the lack of a VA/disability coordination mechanism or focal point. Disability issues (and therefore VA) are included in the mandates of several ministries

without a clear division of tasks and responsibilities. VA is not included in the work of the mine action center, which assumed this was the role of the Ministry of National Solidarity as one of the main ministries dealing with disability issues, but was unable to provide any further information.[35] Survivor responses appear to confirm this vacuum, with 48% saying coordination had worsened since 2005. Just 4% felt the government coordinated better with NGOs, provided regular information on VA achievements, included survivors' needs in national VA priorities or that survivors were involved in the development of plans.

According to a government representative, Burundi participated in the so-called VA26 process assuming they would continue to receive UN technical advice to help them make progress on VA. Another reason was that the UN highlighted the importance of mobilizing additional international resources for VA, which Burundi has called for repeatedly between 2005 and 2009.[36] The government representative assessed that some survivors had received services because of international aid, but was not sure whether this was a result of Burundi's participation in the VA26 process. Among survivors, 64% thought a lack of financial resources prevented VA progress, but 100% said the government lacks the political will.

Conclusions

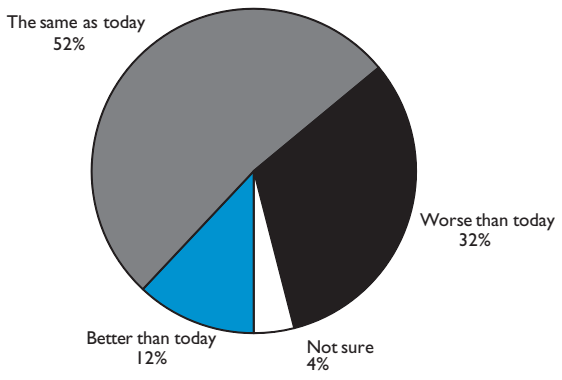
- Burundi remains dependent on international assistance to provide basic health, social and economic services to its population.
- Broader efforts to support Burundi's healthcare and physical rehabilitation services system have benefited some survivors (mostly in the capital), but much work remains to be done.
- NGOs have not implemented any programs specifically for mine/ERW survivors, whose access to broader programs for conflict victims appears to have been limited due to a lack of awareness and the large number of conflict victims.
- Psychosocial support and economic reintegration opportunities are limited for the entire population and almost non-existent for survivors and persons with disabilities.
- While disability was included in several development and poverty alleviation schemes, implementation and benefits have been limited, particularly, it seems, for survivors.
- Burundi has not established effective VA/disability coordination and implementation mechanisms despite early calls regarding the need for a comprehensive program.
- Survivors have not been included in planning or implementation.

Suggestions for the way forward

When asked about how they saw their situation in five years, 32% of survivors thought it would be worse than today; 12% thought their situation would be better; and 52% thought it would remain the same.[37] To assist in a better future the following suggestions may be taken into account:

- Clearly define the role of the ministries working on disability issues and assign a leadership role to one of them, possibly the Ministry of National Solidarity.
- Develop a coordinating mechanism supported by a lead ministry which includes other relevant government bodies, NGOs, DPOs and survivors.
- In the short term, provide international technical assistance to develop national capacity for coordinating and planning VA/disability.
- Develop a disability plan with specific timelines and targets inclusive of the needs of mine/ERW survivors and in consultation with them. Allocate sufficient national and international resources for its implementation
- Proactively promote the inclusion of mine/ERW survivors and other persons with disabilities in programs for war victims and vulnerable groups.
- Urgently develop disability legislation based on UNCRPD and a mechanism to coordinate and monitor its implementation.

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



Young landmine/ERW survivors and other persons with disabilities performing
© Dieter Tielemans, for Handicap International

In their own words…

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

- Healing sick people and ERW survivors.
- Helping me to run a small business and raise cattle.
- Creating associations to support survivors.
- Providing funding to re-launch our economy.
- Acknowledging victims' rights.
- Making a clear national action plan for victims.
- Creating income-generation activities.
- Building homes.
- Providing assistance for our basic survival.

In their own words…

If countries really cared about survivors they would:

- Improve their living conditions by creating jobs.
- Build homes for them and give them mobility devices.
- Listen to survivors.
- Provide social reintegration and follow-up services.
- Ensure healthcare.
- Create a lot of jobs for survivors.
- Have the political will to support disabled people.
- Include a representative of war victims in the government.
- Ratify a law for disabled people and create income-generating activities.

In his own words: the life experience of Claude J. Niyonzima

Claude left school to join the army, but in 2001, at the age of 22, he was seriously injured by an explosive device and has suffered from paralysis ever since. Claude has received medical care from NGOs and the government and psychological support from family and friends. However, he does not feel there are other services available to him, for example, he has not received follow-up physical rehabilitation or economic reintegration opportunities. Claude is therefore unemployed, does not own property, and lacks sufficient financial means.

Claude believes survivors at least deserve adequate healthcare and housing and should be recognized as heroes who have suffered for the good of their country. He thinks the government and the international community should visit survivors and listen to them so as to better understand their needs and find ways to help them.

Cambodia

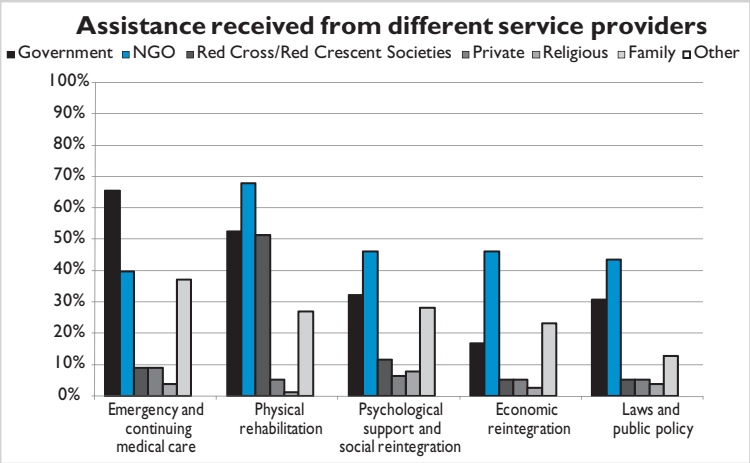
Country indicators

- *Conflict period and mine/ERW use:* Cambodia is severely contaminated by mines, cluster submunitions and ERW as a result of three decades of conflict (used by Vietnam, the Cambodian army, Cambodian guerilla forces and the US).[1]
- *Estimated contamination:* As of May 2009, some 3,867km^2 of land was estimated to remain contaminated, affecting 122 districts; 672km^2 needed full clearance. However, these figures were considered to be exaggerated as current data "presents a suspect area that all in the sector know is a massive, inaccurate and distorting snapshot."[2]
- *Human development index:* 131st of 179 countries, medium human development (compared to 130th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$600 – 182nd of 210 countries/areas (compared to US$330 in 2004).[4]
- *Unemployment rate:* 3.5% (compared to 2.5% in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 22.3% (compared to 26.7% in 2004).[6]
- *Number of healthcare professionals:* 11 per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention and its Optional Protocol on 1 October 2007.[8]
- *Budget spent on disability:* Estimated around US$8 million government support (likely through international sources) and US$7 million NGO support.[9]
- *Measures of poverty and development:* Despite constant economic growth since 2004, many people in Cambodia remained poor, particularly in rural areas. More than 50% of Cambodia's population is younger than 21 and there is a lack of educated human resources. It was estimated that 35% of the population lived below the poverty line.[10]

VA country summary

Total mine/ERW casualties since 1979: 63,402			
Year	Total	Killed	Injured
2004	898	171	727
2005	875	168	707
2006	450	61	389
2007	352	65	287
2008	269	47	222
Grand total	**2,844**	**512**	**2,332**

- *Estimated number of mine/ERW survivors:* At least 43,926.[11]
- *VA coordinating body/focal point:* The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) coordinates VA with the support from the Disability Action Council (DAC); both lack capacity and need external technical advice.
- *VA plan:* The National Plan of Action for Persons with Disabilities, including Landmine/ERW Survivors 2009-2011; implementation slowly started in mid-2009.
- *VA profile:* Between 2005 and 2009, Cambodia remained very dependent on external support to implement services for its significant number of mine/ERW survivors and, indeed, the population in general. Cambodia was devastated by decades of war and continued to suffer from poor infrastructure, bad road networks and a shortage of well-educated staff. Relevant ministries lacked capacity to carry out or coordinate VA/disability services and a 2007 Austcare evaluation found that the government needed to be more responsive to community needs without bias or political corruption.[12] Corruption is rife in Cambodia. Services to survivors were often seen as part of community development projects, as many survivors and affected communities still lacked access to clean water, electricity, sufficient food and arable land. Healthcare varied from community to community but complex care could only be carried out in national-level hospitals in major cities. Road conditions and the cost of services were obstacles, as were the lack of well-trained staff, emergency response mechanisms and equipment or supplies. The physical rehabilitation sector functioned well, but was extremely dependent on international financial and technical support. Nationalization of the sector started but was progressing slowly. A community-based rehabilitation (CBR) network coordinated by MoSVY was started in 2006 to fill the many service gaps at community level. It continued to expand and build capacity in 2009. Psychosocial support was limited and mainly conducted by NGOs who were also crucial in the establishment and support of self-help groups. These groups served an economic reintegration, peer support,



and awareness raising purpose to assist persons with disabilities in organizing and improving their community participation. Economic reintegration activities were mainly carried out by NGOs but some government initiatives of varying quality also existed. However, it was estimated that some 400,000 children with disabilities did not have access to school and that vocational training often did not meet the needs of persons with disabilities and was frequently not followed by actual employment. Discriminatory employment policies continued to exist. Disability legislation pending since 2000 was finally approved in July 2009. Disabled people's organizations (DPO) in Cambodia are active and increasingly well-organized but still need capacity reinforcement. In the short to medium term, no end to NGO and international support for VA/disability could be envisioned. However, donor interest and support has decreased slowly but steadily since 2005.[13]

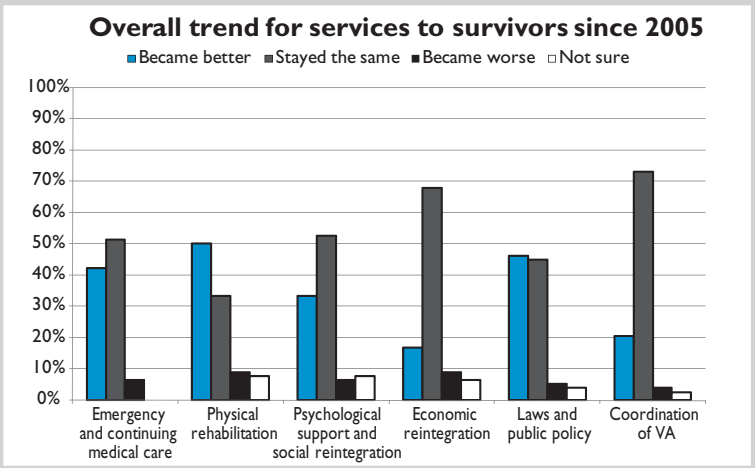
VA progress on the ground

Respondent profile[14]

By July 2009, 78 survivors between 20 and 59 years old responded to a questionnaire on progress in VA in Cambodia since 2005: 67 men and 11 women. Some 71% were heads of households and 77% owned property. Nearly three-quarters of survivors (74%) lived in villages with limited services; 18% lived in remote areas without services; and 5% lived in a main city with a variety of services or the capital.[15] Respondents came from Battambang, Siem Reap, Pursat, Kampong Thom, Kampong Speu, Banteay Meanchey, and Oddar Meanchey provinces. Some 36% of respondents had not received any formal education and just 18% had gone to secondary school or higher. Just one person reported being unemployed prior to the incident; this increased to five after the incident. Most survivors changed their jobs as a result of the incident and became farmers (55 or 71%). Many respondents had their incident during the conflict (1979-1991) when they were recruited to fight or shortly after. Just 8% of people said that their income was sufficient. This profile corresponds with casualty data, which indicates that mines/ERW continue to cause casualties in all parts of Cambodia, usually young males. While the vast majority of casualties are civilians killed or injured in rural areas, many of the older casualties would have been civilians forced to fight during the conflict. Most casualties were recorded in Battambang and Banteay Meanchey provinces.

General findings

Overall, a significant number of survivors saw improvement in VA/disability service provision since 2005, but a significant percentage also found that the situation remained unchanged. Most progress was noted in physical rehabilitation and least in economic reintegration. Some 60% of respondents found that they received more services in 2009 compared to 2005, and 67% found that the services had improved. It needs to be noted that, in addition to the services asked about, many survivors had much more basic needs, such as food aid, clean water and housing. Jesuit Services Cambodia already noted in 1999 that many survivors lacked the most basic necessities; they confirmed this was still the case in 2004, and now in 2009, for a significant number of survivors the situation remained the same.[16] Due to their often low educational levels, many respondents found many questions difficult to answer. Practitioners generally saw more improvement than survivors, particularly in psychosocial support and economic reintegration.



The largest group of respondents (41%) had not been surveyed by NGOs or the government in the last five years, but the second largest (22%) group had been surveyed more than four times. Some 45% of respondents felt that survey activity resulted in their receiving more information about services, as well as more actual services. But just 18% felt it was easier to obtain a pension. Some 21% of survivors had had the opportunity to explain their needs to government representatives at least once. Cambodia operates a very efficient data collection mechanism (the Cambodia Mine/UXO Victim Information System, CMVIS) which captures nearly all casualties in Cambodia, so all respondents would have been interviewed by a CMVIS data collector at one point. CMVIS also started conducting a survey of assistance received by survivors in 2006, but the project remained suspended as of August 2009 due to problems with the questionnaires and a lack of support from its international advisor. The collection of this type of data was seen as crucial to better VA planning and was one of Cambodia's goals for 2005-2009. Since 2007, CMVIS also noted that due to the decreasing number of casualties, it had to reduce its staff which affected its capacity to maintain links with communities and provide referral and information.

Two-thirds of people thought that services for female survivors were equal to those available to male survivors, but 15% said that services for women were "much worse". Women responded more negatively: 45% said services were "equal" and 27% said "much worse". Some 30% of respondents were not sure whether services for children were adapted to their age and 26% thought this was "sometimes" the case.

Emergency and continuing medical care

More than half of survivors (51%) thought that, overall, healthcare had remained the same since 2005 and 42% saw improvement. Some 41% thought that survivors "sometimes" received the medical care they needed; 21% said they "mostly" received needed services; but 14% said this was "almost never" the case. The area of most progress was increased affordability of medical care (68% saw progress), followed by improved infrastructure (67%), and an increased number of health centers (62%). The areas of least progress according to survivors were: medical teams with more complete skills (17% saw improvement) and the availability of emergency transport and of better equipment or supplies in health centers (18% each). Some 53% of survivors thought that the government had increased its support to the health sector. Among practitioners, 47% thought that healthcare had remained the same since 2005. The areas of most and least progress were the same as those identified by survivors. The largest group of practitioners (on average 60%) thought that the government had maintained its efforts.

Basic health services are available at community health centers but for more complex assistance survivors need to go to district referral hospitals or to national-level hospitals. While health centers have been constructed and infrastructure, including road networks have been improved as part of broader development projects, many hospitals still lacked supplies, equipment and even water or electricity. Medical care, medication and accommodation are usually not free of charge, and the cost of continuing medical care in particular was prohibitive for most survivors. However, NGOs assisted in covering the medical costs, transport and food. Cost-sharing and health equity funds also existed to increase access to services for poor people, although mine/ERW survivors were not systematically granted access to these. Only the NGO hospital in Battambang gave high-

quality trauma care, and did so free of charge. Probably, most respondents had been able to benefit from the above measures for their medical cost, but for some an improved economic situation or the existence of community self-help groups (*see below*) will have contributed. Throughout 2005-2009, Cambodia acknowledged that emergency response mechanisms were inadequate, and standards for emergency response, although developed, were not well-implemented. A lack of coordination between NGOs working in mine/ERW affected areas and the government for emergency care were also noted. Medical staff and first aid training was, in 2009, still considered inadequate, despite efforts by some NGOs and the Cambodian Red Cross, possibly confirmed by the fact that survivors did not see remarkable progress in this area.[17]

Physical rehabilitation

Half of the respondents found that physical rehabilitation had improved since 2005 and 33% thought it had remained the same. The largest group of respondents (38%) believed that survivors "always" received the physical rehabilitation services they needed and 33% said that the needed assistance was "sometimes" received. Survivors saw improvements in affordability, quality and staff across the board. Areas of most progress were: more inclusion of transport and accommodation costs (85% noted improvement), better quality mobility devices (87%), increased affordability of services (91%), and increased availability of free repairs to devices (92%). But much fewer respondents (35%) found that waiting periods had become shorter. Just 23% found that they could get services closer to home and 18% thought there were more rehabilitation services. Some 80% of practitioners saw improvement in physical rehabilitation, and, overall they thought that the government had maintained its efforts.

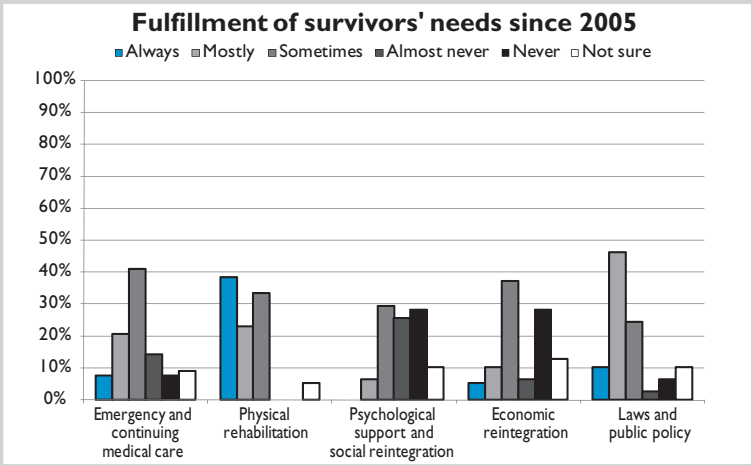
Throughout 2005-2009, it was reported that Cambodia's rehabilitation sector was well-organized, of sufficient quality and could deal with the existing needs. However, since the early 1990s, the sector has been almost completely dependent on international organizations. Throughout 2005-2009, these international organizations financed the cost of treatment, materials and salaries, and have ensured training and quality improvements. They also covered the cost of accommodation and transport or made transport agreements with local authorities.[18] Access to services remained problematic if transport costs were only reimbursed to patients afterwards. Already prior to 2005, international organizations urged the government to take on more responsibility for physical rehabilitation.[19] The government remained reluctant until, in mid-2008, a memorandum of understanding was signed between MoSVY and the five rehabilitation providers in which the ministry committed to gradually take over all financial responsibility for the management of physical rehabilitation services by 2011. A review of responsibilities, completed in 2008 under the hand-over process, showed that MoSVY had achieved less than half of its responsibilities.[20] The service providers noted that MoSVY was late with its contribution to the centers' running costs and that they might lose staff, as government salaries were considerably lower than those paid by operators and staff might not fit the civil servant criteria.[21] The ICRC had already handed over management (but not the entire financial burden) of its centers over to MoSVY and foresaw fewer problems, even though it also paid incentives.

In 2004, the number of rehabilitation centers decreased from 14 to 11, due to a lack of funding.[22] This explains why survivors did not see improvement in obtaining services closer to home. Since 2006, CBR activities funded by UNICEF have started. Although outreach services covered some 20 provinces, Cambodia acknowledged that further improvements should be made in outreach and referral, particularly from hospitals.[23] Service providers thought that the number of centers might decline further after 2011, again due to decreasing donor commitments and because MoSVY would not have the financial capacity to manage the centers by that time. For example, MoSVY allocated US$100,000 to physical rehabilitation in 2007 (through international funding), but the actual annual cost was estimated at more than US$4 million.[24]

Psychological support and social reintegration

More than half of survivors (53%) thought that, overall, psychological support and social reintegration services had stayed the same since 2005. Some 28% thought that survivors "never" received the psychosocial support they needed and an additional 26% thought that this was "almost never" the case. Most progress was perceived in attitudes: 51% thought that survivors were considered to be "charity cases" less often; 55% thought there was less stigma around seeking counseling; and 65% felt more involved in community activities. Some 64% of survivors also felt more empowered. However, just 18% thought that there were more psychosocial support services and 19% thought that there were more peer support groups. More than half of the practitioners thought that there was an improvement in psychosocial support. Most notably, 67% found there were more services.

Indeed, through the CBR network, many self-help groups for persons with disabilities have been started with the support of NGOs. However, while these groups could serve a peer support purpose, their main purposes were economic support and awareness raising. While open to all persons with disabilities, some survivors said they were too poor to participate in the groups. It is also possible that the expansion of the CBR network and self-help groups had not reached respondents yet or that the development of activities was too recent for survivors to see an impact. The awareness-raising component of the CBR network might have played a role in improved community attitudes and involvement. Most practitioner respondents belonged to organizations supporting self-help groups, which would have influenced their response. However, it was also noted that NGOs did not coordinate their self-help group activities or exchange lessons learned. Cambodia acknowledged, in 2009, that there was no formal mechanism or policy for psychological care and that just one facility provided basic training. Mental health units of government hospitals provided some assistance but did not function well and it was noted that MoSVY and the Ministry of Health needed more resources and capacity to work on the issue.[25]



Economic reintegration

The majority of survivors (68%) thought that, overall, economic reintegration opportunities had remained the same since 2005 and 17% saw improvement. Some 37% believed that survivors "sometimes" received the economic reintegration they needed and 28% said this was "never" the case. Nearly three-quarters of respondents thought that unemployment was so high that survivors were the last to be chosen for a job. However, 73% also thought that educational and professional discrimination had decreased and some 63% thought there were more economic opportunities (micro-credits or small business schemes) in their areas. However, just 37% thought that there were more employment opportunities and 31% saw more job placement opportunities. The area of least satisfaction was pensions, where only 28% saw an improvement. A majority of practitioners (60%) found that there were more economic reintegration activities in 2005 than in 2009. The areas of most progress for some 73% of practitioners were: decreased educational and professional discrimination and increased access to vocational training and education.

Inclusive education programs for children with disabilities have been developed by the government and disability awareness training was given to teachers throughout 2005-2009. Education became compulsory for all children in 2007. Government vocational training centers also existed but needed strengthening. Low disability awareness among local

authorities prevented them from encouraging persons with disabilities to go to school, and few children with disabilities actually accessed education. Survivors could often not afford education for their children. Vocational training and economic reintegration for survivors are carried out mostly by NGOs, but the success rate of job placements is low.[26] Cambodia also noted for 2008 that, "many [economic reintegration] projects have been postponed or ended due to the lack of funding."[27] In 2009, the draft VA status report to be presented at the Second Review Conference also showed that the number of people accessing vocational training gradually decreased between 2005 and 2008.[28]

However, the survivors' (and practitioners') perceptions of increased economic opportunities are also related to the expansion of the self-help groups, which provided revolving loan schemes or shared the costs for small-scale projects. The generally low education level of survivors hampered their job placement perspectives. Although job placement services existed, only a fraction of persons with disabilities registered was actually placed.[29] Discriminatory hiring policies continued to exist for government schools (although the Ministry of Education was revising its policies). It was even reported that MoSVY continued to stipulate in its hiring requirements that candidates should be "able-bodied."[30] It is not surprising that survivors saw pensions as an area of least improvement, as these were only for soldiers injured during the conflict. But pension budgets were also reduced because it was thought that many people receiving pensions no longer fit the criteria. Other problems with pensions were delayed payments, bribery and the selling of entitlements in times of need.[31]

Laws and public policy

The largest group of respondents (46%) thought that the rights of survivors had been protected more since 2005 and the same percentage thought that the rights of survivors were "mostly" respected. Most survivors (70%) saw progress in the development of policies and legislation relevant to survivors and 45% also thought that legislation was enforced better. Some 71% of survivors found that awareness about the rights of persons with disabilities had increased and 68% thought that negative terms about persons with disabilities were used less often. More than half of the practitioners (53%) also saw improvement in the laws and public policies for survivors. According to them, most progress was made in the development of legislation (67% thought so) and in decreasing discrimination (80%).

It is likely that these results are strongly linked to the progress made in approving disability legislation. The Law for the Protection and Promotion of the Rights of People with Disabilities was first drafted in 2000, re-drafted in 2004 and submitted to the government in 2006.[32] But real advances only started to be made in 2008-2009 when the king of Cambodia finally signed the law on 8 July 2009. For DPOs and NGOs, this legislation is key to improved VA and disability implementation, even though some acknowledged that certain amendments are needed to bring the legislation in line with the UNCRPD. The awareness-raising efforts and lobbying of DPOs, NGOs and the CBR network have played a crucial role in the adoption of legislation, and exposing discrimination.

MoSVY representatives were not able to respond to preliminary findings and DAC noted that it did not have the capacity or the mandate to provide a response. The Ministry of Health noted that its responsibilities were limited to emergency and continuing medical care and psychosocial support, which it hoped to implement successfully to 2011. One advisor noted that, although progress is slow, there have been several steps in the recognition of the rights and needs of survivors. The person added that there may be survivors that have not seen benefits on an individual basis but the sector as a whole has experienced improvements.

VA process achievements

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

Note: Cambodia was one of the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration in 2007-2008.

In 2005, Cambodia acknowledged that, it "has not done enough for [mine/ERW survivors]. Donors too have not been insistent enough that some of their funds must go directly to assisting the victims." It added, "We have not been creative, compassionate and clever enough to address the real needs of some of the poorest in our country…"[33] In 2009, Cambodia described its situation in much the same way as in the 2005 Zagreb Progress Report, particularly for psychosocial and economic reintegration.[34] Nevertheless, improvements to the lives of mine/ERW survivors and persons with disabilities have been made. But many of these achievements were realized by NGOs with extensive international support and less so by the government, which lacked the capacity and financial means throughout 2005-2009. Despite increased involvement, disability was not a high government priority. Survivor responses indicated a similar sentiment: 65% thought that the government was more involved, but 81% noted that the government lacked resources and 62% said the government also lacked the political will.

As part of its commitment to the implementation of the 2005-2009 Nairobi Action Plan, Cambodia developed some objectives in 2005. The majority of these objectives related to the development of plans and guidelines, as well as data gathering to facilitate the making of these plans, most notably a VA action plan to be started in 2006. Prior to that, in 2004, the Cambodian Mine Action and Victim Assistance Authority's (CMAA) decided to "develop a national plan on the needs of mine/ERW survivors in cooperation with the Disability Action Council (DAC)."[35] A strategic plan 2004-2009 was developed and discussed.[36] Throughout 2005-2009, this plan was not implemented because no budget was allocated to it,[37] nor was it used as the basis for developing other plans because it was unavailable during discussions.

In February 2009, the National Plan of Action for Persons with Disabilities, including Landmine/ERW Survivors 2009-2011, was finalized. Some discussions started in 2006, but the drafting process, which took nearly two years, was only kick-started once external technical support was provided to nudge DAC into action. Broad consultations were held, but some NGO representatives noted that there was a lack of continuity in those participating in the meetings from both the government and civil society side, and that the ministries often did not send people with decision-taking mandates. Nevertheless, practitioners saw improved coordination and 21% of survivors also found this to be the case. Some 36% of survivors knew who was in charge of VA/disability coordination; 42% thought that their needs were taken into account when setting VA priorities and 45% thought that survivors were included in coordination and planning.

Most of the 2009-2011 VA/disability plan's objectives had timelines for 2011 and the plan focused almost entirely on capacity building, information collection/dissemination, enhancing coordination and fundraising. It appears to be assumed that the current service providers will continue their activities, which led non-governmental stakeholders to say that the plan was not conducive to real action and contained objectives that were too broad, unclear and in some cases unrealistic, because it placed so much responsibility on MoSVY. It was said that a roadmap detailing actual activity implementation was needed and that the implementation of the plan would probably be limited to what was realistically feasible under the current capacity and budget constraints. As the 2009-2011 VA/disability

plan was only finalized in early 2009, some operators had not yet received the final plan. However, because many were consulted in the development of the plan and no real change in their activities was envisioned, they thought their activities were in line with the plan.[38]

Responsibility for the coordination of the plan was assigned to MoSVY and one of the main aims of the plan was to strengthen the ministry's capacity and its relationships with implementing partners and survivors and other persons with disabilities.[39] The roles of DAC and CMAA are unclear. Already in 2002, CMAA delegated coordination of VA to MoSVY with the technical support of DAC. None of the three bodies had the financial means and capacity to coordinate or monitor VA in 2005-2009. It was said that the government capacity in conducting VA/disability activities was "in its infancy."

The success rate of the VA/disability plan for 2009-2011 was largely dependent on the capacity of MoSVY to take on a leadership role. Cambodia said that the lack of "a comprehensive strategic management agenda for MoSVY… has made both the proper coordination and accountability of government services very difficult." But added the Nairobi Action Plan gave "an opportunity to take the first steps in articulating specific, measurable, and realistic objectives that would be relevant to the disability sector as a whole."[40] Indeed, MoSVY's initial mandate was limited to war veterans and its structure at all levels was insufficient to deal with the broader disability mandate. Its branches are "often under-resourced, inexperienced, or reluctant to implement MoSVY directives."[41] A disability advisor started assisting MoSVY on 1 July 2009 – until 2006, this person was the director of DAC trying to make DAC a more efficient and independent body.

The DAC and its various working groups provide technical advice to MoSVY, but many of these working groups do not function without external technical support. The viability and sustainability of DAC, which depended on external funding was questioned, unless national contributions would increase. Some also noted that while DAC was supposed to be a semi-autonomous body, it was controlled by MoSVY. CMAA focused on its other mine action activities and its role for VA was limited to reporting and monitoring, a task it said it could not do because the necessary data was not provided by DAC and MoSYV.[42]

In April 2009, the process of transforming the Steering Committee for Landmine Victim Assistance co-chaired by MoSVY and CMAA into the National Disability Coordination Committee (NDCC) was started (also chaired by CMAA and MoSVY). The NDCC's work would be expanded from coordinating VA plans to a general coordination role for the disability sector. Throughout 2005-2009, MoSVY has favored a mainstreaming approach to VA. This approach resulted in the 2009-2011 plan encompassing the needs of all persons with disabilities.

Already in 2004, the Cambodian Campaign to Ban Landmines said that the challenge for the Cambodian government was to address the rights and needs of survivors and their affected communities through decentralized structures and the provision of realistic budgets to meet the needs. They added that international assistance was essential to provide the resources needed for sustainable activities.[43] In 2009, both government and civil society agreed that NGOs and DPOs still carried out and financed most services. Many thought that this would remain unchanged and that even in 2011 MoSVY would not have the financial capacity to conduct VA/disability activities. The VA/disability plan was also seen as a major tool for fundraising. But funding might not be forthcoming, as several operators mentioned donor fatigue and increased funding challenges. These challenges would also make it difficult to maintain the same level of operations in Cambodia in the medium to longer term.[44]

Conclusions

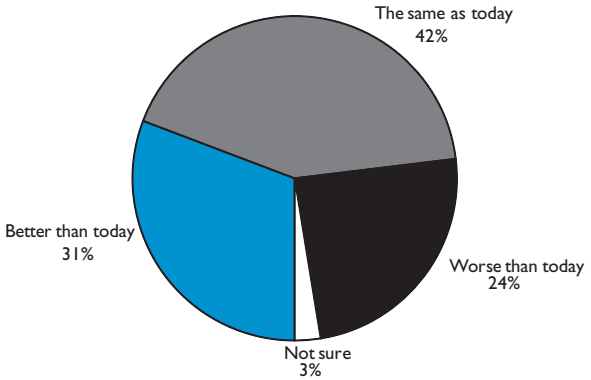
- The vast majority of services for survivors and persons with disabilities were carried out by NGOs and DPOs, and paid for with extensive international resources.
- Most improvement was seen in medical care and physical rehabilitation, especially because costs for survivors appeared to be better covered.
- The CBR network and self-help groups resulted in higher disability awareness and increased economic opportunities but had less of a peer support role.
- Economic reintegration and particularly employment opportunities remained insufficient.
- Advances in legislation concluding in the adoption of disability legislation after more than eights years were seen as major improvements.
- Government involvement and interest in disability issues increased, but this did not result in increased service implementation by the government.
- Capacity and funding challenges at government level were considered to be serious obstacles in 2005-2009 and it was envisioned that these challenges would continue to persist well into 2010-2014.
- The 2009-2011 VA/disability plan focused on government-level improvements but less on actual service provision.
- Donor fatigue and prospects of reduced aid were considered as challenges to continuing the current level of service provision.

Suggestions for the way forward

When asked about how they saw their situation in five years: 42% of survivors thought it would stay the same; 31% thought it would get better; and 24% thought it would be worse. To assist in a building a better future, the following suggestions may be taken into account:

- Urgently implement the 2009-2011 VA/disability plan and adjust the plan as needed to reflect more precisely what service provision will be implemented and by whom.
- Realistically assess the capacity and financial means of MoSVY to implement the plan and readjust responsibilities accordingly, especially in light of possible NGO departures in the medium term.
- Ensure continuity and sufficient mandate for the disability advisor position at MoSVY and, in the medium term, ensure that this position becomes integrated in the ministry's hierarchy.
- Increase DAC autonomy and urgently increase its capacity to serve its role as policy-maker, technical advisor and monitoring mechanism for the disability sector.
- Continue to strengthen the CBR network to include more psychosocial support activities and formalize coordination and practices of self-help groups.
- Increase economic reintegration opportunities through the CBR network, but also by developing more suitable vocational training and more effective job placement mechanisms.
- Ensure that the hand-over of the physical rehabilitation sector is done in a manner that is sustainable for MoSVY and the functioning of the centers. Investigate alternatives in case financial and technical capacity at ministerial level proves inadequate.

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



- Start increasing national resources for VA/disability, but actively seek continued international support for the implementation of the VA/disability plan for 2009-2011.
- Continue to provide adequate international support but insist on greater transparency on the use of funding.

Seng Sam and his fish pond

In their own words…

Respondents described themselves as: living in difficult conditions, wanting more agricultural land, uncertain of how to proceed now that they are disabled, poor, hopeful for a better future, having problems carrying out daily activities…

In their own words…

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

- Provide food and agricultural land (many).
- Land and support to grow livestock.
- Skills training.
- Establish a group for disabled persons to make information sharing easier.
- Provide micro-credit to start a new type of job.
- Support an alternative livelihood.
- Support rehabilitation.
- Provide help in finding a job or teach new skills.
- Give access to healthcare.

In their own words…

If countries really cared about survivors they would:

- Encourage disabled people.
- Support livelihoods.
- Help finding a job.
- Provide a house.
- Give mental support and skills training.
- Provide start-up capital for a new livelihood activity.
- Continue [physical] rehabilitation.

In his own words: the life experience of Seng Sam

Seng Sam, 48, lost his right leg as a soldier after stepping on a landmine in 1991. He lives with his wife and five children in Chrey Krem village (Kravanh district, Pursat province). For a long time after his incident, his family lived in extreme poverty, as he says "we had to live from hand to mouth." Seng Sam and his wife were not able to send their children to school, as they did not have land to cultivate or cattle.

However, with the help of one local NGO (Disability Development Services Pursat, DDSP), Seng Sam became a member of a self-help group in 2003. He also received counseling from NGO staff and encouragement from his family and community members. Seeing his progress, DDSP decided to give him training in community organization, as well as animal raising and vegetable growing skills. In the meantime, Seng Sam has taken a study tour to learn good practices from other communities. He managed to clear a sizeable plot of land of trees. And today he is growing crops and raises a range of animals, including fish, chickens, ducks, pigs and even a cow and buffalo.

The life of his family has improved quite significantly and now Sam Seng can afford to send his children to school. People think he is a very good community leader and role model for others. Seng Sam adds, "I am very committed to try my best for my family, but also to maintain the self-help group and the sustainability of my community after DDSP leave."

Chad

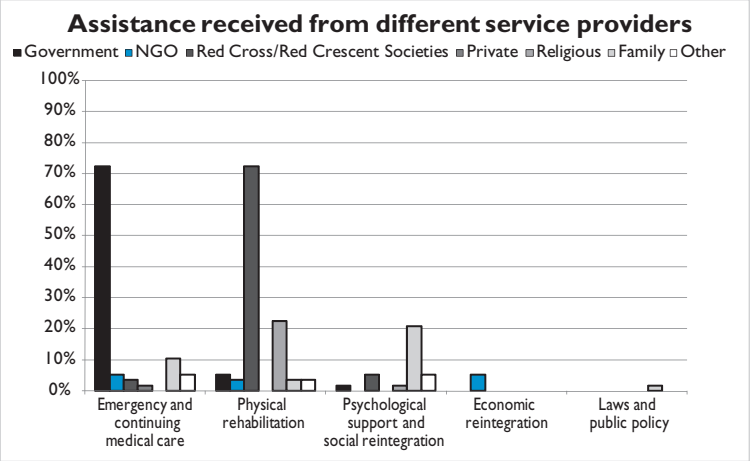
Country indicators

- *Conflict period including mine/ERW use:* At least 30 years of internal conflict and the 1973 Libyan invasion resulted in mine use and ERW contamination. New ERW contamination in and around the capital N'Djamena occurred during fighting between government troops and rebel forces in February 2008.[1]
- *Estimated contamination:* According to the 1999-2001 Landmine Impact Survey (LIS), some 280,000 people live in some 249 mine/ERW affected communities (more than 1,000km²).[2]
- *Human development index:* 170th of 179 countries, low human development (compared to 167th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$530 – 185th of 210 countries (compared to US$283 in 2004).[4]
- *Unemployment rate:* Unknown.[5]
- *External resources for healthcare as percentage of total expenditure:* 23.5% (compared to 23.5% in 2004).[6]
- *Number of healthcare professionals:* Less than four per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Years of conflict have exacerbated poverty in Chad. Some 80% of the population depends on subsistence farming and herding. Poverty limits access to basic education; adult literacy rates are as low as 26%. Crop production is seriously affected by unpredictable rains, recurring droughts and locust infestations. Chad depends on foreign assistance for most public and private sector needs.[9]

VA country summary

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

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



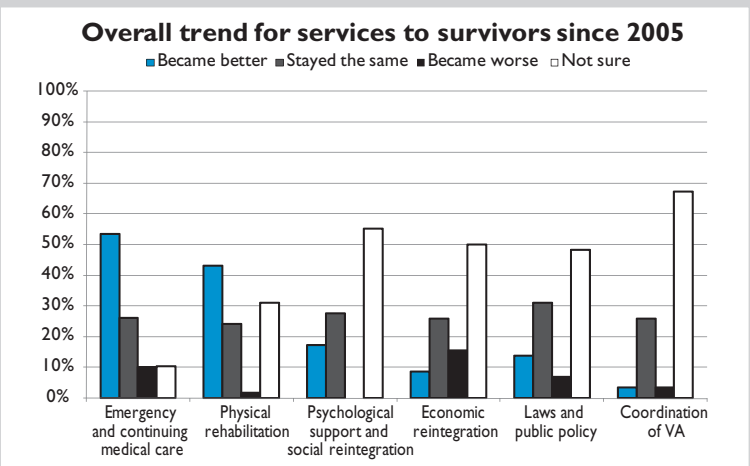
VA progress on the ground

Respondent profile

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

General findings

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



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

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

Emergency and continuing medical care

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

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

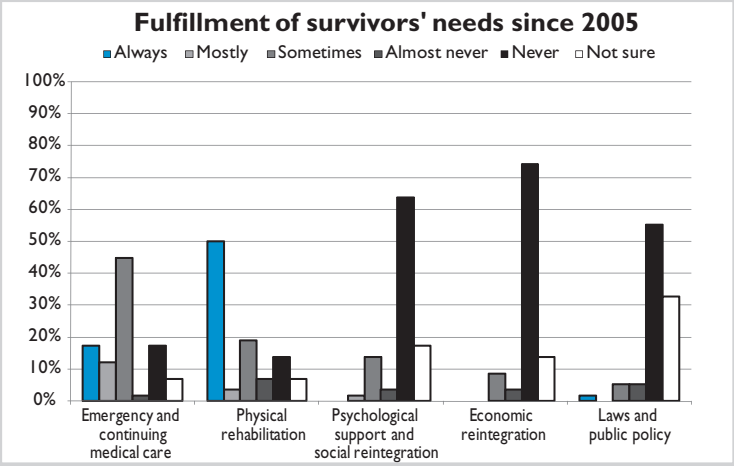
Physical rehabilitation

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

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

Psychological support and social reintegration

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



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

Economic reintegration

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

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

Laws and public policy

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

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

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

VA process achievements

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

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

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

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

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

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

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

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

In their own words…

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

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

In their own words…

If countries really cared about survivors they would:

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

Conclusions

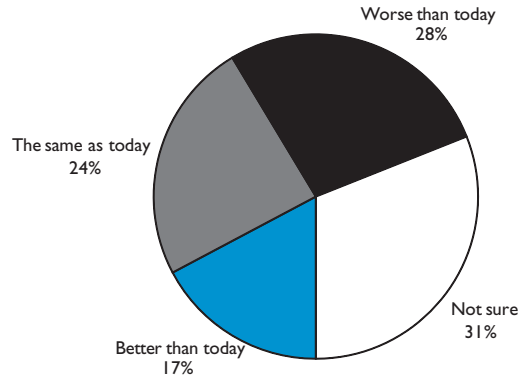
- A lack of consistent coordination capacity and resources prevented the planning and implementation of VA.
- Many basic service systems were incapable of responding to survivors needs, despite some assistance offered to survivors by CND and international relief efforts.
- VA efforts, as far as they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

Suggestions for the way forward

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

- Hold regular VA coordination meetings engaging ministries, local NGOs, DPOs and international organizations, or plan a series of meetings to address specific issues.
- Create a simple multi-year VA plan with specific objectives, clear timeframes and actions to achieve objectives, based on available or likely resources, and adjust it as more means or capacity become available.
- Designate responsibilities among all relevant stakeholders for implementing the plan and ensure that those taking on responsibilities have coordination support.
- Present the plan, along with a clear funding strategy and funding prospects, and transparently report on national and international contributions.

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



- Include survivors and DPOs in planning and coordination to better understand their needs and the scope of the problem. Support the creation of survivor associations and strengthen their capacity.
- Systematically include VA/disability in other health, rehabilitation, development, and relief efforts and ensure access of survivors/persons with disabilities.
- Endorse, monitor and enforce legislation protecting the rights of persons with disabilities.

Colombia

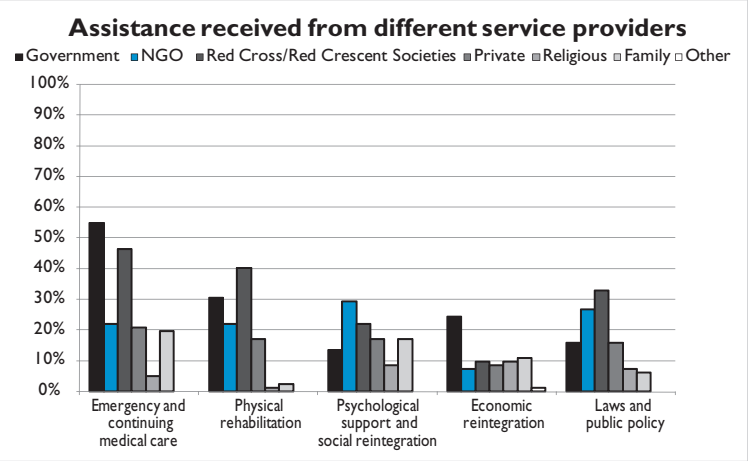
Country indicators

- *Conflict period and mine/ERW use:* Since 1990, mines, improvised explosive devices and other explosive ordnance have been used, mostly by non-state armed groups. Military bases are also mined.[1]
- *Estimated contamination:* The extent of the contamination is unknown and ever-changing due to the ongoing use of devices.[2]
- *Human development index:* 75th of 179 countries, medium human development (compared to 73rd of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$4,660 – 104th of 210 countries/areas (compared to US$2,115 in 2004).[4]
- *Unemployment rate:* 11.8 % (compared to 13.6% in 2004).[5]
- *External resources for healthcare as a percentage of total expenditure:* 0% (compared to 0.1% in 2004).[6]
- *Number of healthcare professionals:* 20 per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention on 30 March 2007, but not its Optional Protocol.[8]
- *Budget spent on disability:* Unknown; for 2009-2019, the Ministry of Social Protection foresaw some US$80,000 (155.110 million Colombian pesos, COP) to assist 1,682 civilian survivors. This equals US$47.5 per person over 10 years, but authorities estimated that they would only be able to identify 420 survivors. An additional US$135,000 (COP258.194 million) was allocated to psychosocial and economic support to 2,799 military and civilian survivors for the same period.[9]
- *Measures of poverty and development:* Colombia has faced years of internal conflict all over the country, which overwhelmingly affects the rural populations. Nearly half of the population lives below the poverty line, most of whom are in rural areas. There are great inequalities in society; underemployment and narcotics trafficking are significant problems.[10]

VA country summary

Total mine/ERW casualties since 1990: At least 7,785			
Year	Total	Killed	Injured
2004	879	201	678
2005	1,128	281	847
2006	1,172	229	943
2007	904	196	708
2008	768	154	614
Grand total	**4,851**	**1,061**	**3,790**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 5,815.[11]
- *VA coordinating body/focal point:* The Presidential Program for Integrated Action against Antipersonnel Mines (Programa Presidencial para la Acción Integral Contra Minas Antipersonal, PAICMA) acted as VA coordinator, but its role was mainly limited to planning and curtailed by internal reorganizations and a lack of continuity.
- *VA plan:* None; but VA is included in mine action strategies and the main program benefiting survivors is the ruta de atención (route of assistance), a legal framework specifying assistance ranging from first aid to economic reintegration provided to conflict victims.
- *VA profile:* Access to services in Colombia throughout 2005-2009 was hindered by ongoing and fast-moving conflict, curtailing government, NGO and international organizations' service provision. Colombia had sufficient capacity and infrastructure to manage VA/disability services, but not in all parts of the country and capacity varied due to conflict. NGOs and international organizations increased their activities throughout 2005-2009 to fill significant gaps in VA/disability service provision. While the number of annual casualties increased constantly from 2005 to 2008, most **recorded** casualties were military. Military casualties received comprehensive medical and rehabilitation assistance through army facilities. However, services depended on rank and status in the army and often social and economic reintegration assistance was lacking. Pensions also varied. Civilian casualties mostly occurring in remote rural areas received much less attention. Many civilian survivors were poor and dependent on support from assistance funds to cover their "integral rehabilitation" under the ruta de atención, but they were still not well aware of their rights in 2009. Procedures to obtain assistance were complex, not all necessary services or supplies were included, and application and assistance periods were limited in time (and reduced further between 2005 and 2009). Delays in payments to survivors and reimbursements



to service providers were further obstacles. Survivors frequently need NGO or ICRC facilitation to access services. While the medical system overall has sufficient capacity, in rural areas first aid and the level of medical care were variable throughout the period under review. Complex medical care and physical rehabilitation were only available in major cities. Even if treatment costs were covered, transport costs and movement restrictions were serious obstacles. NGOs and the ICRC need to provide and/or facilitate physical rehabilitation for most civilian survivors. In principle, psychosocial support is covered by assistance funds, but in reality it is very limited and mostly carried out by NGOs or disabled people's organizations (DPO). Vocational and economic reintegration opportunities exist but are not adapted to the needs of survivors or are small-scale and carried out by NGOs. Complex legal frameworks relative to disability and assistance exist in Colombia. Their complexity prevents survivors (and other conflict victims) from knowing their rights and hinders effective implementation. Efforts to simplify some assistance provisions have, in reality, resulted in even less access to services. A lack of government coordination on issues relating to disability and conflict victims, as well as increased decentralization also hampered implementation.

VA progress on the ground

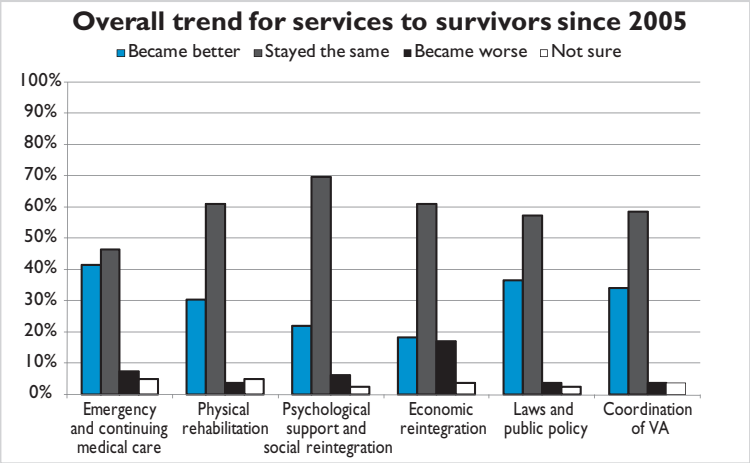
Respondent profile

By July 2009, 82 survivors between 16 and 62 years old responded to a questionnaire about VA/disability progress in Colombia since 2005: 76 men, five women, and one boy. None of the respondents reported being part of the military, but 23 did not answer that question. Some 62% of respondents were heads of households and 20% owned property. Just 33% of survivors had started secondary education or higher and 9% had not received any formal education. More than half of the survivors (57%) lived in villages with limited services; 13% each lived in remote areas without services and in large cities with a variety of services. Before the incident, 6% of respondents were unemployed and nearly half (45%) were farmers. After the incident, 30% of respondents were unemployed and just 15% remained farmers (most farmers became unemployed). Respondents came from Meta, Antioquia, Cauca, Santander, Norte de Santander, Bolivar, Caquetá, Putumayo, and Sucre. While most recorded casualties in Colombia are military, this profile corresponds to the profile of civilian casualties who are mostly men, usually farmers in rural areas.

General findings

Overall, the majority of survivors thought that the situation had remained similar to that in 2005, but for each type of service a significant percentage of respondents saw overall progress, particularly for medical care. Least progress was perceived on economic reintegration. Some 37% of survivors believed that they received more services in 2009 than in 2005 and 41% of respondents thought that services were now better. Practitioners, overall, agreed with survivors, but were markedly more positive about developments in physical rehabilitation. While female participation was too limited for accurate extrapolation, 77% of respondents felt that services for female survivors were "equal" to those available to male survivors and 6% said services for women were "absent". Women did not answer more negatively. The largest group of respondents (35%) did not know if services for children were adapted to their age and 24% said this was "never" the case.

The vast majority of survivors (84%) had been surveyed by NGOs or government in the past five years. However, 54% had never had the opportunity to explain their needs to the government. More than half of survivors (54%) found that survey activity resulted in receiving more information about services; 24% said also receiving more services as a result; but just 17% said that it had also resulted in fewer problems with bureaucracy.



This result reflects the reality that efforts are being made to improve casualty data collection and that particularly NGOs try to identify more civilian survivors. But it also clearly shows one of the main problems in Colombia's service provision to mine/ERW survivors (and other conflict victims). To receive free assistance (under the ruta de atención), all survivors need to speak to their local authorities and receive the necessary papers to certify that they are conflict victims. Many survivors were not aware of these procedures or afraid to register. Local authorities often lacked capacity or did not prioritize this activity. Bureaucratic procedures were also complicated and inefficient, and survivors had to complete them within a certain amount of time (up to 12 months) to be able to get benefits. Payments were slow and coverage inadequate. NGOs often needed to accompany survivors to guide them through the process. In 2008, Handicap International (HI) and the ICRC developed training modules for authorities, NGOs and survivors to raise awareness about the process, as several studies showed that almost no survivors had received information on their rights before.[12] The mine action program developed a directory of services and a guide to receiving assistance already in 2005, but acknowledged in 2009 that the process to receive treatment remained problematic.[13] PAICMA held irregular meetings with survivors in 2006-2008 (two in 2008),[14] to understand the needs of survivors better, but these remained "one-off" meetings and cannot be considered to be a systematic assessment.

Emergency and continuing medical care

Nearly half of respondents (46%) said that, overall, healthcare had remained the same since 2005 and 41% thought it had improved. Some 40% found that survivors only "sometimes" received the medical care they needed; 12% each responded "always" and "never". Those living in large cities or in the capital responded slightly differently but in villages the split between "never" and "always" remained even. The area where survivors noted most progress was better-trained staff (49%) and the availability of first aid (48%). The areas of least progress were the increased number of health centers (26%), sufficiently equipped and supplied centers (30%), improved infrastructure (34%), or services closer to home (37%). Among practitioners, 62% found services had remained the same. They saw very few areas of progress and the least progress was found in the increased number of health centers (10%) and in the availability of medication, equipment and supplies (17%). Most practitioners thought that the government maintained its efforts (38%), but a significant group (31%) believed that the government "had done nothing" in the five years.

While urban centers had sufficient medical capacity and well-trained staff, medical care in rural areas was variable and many health centers lacked supplies and equipment, as evidenced by the answers above. Survivor responses are likely influenced by whether their region was calm or in conflict and by the ease with which services could be reached as a

result. In 2008-2009, the government acknowledged that emergency capacities remained insufficient.[15] Emergency response times depended on the area of the incident and the security situation in the region; in not all regions emergency transport existed. Through the National Development Plan measures were taken to improve the capacity to adequately address rural emergencies and some training was provided to rural health staff. Further training was scheduled. But more importantly, the Colombian Red Cross and ICRC provided emergency services, supplies and first aid training to rural health providers, as well as transportation and referral throughout 2005-2009. They often had access to areas where the government was not able to work. Several other NGOs have also included emergency response in their activities and assisted some communities in developing their emergency plans.[16] Healthcare providers and facilities had to face threats and looting, and referrals were not made systematically. The government acknowledged this in 2009, as well as the unaffordable cost for continued medical care.[17] Military casualties receive faster, better and comprehensive medical treatment for free.

The more negative response by practitioners might be related to the fact that many rural health centers had to be supported by non-governmental partners. The frequent delays in government reimbursements to service providers, which hampered services and even resulted in occasional temporary closures, will also have influenced responses.[18]

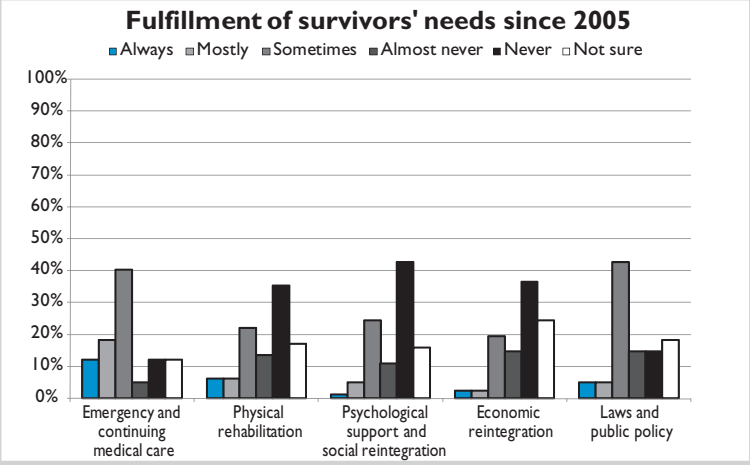
Physical rehabilitation

Some 61% of respondents felt that, overall, physical rehabilitation services had remained the same since 2005 and 30% saw improvement. However, the largest group of people (35%) thought that survivors "never" received the physical rehabilitation they needed and an additional 13% thought this was "almost never" the case. Most improvement was seen in the quality of mobility devices (35% agreed) and in better-trained staff (34%). All other progress indicators scored well below 30%. Just 18% thought it was easier to get free repairs; 16% found that services were available closer to home; 12% thought that transport and accommodation were included more often; and 10% felt that there were more mobile rehabilitation units. Practitioners had a different view, as 55% saw improvement and 34% thought that the physical rehabilitation situation had remained the same. Areas of most progress were: more trained staff (76% thought so), teams with more complete skills (69%) and improved infrastructure and quality of mobility devices and physical therapy (66%). Least progress was seen in inclusion of transport (21% saw progress) and free repairs (28%). With the exception of staff training and infrastructure, practitioners felt that, at best, the government had maintained its efforts.

The survivor responses confirm that throughout 2005-2009 physical rehabilitation services were only available in major cities. While the existing services generally were of an adequate standard, distances, transport and accommodation costs were severe obstacles for survivors. These two costs were not included in the ruta de atención package and NGOs did not cover costs systematically. Mobile rehabilitation units barely existed (for security reasons) and repairs were not always free of charge. The terms for replacements were extended in 2007, which might become problematic in the future, but has not been noticed yet. The sufficient quality of services throughout probably explains why most survivors saw little change compared to practitioners. Especially those practitioners involved in the four-year capacity-building project to improve comprehensive rehabilitation services in cooperation with local authorities, university hospitals, service providers and rural health promoters, launched in May 2008, would have experienced improvement.[19] Military survivors receive comprehensive physical rehabilitation through army centers, but long waits and a lack of follow-up have been reported.[20]

Psychological support and social reintegration

Nearly 70% of survivors thought that psychological and social support services had remained the same since 2005 and 43% thought that survivors "never" received those services. Just 6% of respondents thought that the needed psychosocial support services



were "always" or "mostly" received. Half of survivors noted the most progress in their own empowerment and 41% said they were more involved in community activities. However, just 23% thought that survivors were seen as "charity cases" less often. Other areas with little progress were: the creation of peer support groups (24% saw improvement), the availability of services closer to home (16%), and increased government support (20%). Practitioners agreed with survivors as 66% thought the situation remained the same. They saw least awareness in psychosocial services being equal to other services and in the inclusion of survivors in service provision.

These responses confirm that psychosocial support services are very limited to non-existent, even though survivors are entitled to them under the ruta de atención. The government recognized that efforts were insufficient and that the government bodies responsible did not provide the needed services.[21] Limited assistance was provided by NGOs and some community-based programs to support survivor organizations and DPOs. But programs were small-scale, not systematic and often struggled with capacity and funding. In 2008-2009, the government acknowledged the problem and under a European Commission-funded project, all implementers (government and NGO) were supposed to include psychosocial support.[22] As project implementation only started in mid to late 2008, survivors would not have seen much change. Services for military survivors are available but not extensive and are dependent on the status of the soldier (professional or conscript).[23]

Economic reintegration

Some 61% of respondents thought that economic reintegration opportunities had stayed the same since 2005; 17% saw a deterioration. Also, 37% of respondents thought that survivors "never" received the economic reintegration assistance they needed and 15% said this was "almost never" the case. Just 5% thought that economic reintegration was "mostly" or "always" received. Almost all respondents (94%) believed that unemployment was so high that survivors were the last to be chosen for a job. Responses to specific progress indicators were overwhelmingly negative. The areas where the largest number of survivors saw progress were increased educational opportunities (29%) and increased disability awareness among teachers (24%). Around 20% found that they had better access to vocational training programs either specifically for survivors or general ones. Responses about employment were much more negative. Just 7% thought that employment opportunities and job placement services for survivors had increased; 6% saw pension improvements; and 5% thought that job quotas were enforced or that it was easier to get a bank loan. Some 62% of practitioners also did not see change in economic reintegration and 10% saw a decline. Very low percentages of practitioners (10% or less) also saw improved job placement, employment opportunities or enforcement of quotas. Practitioners were more negative than survivors on the availability of vocational training and how it met market demands (10% saw improvement).

These responses confirm reports throughout 2005-2009 that economic reintegration opportunities for survivors were lacking severely, something the government also acknowledged. PAICMA added that no self-sustainable capacity-building activities for survivors existed and that a government body responsible for employment inclusion of persons with disabilities in the private sector was lacking.[24] NGOs carried out most of

the activities, but their projects were usually small-scale. Vocational training was available at the government's National Learning Institute and free of charge for persons with disabilities, but it often required a prior education level that most survivors did not have. Most civilian survivors were lowly educated farmers who could often also not return to farming. In 2006, it was reported that just 7% of persons with disabilities in Bogotá had access to education.[25] Some categories of persons with disabilities received disability pensions, but most survivors only received a one-time compensation if they applied on time and could manage the bureaucracy.[26] The military is not able to provide sufficient pensions or economic reintegration to all its members and many soldiers need to turn to charities or civilian services.[27]

Laws and public policy

More than half of respondents (57%) thought that the protection of the rights of survivors had remained at the same level since 2005 and 37% saw improvement. Some 43% thought that the rights of survivors were "sometimes" respected. Most progress was seen in the availability of information about rights (56%) and in information about services (49%). Less progress was seen in the inclusion of the rights of survivors in disability legislation (34% saw improvement) and in decreased discrimination and use of negative terms about persons with disabilities (35% each). Among practitioners, 45% thought that the rights of survivors had stayed unchanged and 41% saw improvement. Most progress was seen in the development of relevant legislation, enforcement of legislation and information about rights.

Disability legislation and complex frameworks regulating assistance provision for survivors (and other victims of conflict or vulnerable groups) exist. The regulations and procedures are complex (*see above*). In 2007, progress was made in mainstreaming the two main regulations relevant to mine/ERW survivors into one decree.[28] The new decree (Decree 3990) extends provisions to include more services (mostly medical care and rehabilitation needs for children), and more authorities were allowed to carry out the administrative procedure to speed up the process. However, both PAICMA and operators noted that the actual implementation of the decree encountered problems from the beginning.[29] The first negative effects were also visible as of 2009, such as less time to complete the complex bureaucracy both for applicants and authorities (after which claims are rejected), stricter definitions, and more documentary proof required. There also was a continued lack of awareness among services providers. The fact that both survivors and practitioners saw improvement in the rights situation is most likely due to the effect of efforts to raise awareness about their rights among survivors and subsequent improved access to services. PAICMA provided information sessions to local authorities (particularly after the 2007 elections) and service providers. It also tried to follow up with recent casualties to inform them about their rights, but with varying success.[30] NGOs and the ICRC also increased their awareness-raising activities (*see above*).

Due to the preparations for the Second Review Conference in Cartagena in November-December 2009, and frequent staff changes for VA, PAICMA was not able to provide a response to preliminary survey findings.

VA process achievements

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

Between 2005 and 2009, Colombia does not appear to have made significant progress in VA. PAICMA achievements were mostly limited to awareness raising and some capacity building. Actual assistance was, as prior to 2005, carried out by other mechanisms and significant gaps remained to be filled by NGOs. Planning was also often limited to coordination and data collection/dissemination. Changes to the lives of survivors usually originated from developments in the security situation, whether local authorities prioritized assistance, the efficiency of assistance funds and NGO activities. Nearly all survivors (90%) said that the government lacked the political will to improve VA.

As one of the 26 countries with the greatest numbers of survivors and, therefore, the greatest responsibility, but also the greatest needs and expectations for assistance, Colombia presented incomplete objectives in 2005. Two related to casualty data collection, one to reducing casualties and providing healthcare and one to develop a VA strategy. The objectives have not been updated since and none of the objectives were specific or time-bound, which was acknowledged by PAICMA.

Survivors were one group included in broader programs for conflict victims and their assistance was foreseen under the legal framework of ruta de atención. This framework has existed since 1997 and in 2007 was presented as the "Integral Route for Mine/UXO Victims" – the VA strategy. Under each phase of the route, basic information is provided about the type of assistance, the service providers and claims agencies. The timeframes within which someone can receive assistance are specified by law.

The use of an existing strategy to benefit survivors was effective planning. But known gaps in the framework (lack of awareness among service providers and survivors, payment and reimbursement delays, difficult bureaucracy and gaps in services) as evidenced above, were not addressed sufficiently. Efforts remained mostly limited to legal adjustments, with potentially negative impact, and to awareness raising.

Planning and awareness raising appear to be the roles PAICMA has limited itself to throughout 2005-2009. The Program for Mine Accident Prevention and Victim Assistance was originally launched in 2001 (before increased conflict and casualties starting in 2002) in response to the lack of adequate assistance to survivors, but service provision remained unchanged under the ruta de atención. Since 2001, the VA programs have operated in much the same way. With PAICMA (or its predecessors) aiming to carry out baseline studies about the needs of survivors and developing new plans to coordinate assistance, while doing much less to really address the gaps in the assistance framework it depends on completely.[31]

Throughout, the challenges and gaps have been acknowledged, including in the National Strategy for Integral Action against Antipersonnel Mines 2009-2019. The plan's specific objectives are: opportune and complete access for survivors to necessary services for integral rehabilitation and socio-economic inclusion; integrated services provided by government and NGOs with reference to survivors; and for the assistance route including psychosocial and socio-economic reintegration to be completely developed and implemented. However, the proposed activities to achieve this are, again, limited to improving data collection and dissemination, raising awareness, stimulating capacity building and developing plans.[32] On 18-21 August 2009, PAICMA has scheduled an international seminar to promote a shared vision of VA in Colombia, review challenges, and establish the 2009-2019 plan as the guiding framework.[33]

PAICMA is also in charge of coordinating and monitoring VA. Its main partners would be the Ministry of Social Protection and its payment funds, under whose mandate most services under the ruta de atención fall, and NGOs. However, the ruta de atención is inadequately linked to other disability programs existing at the same ministry. Survivors

are often not eligible for these other disability programs because they do not fit the criteria and because they are supposed to receive complete assistance under the ruta de atención. Since 2001, the aim has been to include VA in plans of departmental authorities and their mine action committees if they existed. However, success was dependent throughout on the interest of the local authorities in VA, their capacity, continuity in the leadership, and other competing interests. Coordination with NGOs was said to be unsystematic for most of 2005-2009 and NGOs noted that they were not systematically involved in strategic planning. PAICMA coordination capacity was hampered by internal reorganizations (lasting until July 2008)[34] and a lack of continuity and/or capacity in the VA coordinating position.

Survivors appeared to confirm the lack of coordination progress. While 45% said they knew who was in charge of VA coordination congruent with awareness-raising efforts, fewer (34%) saw improved coordination since 2005 and just 16% thought that survivors were included in coordination. Some 23% thought there was better coordination with the disability sector and 22% believed that the needs of survivors were taken into account when developing VA priorities. One-fifth thought that survivors were included in the development of VA plans and just 10% thought they received regular information about VA achievements. Among practitioners, 31% thought that survivors were more included in planning and 34% thought that survivors' needs were taken into account while planning. While many practitioners started to see improved coordination between government and NGOs (since mid-2008), most (69%) did not think it had resulted in fewer gaps in services.

Conclusions

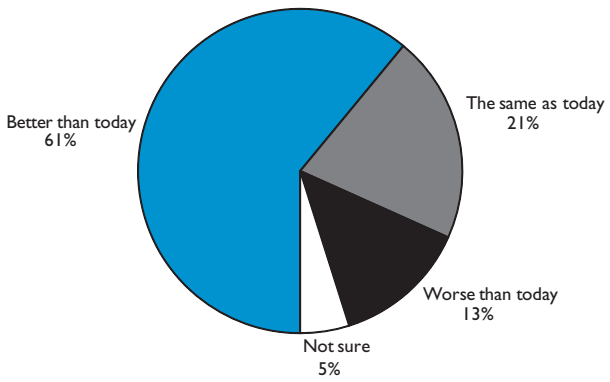
- Colombia has a program that, in principle, should provide comprehensive assistance to survivors and other conflict victims, but in practice many gaps remained unsolved in 2005-2009.
- Both service providers and survivors were impacted by the lack of resources, complex bureaucracy, and limitations of payments by assistance funds.
- Many service gaps needed to be filled by non-governmental operators.
- PAICMA's role was limited to awareness raising and planning, but its plans did not address real service provision challenges.
- PAICMA does not appear to have made use of the tools put at the disposal of the 26 countries with the responsibility for the greatest numbers of survivors by the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration to improve existing assistance frameworks for survivors and conflict victims.
- The needs of survivors were assessed unsystematically and survivors were not included in planning, implementation or monitoring of assistance.
- The complex legal framework and modifications to it have had a negative impact on service provision.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 61% of survivors felt that it would be better than today; 21% thought it would be the same; and 13% thought it would be worse. To assist in a better future ahead the following suggestions may be taken into account:

- Develop concrete and time-bound actions, beyond awareness raising, to address gaps in the ruta de atención.
- Until gaps in the ruta de atención are addressed, develop additional programs to lessen the impact of these gaps, particularly for economic reintegration.
- Suspend or lengthen time limits in which assistance can be applied for and consider reviewing legal frameworks again, in part to address new challenges caused by recent adjustments.
- Increase resources to assistance funds and hasten payments to services providers and survivors alike.
- Reconsider PAICMA's VA coordination role beyond awareness raising and develop greater synergies with other programs for persons with disabilities.
- Equalize assistance to military and civilian survivors.

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



Eli Martinez walking - Eli Martinez at work
© Gaël Turine/VU, for Handicap International

In their own words…

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

- Housing benefits.
- Creation of job opportunities for survivors to enable them to become self-sufficient.
- Creation of job opportunities for survivors' families because they are victims too.
- Provision of comprehensive support as stipulated in established standards.
- Ensuring that rights have no time limits.
- For the government to show more concern for us.
- Taking more account of the needs of widows.
- Respect and deliver survivor rights.
- Healthcare.
- Providing employment.
- Economic, employment and housing support.

In their own words…

If countries really cared about survivors they would:

- Expand coverage of existing services to remote areas of the country.
- Make authorities and officials show more concern.
- Ensure that laws are comprehensive and fair.
- Ensure that laws are enforced.
- Help us talk to the government to get our rights.
- Help us more because our government does not.
- Make the government enforce the rules.
- Provide education, employment and housing for the disabled.
- Help us to keep working.
- Raise awareness that survivors have rights.

In their own words…

Survivors described themselves as: uneasy, responsible, strong, fighters, good, survivors, soldiers, cheerful, unsure, shy, and reserved.

In his own words: the life experience of Eli Martinez

Eli Martinez was 28 and working in a gold mine in the Piamonte region when he had his mine incident in 2002. The riches in the soil attracted both paramilitary and guerrilla forces and was a scene of conflict. As he did so many times each day, Eli threw a stone he had examined for gold on a pile, but the stone landed on a mine, which exploded. Eli remembers, "I thought I had lost a leg, because I had heard that this is what generally happens."

Eli was rowed across the river by his fellow workers and it took 1.5 hours to reach the health center. There he realized that shrapnel had damaged his eyes and injured his arm and hand. The staff at the health center decided they could not treat his eyes and that he needed to go to the university hospital in Medellín, hundreds of kilometers away. By the time Eli got there it was too late; his eyes had to be removed.

Eli went back to live with his mother and it was tough for both of them. Eli likes working, saying, "I like being busy and I have always worked." So he thought he had lost everything. But gradually he started to learn everything all over again, how to identify sounds around him, how to move around his house… and he started to help his mother in her crafts shop. In 2008, an NGO paid for him to take courses at a center for the visually impaired. Eli learned how to walk with a cane, to read and write in Braille and to count using an abacus. He adds, "I can already write, but reading is more difficult." But at least there are prospects for a better future.

Croatia

Country indicators

- *Conflict period and mine/ERW use:* During the 1991-1995 Croatian War of Independence all parties to the conflict, including the Former Yugoslav Army and Croatian Police Force/National Guard, used mines.[1]
- *Estimated contamination:* Some 954.5 km^2, affecting approximately 834,000 people (18% of the population).[2]
- *Human development index:* 45th of 179 countries, high human development (compared to 48th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$13,570 – 65th of 210 countries/areas (compared to US$7,675 in 2004).[4]
- *Unemployment rate:* 14.8% (compared to 18.9% in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 0.1% (compared to 0.1% in 2004).[6]
- *Number of healthcare professionals:* 80 per 10,000 population.[7]
- *UNCRPD status:* Ratified the Convention and Optional Protocol on 15 August 2007.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Once one of the wealthiest of the Yugoslav republics, Croatia's economy suffered during the 1991-1995 conflict, but has recovered steadily since 2000. Its economy is still considered to be "in transition" and challenges include high foreign debt, high unemployment, overdependence on tourism, and uneven regional development.[9]

VA country summary

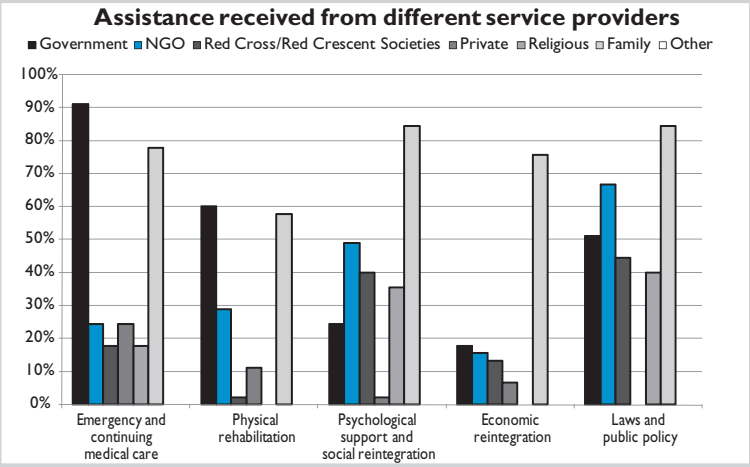
Total casualties since 1980: Unknown – at least 1,962			
Year	Total	Killed	Injured
2004	19	14	5
2005	22	8	14
2006	12	1	11
2007	8	3	5
2008	9	3	6
Grand total	**70**	**29**	**41**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 1,421.[10]
- *VA coordinating body/focal point:* The Croatian Mine Action Center (CROMAC) is in charge of VA coordination, but its appropriateness is questioned by stakeholders given its lack of VA expertise and involvement. *Ad hoc* coordination is meant to be ensured by a Ministry of Foreign Affairs representative, but the representative has been rendered powerless by a lack of political will and budgetary resources.
- *VA plan:* None; mine/ERW survivors are included in the National Strategy for Equalization of Opportunities for Persons with Disabilities 2007-2015.[11]
- *VA profile:* While some areas of VA improved between 2005 and 2009, a lack of political will hampered progress on the government's implementation of the Nairobi Action Plan.[12] Accurate information about the number of survivors in Croatia, their needs, or services received was unavailable. Health and social services in Croatia function largely on national capacity and are considered sufficient, with relatively strong medical and rehabilitation infrastructure in the cities and social insurance covering most healthcare costs. However, quality, accessibility and affordability issues remain, particularly for physical rehabilitation. Between 2005 and 2009, the challenge of high unemployment among survivors remained unresolved and actually worsened as a result of the global economic slowdown, despite the training of job counselors on disability issues and the establishment of a dedicated employment department. Psychosocial support remains inadequate because of the general public's and professionals' lack of knowledge about this issue, a lack of community involvement, and a lack of peer support mechanisms (even though there were efforts to improve access to counseling centers). Awareness of disability rights improved among survivors and the general public, but implementation of existing disability legislation was lagging.[13]

VA progress on the ground

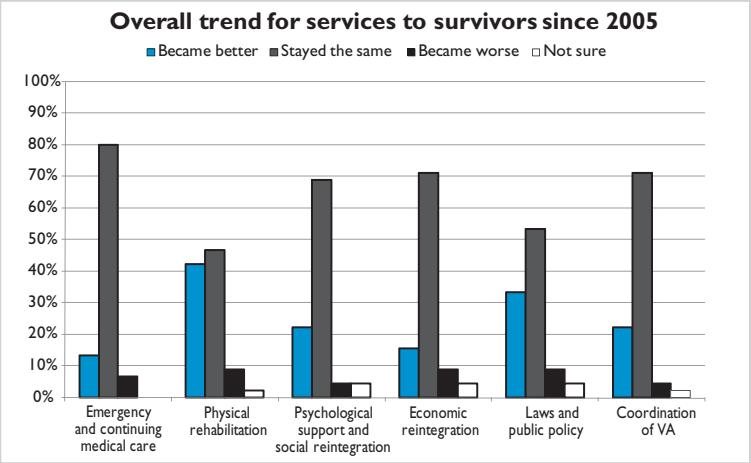
Respondent profile

By July 2009, 45 survivors had responded to a questionnaire on VA progress in Croatia: 40 (88%) were men. Respondents were between 21 and 75 years old with 77% between the ages of 26 and 45. Some 31% were heads of households and 58% owned property. Most survivors (58%) lived in rural areas with limited or no services and 42% lived in the capital or large cities with services. Some 84% had completed at least secondary education. Four people were unemployed or retired at the time of their incident, while 28 others reported being unemployed or retired as a result of the incident. Of those surveyed, 21 said their income was insufficient; for 24 it was sufficient. Most respondents had experienced their incident prior to 1998. The profile of respondents corresponds to the casualty profile extrapolated from CROMAC data, which indicates that some 85% of recorded casualties happened prior to 1998.



General findings[14]

Many survivors noted little overall change in VA/disability services. No respondents felt they were receiving more services in 2009 than in 2005; even though 40% believed that the services had improved. Some 80% of respondents felt services for female survivors were either worse than those available to men (14 people) or even completely absent (22 people). Women responded more negatively than men. Just 18% of people thought services for child survivors were mostly adapted to their age level.



While 22% of respondents had never been surveyed by anyone in the past five years, most (69%) had been surveyed by NGOs or authorities at least twice. Survivors said these surveys resulted in their feeling more heard and in their receiving information about services. Nearly three-quarters of survivors (73%) said they had had the opportunity to explain their needs to government representatives at least once, but without much result.

Emergency and continuing medical care

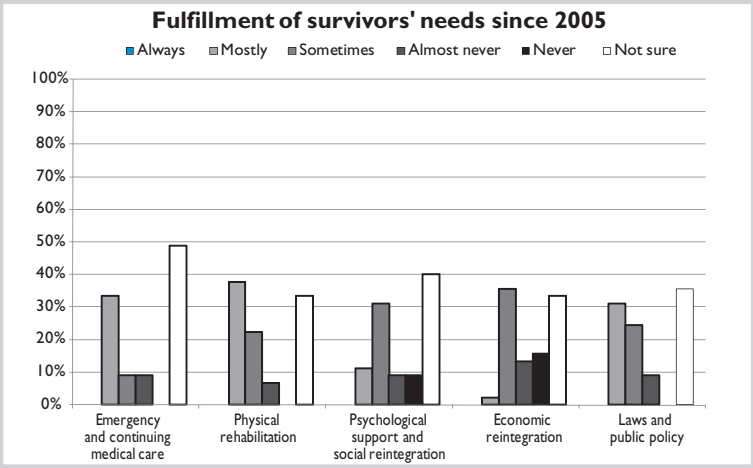
The vast majority of survivors (80%) said healthcare remained at the same level overall since 2005, while 6% said the situation had deteriorated. Nearly half of all respondents were not sure whether survivors receive the medical care they need, but 33% thought survivors receive the care needed most of the time. Improvements were clear in specific areas. Some 73% of respondents noted that facilities were better equipped and stocked; 56% found emergency transport increasingly available; 53% believed centers were better able to carry out complex procedures; and 51% said there were more first aid responders. However, just 11% of respondents saw improvements in the training of medical staff or more complete teams with a variety of skills. Similarly, only 13% found that physical

accessibility to health centers had improved or that their numbers had increased, while 78% said it had not become easier to get referrals to other services, and 71% said services had not become more affordable.

These results correspond to Croatia's statement of May 2009 that its emergency medical response capacity had improved, but that access remained uneven in rural areas, particularly for persons with disabilities.[15] Patients often must pay financial incentives to doctors, despite the fact that medical services are meant to be free of charge according to Croatian law[16] – and this is precisely the area where very few respondents reported any positive change. The lack of positive response to healthcare improvements may also be a reflection of the fact that a solid health network already existed in 2005 and was, therefore, less in need of improvement.

Physical rehabilitation

More respondents (42%) believe there has been more overall improvement in physical rehabilitation than in any other area since 2005. Just 8% felt the situation had deteriorated. Some 38% noted that survivors "mostly" receive the assistance they need, 22% said they "sometimes" receive the assistance needed, 7% said such assistance was "almost never" received, and 33% did not know. Despite a sense of overall improvement, the quality of prostheses and mobility devices was the only specific area where a majority of respondents saw an improvement (53%). Another related area of improvement was the availability of more types of devices (44%). Again, affordability, proximity and access were major stumbling blocks, with just 9% feeling it had become easier to reach centers and 4% finding it easier to access more affordable repairs. Less than a quarter of respondents found that mobility devices had become more affordable (22%).



The overall positive response to improvements in the rehabilitation sector can be explained by the importance attached to the enhanced daily comfort made possible by better devices. This reduces the need for repairs and adjustments, which in turn can make the distance to services less important. Initiatives to train technicians appear to have been a positive contribution, even though these people had to be trained abroad because Croatia lacks the capacity. Nevertheless, capacity remained inconsistent and insufficient to meet demand, according to rehabilitation specialists.[17] Government work to reduce the bureaucracy of accessing services and a national insurance system which reportedly pays some of the costs of new devices were insufficient to improve access and affordability.

Psychological support and social reintegration

Just 22% of respondents saw an overall improvement in psychological support and social reintegration efforts since 2005, while 69% found this area had remained the same. Only 11% of respondents thought survivors "mostly" received the psychosocial support they needed; 18% responded "never" or "almost never"; 31% said "sometimes"; and the rest were unsure. The specific areas where a narrow majority of people observed improvement were all related to general societal beliefs: 71% believed survivors were no longer considered "charity cases;" 60% felt the stigma around seeking counseling had decreased; 55% observed increased government support; and 53% found physical access to services had improved. This does not appear to have led to more social reintegration, with only

31% feeling more empowered and reporting an increased number of peer support groups. Just one-third of respondents felt more involved in community activities.

Croatia has acknowledged the importance of mental health assistance for survivors and other war victims and operates a government-run network of counseling centers. These services are not community-based and are generally not well-known in the community. Throughout the period, peer support was only provided by one NGO, which decreased its activity over time. The national psychosocial support and rehabilitation center for survivors remained incomplete, despite having been under construction since April 2004.[18] This, paired with better general awareness on disability issues (*see below*), explains why attitudes improved but survivor participation did not.

Economic reintegration

Some 71% of respondents believed economic reintegration services had remained the same since 2005. Just one respondent stated that survivors "mostly" receive the economic reintegration they need; 29% found this "never" or "almost never" to be the case. Areas of progress, again, related to increased awareness, evidenced by less discrimination (46%) and more awareness of disability issues among teachers (44%). However, few found there were more educational or employment opportunities (38% and 15% respectively). Only 7% said it was easier to get bank loans, that there were more job placement services, or that employment quotas were better-enforced. Less than half of the respondents reported more government support for the issue. Those who saw more government support mostly referred to pension increases. Some 42% of survivors – mostly veteran survivors who can receive pensions 10 times higher than civilians – said pensions had improved.

In 2004, the lack of employment and vocational training for survivors were identified as weak spots. Since then, efforts have been limited to small-scale projects, mainly undertaken by private organizations and often restricted to the capital. Despite government efforts to train employment counselors on disability issues and to establish a disability employment department, the number of persons with disabilities placed in employment decreased in 2008 compared to previous years.[19] A government representative also remarked that employers hired people with disabilities to receive incentives but would fire them as soon as the incentives ended.[20]

Laws and public policy

One-third of respondents agreed with the statement that the rights of survivors had been better protected since 2005. A similar percentage thought the rights of survivors were "mostly" respected. Most notably, 71% said they had increased access to legal action when their rights were violated; 60% felt there was more awareness of the rights of persons with disabilities; and the same number said fewer negative terms were used when speaking about persons with disabilities. Respondents were split 50/50 over whether legislation and policies were increasingly enforced or not. The same split applied to whether there was greater survivor inclusion in policy-making or not. More importantly, just 29% felt discrimination against them had actually decreased and 40% said they were more involved in services.

Croatia has a complex legal framework with some 200 laws relevant to the rights of persons with disabilities. These have been further reinforced since 2005 through the adoption of international frameworks such as the UNCRPD and the Council of Europe's UNCRPD Action Plan, as well as a national strategy to implement these international instruments. In 2008, the parliament appointed the first ombudsman for persons with disabilities. Awareness-raising campaigns have also been conducted, which explains the heightened disability awareness among the general public. It is acknowledged, both inside and outside government, that many of these changes have been "cosmetic" and have led to little real change in the lives of survivors or other persons with disabilities.[21] Survivor responses confirm that the foundation for positive change has been laid, but that more political will is needed for implementation of that change.

When asked to respond to preliminary findings, a government representative was not surprised and felt there probably had not been much change for most survivors, adding that those survivors who did see improvement would have had to make a significant effort to receive the services they had received. They were described as the "lucky few." It was further noted that many in government would be likely to disagree with these findings and would particularly point to legislative improvements and participation at the international level, even though such participation has not created real change in the lives of survivors.

VA process achievements

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

As a country with greater economic capacity than many other mine-affected countries, Croatia has depended largely on its own national resources and capacity for VA/disability, particularly in the health sector. In areas such as psychosocial support and economic reintegration, some national NGO representatives assert that the government has not assumed sufficient responsibility and has instead left service provision to organizations with limited access to national and international resources.

Initially, the fact that Croatia was one of the 26 countries with a significant number of survivors and therefore the greatest responsibility to act, but also with the some of greatest needs and expectations for assistance, meant that the profile of VA was raised and the government was pressured to increase its efforts. Croatia quickly developed mostly SMART objectives, which it presented in 2005 and revised minimally in 2007. In its capacity as co-chair of the Standing Committee on Victim Assistance and Socio-Economic Reintegration in 2003-2004, Croatia encouraged the inclusion of survivors or other persons with disabilities in State Party delegations to international meetings to enhance cooperation with civil society.[22] Croatia included a survivor as part of its delegation to Mine Ban Treaty meetings in 2005-2008.

When in December 2005 CROMAC was legally assigned the role of "coordinating and implementing" VA, some interpreted this as greater receptivity within the government to work on VA. However, CROMAC's coordination efforts remained limited to annual meetings between CROMAC and NGOs. Participants noted these meetings were merely information-sharing sessions. This seems to be confirmed by the fact that only 22% of survivors observed improvements in VA coordination. It was also remarked that a mine action center like CROMAC might not be the right government institution to coordinate VA and that CROMAC requirements for VA staff positions did not include any actual expertise in VA. Among survivors, the CROMAC meetings do not even appear to have served their information-dissemination purpose, as 93% stated the government did not provide regular information about VA achievements. It would appear that since 2005, more information has been shared by Croatia outside of Croatia than has been shared domestically, particularly among the affected population; this was acknowledged by one government representative.

As of August 2009, no plan to achieve the objectives set in 2005 had been developed, partly due to lack of involvement by the VA focal point. Progress on the objectives was not monitored and it would appear that many objectives have not been achieved.[23] There is a commitment to consolidate data on casualties and survivors' needs in order to more effectively implement the objectives, but as of May 2009, this task had not been completed, impeding Croatia's ability to develop specific targets for persons to be reached or a plan

to achieve the targets. Several of Croatia's VA objectives relate to the development of strategies, coordination mechanisms, or guidelines. Actual service provision depends on the development of these mechanisms, which, as of 2009, were not functioning because of a coordination vacuum. For psychological support and social reintegration – known to be weak components – very few objectives are set. Specific and ambitious percentages of persons to be reached have been mentioned (60%-70%) for these two components.[24] However, without a needs assessment or accurate data, it is impossible to judge who needs services or what percentage might have received them by 2009. Survey responses indicate these targets have not been reached.

Croatia's leadership on survivor inclusion at the international level has not been replicated domestically, as only 37% of respondents felt the needs of survivors were taken into account in developing national VA priorities. Despite it being a national priority, the inclusion of survivors in VA coordination did not appear to be systematic, with just 31% of respondents feeling they or their representatives had been involved. This response even overstates actual participation, as more than 75% of survivor respondents are members of the country's only remaining survivor association and are thus indirectly represented at meetings through the association's leader.

The perception is that unlike many other mine-affected counties, Croatia does not lack financial resources. What it lacks is political will. The early promise of change for Croatia's survivors had not been sustained. Overall, greater focus has started to be placed on promoting the rights of all persons with disabilities, especially within the framework of UNCRPD. It is too early to measure the impact of Croatia's ratification of the UNCRPD, but with sustained energy, this could become a new avenue for promoting positive changes for mine/ERW survivors.

Conclusions

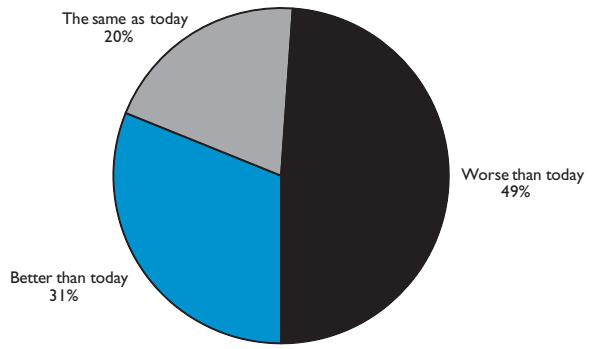
- Economic reintegration is the area which reports the least progress and which also most concerns respondents, based on their stated VA priorities for the next five years.
- Existing coordination mechanisms have been ineffectual and did not seem to contribute to VA.
- Though top-up fees and costs for the uninsured remain a concern, respondents seemed generally satisfied with healthcare services.
- Quality of prosthetic devices improved and resulted in more positive evaluation of the sector by survivors, despite the lack of centers nearby and not all costs being covered.
- Progress has been made in raising awareness about the rights of survivors and other persons with disabilities. This should be converted into steady pressure to implement existing laws and increase equal and active participation.

Suggestions for the way forward

When asked about how they saw their situation in five years: 49% thought it would get worse, 20% thought it would remain the same and only 31% thought it would be better. To assist in a better future ahead the following suggestions may be taken into account:

- Consolidate and verify survivor data to establish a baseline for assessing needs and measuring progress. However, the completion of such consolidation should not be a condition for the start of implementation.
- Ensure greater synergy with UNCRPD implementation plans by ensuring that the rights and needs of survivors are included in them and consider transferring VA coordination to the ministry responsible for disability.
- Include survivors and other persons with disabilities in a meaningful way in policy development and monitoring.
- Raise the status of the governmental body responsible for VA/disability coordination and implementation in order to increase the involvement of all relevant ministries.

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



- Provide sustained support to develop a peer support network and other social reintegration activities and to strengthen NGO activities in this area.
- Increase government investment into expanding economic opportunities for survivors by adapting existing programs to include survivors and by establishing specific programs when necessary.

Davor Meštrović stops to rest while biking
© Mato Lukić

In their own words…

If countries really cared about survivors they would:

- Provide opportunities to make survivors feel like useful members of society.
- Familiarize survivors with their rights and increase their rights.
- Make more funds available for aid.
- Give greater economic and social rights to survivors, not just talk about it.
- Create adequate employment opportunities, taking into account survivors' abilities.
- Give equal social, medical and financial rights to survivors no matter whether they were soldiers or civilians.
- Create a national strategy for assisting survivors.
- Give special attention to women survivors.
- Help improve family life.

In their own words…

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

- Help survivors to re-enter normal life through employment and financial aid.
- Encourage employment of survivors.
- Care as much for [civilian] landmine survivors as for disabled military personnel.
- Acquire a better understanding of the situation "on the ground."
- Improve legislation.
- Play a more active role in solving the problems of survivors.
- Improve medical care and equipment.
- Ensure equal rights for all survivors.

In their own words…

Survivors described themselves as: victim, worried, surviving/fighter, cared-for, lucky/free, disabled/unwell, young man/student, powerless, satisfied, retired, unfortunate, loser.

In his own words: the life experience of Davor Meštrović

On 22 May 1992, the 11-year-old Davor Meštrović was playing in the woods near an army barrack outside Karlovac when he stepped on a mine. He lost both his legs below the knee and his playmate suffered minor injuries. Soon after his injury, his mother died from cancer and his stepfather abandoned him and his two stepbrothers.

Davor's prospects seemed bleak, especially when he turned 18 and could no longer stay at the state orphanage. Luckily, some friends and the Karlovac Mine Survivors' Association decided to help him. With this support, he followed training to become a prosthetic/orthotic technician and he is now employed at a private orthopedic center. He earns the mimimum wage and gets some additional disability benefits. Nevertheless, Davor has been able to pay for the education of one of his stepbrothers, while also taking care of his wife and one-year-old daughter. They live in a rented apartment in Zagreb. But Davor's disability gives him priority status for housing assistance, for which they have now applied. With some luck, he and his family will be under their own roof by Christmas.

Democratic Republic of Congo (DRC)

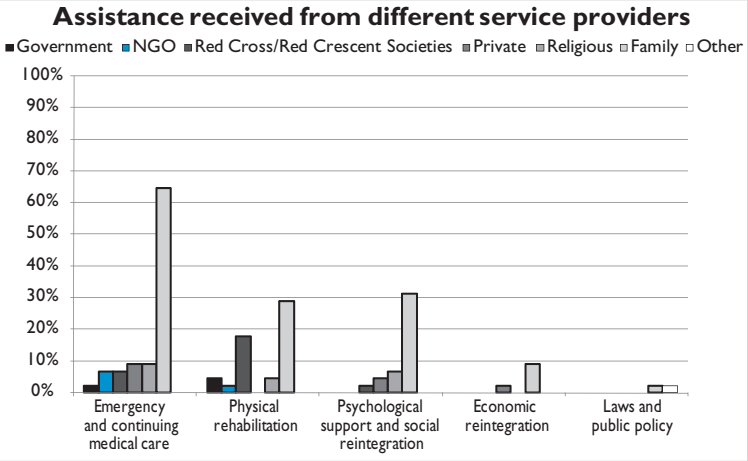
Country indicators

- *Conflict period and mine/ERW use:* Contamination by mines, cluster submunitions and other ERW, including abandoned explosive ordnance (AXO), in the DRC is the result of ongoing armed conflict since 1996. There is earlier contamination as a result of use by foreign forces.[1]
- *Estimated contamination:* As of June 2008, there were some 1,893 suspected hazardous areas but their size and the number of people affected was unknown.[2]
- *Human development index:* 168th of 179 countries, low human development (compared to 168th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$150 – 209th of 210 countries/areas (compared to US$109 in 2004).[4]
- *Unemployment rate:* Unknown, but often cited as approximately 80%.[5]
- *External resources for healthcare as a percentage of total expenditure:* 28.8% (compared to 19.4% in 2004). [6]
- *Number of healthcare professionals:* Six per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* In the DRC more than 1,000 people are reported to die every day from war-related causes, including disease, and violence.[9] Since conflict started, an estimated 4 million people have died from violence, hunger and disease as a result of the conflict, and 2.5 million people have been made homeless. The DRC has significant natural resources, but exploitation of these does not benefit the vast majority of people. Continued conflict and subsequent reluctance from foreign investors, as well as the economic slowdown in 2008, continued to deteriorate the already weak economy. Some NGOs estimate that 80% of the population lives below the poverty line and that life expectancy is just under 42 years.[10]

VA country summary

Total mine/ERW casualties since 1996: At least 2,184			
Year	Total	Killed	Injured
2004	61	16	45
2005	60	18	42
2006	44	17	27
2007	28	4	24
2008	14	3	11
Grand total	**207**	**58**	**149**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 1,247.
- *VA coordinating body/focal point:* The Director of the National Community-Based Rehabilitation Program in the Ministry of Health (MoH) is the VA focal point, but this person lacks sufficient means and institutional support.
- *VA plan:* None presented, but since 2007 it has been reported that a draft report existed, which needed updating based on a needs assessment.[11]
- *VA profile:* Most people in the DRC are unable to access services and due to conflict, poverty and mass displacement the government is not able to address the many needs. In most places, access to services ranged from limited to non-existent and was further hampered by long distances, inaccessible terrain and the cost. Most services are provided by NGOs working to alleviate the emergency situation. But continued outbursts of conflict canceled out much of the progress made and increased the demands, while some NGOs also faced funding challenges. As one group among many vulnerable people, mine/ERW survivors and other persons with disabilities received few services throughout 2005-2009, even though the DRC's Poverty Reduction Strategy Paper takes measures for persons with disabilities into account. The government acknowledged that it lacked the means and capacity to make progress on VA. The vast majority of people did not have access to healthcare because of a lack of staff, medication and equipment and because they had to pay for it. Waits, also for emergency procedures, were long (up to two days). Despite significant international investment, the health system was said to be on the verge of collapse in 2009.[12] The physical rehabilitation sector was under-resourced and the few functioning centers entirely dependent on international support which has increased systematically since 1999. In 2005, the government noted that the economic and political situation made it impossible for the government to support the creation of employment for mine/ERW survivors and other persons with disabilities.[13] This situation remained



unchanged in 2009. Opportunities for psychological assistance were limited to *ad hoc* NGO projects for all conflict-traumatized. Within the healthcare system, social workers had received little more than basic training. The implementation of the National Community-Based Rehabilitation Program (PNRBC) was hampered by a lack of funds and access to communities. This program was envisioned as one of the main ways to implement VA. While persons with disabilities were included in the Constitution which entered into force in 2006, no specific disability legislation existed as of 2009. The UN Mine Action Coordination Centre (UNMACC) is responsible for casualty data collection, but data remained incomplete both due inaccessibility of some areas and a lack of capacity at UNMACC.[14]

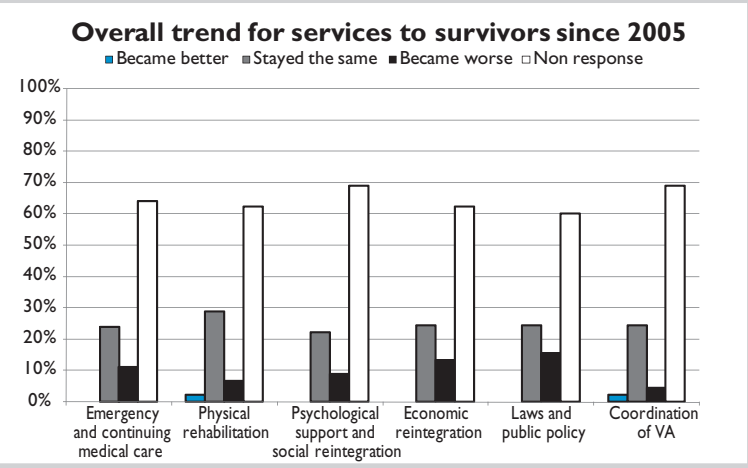
VA progress on the ground

Respondent profile[15]

By July 2009, 45 survivors between 12 and 70 years old had responded to a questionnaire on VA progress in the DRC since 2005: 78% were adults and 22% children. Some 87% of respondents were male and 46% of respondents were heads of households. At least 22% had received no education at all. At least 24% of respondents were unemployed before the mine/ERW incident; this increased slightly to 31% after the incident. Of those respondents answering the question, 92% considered their income insufficient. The largest group of respondents (38%) lived in villages with some services; 35% in the capital of the country; 16% in remote areas without services; and the remaining 11% in large cities. Incidents occurred between 1967 and 2009, with most between 1990 and 2000, which corresponds to UNMACC reporting on casualties. UNMACC also indicated that the majority of casualties were men and most casualties were civilian.

General findings

Overall, respondents saw no progress on VA service provision in the DRC between 2005 and 2009. None of the respondents said that they received more or better services in 2009 than in 2005. There was a high non-response rate to the questions asking about the overall situation of healthcare, physical rehabilitation, psychosocial support, economic reintegration, and laws and public policy, whereas nearly all respondents answered all the other survey questions on services (96% completed all responses for specific progress indicators). This may be statistically significant in itself, likely indicating either that there was no applicable response (the response 'stayed the same' may not adequately describe a continuing absence of services) or possibly indicating a high degree of frustration with the lack of services, and lack of improvement in all areas.



Most respondents (67%) thought that services for child survivors were "never" adapted to their needs

and 69% reported that compared to male survivors, services for female survivors were "absent"; with just 11% reporting services were "equal".

None of the respondents had been surveyed by NGOs or government in the past five years. This finding might confirm the lack of systematic data collection due to the inaccessible terrain, a lack of infrastructure, and security reasons. UNMACC reported that casualties were under-reported and the two organizations supporting survey efforts indicated repeatedly that it was very difficult to locate mine/ERW survivors as many live in very remote areas or move because of conflict and because it might take days to reach a person due to the size of the country and the bad roads. Additionally, many survivors had their incidents well before 2005, and might have been surveyed at the time.

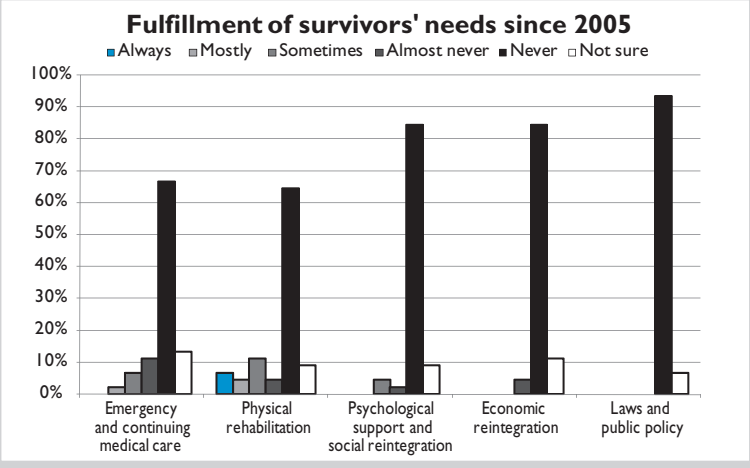
Emergency and continuing medical care

Of those responding to the question whether, overall, healthcare services had improved, stayed the same or become worse since 2005, 24% said the situation had stayed the same and 11% that it had become worse (64% did not answer). Most respondents (67%) said that, in the last five years, mine/ERW survivors "never" received the medical care they needed and another 11% found this "almost never" to have been the case. The most progress (but just 9%) was seen in an increase in available first aid workers. Another two respondents (4%) believed that health centers had teams which were more complete than before.

These bleak responses fit with the known healthcare situation in the DRC. According to the 2005 Zagreb Progress Report, the DRC had some 400 hospitals.[16] In 2006, the World Health Organization (WHO) described the state of 200, or half, of those hospitals as "catastrophic."[17] The same year, the UNMACC reported that the majority of survivors "are left to themselves, exasperated by the fact that the national health system does not have the capacity to provide assistance."[18] From 2006 to 2009 it was regularly reported that emergency healthcare in the DRC remained severely inadequate despite continuous international investment. Overall, the sector could not cope with the ongoing crisis and lacked supplies, equipment and staff. It was said there were only 10 trauma surgeons in the whole country in 2006. Instability resulted in the looting of medical equipment. In the many places where public health services had collapsed ongoing conflict hampered international relief efforts and at the same time increased the number of people in need of health services. [19]

Physical rehabilitation

The most progress was reported in the area of physical rehabilitation and prosthetics. Nonetheless, the majority of respondents (64%) reported that survivors "never" received the physical rehabilitation they needed in the last five years. Improvement in services because of better-trained staff and better quality prosthetics was noted by 22% of respondents. Some 20% thought rehabilitation centers had more complete teams. Also, 16% found it easier to obtain replacement devices and said that rehabilitation services were more affordable. Just 13% noted increased free-of-charge repairs. No respondent believed that the government had provided more support to physical rehabilitation.



The progress registered by some respondents can likely be seen as the effects of ongoing ICRC support to

orthopedic centers. Since 2005, the ICRC has increased its support from three to five centers, covered patients' costs, supplied imported materials, and provided training.[20] While the MoH is responsible for the rehabilitation sector it did not manage any physical rehabilitation centers in 2005-2009. The PNRBC of the MoH did not have sufficient resources to operate effectively since its establishment in 2002. The centers were instead run by NGOs, religious organizations, or private companies, which did not have the financial means to provide free-of-charge services. Many centers were also not functioning, could not produce mobility devices or needed staff training.[21]

Psychological support and social reintegration

Most respondents (84%) reported that survivors "never" received the psychological support and social reintegration they needed in the last five years; 4% said "sometimes"; 2% said "almost never"; and 9% were not sure. No respondents reported an increase in the number of services, the number of social workers, or the availability of peer support in the five-year period. The response with the most agreement from respondents (16%) was regarding feeling more empowered as an individual. Another 9% reported becoming involved in psychosocial support for others. Just 4% felt more involved in community activities in general or believed that there was less stigma attached to seeking psychological counseling. No respondents believed that survivors were considered to be "charity cases" less often or that the government had provided more support to psychosocial activities.

Survivor responses match other reporting regarding the persistent lack of services. In 2005, the DRC noted a lack of institutional responsibility and standards for providing psychosocial support to mine/ERW survivors.[22] Psychosocial care for persons with disabilities or war traumatized people was almost non-existent. There were no known psychological support programs for survivors, although some health and rehabilitation staff had a limited basic knowledge of psychosocial care.[23] In 2007, the DRC acknowledged the challenge of establishing a framework for psychological support and integrating it in the CBR strategy.[24] Limited psychological support services from NGOs dealt with war trauma in general and started to focus increasingly on the extensive problem of sexual violence and rape as a weapon of war.[25] In November 2008, the DRC reported that it would aim to support the creation of a survivor organization, but no further developments have been identified.[26]

Economic reintegration

No respondents saw an overall improvement in economic reintegration opportunities since 2005. Most respondents (84%) believed that survivors "never" received the economic reintegration they needed and another 4% said "almost never" (the remainder was not sure). Other than four respondents (9%) who believed that discrimination in employment had decreased, absolutely no progress was reported in any area of economic reintegration.

These responses are disappointing, but not surprising given the deplorable economic situation and extremely high levels of unemployment (up to 80%). In 2005, the DRC noted that the situation in the country prevented it from supporting economic reintegration opportunities for survivors, and continued to acknowledge this throughout the period under review. In 2009, economic reintegration activities continued to be almost non-existent in the DRC. No micro-credit or small business opportunities for persons with disabilities were known to exist. Limited public and private funding was given to training centers for persons with disabilities which existed in some urban centers. These had very limited capacity[27] and mine/ERW survivors were not reported to have accessed any particular vocational or economic services. [28]

Laws and public policy

The vast majority of respondents (93%) reported that in the last five years survivors had never had their rights enforced through the implementation of laws and public policies (7%

were not sure). Just 9% of respondents thought that new legislation and policies relevant to survivors had been developed, but none reported progress on the enforcement of legislation. Few respondents (7%) reported that discrimination against survivors had decreased and some 11% reported that there was less use of negative terms about persons with disabilities. However, no increase in public awareness about the rights of survivors or persons with disabilities was observed and no respondents reported that they had more access to information about services or their rights.

The respondents' negative assessment of progress in ensuring the rights of survivors corresponds with the need for existing laws to be implemented and specific disability legislation to be introduced. Disability was included in the Constitution of 2006, and since 2003, the DRC has frequently stated that it is planning to draft, or in the process of drafting disability legislation that would respond to the needs of mine/ERW survivors. In 2008 it reported that the lack of disability legislation was an obstacle and that some awareness-raising efforts had been undertaken.[29] However, no legislation was presented and in 2008, local associations for and of persons with disabilities in Kinshasa started to work on draft disability legislation based on the provisions of the Constitution.[30] Throughout 2005-2009, reports of discrimination and the government not effectively enforcing existing legal provisions were common. The DRC has also since 2007 reported that it was in the process of acceding to the UNCRPD, without result as of 1 August 2009.[31]

No government representatives were able to provide comments on the above findings.

VA process achievements

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

As a country with sparse health and social resources, a devastated economy and ongoing conflict, it is not surprising that few gains were made in VA in the DRC between 2005 and 2009. While the DRC acknowledged the importance of VA and its integration into the broader disability sector, it stated that progress could not be made due to the absence of funds and technical assistance and due to a weak legal framework.[32] A 2008 independent evaluation of the mine action center UNMACC very briefly noted the severe lack of available VA services.[33]

As one of the 26 States Parties with significant numbers of mine survivors, and with "the greatest responsibility to act, but also the greatest needs and expectations for assistance," the DRC presented its 2005-2009 objectives in 2005 and revised them in 2006. The objectives that were given timeframes were all to be achieved in 2009; several other objectives remained unspecific. No plan has been presented even though it has been reported since 2007 that a draft plan had been prepared. In 2008, it was said that a further needs assessment was needed to complete the plan – completion was ongoing as of 2009.[34] By 2009, the DRC reported that victim assistance had stalled entirely due to the adverse conditions in the country.[35]

Already in 2005, a UN Mine Action Service (UNMAS) assessment mission to the DRC recommended that the UNMACC and the government work together in drafting a national VA strategy and designating a VA focal point. UNMAS noted that this preferably should be within the Ministry of Social Affairs and Family,[36] which is in charge of disability issues in general. But there is no evidence of this ministry taking on VA and responsibilities remained unclear until, in late 2007, the director of the Ministry of Health's PNRBC was

delegated to be the focal point. However, the absence of institutional support for the focal point hampered progress and the program had insufficient resources to fulfill its role effectively.

Despite initial UNMAS engagement, UNMACC's role in VA was limited to data collection throughout 2005-2009, and the 2008 evaluation of UNMACC recommended that it develop a "meaningful victim assistance policy."[37] In 2009 UNMACC took steps to hire a VA coordinator to facilitate casualty data management, VA planning and coordination, and liaison with the ministries of health and of social affairs and family on VA issues. As of mid-June 2009 the position had not yet been filled,[38] but the position may be seen as an attempt to help advance planning and inter-ministerial coordination. The UNMACC evaluation also recommended that mine action operators do more to assist mine/ERW survivors through appropriate existing programs in the health, social and economic sectors rather than setting up separate projects.[39]

The Poverty Reduction Strategy Paper of the DRC makes reference to persons with disabilities and possible activities include: the establishment of a national program for persons with disabilities; improvement of economic and social conditions by promoting education and training, and health and mobility improvements.[40]

No survivor respondents reported that there was more government involvement in VA in 2009 than in 2005 or that information was provided about VA achievements. No respondents thought that the needs of survivors were taken into account when setting VA priorities. A small percentage of respondents (9%) agreed that inclusion of survivors and their organizations in disability and VA monitoring increased. Yet there was no reported progress in the inclusion of survivors or their representative organizations in implementing VA services or developing policies.

Conclusions

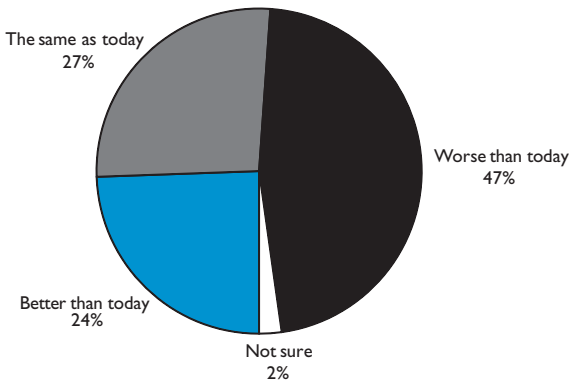
- Due to the dire situation in the DRC, VA/disability was understandably not a priority.
- The devastation of the health system was such that it needed much more effort than ever could be achieved by VA measures.
- Thanks to the non-governmental operators there was some improvement in physical rehabilitation but, overall, services were insufficient.
- Institutional or international support for VA was lacking and coordination on VA or disabilities between relevant ministries was insufficient.
- The lack of a focal point with a clear mandate hampered planning, as did the absence of reliable data. However, the latter does not constitute sufficient reason for a lack of progress.
- Financial and technical support to implement the PNRBC was absent.
- NGOs and international organizations focused mainly on the emergency situation and did not systematically integrate the needs of mine/ERW survivors or other persons with disabilities in their programs.

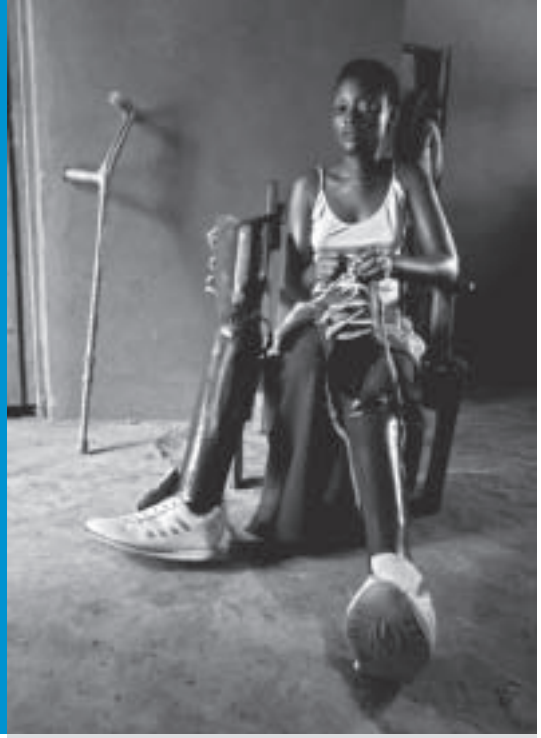
Suggestions for the way forward

When asked about their expectations, nearly half of respondents (47%) thought that their situation in five years would be worse than it is now; 24% believed that it would be better; and 27% said that it would stay the same. To assist in a better future ahead, the following suggestions may be taken into account:

- Provide support to the government VA focal point, for example through UNMACC support, to create a broad coordination mechanism with sufficient capacity to act.
- Implement a comprehensive needs assessment, as the situation allows, but do not let planning progress depend only on this.
- Develop a disability plan, or set of plans for each service sector formulated by the appropriate ministries in consultation with international organizations, local NGOs and survivors.
- Increase coordination between ministries, UNMACC and NGOs to improve implementation and reporting, and to support the implementation of the PNRBC.
- Prepare coordinated proposals for VA/disability project funding.
- Empower local services, encourage grassroots projects which require minimal start-up funding.
- Introduce pilot projects for economic reintegration, such as training and micro-credit, mindful of the weak economic situation and adapted to local conditions.
- Establish survivor organizations and peer support groups as a cost-effective alternative to establishing formal psychological counseling mechanisms.

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





Théthe Solo Lembenda at her house
© Arne Hodalics, for Handicap International

In her own words: the life experience of Théthé Solo Lembenda

During the 6-day war between Rwandan and Ugandan forces in 2001 in Kisangani, Théthé was just 11 years old when she stepped on a mine. She was treated by the ICRC at the General Hospital of Kisangani and her first prosthetic device was supported by an international NGO. Through this NGO she also received intensive psychosocial support to help her accept her disability.

As a result, she was not rejected by her family or by her community and is now studying commerce in high school. After her high school studies she would like to receive support so that she can go to university and then start an economic reintegration project to assist other persons with disabilities.

In their own words…

If countries really cared about survivors they would:

- Provide housing for survivors.
- Offer financial support.
- Build housing.
- Provide a sewing machine.
- Improve coordination of victim assistance implementation.
- Provide aid to get prostheses.
- Build victim assistance centers.
- Take responsibility for the psychosocial and economic needs of survivors.

In their own words…

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

- Improve rehabilitation services.
- Make peace.
- Include economic reintegration in national plans.
- Include survivors in activities.
- Create reintegration centers.
- Include reintegration activities in the national budget.

In their own words…

Survivors described themselves as: boy, widower, student, having to rely on parents, woman, amputee, believer, disabled, father, unsupported, child, single, survivor, and married young.

In their own words…

A diverse range of opinions were expressed in survey responses and some respondents chose to include comments about services, such as:

- "Just after my incident, everything went well and I was treated well. But once I healed that was no longer the case. When I have a health problem now everything is difficult: no money, no access to services. Moving around is a problem too; it used to be a right [for disabled persons] to take a taxi for free, but this no longer happens in Kinshasa as the drivers refuse to take us. We are powerless because there is nobody to speak for us."
- "They should take care of all the victims. I am disabled today because I fought for this country. The government should be grateful and help us not dump us."
- "The government should do something for me, because I am getting closer to death… it should take care of me and buy a house and then I could die in peace."

El Salvador

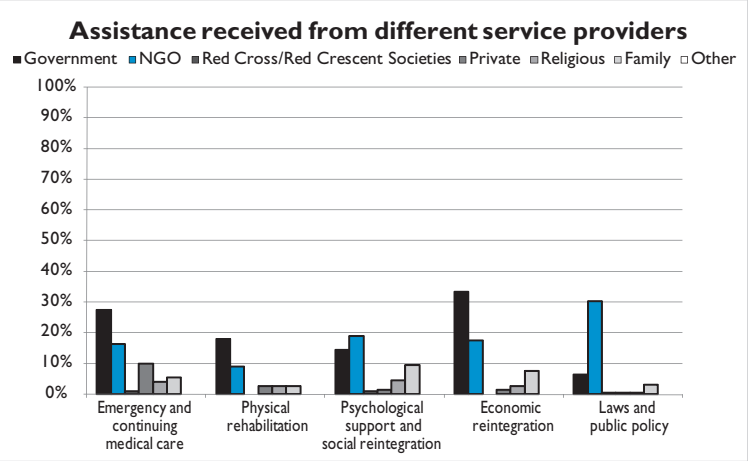
Country indicators

- *Conflict period and mine/ERW use:* The Salvadoran military and opposition forces used mines and ERW throughout the civil war between 1980 and 1992. Gangs reportedly use improvised explosive devices.[1]
- *Estimated contamination:* El Salvador has been mine-free since 1994, but minor ERW contamination remains.[2]
- *Human development index:* 103rd of 179 countries, medium human development, (compared to 103rd of 177 in 2004).[3,4]
- *Gross national income (Atlas method):* US$3,480 – 119th of 210 countries/areas (compared to US$2,333 in 2004).[5]
- *Unemployment rate:* 6.3% official rate, but high underemployment (compared to 6.5% in 2004).[6]
- *External resources for healthcare as percentage of total expenditure:* 3.1% (compared to 1.7% in 2004).[7]
- *Number of healthcare professionals:* 20 per 10,000 population.[8]
- *UNCRPD status:* Ratified both the Convention and its Optional Protocol on 14 December 2007.[9]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* El Salvador is one of the 10 poorest countries in Latin America. The economic growth it has experienced since the early 2000s has been spurred, to a large extent, by remittances from family members abroad and not by long-term investments. More than 40% of the population lives on less than US$2 per day. El Salvador also faces frequent natural disasters and high levels of societal violence. Immediately after the civil war, El Salvador received considerable international assistance for the peace process, but this support has decreased since.[10]

VA country summary

Total estimated mine/ERW casualties since 1980: Unknown			
Year	Total	Killed	Injured
2004	0	0	0
2005	4	2	2
2006	6	1	5
2007	4	0	4
2008	14	2	12
Grand total	**28**	**5**	**23**

- *Estimated number of mine/ERW survivors:* 3,158; the most recent mine casualty happened in 1994.[11]
- *VA coordinating body/focal point:* The National Council for Integrated Attention for Persons with Disabilities (Consejo National de Atención Integral a las Personas con Discapacidad, CONAIPD) is the central government body coordinating VA and UNCRPD. It includes organizations of persons with disabilities, though some complain their inclusion is limited and that CONAIPD lacks the authority to compel ministries to act.
- *VA plan:* In 2007, VA objectives and plan were developed to implement the 2005-2009 Nairobi Action Plan. The Plan of Action for compliance with the UNCRPD entered into force in May 2008.[12]
- *VA profile:* While El Salvador has been an active participant at Mine Ban Treaty meetings, only modest progress has been made in improving services for civilian survivors. There have been greater improvements for former military survivors. Often, those advances were achieved through the broader disability framework and usually financed with national resources. However, insufficient national resources are allocated to disability issues. Decentralization of the national health system, which started in 2003, aimed to increase access to medical services in rural areas, but mobile units face fuel shortages and health centers are basic. Access to specialized services in major cities remains challenging for civilian survivors. In major cities, there is a variety of physical rehabilitation services, but their centralized locations are problematic for those not receiving transportation or accommodation support. In 2008, the government reported that only two facilities provided services to survivors and that one of them was open to military survivors only.[13] There were also complaints regarding the poor quality of devices. Between 2005 and 2009, community-based rehabilitation (CBR) spread to 64 municipalities "in extreme poverty" to connect persons with disabilities to a range of rehabilitation and reintegration services. A national policy on



psychosocial support does not exist. Throughout 2005-2009, activities remained unsystematic and mostly carried out by NGOs or veterans' organizations. Since 1999, economic reintegration for survivors has been taking place on a limited scale. While some programs have been established since that time, economic opportunities remain extremely limited for survivors due to high general unemployment, non-enforcement of employment quotas, a lack of access to basic education and the relatively "old" age of survivors. El Salvador has ratified the UNCRPD and has disability legislation, but reform of other relevant legislation regulating protection of war victims has been incomplete since 2005, and persons with disabilities protested the non-enforcement of legislation and pension suspensions several times in 2005-2009. Plans made in 2005 to consolidate data on survivors and services have not been achieved, although data does exist at various organizations. It is therefore impossible to say how many survivors have received assistance.[14]

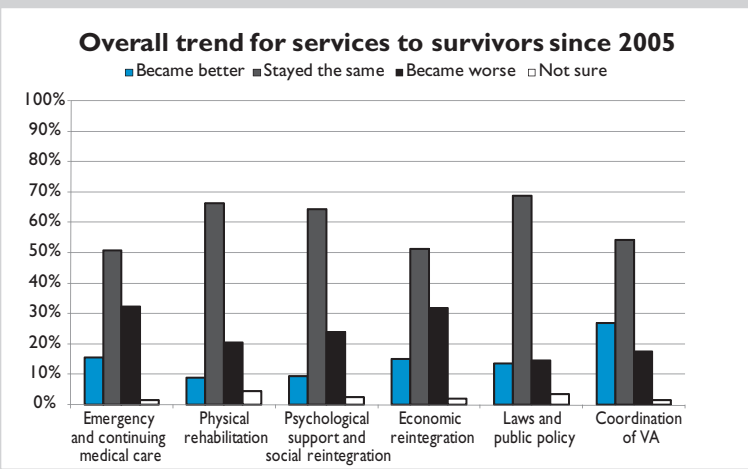
VA progress on the ground

Respondent profile

By July 2009, 201 mine/ERW survivors had responded to a questionnaire about VA progress in El Salvador since 2005: 192 men, eight women and one girl; 87% were between the ages of 35 and 50. Some 89% were heads of households and 48% owned property. A majority of these survivors (62%) live in rural areas with limited or no services and 35% live in the capital or another large city.[15] Just 12% had completed secondary education or beyond (including vocational training) and 10% had never received any formal education. Of those responding, some 16% were unemployed at the time of the survey, as compared to 6% before the incident.[16] Of those surveyed, 90% said their income was insufficient. This matches the profile of survivors in this country, nearly all of whom are men. Most experienced their incident as soldiers or, to a lesser extent, as civilians during the conflict in the 1980s, usually living in rural communities affected by the conflict.[17]

General findings

Despite noting some positive developments, the vast majority of respondents felt the overall situation of VA had stayed the same or gotten worse since 2005. Just 20% felt they now receive more services and 19% felt they receive better services compared to 2005. The most positive results were seen in the promotion of survivors' rights. While female participation in the survey was too limited for accurate extrapolation, 52% of respondents felt services for female survivors were "equal" to those available to men; 28% thought they were completely "absent". The nine female survivors did not respond more negatively than the men. Nearly half (47%) found services for child survivors were "never" adapted to their age level.[18]



While 35% of respondents had been surveyed by the government or NGOs at least once since 2005, the majority (58%) had never been surveyed.[19] Survey activity produced few concrete results: 47% reported receiving a pension more easily; 41% felt listened to; 23% thought they had received more information about services; and 14% said they had received more services as a result. These findings correspond with the fact that comprehensive figures for military survivors are the only ones available. Most NGOs working with war-affected individuals said there were many more mine/ERW survivors than those registered and that a comprehensive assessment was needed.[20] Since 2005, El Salvador has been saying it will update and verify existing statistics, but as of August 2009 this has not happened.

Emergency and continuing medical care

Over half of all respondents (51%) felt healthcare for survivors had stayed the same since 2005 and 32% felt it had gotten worse. Some 54% felt survivors "never" or "almost never" received the medical care they needed and said it was not a government priority. Just 16% thought survivors "always" or "mostly" received the services they needed. Respondents noted progress in terms of access, but not in quality. Some 39% said physical access had improved, 34% found it easier to access to healthcare closer to home (34%), and 32% found it easier to obtain referrals. Access closer to home was observed more by respondents in cities (48% compared to 25% in rural areas). Some also noted increased emergency transportation (29%) and first aid workers (24%). Just 15% of respondents saw quality improvements, better trained staff (14%), or increased availability of medication (8%). Practitioners confirmed the views of survivors and also noted the most progress had been made in physical access.

These results confirm that decentralization efforts by the government to bring healthcare to rural areas have had some effect. However, the effects of these efforts have been diminished by the fact that most facilities outside of major cities only provide basic assistance and lack infrastructure and staff. Mobile units experience fuel and road network challenges. Complex procedures can only be carried out in the major cities and are not always free of charge. The lack of accommodation for family members accompanying survivors seeking services is also a problem.[21] While some survivors agreed with the government's reports, which claim it can handle any kind of emergency, this is likely because they themselves did not actually need this type of assistance. Reports exist to contradict the government's statement, such as the fact that the evacuation of four children injured in 2008 to an appropriate facility took more than five hours because of a lack of emergency transport, bad roads, and a lack of necessary equipment at the nearest health center.[22]

Physical rehabilitation

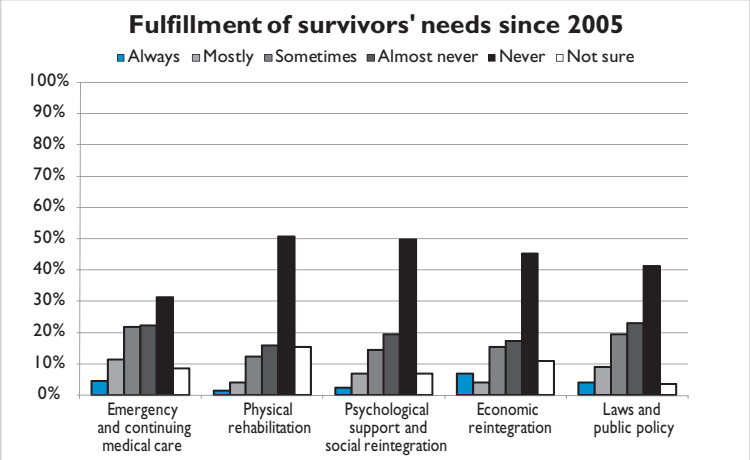
Some 66% of respondents felt rehabilitation services had remained the same since 2005. One-fifth saw deterioration, but this increased to 24% when only respondents from rural areas were considered. More than half (51%) said survivors "never" received the physical rehabilitation they needed; just 5% said it was "always" or "mostly" received. When looking at specific progress indicators, proximity and quality of services were the areas where least progress was felt. Just 13% thought there were more centers in their area, while 15% said they could get services closer to home or that there were more mobile workshops to carry out repairs. Less than 20% also said the quality of physical therapy or mobility devices had improved (17% and 19% respectively). Practitioners' responses were split, but those working with both military and civilian survivors felt services largely remained the same. Those working with military survivors saw more improvement, particularly in the quality of devices and staff capacity.

As one government representative explained, El Salvador has sufficient physical rehabilitation capacity, but lacks the financial resources to ensure survivors benefit from it. There are several physical rehabilitation centers and most are private. Just two public rehabilitation centers assist survivors; one of them is open to military only. Between 2005 and 2009, it was reported that waiting periods were long and devices of poor quality.

The 2008 review of CONAIPD's VA sub-committee, organized to analyze progress on the country's 2005-2009 VA objectives, added that the high cost of materials to produce mobility devices is another obstacle.[23] In 2008, El Salvador reported some progress in developing the minimum quality standards planned since 2005, but said they had not yet been approved. No progress was reported on agreements with other rehabilitation centers to allow survivor access.

Psychological support and social reintegration

Most respondents (64%) felt that, overall, psychological support and social reintegration services had remained the same since 2005; 24% felt services were worse. Half believed survivors "never" received the psychosocial support services needed and another 20% found this "almost never" to be the case. Just 12% said there was increased government support for psychosocial services. When looking at specific progress indicators, positive results were noted, particularly in the survivors' own attitudes: 72% felt empowered; 68% are more involved in community activities; and 58% are more involved in psychosocial support activities for other survivors. Much less progress was perceived in society's attitudes: 12% thought there was more awareness about the importance of psychosocial support, while only 14% felt such support was considered equally important to other services. More importantly, just 26% believed survivors were no longer considered to be "charity cases"; 35% felt there was less stigma associated with seeking psychosocial support. No noticeable improvements were seen in the proximity, quality or quantity of services, better trained staff or more staff (all reported by 25% of respondents or fewer).



These positive results regarding the survivors' personal situations can be attributed to the fact that many respondents belong to a peer support network developed by a national NGO (Red de Sobrevivientes y Personas con Discapacidades, Network of Survivors and Persons with Disabilities, RSPD). The military provides some services to its staff and the government is continuing to expand the CBR network. However, the vast majority of services for civilians with disabilities are provided by NGOs who neither have a national policy to guide their activities nor the means to support them. In 2008, the government still focused mostly on awareness raising among the general population and health and social sector workers and had yet to develop guidelines.[24] This explains the negative perceptions of the quality and quantity of services.

Economic reintegration

Nearly one-third (32%) of survivors believed opportunities for economic reintegration deteriorated since 2005; 51% thought the situation had remained the same. Most respondents (63%) felt survivors "never" or "almost never" received the economic reintegration assistance they needed. Nearly all (92%) also believed unemployment was so high that survivors were the last to be chosen for a job. The most positive result, by far, was that 55% of respondents noted an increase in pensions, and indeed these pensions were increased by 20% for all "war victims" (including civilian and military survivors) in January 2009. In all other areas, the perceptions of progress were lower: 37% said discrimination in education and employment had decreased and 31% saw an increase in economic opportunities. Fewer than 25% saw improvement in access to education, vocational training, employment opportunities, bank credit, improved enforcement of employment quotas or the affordability of training opportunities.

Since 2005, El Salvador has expressed its concern over the lack of economic reintegration opportunities available to survivors and has called for external support.[25] As of May 2009, one government representative interviewed for this report had seen no increase in this support. The 2008 VA review reported that economic reintegration programs had benefited few survivors and "a minimal percentage of survivors had been employed."[26] Employment quotas are not enforced, other efforts are limited; and awareness is lacking. It was further noted that the average age of survivors (40 or older) is an obstacle since employers prefer to hire younger people. Many survivors also complained that discrimination and inaccessible education facilities exacerbate their already low educational levels. The poor economic climate and high rates of underemployment are also disadvantageous.

Laws and public policy

Most people (69%) felt protection of their rights had remained the same since 2005, while 13% saw improvement. Some 64% felt survivors "never" or "almost" never obtained their rights. Nevertheless, respondents were positive about several specific progress indicators. They said laws and policies benefiting survivors are being increasingly enforced (65%) and that survivors are more involved in disability rights monitoring (55%). Nearly half also thought there was more public awareness of survivors' rights (48%) and of the rights of persons with disabilities (47%). Some 44% received more information about their rights and 43% perceived that negative terms about persons with disabilities were used less often. However, 63% did not actually feel less discriminated against and 68% did not feel they had easier access to legal action when their rights were violated. Practitioners believed the government has done more to promote disability rights but less to include the needs of survivors into disability legislation or to reduce discrimination against survivors.

These results seem contradictory at first, but they confirm the fact that El Salvador's main efforts were in awareness raising and strengthening legislation. For example, the country expanded the mandate of the main body responsible for assistance to war victims, but these reforms remain incomplete. However, pensions were increased as a concrete result of this reform, probably contributing to the sense that legislation for survivors was better-enforced. The ratification of the UNCRPD has not yet led to increased implementation of activities or allocation of resources, but it did help raise awareness of the issue in the government. These results also correlate with the November 2008 review, which noted there had been awareness-raising campaigns about disability rights but that exclusion and discrimination persisted throughout society.[27]

When asked how they would respond if survivors in El Salvador were to say their situation had remained the same, one government representative said this would be surprising. The representative felt that, given government efforts to improve services, survivors must either not be aware of their rights or not taking advantage of the available opportunities. The representative added this might be due to depression related to their disability.

VA process achievements

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

Note: El Salvador last submitted an Article 7 transparency report in August 2006.

In December 2004, a Salvadoran government official said VA would be El Salvador's "greatest challenge in meeting its commitment to the Ottawa Convention" and that it lacked "sustainable, long-term, victim assistance programs."[28] Throughout 2005-2009, El Salvador made VA progress dependent on international support and repeated this fact at

several international meetings. Increased funding was one of El Salvador's main reasons for becoming part of the group of 26 countries with responsibility for the greatest number of survivors, as well as the greatest needs and expectations for assistance. However, a government representative also acknowledged there was a "huge difference" between El Salvador and some of the other members of the so-called VA26, as El Salvador does have reasonable national technical and financial capacity. International funds have not been forthcoming and nearly all VA funding is national. Practitioners felt the government could have done more to raise funds from the international community.

El Salvador presented its reasonably SMART objectives in 2005. Between 2005 and mid-2007, civil society representatives noted they had not been consulted in the VA process.[29] CONAIPD only organized its first stakeholder workshop to review the objectives and develop a plan (presented in November 2007) in June 2007. During the process the objectives became less ambitious and often less specific, especially in the area of economic integration. Timeframes were extended from 2005-2007 to 2009 and targets for the number of beneficiaries to be reached were removed altogether. Most of these objectives had not been achieved as of August 2009.

Many objectives concern reaching agreements, developing training manuals/strategies, seeking financial support, and strengthening coordination. Although one government representative felt increased government coordination was the greatest benefit of the VA26 process for El Salvador, that same person mentioned in May 2009 that "strengthening institutional and inter-sectoral coordination" was also one of the most important challenges.[30]

CONAIPD, the general coordination body for disability issues, has integrated VA into its mandate since 2005 (it performed VA coordination even before then) and established a VA sub-committee in 2006.[31] However, the existence of this elaborate disability coordination structure has not led to any significant progress, as the independent government body CONAIPD is not an implementing agency, nor does it have the mandate to direct government ministries. Because of increased stakeholder involvement since mid-2007, there is a general perception among practitioners that coordination among government ministries and the NGO sector has improved. Practitioners also noted an increased awareness of VA. However, survivors did not see these improvements. Just 27% said coordination of VA had improved, 23% thought the government coordinated better with NGOs, and 20% thought survivors or their families were involved in coordination. Just over half knew who was responsible for VA/disability coordination.

It has also been reported since 2004 that insufficient resources have been allocated to disability. There is a lack of political will to address the issue of VA/disability.[32] In May 2009, El Salvador noted that one of its main challenges would be to convince the new administration "of the importance of assistance to victims and persons with disabilities in general."[33] Nevertheless, practitioners felt national ownership and commitment towards VA had increased since 2005; they noted greater political will, a greater sense of national responsibility, and some increases in national funding. Survivors, again, did not agree: only 24% thought the government allocated more funds and 94% thought the government lacked political will, most likely because they had not seen the direct benefits of this commitment. Additionally, 79% felt their needs were not taken into account when deciding VA priorities.

El Salvador favors a mainstreaming approach for VA and has joined several international disability frameworks. One government representative thought these legal frameworks were important tools to apply pressure on various ministries to act, particularly the UNCRPD. The representative also said the UNCRPD was the most comprehensive framework and would serve government planning better than the Mine Ban Treaty or other frameworks. Therefore, the implementation of the UNCRPD has become an area of greater focus.

Conclusions

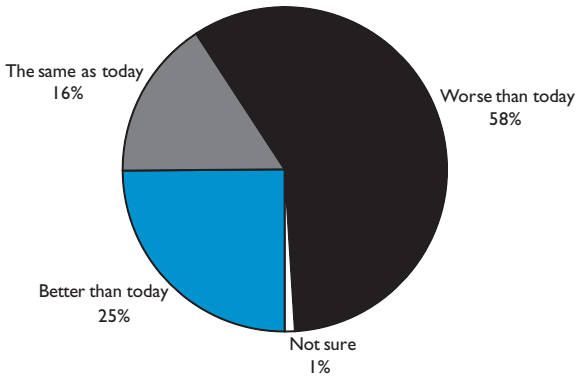
- Little progress has been made in improving the lives of survivors and other persons with disabilities.
- Services remained too centralized despite government initiatives.
- The least progress has been made on economic reintegration activities, and future prospects are not positive due to the aging survivor population and a lack of systematic service provision, both for persons with disabilities and in general.
- Survivor participation in peer support networks, provided by NGOs, has contributed to their sense of empowerment and involvement.
- Sophisticated disability coordination mechanisms exist, but they have neither the mandate nor the means to enforce better implementation of existing legislation.
- Despite some improvements in coordination with civil society, survivors have been insufficiently involved in policy development and monitoring. Priorities were not perceived to be based on their needs.

Suggestions for the way forward

When asked about how they saw their situation in five years, 16% of survivors thought it would remain the same; 58% thought their situation would be worse; and 25% thought it would be better than today.[34] To assist in a better future the following suggestions may be taken into account:

- Create education and employment opportunities for persons with disabilities and make existing programs inclusive for survivors and other persons with disabilities.
- Strengthen the CBR network, improve the capacity of rural health facilities, and investigate ways to cost-effectively decentralize some physical rehabilitation services.
- Support transportation and economic access to private-sector physical rehabilitation.
- Generate greater synergy between VA objectives and UNCRPD implementation.
- Give CONAIPD a mandate to direct other government bodies and allocate sufficient budget for implementation of disability activities.

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



Conducting the survivor survey
© RSPD

In their own words…

Survivors described themselves as: perseverant, satisfied, friendly, fighters, contributors, serious, entrepreneurial, responsible, workers, optimistic, active, leaders, quiet, dynamic, charismatic, depressed, worried, sociable, resourceful, successful, students, needy, sick…

In their own words…

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

- Increasing pensions.
- Housing, health and economic assistance.
- Economic opportunities.
- Improving laws.
- Improving survivors' economic situations and providing their children scholarships.
- More rehabilitation programs.
- Improving healthcare conditions to also include follow-up care.
- Helping us to not feel abandoned and unsupported.
- Informing us about government plans.
- Improving our quality of life.
- Access to economic reintegration.

In their own words…

If countries really cared about survivors they would:

- Enforce the laws.
- Provide services and pay attention to them.
- Include them in deciding about laws.
- Demand that the government provides better assistance, education and employment.
- Have hospitals for survivors.
- Help survivors have a productive life.
- Collaborate more with NGOs for our well-being.
- Implement the Convention on the Rights of Persons with Disabilities
- Provide more support from other countries.
- Work more closely with survivors in all economic, social and cultural programs.
- Listen to survivors.
- Do a new formal survey of survivors.

In his own words: the life experience of Dimas Gonzalez

In June 1985, Dimas Gonzalez stepped on a landmine. He was just 13 but already a combatant, fighting for the guerilla army. Aside from emergency medical care, nine years would pass before Dimas received a prosthetic limb and a pension as part of the peace process measures. He also received a scholarship to finish high school and to start electrical engineering at university. However, he was unable to complete his degree because the university was too inaccessible and he needed to work to support his family.

Dimas feels lucky to have found work, since he feels there are few job opportunities for survivors. In 2005, he became an outreach worker for RSPD in San Salvador, where he enjoys helping other survivors improve the quality of their lives. Dimas does not think the government has done enough to help survivors – he says free healthcare is a priority, but also feels all survivors deserve comprehensive care to address their needs.

Eritrea

Country indicators

- *Conflict period and mine/ERW use:* Eritrea is contaminated by mines/ERW as a result of World War II, the 1962-1991 struggle for independence and the 1998-2000 border conflict with Ethiopia. Cluster munitions were also used in Eritrea.[1]
- *Estimated contamination:* The 2003 Landmine Impact Survey found 481 affected communities, covering approximately 130km² and impacting some 655,000 people.[2]
- *Human development index:* 157th of 179 countries, low human development (compared to 156th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$300 – 202nd of 210 countries/areas (compared to in US$252 in 2004).[4]
- *Unemployment rate:* N/A.[5]
- *External resources for healthcare as percentage of total expenditure:* 26.5% (compared to 33.9% in 2004).[6]
- *Number of healthcare professionals:* Seven per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Eritrea suffers from overall poverty, of low standards of living and income, and inadequate basic social services. Some two-thirds of the population are poor and just over one-third are extremely poor. About 65% of poor people live in rural areas but poverty is at its worst in small towns, where some 81% of the population is living below the poverty line. Eritrea lives mostly off subsistence farming or herding. The government limits access to and the availability of foreign currency and much of the budget is invested in the military.[9]

VA country summary

Total mine/ERW casualties to 2009: Unknown – at least 5,198			
Year	Total	Killed	Injured
2004	30	13	17
2005	68	16	52
2006	32	9	23
2007	70	17	53
2008	64	18	46
Grand total	**264**	**73**	**191**

- *Estimated number of mine/ERW survivors:* Unknown; the 2003 Landmine Impact Survey identified 2,498 survivors and other estimates have been as high as 84,000.[10]
- *VA coordinating body/focal point:* The Minister of Labor and Human Welfare (MoLHW), through its Department of Social Affairs, is responsible for persons with disabilities, including mine/ERW survivors.
- *VA plan:* None; although a strategic plan for 2002-2006 existed (Direction to Establish a Model of Victim Support Utilizing Community-Based Rehabilitation); the status of its implementation is unknown.[11]
- *VA profile:* Information about VA/disability activities throughout 2005-2009 was extremely limited due to tight government control, restrictions on non-governmental operators and Eritrea's limited participation in the Mine Ban Treaty. NGO and UN programs and support for VA/disability, which started to lessen already in 2003, decreased constantly between 2005 and 2009. Nearly all key disability partners had left Eritrea by 2009 and others were working in a challenging environment. Eritrea stated that persons with disabilities received assistance regardless of the cause of their disability, but it was reported that few resources were allocated to disability services, particularly services for civilians. The government generally provided better services for soldiers and people injured while fighting in the war of independence and the conflict with Ethiopia. Throughout 2005-2009, healthcare remained limited particularly in rural areas, despite the fact that international organizations reported that Eritrea had made significant efforts to improve medical services for its citizens. Complex medical care could only be carried out in the capital Asmara and the quality of healthcare remained low due to a lack of skilled staff, equipment and materials. Services were spread unequally and out of reach for many because of widespread poverty. Prosthetic and orthotic devices were available in three centers managed by MoLHW, which could not meet the needs of the significant number of persons in need of these services. During the period under review, quality was poor and materials and trained staff lacking.

Basic physical rehabilitation, psychosocial services and economic reintegration were provided through the community-based rehabilitation network, which MoLHW started in 1995 and gradually expanded. By 2008, some 80% of the country, including some of the most mine/ERW-affected areas, was covered by the CBR network and reportedly the network had reached full national coverage by 2009, which was three years earlier than scheduled (2012).[12] Eritrea reported that the CBR network employed some positive discrimination techniques for the economic reintegration of persons with disabilities, and the government was reported to have committed significant resources to the training and support of persons with disabilities which had resulted from war and conflict, but the vast majority of these were soldiers. Due to overall economic difficulties, MoLHW estimated that 90% of persons with disabilities were unemployed. Work on developing specific disability legislation was suspended in 2005 to make it in line with the (then proposed) UNCRPD. As of 2009, no specific disability legislation existed and relevant parts of the constitution were not implemented. Discrimination, stigmatization and abandonment of persons with disabilities (particularly women) was said to be common. Data collection by the Eritrean Demining Authority (EDA) reportedly improved, but it remained incomplete and did not cover all areas. No efforts were made to integrate or use the data of the National Survey of Persons with Disabilities completed in 2005, which included information on mine/ERW survivors and was said to contain indicators for monitoring ongoing service provision.[13]

VA progress on the ground

For Eritrea, no respondent surveys had been completed by July 2009, as the country's situation made it impossible for the several civil society organizations approached to assist without jeopardizing activities. The situation of mine survivors in Eritrea is not known and few of their voices have been heard internationally since 2004. The Landmine Impact Survey reported that most recent survivors had received emergency medical care but less than 3% had received physical rehabilitation and none had received vocational training.[14]

There are no known survivor organizations in Eritrea and an international survivor-led NGO was ordered by the government to close its offices in 2003.[15] During 2008, only three government-aligned domestic rights NGOs were permitted to operate, including the Eritrean National War Disabled Veterans Association (ENWDVA), a disabled people's organization providing a variety of services, including counseling and micro-finance projects to its members.[16]

Since 2006, the UN has reported with increasing regularity that NGO activities have been brought under government control in Eritrea and it is also difficult for UN humanitarian agencies to operate. According to UN staff in 2009, due to "movement restrictions, and the curtailing of project activities by key partners, it is difficult to get an accurate picture of the real needs in Eritrea."[17] The number of international NGOs working in the country dropped significantly to five in 2009, down from 37 in early 2005. At the beginning of 2008, nine international humanitarian organizations were operational in Eritrea. Of these, reportedly, the government allowed only the ICRC to operate adequately and even then strictly limited its field of operations.[18] The government requested the UN technical advisors for the mine action program, including one for VA, to leave in mid-2005.[19] In January 2009, the UNDP reported starting a modest program of assistance to MoLHW, including assistance in developing nationwide rehabilitation services for persons with disabilities through the CBR program and existing rehabilitation centers. The UNDP planned to emphasize increasing MoLHW's capacity to plan, coordinate and monitor activities.[20]

In July 2009, a workshop aimed at "strengthening the efficiency of the contribution of development partners and promoting better coordination with implementing ministries" was conducted by the NGO Supervision Department of MoLHW. Participants were asked to "refrain from the repeated mistakes and limitations on their part and to abide by Eritrean laws and regulations…"[21]

VA process achievements

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

Eritrea declared responsibility for significant numbers of mine survivors and "the greatest responsibility to act, but also the greatest needs and expectations for assistance" at the First Review Conference in Nairobi in 2004. However, throughout 2005-2009, Eritrea has done little or nothing to engage in the VA process initiated to assist these, now 26, countries taking on the responsibility to fulfill the needs of their survivors. Little is known about the actual efforts Eritrea has made to improve the lives of its survivors.

MoLHW is responsible for disability issues in general and no special focal point for mine/ERW survivors exists. Although it had started work on a disability policy, this was not completed as of August 2009. However, in 2003, MoLHW did endorse the 2002-2006 VA strategic plan entitled *Direction to Establish a Model of Victim Support Utilizing Community Based Rehabilitation in Eritrea*. In 2004, UNDP advisors, then supporting the mine action program, noted that the CBR program could represent "the most comprehensive landmine victim support program in the world."[22] In the same year, it was reported that VA was a main pillar of mine action in Eritrea.

In a promising first step, Eritrea presented some objectives for the 2005-2009 period as part of its commitment to implement VA under the Nairobi Action Plan in November 2005.[23] These objectives were likely devised by the UN technical advisor for VA prior to leaving the country in 2005. The objectives were not specific, measurable, achievable, relevant, or time-bound, but were never revised. Plans were not developed, no division of responsibilities was assigned and NGOs and local associations were not involved. It is not known if the 2002-2006 strategic plan, which focused on changing community attitudes towards persons with disabilities, addressing their needs through CBR and improving access to relevant services, has been used. As mentioned above, progress has been made in expanding the CBR network, but there is insufficient information to measure the network's impact on the lives of persons with disabilities and survivors.

In 2004, Eritrea gave presentations on VA at both intersessional Standing Committee meetings and it participated in the Africa regional workshop on advancing VA in mid-2005. Again, this is likely due to the UNDP capacity-building program assisting the mine action authorities. Since then, Eritrea has only made one intervention on VA – at the 2008 intersessional Standing Committee meetings. The statement was not made by MoLHW as the body in charge of disability but by the mine action authority EDA, and it did not directly address Eritrea's VA/disability objectives or strategies.[24] Eritrea did not request process support from the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration.[25]

Conclusions

- Isolated and increasingly self-contained, whatever is known of Eritrea's VA/disability effort was linked to the CBR program.
- Despite activities on establishing a VA strategic framework prior to 2005, Eritrea did not make use of the tools put at its disposal by the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration in 2005-2009.
- While the CBR program was expanded significantly and said to have assisted numerous persons with disabilities, its impact on mine/ERW survivors and persons with disabilities was largely unknown.
- Many services for mine/ERW survivors and persons with disabilities, particularly civilians, remained limited, unequally distributed and unaffordable. This was likely further hampered by the decreased ability of NGOs and international organizations to operate.
- A lack of survivor and civil society participation hampered service provision.

Suggestions for the way forward

- Engage in VA/disability issues and meetings, by transparently presenting the scope of the problem and activities undertaken.
- Improve mine/ERW casualty data collection and incorporate it in the disability data that has been collected.
- Reactivate the disability data collection mechanism so that it becomes a permanent surveillance mechanism that really uses service provision and socio-economic indicators for planning of VA/disability activities.
- Reevaluate VA objectives based on progress made under the CBR program.
- Present a time-bound plan with specific actions for the disability sector, including the needs of mine/ERW survivors (both civilian and military).
- Include survivors and persons with disabilities in all aspects of planning, implementation and monitoring of VA/disability activities.
- Engage civil society in VA/disability planning, implementation and monitoring.

Female landmine survivor in Eritrea

Ethiopia

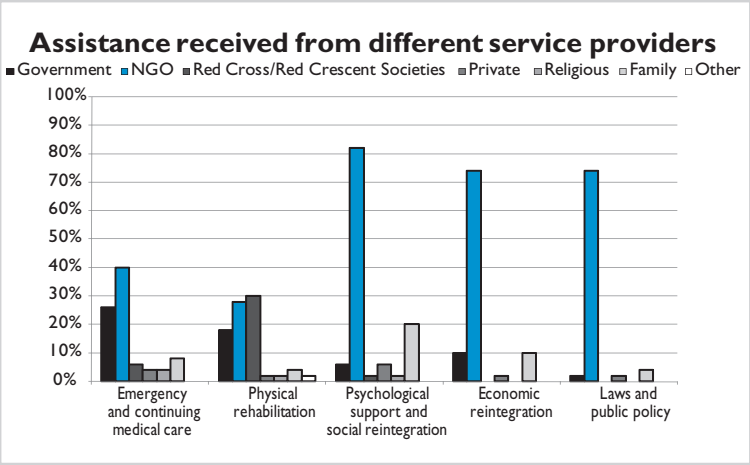
Country indicators

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

VA country summary

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

- *Estimated number of mine/ERW survivors:* Unknown, but at least 7,398.[10]
- *VA coordinating body/focal point:* The Ministry of Labor and Social Affairs (MoLSA) is responsible for VA/disability and represents Ethiopia internationally as the VA focal point. However, the Ministry of Health (MoH) has also claimed responsibility. A Disability Council was created under the Prime Minister in 2008 for UNCRPD implementation.
- *VA plan:* None, but stakeholders have recommended the development of a plan since November 2006.
- *VA profile:* Throughout 2005-2009, VA/disability was not a priority issue in Ethiopia because of the overall dire development conditions in the country. Ethiopia acknowledged that progress was slow due to a lack of resources, poor government coordination, and a lack of capacity. Services remain largely urban-based – while some 80% of persons with disabilities live in rural areas – and unequally spread across regions, in line with the political interests of the government. Where activities did take place, they contributed to survivors' positive perceptions of progress. Nevertheless, survey results in the Somali region, which is under-served, indicated in 2008 that only 50% of survivors had received medical care, 1% had received physical rehabilitation, and no one had received any psychosocial support. These results resemble those of the 2003 LIS, indicating 48% of survivors had received medical care, 7% rehabilitation, and none had received vocational training. In some regions, the government limits NGO operations. As of 2009, sufficient medical care is still lacking and out of reach for most, despite improvements made in coverage and emergency response through long-term health sector development plans linked to Ethiopia's poverty reduction strategy. In principle, healthcare is free for people who can present a certificate proving they cannot afford it. MoLSA is responsible for management of the physical rehabilitation sector. In practice, centers are run by the regional Bureaus of Labor and Social Affairs offices (BoLSA) with extensive international support. Throughout 2005-2009,



the ICRC gradually aimed to phase out its direct financial support and handed over more responsibility to the government, but as of 2009 it still provided contributions. Other international NGOs phased out earlier. Despite the construction of new centers, it was still thought their number remains insufficient, and existing centers lack staff and resources. Survivors could not afford transport or accommodation costs. Psychosocial support and economic reintegration services, mostly operated by NGOs, remain limited and are inadequate to deal with the needs of mine/ERW survivors and other persons with disabilities. Economic reintegration is further limited by extreme poverty, conflict and geographic obstacles. The disabled people's organizations (DPO) have insufficient capacity to effectively advocate for the rights of persons with disabilities and, despite legislation, discrimination is common. In 2009 there was still no national casualty data collection mechanism or readily available casualty data. In 2005-2009, international institutions continued to fund several large-scale healthcare reform, poverty alleviation, and conflict resolution programs relevant to VA/disability which would likely have been beneficial for mine/ERW survivors.[11]

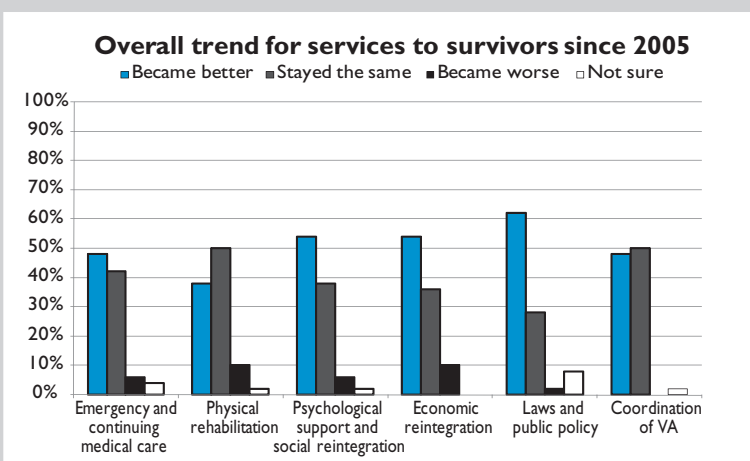
VA progress on the ground

Respondent profile

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

General findings

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



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

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

Emergency and continuing medical care

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

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

Physical rehabilitation

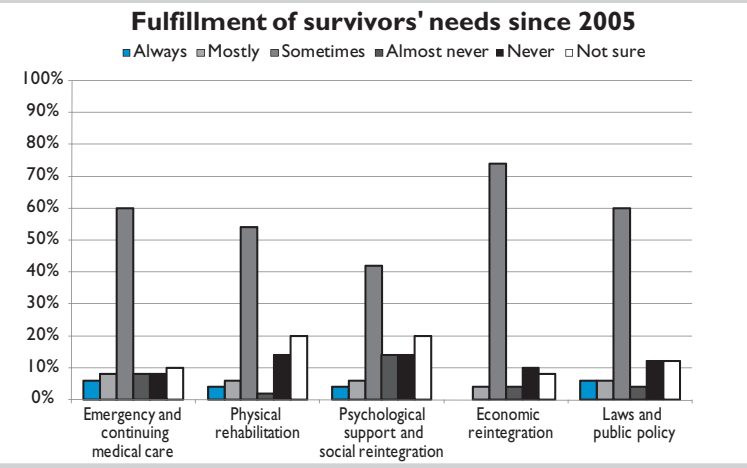
Half of all respondents believed that, overall, physical rehabilitation services had remained the same since 2005, while 38% saw improvement. Nevertheless, most respondents (54%) thought survivors only "sometimes" received the physical rehabilitation services they needed; 14% said this was "never" the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

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

Psychological support and social reintegration

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

The survivor responses need to be taken with caution, as they are strongly influenced by the fact that these urban-based respondents were contacted by a peer-run VA NGO offering psychosocial support. Also, the NGO began its activities in 2000, which means most respondents have most likely been experiencing progress since before 2005.[18] Therefore, the outcomes do not correspond with what has been reported throughout 2005-2009; in 2008 the government acknowledged psychosocial support activities were limited and mostly carried out by NGOs. This is best reflected by the fact that only 36% of survivor respondents thought survivors were seen as "charity cases" less often. The government added that the capacity of DPOs was too weak to be effective. It also noted in 2008 that children with disabilities had extremely limited access to education and that a needs assessment, more awareness, resources and better coordination are needed to improve inclusive education.[19] However, the survivor responses are a positive indication of the effectiveness these types of activities can have for survivors.



Economic reintegration

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

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

Laws and public policy

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

These results are interesting because Ethiopia has actually reviewed very few of its existing disability laws, apart from employment legislation, which has been under review since 2008. Reports of discrimination, particularly in rural areas, are common and existing legislation was considered to be inadequate and in need of review. Ethiopia subscribed to several disability initiatives, such as the African Decade of Persons with Disabilities (2009-2010) and has signed the UNCRPD, but little implementation has ensued. However, awareness-raising efforts have increased. UNICEF was commissioned to conduct a review of disability legislation, and a Disability Council for UNCRPD implementation was created in 2008. While these efforts are just preparatory steps, survivors in the capital would have been more aware of these efforts, particularly since some NGOs organized workshops to promote the UNCRPD in 2008.[21]

The government was unavailable to comment on preliminary findings.

VA process achievements

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

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

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

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

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

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

Conclusions

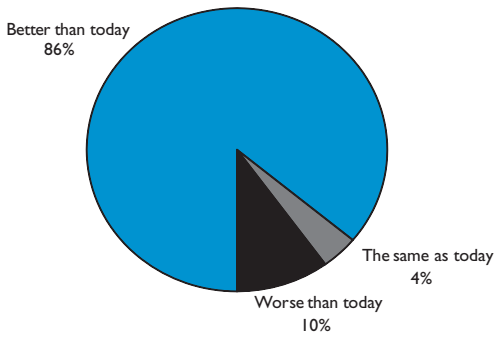
- Despite survey sample bias, service provision appears to have improved in the capital, but this situation is not representative for the vast majority of survivors in rural areas.
- Where progress in VA was made, it was either through major development projects or the work of local and international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

Suggestions for the way forward

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

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

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



Aynalem Zenebe doing a crossword puzzle
© Gaël Turine/VU, for Handicap International

In her own words: the life experience of Aynalem Zenebe

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

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

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

In their own words…

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

In their own words…

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

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

Guinea-Bissau

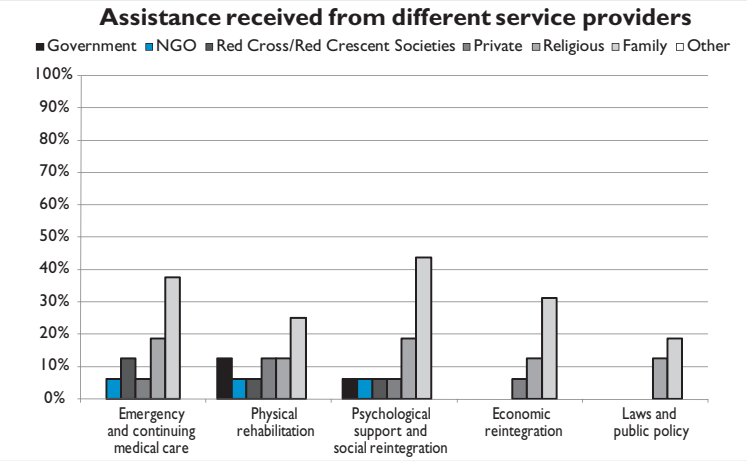
Country indicators

- *Conflict period and mine/ERW use:* Guinea-Bissau is contaminated with mines/ERW from the 1963-1974 Liberation War, the 1998-1999 Civil War, and because of spill-over from the conflict in Casamance (Senegal). Badly stored and abandoned ammunitions are also a problem.[1]
- *Estimated contamination:* As of 2009, there are 12 minefields covering an estimated 2.2 km^2 and five ERW-contaminated sites covering an estimated 0.93 km^2.[2]
- *Human development index:* 171st of 179, low human development, (compared to 172nd of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$250 – 206th of 210 countries/areas (compared to US$150 in 2004).[4]
- *Unemployment rate: N/A:* 82% of population works in subsistence farming.[5]
- *External resources for healthcare as percentage of total expenditure:* 31.4% (compared to 19.5% in 2004).[6]
- *Number of healthcare professionals:* Eight per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Conflict has destroyed much of Guinea-Bissau's infrastructure and economy. Continued political instability has further decreased access to basic services. It has also made international donors unwilling to commit funding, even though Guinea-Bissau depends on external aid for even its most basic public expenditures. Life expectancy is among the lowest in the world, nearly two-thirds of people live below the poverty line, income distribution is extremely unequal, and none of the Millennium Development Goals are expected to be reached.[9]

VA country summary

Total mine/ERW casualties since 1980: Unknown – at least 1,140				
Year	Total	Killed	Injured	Unknown
2004	30	6	24	0
2005	16	7	9	0
2006	43	18	25	0
2007	8	1	6	1
2008	1	0	1	0
Grand total	**98**	**32**	**65**	**1**

- *Estimated number of mine/ERW survivors:* At least 1,140 total casualties (some 70%, or 798, were estimated to be survivors).[10]
- *VA coordinating body/focal point:* The National Mine Action Coordination Center (CAAMI) is responsible, but there has been very little activity because of a lack of funds, capacity and government support. The Ministry of Social Solidarity and Poverty Reduction is responsible for disability issues.
- *VA plan:* None; there is no disability plan either, but mine/ERW survivors and other persons with disabilities are included in the Poverty Reduction Strategy Paper.
- *VA profile:* Guinea-Bissau was unable to make any significant VA progress between 2005 and 2009 due to its dire developmental state, near total lack of even the most basic services, and ongoing political turmoil. Access to services has declined since 1998. The government acknowledged in 2008 that "the situation of persons with disabilities in general and of mine victims in particular continues to be a problem."[11] No service provision for mine/ERW survivors is possible without international support. This support has remained limited to *ad hoc* activities, such as material donations and renovations, without a clear follow-up or continuation strategy. Whatever services are available are located in the capital Bissau, including emergency response, ongoing medical care, and physical rehabilitation. A lack of transportation and road infrastructure prevents emergency evacuations. The medical system is under-funded, under-equipped and under-staffed to such a degree that it cannot address the most basic needs of the population. The only functioning rehabilitation center, run by a national NGO, lacks trained professionals and materials to produce devices. International support has also decreased; subsequently, the production of prostheses and orthotics continued to decline throughout the period. Despite donated materials, prosthetics are still too expensive for most survivors. There are next to no psychosocial support or economic reintegration opportunities, but a survivor association was formed in 2008. Legislation



prohibiting discrimination against persons with disabilities exists but was not enforced. In 2009, no progress was made in legal reforms to expand "war victim" benefits to include mine/ERW survivors. CAAMI started to lobby for this reform in 2004.[12]

VA progress on the ground

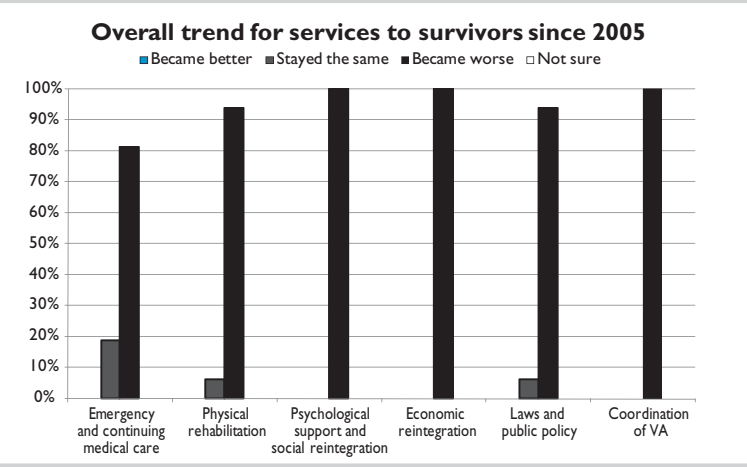
Respondent profile

By July 2009, 16 survivors between 13 and 80 years old responded to a questionnaire about VA progress in Guinea-Bissau since 2005: 12 men, two women, one boy and one girl. Some 69% were heads of households, but no one owned property. Three-quarters of respondents lived in small towns or rural areas with limited or no services, and 25% lived in the capital. Just 19% completed primary education or higher; 43% started primary school but did not complete it; and 38% had no formal education. Nearly one-third of survivors (31%) were unemployed after the incident compared to just 6% before. No respondents felt that their household income was sufficient.

Political instability, difficult road conditions, poor telecommunications, the dispersed rural survivor population, and the lack of in-country capacity made it impossible to survey more people. However, the consistency of responses, regardless of living area, gender or age, provides a valuable snapshot of the living conditions of some survivors in Guinea-Bissau.

General findings[13]

Most respondents felt all services had declined since 2005, and no one felt they had received more or better services. While the survey sample and female participation are too limited for accurate extrapolation, 63% of respondents felt services for female survivors were "absent" and 37% thought they were "much worse" than those for men. All respondents noted that services for child survivors were "never" adapted to their age level.



More than half of all respondents (56%) had been surveyed by NGOs or the government at least once since 2005; 44% had never been surveyed before. Respondents saw few benefits from survey activity, but 38% felt they had received more information about services as a result. Most (81%) had never had the opportunity to explain their needs to the government.

Emergency and continuing medical care

Many survivors (81%) believed medical care had worsened since 2005; the remaining respondents felt it had remained the same. Some 88% added that survivors "never" received the medical care they needed and 12% said this was "almost never" the case. Also, 81% did not think healthcare for survivors was a government priority. Survivors saw no progress on most specific indicators. A small minority (6%) saw improvements in accessing healthcare closer to home, staff capacity to deal with complex issues, and the availability of first aid workers and emergency transport (likely because they were assisted by CAAMI). Survivors commented that the main obstacles were access to facilities because of the distance and costs, insufficient funding for the sector, and a lack of government interest.

In 2005-2009, there were just two functioning hospitals (one military) and a few health posts, all lacking qualified personnel and resources. Poor transport and roads prevented access to facilities; emergency transport was nearly non-existent. The WHO provided some limited support to survivors in 2004-early 2006 and supported an upgrade to the national hospital in Bissau, as well as training to 25 medical personnel. Some additional *ad hoc* support to the medical sector as a whole came through in-kind assistance from Cuban doctors (2005) and an African Development Bank Loan (2007). Emergency services at the national hospital are free, but other services are not; as such, the cost of services remains a barrier for survivors. However, by 2009, the medical situation for survivors remained fundamentally unchanged or potentially worse in the absence of any dedicated VA support.[14]

Physical rehabilitation

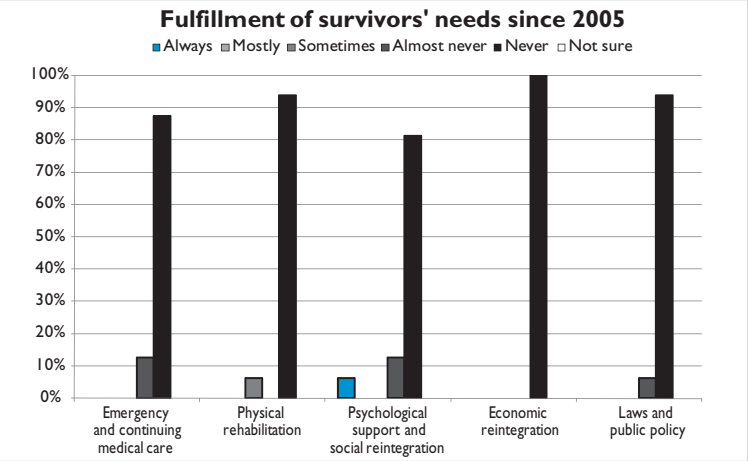
Nearly all respondents (94%) believed physical rehabilitation services had declined since 2005 and that survivors "never" received the services they needed. The remaining 6% thought services had stayed the same, but that survivors "sometimes" received the physical rehabilitation they needed. Again, a very small minority (6%) of respondents found improvement in just one specific area: increased free-of-charge repairs.

Government and ICRC Special Fund for the Disabled (SFD) reports confirm the survivors' responses. After the national center was damaged in the 1998-1999 war, the NGO ANDES now runs the only rehabilitation center in Bissau. Until the end of 2004, ANDES was supported by Handicap International, but since that time it has depended on material support from the ICRC SFD. The ANDES center struggled with insufficient supplies and staff throughout 2005-2009. For example, in 2008, just two survivors received prosthetic devices, while overall production declined by 50% from the previous year. The lack of qualified staff compromises quality and the cost of services is an obstacle.[15] Overall, physical rehabilitation assistance for survivors has only been possible through international contributions, mostly by the ICRC. Renovations to the national government center were started in 2008, but the center has not reopened.

Psychological support and social reintegration

All respondents said psychological support and social reintegration had declined since 2005 and 81% believed survivors "never" received these services (13% "almost never" and 6% "always"). No respondents saw improvements in any specific areas related to the provision of services. Only 13% felt more empowered. Some 6% felt more involved in community activities or in psychosocial support activities for other survivors, and 6% also found that psychosocial support services were considered equally important to other services.

In 2005-2009 the government reported there were almost no services available for psychological support or social reintegration, though there is a significant need for such services among the population as a whole. The NGO ANDES has carried out some limited psychosocial assistance. Prior to 1998, some activities of a more systematic nature were provided.[16] The perception of decline may therefore date back to this period. The only



progress reported by the government was the creation of a national association of mine/ERW survivors in 2008, but it is unknown what this organization's activities are[17] and it does not appear to have reached respondents yet. The few who reported receiving psychosocial support received it from friends and family, or religious organizations. One person received these services from the government.

Economic reintegration

All respondents believed there had been a decline in the provision of economic reintegration services since 2005 and that survivors "never" received the assistance needed. They also thought unemployment was so high that survivors were the last to be chosen for work. There are no official unemployment figures in Guinea-Bissau, but 82% of people are said to live from subsistence farming.[18] Prior to their incidents, 56% of respondents also worked in subsistence farming; this number declined to 31% after the incident, as survivors were no longer able to farm due to their disabilities and the lack of adequate physical rehabilitation services.

In 2005, the government recognized the challenges that survivors face in economic reintegration, stating that "landmine survivors must compete in a depressed economy for scarce jobs."[19] CAAMI added that "there were no real prospects for socio-economic reintegration, either on a project basis or structurally, in the foreseeable future."[20] It has repeated this statement since and all planned economic reintegration activities have been postponed since early 2005 due to a lack of funds. In 2006, just four survivors received vocational training with support from UNICEF. In 2008, echoing the views of survivors, the government saw this as the area that remained the greatest problem for survivors, again pointing to a lack of funds.[21]

Laws and public policy

Nearly all respondents (94%) believed survivors' rights were respected less than in 2005 and the remaining 6% said the situation was the same. All respondents believed survivors' rights were "never" or "almost never" protected, nor did they see any improvements. They commented that discrimination was an obstacle to receiving any kind of services.

Laws prohibiting discrimination based on disability are weak and no progress has been made in improving their enforcement.[22] CAAMI's attempts to lobby for reform of the Constitution to include mine/ERW survivors as "war victims" who receive benefits have been unsuccessful. However, it was reported in May 2009 that reform has started and that survivors might thus receive equal benefits to the veterans of Guinea-Bissau's War of Liberation. However, one government official noted that the government did not have the necessary funding to implement this reform.

When asked to respond to preliminary findings, one government official agreed with survivors who felt there had been no progress over the last five years. The representative added that survivors "had the right to complain and we must try to support them." Both the government and survivors recognized that the government lacks financial resources to provide the necessary services. However survivors also said a lack of political will is to blame for the deterioration of services in their country.

VA process achievements

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

Since 2005, Guinea-Bissau has not made significant progress in improving the lives of mine/ERW survivors. In some areas, services have declined or there is a perception of decline over the long run because of the somewhat greater capacity prior to the 1998-1999 conflict. Guinea-Bissau is only able to provide individual services to a small number of survivors and is unable to actually develop a service network and infrastructure, either by developing national capacity or through international humanitarian assistance. This situation is not only true for VA but for all basic services for the entire population, with Guinea-Bissau totally dependent on international assistance for any progress. However, due to continued instability, little international aid is forthcoming.

Already in 2002, CAAMI was aware of the need for a comprehensive VA plan, but also knew that it needed international financial and technical support, an appeal it has repeated up to 2009. As one government representative said, the goal of becoming part of the 26 countries with the greatest number of survivors and the greatest responsibility to act, but also the greatest needs and expectations for assistance, was to secure external support to implement a plan to improve survivors' lives. No substantial support has been received by Guinea-Bissau. The representative also acknowledged that the government itself has not invested anything either since 2005 because "there is no money." Often it is even unable to pay basic operating expenses, such as government salaries, for months at a time.

In 2005, Guinea-Bissau presented its 2005-2009 objectives, the majority of which relate to the development of strategies, data collection and capacity building. Just one objective has a specific target: "To provide economic reintegration services to 50% of known survivors."[23] All socio-economic activity has had to be postponed due to funding gaps and the overall dire economic situation. No notable progress is noted on any of the objectives, despite the limited *ad hoc* activity noted above. Guinea-Bissau's progress updates at international forums have been limited to appeals for funding or repeated activities which all ended by early 2006.

All survivors felt their needs were not taken into account when developing national VA priorities, nor did they feel involved in coordination meetings, plan development, or implementation. They did not feel they received regular updates on progress towards these objectives. Survivors also did not know who was in charge of VA coordination, nor did they believe coordination had improved.

This reflects the coordination challenges faced by the mine action center CAAMI and its inactivity. A major focus of its coordination role was to seek international assistance. However, CAAMI lacked both VA expertise and fundraising capacity. Activities slowed down particularly after the departure of the mine action technical advisor, who had dedicated a significant effort to VA, in early 2007. In 2009, a UN representative cited the absence of a government fundraising strategy and many competing priorities as further reasons for the lack of external support for VA. Additionally, most support by international organizations has been unsystematic and limited to stop-gap activities. None of the mine action NGOs present are working on VA, nor are any known international NGOs working on disability issues.

Conclusions

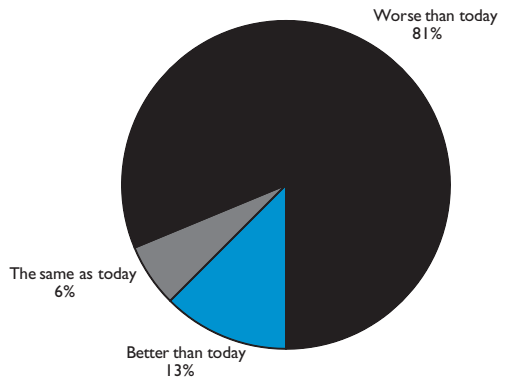
- Guinea-Bissau lacks the infrastructure, resources, and possibly the political will to provide for the basic needs of its citizens; as a result, service provision for survivors was not a priority.
- CAAMI was unable to provide more than individual services to a limited number of survivors due to funding and capacity problems.
- The few existing (medical and rehabilitation) services were inaccessible and unaffordable for survivors, and in most cases they were lacking completely, especially psychosocial and economic reintegration opportunities.
- The international community has not shown the political will to provide the much-needed assistance.
- The inclusion of mine/ERW survivors in the poverty reduction strategy did not lead to progress, likely because this process as a whole was stalled as well.

Suggestions for the way forward

When asked about how they saw their situation in five years, 81% of survivors thought it would be worse than today; 13% thought it would be better; and 6% thought it would remain the same. To assist in a better future, the following suggestions may be taken into account:

- Provide technical support to CAAMI to raise the profile of VA nationally and internationally by developing coordination capacity, VA activities and their accompanying funding strategies.
- Create greater linkages between CAAMI and the ministry responsible for disability issues to integrate the needs of survivors into a general disability plan, with the view of mainstreaming VA in the medium term.
- Include survivors and other persons with disabilities in the planning and implementation of programs for their benefit.
- Provide international assistance for VA specific activities in the short term, for the disability sector as a whole, and to promote sustainable, national development in the long term.

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



From left to right: Banha Ca, Wilson Mendosa and Fidel Demba, three landmine survivors from Bissau
© Anna Roughley

In their own words: the life experiences of Banha Ca, Wilson Mendosa, and Fidel Demba

Between 1999 and 2001, Banha Ca, Wilson Mendosa and Fidel Demba were all injured by ERW or mines in the same area of Bissau, Enterremento. Banha, just 12 at the time, was fleeing fighting during the civil war. Wilson, 10, was playing football. Fidel, 11, was collecting cashew nuts. Banha and Wilson have not received any assistance. Fidel received a prosthetic leg two years ago, provided free of charge through ANDES, although he was told future repairs or replacements would cost money.

Banha and Wilson depend on their families to support them, even though Banha works as a mechanic. Wilson fears that unless he receives further training he will not be able to "be a man" and support a family one day. Fidel, already married with two children, works as a radio technician, but depends on the money his wife earns washing clothes to supplement the family income. Banha and Fidel would like to learn new skills and increase their earnings. Wilson dreams of finishing his studies and studying abroad.

In their own words...

Survivors described themselves as: needing assistance, landmine victim, accident, who can help me?, poor person, in need of financial support, disabled.

In their own words...

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

- Improving the quality of life for survivors.
- Improving healthcare services.
- Increased financial assistance.
- Better health.
- Training so I can support a family.
- Help.
- Economic and social reintegration.

In their own words...

If countries really cared about survivors they would:

- Provide us with financial assistance to help us get out of our homes and on with life.
- Improve our daily lives.
- Provide financial support so assistance can be provided like before.
- Provide pensions.
- Remember we still need help.
- Help us have a livelihood.

Iraq

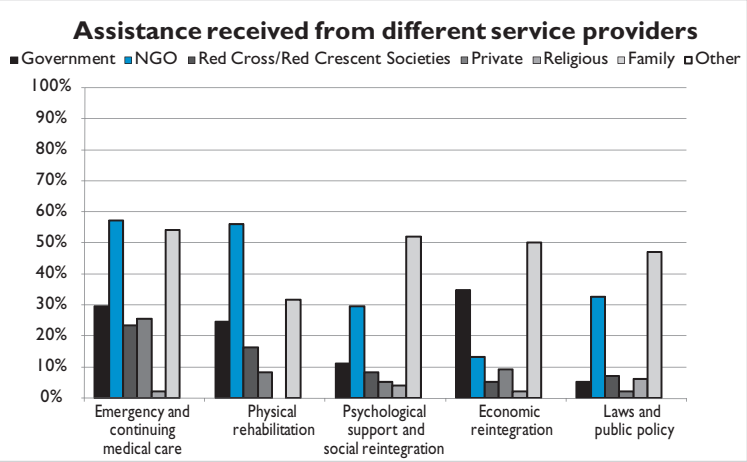
Country indicators

- *Conflict period and mine/ERW use:* Iraq is contaminated by mines, cluster submunitions and other ERW, as well as improvised explosive devices, as a result of conflict since the 1980s.[1]
- *Estimated contamination:* The Iraq Landmine Impact Survey (ILIS) estimated that 1,730km² of land was contaminated, affecting 1.6 million people, but these results exclude 5 (of 18) governorates and border minefields (6,370km²).[2]
- *Human development index:* No ranking in 2008 or 2004.[3]
- *Gross national income (Atlas method):* No ranking (US$930 in 2004).[4]
- *Unemployment rate:* Higher than 50% (not available 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 12.6% (compared to 2.6% in 2004).[6]
- *Number of healthcare professionals:* 20 per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Iraq is an oil rich country, which used to experience significant wealth and was among the most developed in the Middle East. This has changed due to decades of conflict and, as of May 2009, some 25% of the population lived below the poverty line. But large disparities existed, poverty being a rural phenomenon and much more prevalent in southern and central Iraq where up to 50% lived below the poverty line. Due to conflict, Iraq was also one of the only non-African countries where life expectancy decreased since the 1990 (from 66.5 to just under 58).[9]

VA country summary

Total mine/ERW casualties since 1980: Unknown – between 8,249 and 21,429				
Year	Total	Killed	Injured	Unknown
2004	261	62	132	67
2005	358	67	111	180
2006	99	54	29	16
2007	216	101	114	1
2008	266	81	160	25
Grand total	**1,200**	**365**	**546**	**289**

- *Estimated number of mine/ERW survivors:* Unknown, but at least several thousand.
- *VA coordinating body/focal point:* None; VA is part of the mandate of the Directorate of Mine Action which has not been able to work on VA; the federal and regional ministries of health and social affairs are responsible for disability issues.
- *VA plan:* None; VA was included in mine action plans which were never executed.
- *VA profile:* Despite the significant number of mine/ERW survivors and persons with disabilities, VA and disability were not priorities in Iraq between 2005 and 2009. Obviously, ongoing conflict caused many competing priorities and hampered government capacity and control. Competing political agendas and targeted attacks on NGOs and international organizations further hampered coordination and service provision. Whereas Iraq once had one of the best developed medical and service networks of the Middle East, services have deteriorated significantly due to decades of conflict and embargoes. Many facilities damaged as a result of the 2003 US-led invasion have been renovated at a slow pace due to insecurity. Seeking timely treatment was often impossible due to curfews, roadblocks or the danger of getting caught up in fighting. Overall, the situation is significantly better in the more stable northern Iraq where more NGOs operate, where there is more coordination, and more regional government capacity. Nevertheless, the large number of survivors (also coming from other parts of the country), limited means, and spill-over conflict remained significant challenges. In 2008, the ICRC reported that the healthcare system in Iraq was in a "worse shape than ever."[10] Some 75% of medical personnel had left the country in 2008 (50% in 2007 and 25% in 2006). The others had to deal with an increased demand, looting, violations of medical neutrality and lacks of supplies, water and electricity. Whereas physical rehabilitation centers were available in all major cities, many have not been functioning at full capacity since 2003 and struggle with staff and material shortages. High transport and (in some



case reinstated) service costs were further obstacles. Since 2008, access to services was slowly improving. War-related mental health problems were massive in Iraq, but treatment largely non-existent and stigmatized; the few existing community-based activities had to be ceased for security reasons. General unemployment is rampant in Iraq, and it was said that 90% of persons with disabilities lived below the local poverty line. Poverty levels are the highest in mine/ERW-affected areas in central and southern Iraq. Limited economic reintegration programs are carried out by NGOs (mostly in the north) but lack the means to ensure continuous service provision and are dependent on external support. Some large World Bank-backed programs provide a social safety network for vulnerable groups, including persons with disabilities, but it is unclear how effective these are. Discrimination against persons with disabilities was common, most disabled people's organizations (DPO) weak and legislation unimplemented and in need of reform (ongoing since 2008).[11]

VA progress on the ground

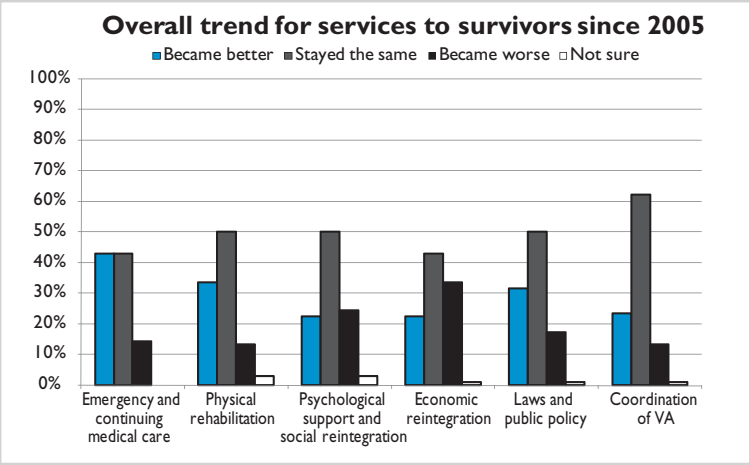
Respondent profile[12]

By July 2009, 98 survivors had responded to a questionnaire on VA progress in Iraq since 2005: 81 men, 16 women and one boy. Respondents ranged from 16 to 78 years old with 68% between the ages of 25 and 45. Two-thirds were heads of households, but just 20% owned property. Iraq is urbanized with large cities: 11% of responses came from the capital Baghdad; 39% came from large cities with a variety of services. However 30% of people were from villages or districts with limited services and 14% were from rural areas without services; the remainder did not respond or said that they were internally displaced. Responses were collected from Sulaymaniyyah, Erbil, Dohuk, Basrah, Maysan, and Anbar governorates.

Just 29% of people said their family income was sufficient, and 69% said it was insufficient.[13] Eight people were unemployed prior to their incident, after the incident this figure rose to 41 (including seven of 12 military and one deminer). While some people said they lost their employment due to their disability, many blamed the ongoing conflict. Some 38% had started secondary school or higher and 19% had not received any education. Respondents reported having their incidents throughout the 1980s until recently. This profile corresponds with what is known about the casualty profile in Iraq, with casualties during and after the various conflicts in all parts of the country. The vast majority of casualties are male (90%) and between 15 and 45 years old.[14]

General findings

Overall, the majority of respondents found that services had remained largely the same in the last five years, due to conflict and a lack of government capacity (69%) or political will (91%). More than three-quarters of respondents (77%) did not find they received more services and 64% did not think services were better. Responses varied significantly between regions with many more people seeing improvement in northern Iraq and more people seeing deterioration in the south. As just over 61% of responses were received from northern Iraq where security is better and services more available, this biased results. Most progress was seen by people living in large cities, excluding Baghdad, and in villages. More than half of respondents (56%) thought that services for women were "equal" to those for men; 15% said services for women were "absent"; and 12% said "worse". Three-



quarters of women found the level of services they received equal to that of men. Two-thirds of survivors thought that services for children were "never" or "almost never" adapted to their needs.

More than half of respondents had never been surveyed by NGOs or government in the last five years and 21% had been surveyed once. Just 8% had been surveyed three or more times. Half of the respondents felt more listened to as a result; 43% said that they had received more information about services through survey activity; and only 23% felt it had also resulted in more actual services. Just 17% had had a chance to explain his/her needs to a government representative. This would correspond with the lack of systematic data collection in Iraq, particularly in central and southern Iraq and the lack of government capacity to deal with mine/ERW casualties and VA. The only systematic and reliable data collection taking place in Iraq was the 2004-2006 ILIS, which could not cover all governorates due to security reasons and only covered casualties living in mine/ERW contaminated areas.

Emergency and continuing medical care

Some 43% of respondents found that, overall, medical care had stayed the same since 2005, while the same percentage saw improvement; 14% saw deterioration (all in southern and central Iraq). However, 44% of people believed that survivors "never" or "almost never" received the medical care they needed and another 26% said this was only "sometimes" the case. Some 39% thought that the government provided more support to the sector (mostly in the north). When looking at specific progress indicators, 60% thought that there were more health centers and that quality of services was better; 68% thought that infrastructure improved and 57% thought that healthcare was more affordable. People were somewhat less satisfied with the availability of medication (47% saw improvement), of emergency transport (44%), of supplies and equipment (34%), or referrals (26%). Less than half also found that staff was better trained, that there were more first aid workers or more complete medical teams. Practitioner responses also indicated that medical care had improved (82%), also noting more facilities and improved quality. About half indicated that the government had increased its efforts, but they also noted extensive international support.

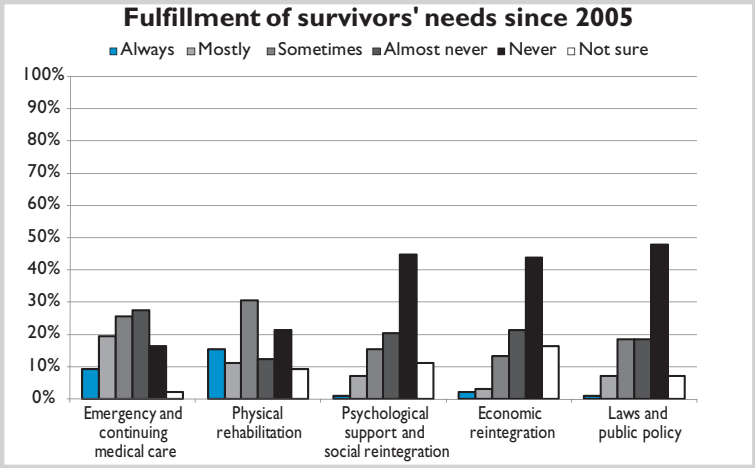
At first sight, these responses are not in line with reports from the ICRC and international NGOs that healthcare continued to deteriorate throughout 2005-2009; that neutrality of the medical profession was violated; that students were threatened; and graduates not fully qualified. Hospitals were also reported to be under-equipped, and suffering from water, fuel and electricity shortages. However, it needs to be taken into account that Iraq's medical sector suffered from decades of conflict since the 1980s and experienced years of sanctions and economic embargoes since 1991 (affecting import of medical supplies). These were lifted in 2003. In the aftermath of the 2003 US-led invasion and subsequent damage, large internationally funded reconstruction projects have been started focusing on healthcare and social infrastructure and many NGOs or international organizations have increased their operations.[15] Rural areas with limited or no infrastructure might have been reached for the first time as a result of the activities of NGOs. Or as one survivor commented "Civil society organizations played a crucial role in improving healthcare in recent years." This would appear to confirm the ILIS finding that 90% of mine/ERW-affected communities did not have government-run health services. Improvements in the security situation since late 2007 would also have had a positive influence on responses.

In northern Iraq, the government increased its budget allocation, gradually took over responsibility for some NGO-operated facilities and improved its coordination with other stakeholders. Despite some capacity gaps and limited funding, this would have contributed to a more tangible feeling of progress in this part of Iraq.

Physical rehabilitation

Half of the respondents found that physical rehabilitation had remained unchanged since 2005; 34% saw improvement and 13% deterioration.[16] Some 31% found that survivors "sometimes" received the physical rehabilitation they needed. The second largest group, 21% of respondents, found that survivors "never" received the needed assistance. Survivors saw most improvement in qualitative aspects: easier to obtain free services (64%), better trained staff (59%), better quality mobility devices (58%), and more types of devices (57%), shorter waiting lists (55%), and better physical therapy (54%). Areas of least progress were related to proximity, just 17% thought there were more centers; 14% found that they could access services closer to home; and just 13% thought there were more mobile workshops. There was little variation across regions. Practitioners saw much more improvement (82%), likely because most respondents worked in the sector and would have seen improvements first-hand. The main areas of progress were the quality of services, easier-to-obtain replacements, free of charge services, and increased variety in device types, confirming survivor responses. Practitioners also saw less improvement in the number of the number of centers (36%), but were less negative than survivors. About half of practitioners indicated that the government "did nothing" or maintained its efforts to further improvement in the sector.

These reports correspond with the systematic quality improvements carried out by NGOs, particularly in the north, and by the ICRC all over the country. Possibly more people were also using NGO services, explaining the increased perception of affordability. Since 2005, the ICRC has increased its support considerably. Training support and material distribution appeared to have positive effects. However, it would appear that reconstruction efforts by international organizations and the construction of new centers had limited impact on responses. The reconstruction of a network of centers that covered most of the country so that most patients would not have to travel long distances was less felt by survivors. This is probably because, for many, traveling from rural areas remained difficult and the cost of transport was unaffordable unless paid for. Some people from the south or center of Iraq might still be traveling to northern Iraq for services, even though this was no longer needed for security or capacity reasons. Only one NGO in northern Iraq provided outreach services; in other parts of the country there were no community-based activities. In 2009, the ICRC also noted that "patients are not coming to existing structures."[17] This could explain why survivors who did go thought waiting periods had become shorter.



Psychological support and social reintegration

Nearly one-quarter of respondents found that, overall, psychological support and social reintegration activities had deteriorated since 2005 and 50% thought they had stayed the same. However, 45% found that survivors "never" received the psychosocial support they needed and another 20% thought this was "almost never" the case. Just 8% thought that survivors "mostly" or "always" received the needed psychosocial assistance. When

looking at specific progress indicators, most progress was made in the survivors' own attitudes: 51% felt more empowered; 52% was more involved in community activities; and 44% became involved in providing psychosocial support for others. Some 46% also thought that survivors were considered as "charity cases" less often. However, just 11% thought that peer support groups had been created. Just 3% found that services were available closer to home; 18% said there were more social workers; and 24% thought that quality of services had improved. Among practitioners, 73% thought that psychosocial services remained the same since 2005 and that the government had maintained its efforts. The only area where a majority saw progress was the empowerment of survivors (55%), but they did not believe survivors were more involved (18%) or that there were any quality or quantity improvements.

These responses confirm that psychosocial support services were very limited in 2005-2009 and mostly run by NGOs, as part of the rehabilitation services. As reflected in the responses, there was a lack of trained staff and awareness raising on the need for mental health services. Community-based services were non-existent, particularly since the Red Crescent had to end its mental support program for war-traumatized due to a lack of funding and for security reasons.[18]

Economic reintegration

One-third of respondents thought that, overall, economic reintegration opportunities had decreased since 2005 and another 43% said the situation remained unchanged. Some 44% of people said that survivors "never" received the economic reintegration assistance they needed and an additional 21% found this "almost never" to be the case. Just 5% thought this was "mostly" or "always" the case. Nearly all respondents (95%) said that unemployment was so high that survivors were the last to be chosen for a job. However, the areas where most improvement was noted were: less discrimination (47% saw progress) and increased awareness among teachers (39% saw progress). Other specific indicators scored less than 30% progress ratings: easier access to loans (10%), enforcement of employment quotas (15%), more job placement, employment opportunities or increased government support (17% each), and access to training closer to home (18%). A majority of practitioners (64%) saw improvement in economic reintegration activities, but it needs to be noted that most of these were practitioners from the north involved in these activities. At best, practitioners found that the government had maintained its efforts, but a significant minority (around 27%) found that the government "did nothing." Specific areas of progress concurred with survivor responses, and least progress was seen in job placement and increased employment opportunities.

These results reflect the limited economic opportunities for survivors in all parts of the country, but particularly in the southern and central areas where hardly any initiatives exist and a significant percentage of the population is chronically poor (meaning that even with food aid and assistance they are not able to provide for their basic needs). Agriculture is one of the main mainstays of the economy but continued contamination of cultivable land is an obstacle and recent drought, economic slowdown and rampant unemployment increasingly resulted in people using contaminated land and collecting scrap metal (also in northern Iraq). The government runs a few educational programs for persons with disabilities, which are ineffectual. With World Bank support, it also operates the Social Safety Net program for vulnerable groups (at least 1 million people), and pays pensions to veterans, but these needed to be supplemented by work. It was also reported that the government does not employ persons with disabilities and they were not accepted at most schools. While economic reintegration activities were more common in the north, they could not be sustained without international support, which was variable.[19]

Laws and public policy

Half of the respondents thought that the protection of their rights had remained the same since 2005 and 32% saw improvement. However, some 48% thought that survivors'

rights were "never" respected and another 18% thought this was "almost never" the case. Two-thirds of respondents believed that less negative terms were used about persons with disabilities; 59% thought that discrimination against survivors had decreased; and 55% thought that there was more disability awareness among the general public. Least improvement was seen in the actual enforcement of legislation (28%) and representation of persons with disabilities in government (14%). Among practitioners, 64% saw no change in the rights situation of survivors, but they were more positive than survivors about enforcement (45% saw improvement); progress on awareness and discrimination were judged similarly (64% saw improvement).

Iraq has legislation to protect the rights of persons with disabilities, but it was largely unimplemented and in need of review. In northern Iraq, this review was started in 2008 and ongoing as of August 2009. At federal level, review and disability policy development was started under a World Bank project in early 2008, but also shelved in November 2008 because of a lack of government capacity.[20]

When asked to respond to preliminary report findings one UN representative noted that the situation had improved slightly, especially for physical rehabilitation due to the improved security situation and because more centers in central and southern Iraq started functioning again. However, the representative further noted that it was impossible to judge for the situation of Iraq as a whole. Adding that the situation in northern Iraq was very different, as was the quality of interventions by different service providers and that the judgment could only made on the basis of statistics (which are not always available). But when looking at northern Iraq, it would appear that the targeted survivors were "fully satisfied and their living conditions improved significantly." However, this target group was only "about 10% of total survivors requiring such type of services in the KRG [Kurdish Regional Government]."

VA process achievements

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

Note: Iraq became a State Party to the Mine Ban Treaty on 1 February 2008.

In July 2008, Iraq reported large numbers of casualties in its initial Article 7 report. This was perceived as a sign that Iraq, as the 26th State Party, declared responsibility for significant numbers of survivors, but also had the greatest needs and expectations for assistance. Under this informal, so-called VA26 process Iraq would have to define its own SMART objectives, develop plans to achieve these objectives, implement the plans, and monitor and report regularly on progress.[21] As of August 2009, the process to identify an appropriate in-country VA/disability expert and focal point was still ongoing.[22] It was hoped to have identified someone, likely at the Ministry of Health (MoH), by the Second Review Conference in November-December 2009. In 2008-June 2009, Iraq remained largely unengaged in the VA26 process, but in late July a message went out from UNDP to all relevant stakeholders to start compiling information for a report to the Second Review Conference.

Throughout 2005-2009, it was reported that VA/disability was not a priority for Iraq and that the main challenges were the lack of a comprehensive approach, insufficient services, a lack of awareness, and a lack of comprehensive casualty data.[23] At national level, the DMA (or previously the National Mine Action Authority, NMAA) in principle included VA in its mandate, but has not taken the lead on coordination or implementation due to continuous

management challenges and security obstacles. There is no VA expertise at federal level, even though there is a VA director, or at the southern regional mine action center. The position of VA technical advisor has been unfilled since May 2006.[24] As of July 2009, the DMA was hoping to organize a VA workshop to stimulate progress on the issue. No date or agenda had been set as of August 2009, nor did stakeholders appear to be informed.

In northern Iraq the situation was different, with two relatively strong and well-coordinated regional mine action centers, dedicated and continuous UN support to VA, stable government involvement, and a varied network of service providers. Since 2005, the Kurdish Regional Government has taken increased responsibility for the management and financing of services, and while VA/disability services are efficient they remained in need of international support or increased regional government means for long-term sustainability. Coordination between northern Iraq and the federal level is weak.

Survivor responses also showed this distinct situation, 17% said they received regular information on VA achievements; 22% said that the government allocated more funds to VA; 31% knew who was in charge of VA coordination; and 45% said that the government coordinated more with NGOs. Almost all of the positive responses were from survivors in northern Iraq. Just 20% said that survivors were more included in VA coordination and 24% thought that the needs of survivors were taken into account when developing plans. Among practitioners, 64% found that coordination had improved (all were from the north); but just 36% thought the needs of survivors were taken into account while developing plans.

At federal level, the MoH is the key partner of the World Bank Emergency Disability Project (2005-2010). Aside reconstruction and capacity building (mainly for the physical rehabilitation sector), this project in 2008 also aimed to undertake major reform of the disability sector through legislative reform, policy-making and the establishment of a multi-sectoral working group at the MoH. Activities were started and MoH ownership of the project increased. Nevertheless, the World Bank decided to cancel the component due to insufficient capacity at the MoH. The mine action authorities or UN dealing with VA have not been involved or well-aware of the project, despite coordination with MoH on other issues.[25]

One UN representative noted that the issue of Iraq becoming part of the VA26 had not been well-communicated to stakeholders, both on the implementation and policy side. It was further noted that it was unclear whether the "relevant [ministry] people are on top of it," but that the primary responsibility lay with the government. It was unknown who had been approached so far in-country and what steps had been taken as of August 2009.

Conclusions

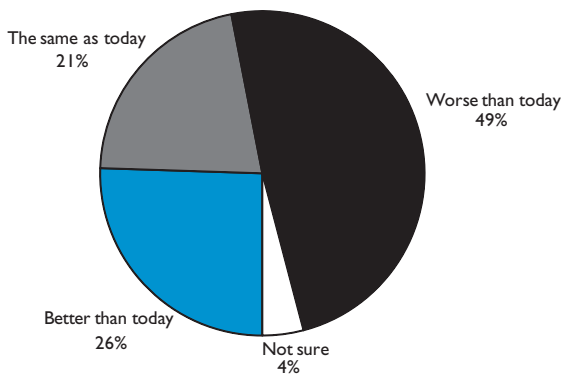
- Provision of services in Iraq continued to be hampered by conflict, despite a large international presence nationwide and relatively satisfactory national capacity in the north.
- Great disparities existed between the north and other parts of the country both in terms of service provision and coordination.
- Economic reintegration and psychosocial support activities were desperately lacking, in part due to the country's situation, while international reconstruction assistance had a positive influence on medical care but less so on physical rehabilitation.
- Security challenges hampered access.
- At federal level, coordination and government leadership for VA/disability were lacking; in northern Iraq with its well-established programs coordination and government ownership improved significantly.
- For many stakeholders in Iraq it is unclear what the so-called VA26 process entails and what benefits it could bring.
- Links between VA and the disability sector were nearly non-existent.

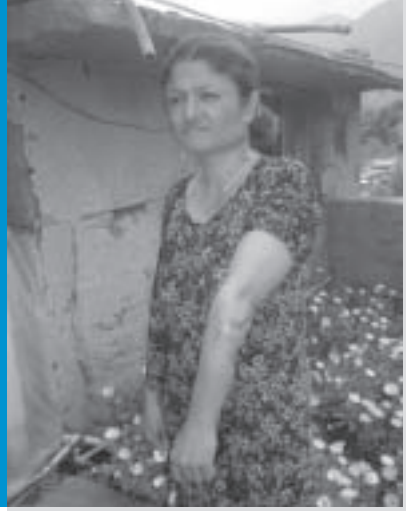
Suggestions for the way forward

When asked about how they saw their situation in five years: 49% of survivors thought it would get worse; 21% thought it would remain the same; and just 26% thought it would be better.[26] To assist in a better future ahead the following suggestions may be taken into account:

- Identify a focal point with sufficient mandate and political will to address VA and turn disability into a priority issue in the government.
- Use the experience of northern Iraq and the long-term UN support and the lessons learned for development of national plans.
- Urgently operationalize comprehensive casualty data collection, with the view to integrate it in injury surveillance or disability statistics in the longer term.
- Expand international support to economic and mental health programs and provide more sustainable support to existing VA/disability economic reintegration initiatives.
- Investigate options for community-based activities in the north, but also in less secure areas, through training of community members or the establishment of survivor/disability groups.
- Develop plans for VA/disability, possibly by building on shelved disability reform at the federal MoH.
- Ensure a twin-track approach, developing VA-specific programs where needed and integration into larger disability frameworks when possible.
- Include survivors and persons with disabilities more systematically in VA/disability planning, implementation and monitoring to increase their sense of progress and reduce isolation.

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





Chiman Jamal Ahmad Salih showing a piece of plastic lodged in her arm

In her own words: the life experience of Chiman Jamal Ahmad Salih

Chiman was born in 1983 in Awakurte village (Sulaymaniyyah), which her family had to leave in 1988 because of conflict. But they returned back home in 1997, because they no longer could afford life in the city. So they started farming their land which was contaminated with mines. Just a few months after coming home, Chiman trying to help her mother collecting wood to warm the water for the bath, finds a plastic box, which she thinks might be good for the fire. Chiman takes the box, an antipersonnel mine, home and puts it in the fire where it explodes, killing her younger brother and sister and injuring her.

One of her hands and one of her feet is paralyzed and, to this day, pieces of melted plastic are lodged in her body despite several operations. Doctors told Chiman that the only solution for her would be to get treatment abroad, which is impossible. In the meantime, she tries as best as she can to help the family. She was very happy to be asked for her opinion but remarked that many of the services enquired about do not exist in her village, even though they are much needed, for example mental health support. Chiman added that she thought that these services might only exist in developed countries.

In their own words…

Respondents described themselves as: disabled rights advocate, in need of financial assistance, ambitious, exhausted, patient, dead, powerless, long-suffering, a complete person, doing fine, a capable woman able to cope with problems, optimistic, a person without rights…

In their own words…

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

- Guarantee survivors' rights and provide them and their families with a decent life.
- Assistance in finding employment (several).
- Operate on me and provide me with a job with which I can earn a livelihood.
- Rehabilitation and training, as well as awareness raising around disability issues.
- More social workers to help survivors.
- Pass legislation to protect the rights of the disabled.
- Send survivors abroad for treatment.
- Increase pensions.
- Financial support for survivors to set up small businesses, and to provide them with cultural services.

In their own words…

If countries really cared about survivors they would:

- Implement plans and programs and involve survivors in the implementation.
- Ensure that survivors were the responsibility of the government, and that article 32 of the Iraqi Constitution would be enforced to protect the rights of survivors.
- Establish strategic plans to help the disabled.
- Make survivor rights legally binding and punish countries that do not deliver.
- Grant them their rights completely, and not just on paper.
- Help survivors achieve their aspirations in order to mend their devastated psyches.
- Provide housing for the disabled.
- Better pensions for survivors.
- Provide better medical care, improve social awareness, reintegrate survivors and implement disability rights.
- Give survivors more moral support, build specialized hospitals and provide transport.

In their own words…

A diverse range of opinions were expressed in survey responses and some respondents chose to include comments about services, such as:

- *"Iraq signed up to Ottawa more than a year ago but has not yet started to implement its VA programs."*
- *"We don't have full rights. It's only ink on paper."*
- *"Those concerned are currently busy surfacing roads, on the one side, and blowing them up, on the other. Where exactly is the economy for there to be economic reintegration?"*
- *"The most basic necessities of life are not available, so how do you expect that we will receive psychological assistance and help with social reintegration."*
- *"I feel that survivors have better rights now than before because some media broadcast via satellite about the situation of survivors and their suffering."*

Jordan

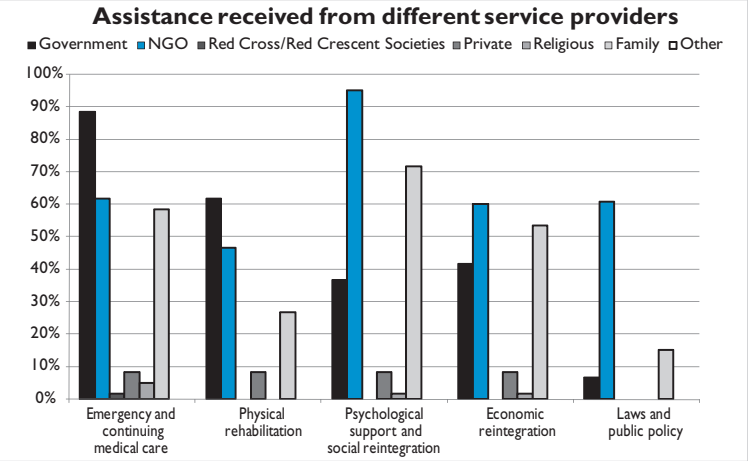
Country indicators

- *Conflict period and mine/ERW use:* Jordan is contaminated by mines and ERW as a result of the 1948 partition of Palestine, the 1967-1969 Arab-Israeli conflict, the 1970 civil war, and the 1975 confrontation with Syria.[1]
- *Estimated contamination:* As of 2008, there are approximately 10.5km^2 of mine contamination, affecting approximately 63,000 people (10% of the population); the extent of ERW contamination is unknown.[2]
- *Human development index:* 86th of 179 countries, medium human development (compared to 90th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$3,310 – 122nd of 210 countries/areas (compared to US$2,161 in 2004).[4]
- *Unemployment rate:* 12.9% official rate, but the unofficial rate is approximately 30% (compared to 16% official rate; actual rate 25%-30% in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 4.6% (compared to 4.8% in 2004).[6]
- *Number of healthcare professionals:* 56 per 10,000 population.[7]
- *UNCRPD status:* Ratified the Convention on 31 March 2008, but not its Optional Protocol, which it signed on 30 March 2007.[8]
- *Budget spent on disability:* National funds are allocated to the national disability strategy, but the amount is unknown.[9]
- *Measures of poverty and development:* Jordan is on track to reach its Millennium Development Goals, but some 13% of people lived below the poverty line. Unemployment and poverty were likely to increase with the young and rapidly growing population, the global economic slowdown, and continued dependence on foreign assistance. Since 1999, economic reform and increased exports have improved living standards. In 2007, King Abdullah instructed the government to focus on socio-economic reform, developing healthcare and housing networks, and improving the educational system.[10]

VA country summary

Total mine/ERW casualties since 1949: Unknown – at least 779			
Year	Total	Killed	Injured
2004	9	0	9
2005	6	0	6
2006	9	2	7
2007	7	2	5
2008	18	6	12
Grand total	**49**	**10**	**39**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 654.[11]
- *VA coordinating body/focal point:* In November 2008, the National Committee for Demining and Rehabilitation (NCDR) delegated VA coordination to the Higher Council on the Affairs of Persons with Disabilities (HCAPD) established in 2007. HCAPD has efficiently begun coordinating and integrating VA into its work.
- *VA plan:* None, but the 2007-2015 National Disability Strategy is to be revised to include mine/ERW survivors at the end of 2009.
- *VA profile:* Jordan is active in disability issues, but it was acknowledged that persons with disabilities are still among the most disadvantaged. While the NCDR made VA plans in 2005-2008, implementation lagged behind, due to a lack of national and international funding and expertise for the sector. Many organizations work on disability issues (some 200, including 44 international). Military survivors receive better services than civilians. Services have been strained due to the refugee influx from Iraq (and Palestine). Throughout 2005-2009, the healthcare system, principally run by the Royal Medical Services, was considered adequate. Basic care was free for all, but ongoing medical care was only free for those with insurance – an obstacle for survivors. As of 2007, survivor expenses were being increasingly covered on a case-by-case basis. In 2004, it was acknowledged that physical rehabilitation capacity was insufficient, equipment run-down, and services too centralized. With international support, the government started construction of two major rehabilitation centers in 2004, but these only began operations in 2007-2008. As of 2009, services were still predominantly in the capital and waiting lists long. Throughout the time period under review, psychosocial support has been left to NGOs (mostly national), who have a strong presence and cover both civilian and military survivors. Peer support groups remain rare. Some government vocational training and economic reintegration programs for



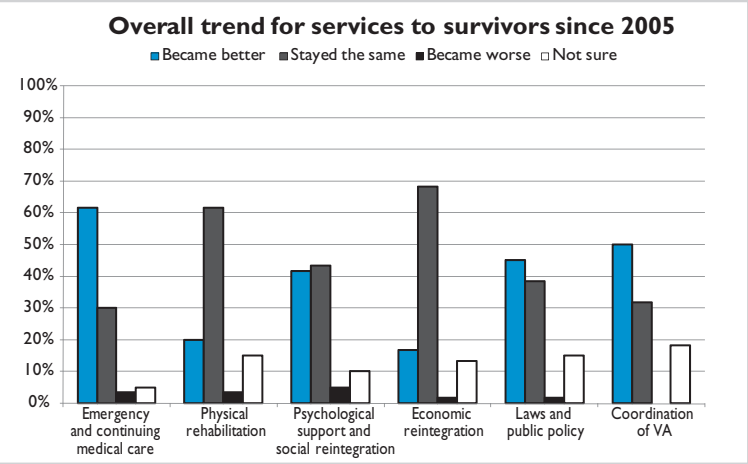
vulnerable people exist and some rehabilitation centers also provide these services, but survivors remained mainly dependent on small-scale NGO activities. Economic reintegration was seen as the main challenge in 2009, not only due the lack of systematic service provision, but also because of the attitudes of survivors, who often expect compensation only. Disability issues received high-level government and royal family support throughout 2005-2009, with Jordan developing strong legislation and being active at the national, regional and international levels. Implementation has, thus far, been more challenging. The number of mine/ERW survivors who have received assistance over the past 10 years is unknown, but Jordan has reported that all known mine/ERW survivors received some form of physical rehabilitation and psychological support.[12]

VA progress on the ground

Respondent profile

By July 2009, 60 survivors had responded to a questionnaire on VA progress in Jordan since 2005: 54 were men, five were women and one was a boy. Respondents were between 17 and 75 years old, with 77% between the ages of 30 and 59. Some 83% were heads of households and 43% owned property. Most survivors (57%) lived in the capital Amman or large urban centers with services; the remainder lived in rural areas with limited or no services. Some 28% had completed the 10 years of compulsory basic education or higher (20% followed higher studies); 12% never had any schooling, while the majority had started but not completed basic education (58%). Twenty were unemployed at the time of the survey, including 12 who had lost their employment as a result of their incident. Some 67% said their income was insufficient; just 10% said it was sufficient (the remainder did not respond). A significant number of respondents were ex-military (28%) who had been injured while on duty. Most of the civilians experienced their incidents prior to 2000. This corresponds to the profile extrapolated from official casualty data, which indicates that 87% of registered casualties occurred prior to 2000, that some 81% of these were men, and that some 41% of these were military.[13]

General findings



Overall, survivor responses showed progress since 2005. Half of all respondents said they received more services compared to 2005 and 47% also said the services had improved. More than 60% said the government was more involved now, while 48% said the government allocated more resources. Three-quarters of respondents felt services for female survivors were equal, and the female respondents did not respond more negatively. Most people (55%) did not know whether services for child survivors were adapted to their age level, but 25% thought this was the case "always".[14]

Eighty-eight percent of respondents had been surveyed by NGOs or the government three times or more during the last five years; just four people had never been surveyed. For 87% of them, the surveys resulted in more information about services, fewer difficulties with bureaucracy (68%), or more services (62%). Surprisingly, 60% also noted receiving money from people collecting the information. Nearly three-quarters of survivors (73%) said they had had the opportunity to explain their needs to government representatives at least once.

Emergency and continuing medical care

Almost 62% of respondents noted healthcare had improved over the last five years, and just 3% found the situation had worsened. Similarly, 80% said survivors "always" or "mostly" receive the medical care they need. Within specific areas, improvements were found across the board: more and better health centers (83%), assistance closer to home (82%), better quality (85%) and better-trained staff. People were least satisfied with the system's ability to carry out follow-up procedures (only 20% saw improvement), and with the rate of improvement of physical access (23%), or with the availability of supplies and medication (32%).

The overall positive assessment corresponds to the fact that Jordan has a relatively well-established health system where 90% of people live in close proximity to healthcare. Basic care is free and ongoing medical care is free for those with insurance. Disabled military are automatically insured. Since 2007, it has been reported that survivors without insurance who cannot afford follow-up treatment are covered on a case-by-case basis by NGOs, the NCDR, or the government. While the government, in May 2009, identified the need to build surgical capacity and strengthen the referral network,[15] this was not perceived as a major obstacle by survivors, probably because service provision has been largely adequate, despite waiting lists. Additionally, military respondents acknowledged they receive better services, which will have had an influence on these results.

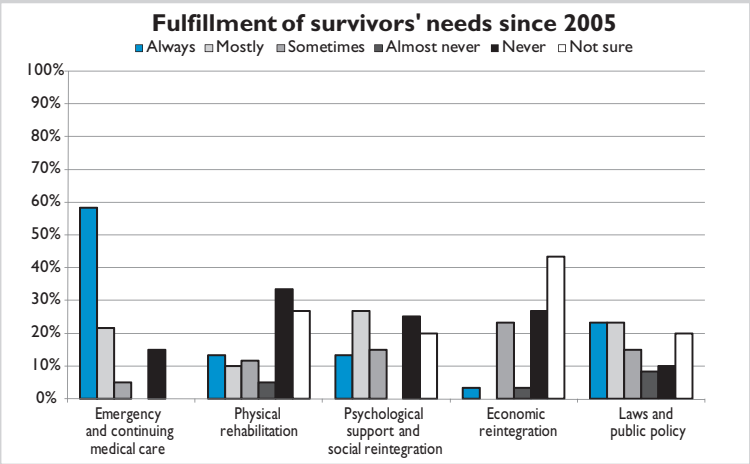
Physical rehabilitation

Most survivors (62%) thought physical rehabilitation had stayed the same since 2005; 20% found it better; 3% found it worse; and the rest did not respond. However, 38% added that survivors "never" or "almost never" received the physical rehabilitation services they needed. Less than a quarter of all respondents (23%) said survivors "mostly" or "always" received the needed services. Less than half (47%) said there was increased government support for the sector. Many saw improvement in the quality of devices and of staff capacity (48%). People were least satisfied with the availability of outreach workshops for minor interventions (5%), the waiting lists (22%), the availability and proximity of services (25%).

At first glance, the survivor responses do not appear to corroborate the government reports from 2009 that all known survivors have received physical rehabilitation.[16] However, these negative responses likely reflect obstacles related to the centralization of services, the lack of outreach and physiotherapy, and the long waiting lists, which the government has also acknowledged. Since 2004, Jordan has aimed to increase its physical rehabilitation capacity by constructing two new centers, but these centers only became operational more than two years after their construction was completed, and did not work at full capacity from the start. The improvements noted were probably due to training initiatives undertaken since 2007 and the fact that there was sufficient basic capacity prior to that.

Psychological support and social reintegration

Some 43% of respondents noted that psychological support and social reintegration remained the same compared to 2005; 42% actually said it had improved; and 5% found it worse.[17] One-quarter thought survivors "never" received the psychosocial support they needed, but 40% said such support was "always" or "mostly" received – a more positive result than in other countries. Most agreed there were more social workers (65%) and that



staff was better trained (62%). More importantly, they felt they were no longer seen as "charity cases" (62%); felt more empowered (60%); and thought there was less of a stigma in seeking formal counseling (57%). More than half of all respondents also felt this type of assistance was considered equally important to other services and that the quality had improved. The areas of least progress noted were the development of peer support groups and increased government support (38% each).

This overall positive response is related to a strong civil society presence in this area, with Survivor Corps' outreach workers (previously Landmine Survivors Network Jordan) and the Hashemite Commission for Disabled Soldiers focusing on the issue. While peer-support home visits by disabled staff and these organizations are carried out, few peer-support groups have yet been established.[18] The government has not been able to provide, develop, or support a nationally sustainable peer-support program and acknowledged this in 2009.[19]

Economic reintegration

Just 17% of survivors identified progress in economic reintegration since 2005, while 68% said it remained the same.[20] Just 3% said survivors "always" receive the economic reintegration they need, but 27% said this was "never" the case (3% "almost never", and 23% "sometimes").[21] The most progress was perceived in attitudes towards persons with disabilities: 58% found that educational and professional discrimination had decreased. However, at the practical level, most respondents saw neither increased employment (72%), nor educational opportunities (58%), nor increased job placement (65%). They did not find it easier to get bank loans and did not think employment quotas were better-enforced (58%). Of those answering the question, 96% thought unemployment was so high that survivors were the last to be chosen for a job (12 people did not answer).

This negative response corresponds to the government assessment that there are only "minimal systematic approaches to economic empowerment after a landmine injury."[22] While some vocational training and financial support is provided by the government, most economic reintegration activities are small-scale and carried out by NGOs. High general unemployment and non-implementation of employment quotas are further obstacles.[23] The government said it "realized" this was the area in which survivors have had "the least support."[24] When asked about their VA priorities for the next five years, most survivors included economic reintegration as a priority.

Laws and public policy

Nearly 50% of respondents said the rights of survivors were "always" or "mostly" respected and 45% believed their rights situation had improved since 2005; 38% said it had stayed the same. Just 18% thought survivors "never" or "almost never" enjoyed equal rights. More than half thought disability rights were a government priority. Most survivors agreed discrimination had decreased (67%) and awareness about survivors (67%) and persons with disabilities (63%) had increased. Other major progress points were: increased inclusion in policy-making and VA implementation, and less use of negative terms (65% each). However, less than half of all respondents saw an improvement in the actual enforcement of legislation (45%).

This overall positive picture confirms the active, high-level involvement of the government and the Jordanian royal family on disability issues both nationally and internationally. In 2007, Jordan developed and approved strong rights-based disability legislation and a subsequent national disability strategy. It has a disability focal body with resources and capacity. Jordan also ratified the UNCRPD, has a chair on the convention's monitoring committee, and hosted a regional discussion already in 2005 on the implementation of the (then-proposed) UNCRPD. Jordan has also acknowledged the need for better law enforcement. Survivors from Jordan have been present at international meetings throughout 2005-2009.

When asked how they would respond if survivors in Jordan were to say their situation had stayed the same over the last five years, a government representative correctly assessed that the overall response would not be negative. The representative said improvements had been made not only because the number of survivors is relatively limited, but also because of political will from the royal family, the government and a strong civil society presence. The main challenge, according to the representative, is economic reintegration, as no clear plan is in place. The persistence of charitable views among service providers and survivors' expectations that compensation alone will be provided are also factors in this challenge.

VA process achievements

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

Jordan declared its responsibility for significant numbers of survivors in November 2007 and was included in the group of 26 states with significant numbers of survivors and the greatest responsibility to act but also the greatest needs and expectations for assistance in June 2008.[25] It stated that while the total numbers of casualties "may not compare highly on a global scale, they are significant when measured against the size of the population."[26] One government representative noted that Jordan put itself on the so-called VA26 list because high-placed authorities found VA was the weakest mine action component.

Like the other countries, Jordan has committed to define its own SMART objectives, develop plans to achieve these objectives, implement the plans, and monitor and report regularly on progress.[27] Since Jordan only joined the VA26 in mid-2008, its timeframe for working with the tools provided by the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration has been shorter than for the 24 other countries which have been in the process since 2005.[28] As of August 2009, Jordan had not yet presented SMART objectives or a VA/disability plan under the VA26 process, but was scheduled to do so at the end of 2009.

Jordan has always expressed the need to address the plight of survivors. The NCDR has had a VA steering committee since 2004, including government and NGO stakeholders. In the same year, Jordan identified the need for a national VA program. Steps would include the creation of a survivor registry and the development of a comprehensive plan with measures to improve access to and affordability of physical rehabilitation; to develop vocational training; and to provide financial assistance or micro-credit.[29] Subsequently, VA was included in Jordan's National Mine Action Plan 2005-2009 and budgeted at US$1.325 million.[30] The NCDR also developed a separate draft VA action plan in 2007, but never finalized it. The draft included: developing and mainstreaming VA capacity for long-term sustainability; unifying and verifying casualty data; issuing "victim cards" and recording assistance provided; and ensuring assistance to all survivors under NCDR coordination.[31]

Progress has been made on data collection, partly due to the 2006-2007 Landmine Retrofit Survey initiated for other mine action purposes.[32] Furthermore, progress has been made in increasing the number of physical rehabilitation centers – albeit only in the capital and with delays − and in facilitating access to medical and rehabilitation services to the poor. No progress was made on the much-needed economic reintegration. The reasons most frequently cited were a lack of funds, more pressing mine action priorities, and a lack of NCDR VA capacity. Even though the NCDR has employed a VA officer since 2005, and even though this post was even filled by a mine survivor for a short time, the position changed hands regularly and was filled more often than not by people without VA expertise (including during 2007-2009). While stakeholder coordination has improved since 2005, the linkage to the rapidly-developing disability sector remained insufficient until late 2008.

The only real impetus for change came when the NCDR decided to start mainstreaming VA and to delegate VA coordination to HCAPD in November 2008. The HCAPD, a body with a relatively strong mandate presided over by Prince Raad, develops and monitors disability policy and standards, provides training and awareness, and supports the cost of some services. While one government representative said it had taken HCAPD some convincing to take on VA as a specific issue, by 2009, a VA steering committee had been formed at HCAPD that includes all stakeholders. The HCAPD also recruited several staff members with significant experience working specifically on VA.

Within this framework, Jordan will not develop separate VA strategies, but will take advantage of the advances in the broader disability sector. VA will be mainstreamed into the National Disability Strategy 2007-2015 and into other relevant strategies which will address and include VA-specific issues as needed. It is hoped that consultations on VA will also contribute to the review of the national strategy and highlight weaknesses that otherwise might have been missed.

Survivors from Jordan have been actively involved at Mine Ban Treaty meetings, usually as part of civil society delegations. Survivor responses indicate that this does not always seem to have been the case nationally, as only 55% said the needs of survivors were taken into account when developing VA priorities, only 43% said they were involved in the development of VA plans, and only 35% said they were included in coordination meetings. The survey response even overstates actual participation, as most or almost all of the survivors were members or staff of the main NGOs working on VA.

An HCAPD representative said Jordan expected increased international support as a result of becoming one of the 26 priority countries. However, the representative also added that progress was just as much a question of political mandate and continued national interest. As of 2009, VA was still considered the weakest mine action component. With sustained effort and support, this is expected to change and to result in a mutually reinforcing process for both VA and the national disability strategy.

Conclusions

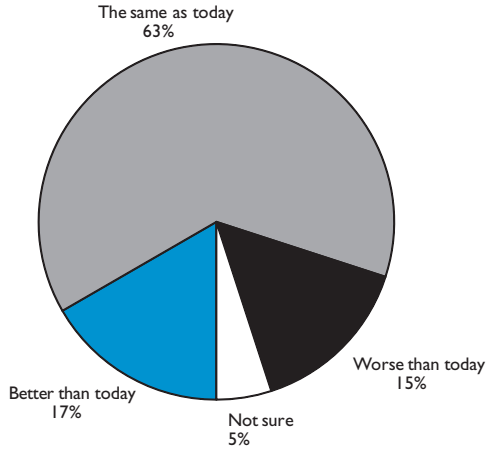
- Adequately functioning state systems have ensured the provision of basic medical and physical rehabilitation services, resulting in most survivors receiving services but not always being satisfied with their quality or proximity.
- Due to the relatively small scale of the problem, NGOs and government providers have been able to ensure adequate coverage.
- Economic reintegration opportunities are crucially lacking, as is the perception that survivors are productive members of society (including among survivors themselves).
- The HCAPD is the most appropriate focal point for VA, but the NCDR has been crucial in gathering sufficient data and attention to enable the mainstreaming of VA into the disability sector so it could benefit from the advances made there.

Suggestions for the way forward

When asked how they saw their situation in five years: 15% thought it would get worse, 63% thought it would remain the same, and 17% thought it would be better (5% did not answer). To assist in a better future ahead, the following suggestions may be taken into account:

- Ensure continued synergy with the broader disability sector, including the revision of the national disability plan addressing the rights and needs of survivors.
- Look at cost-effective measures to ensure decentralization of physical rehabilitation services and/or increase rehabilitation capacity at regional hospitals.
- Equalize benefits and quality of care for both civilian and military disabled persons.
- Invest in economic reintegration by expanding services, creating a formal service provision network, training service providers, and raising awareness about survivors as productive contributors to society.
- Increase involvement of survivors in the development, implementation and monitoring of disability policy and awareness raising.

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



Kamel Saadi performing in the mine/ERW risk education play
© LLCR

In their own words…

If countries really cared about survivors they would:

- Create jobs in parliament for survivors.
- Enforce all laws related to persons with disabilities.
- Secure the needs of all persons with disabilities.
- Deliver justice to survivors.
- Realistically assess the needs of survivors.
- Provide comprehensive rehabilitation.
- Accept our rights and provide social integration.
- Pay compensation, provide a decent life, and provide follow-up care.
- Our country would cooperate with Europe to help survivors.
- Just give [survivors] financial compensation (repeated more than 20 times).
- Jordan should show more interest in survivors and in the region.
- Provide similar care as in Europe.
- End discrimination.

In their own words…

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

- Housing and a monthly income.
- Financial support.
- Economic empowerment.
- Integration into the labor market.
- Compensation for survivors.
- Providing survivors with a decent livelihood so they do not feel inferior.
- Passing a new law for the disabled.
- Tax exemptions for upper-limb prosthetics.
- Assessing the financial needs of survivors.
- Micro-credit to start projects.
- Everything in this questionnaire.
- Opening centers for prosthetics training.

In their own words…

Survivors described themselves as: optimistic, active, conscientious, sociable, ambitious, grateful to God, wronged, tired, believers, miserable, perseverant, cheerful, honest, steadfast, believing in progress, heroic, great, disabled men, strugglers, patients, sporty, smart, dynamic.

In his own words: the life experience of Kamel Saadi

In 1979, Kamel was 14 when he lost his left leg below the knee as he stepped on a landmine during a family outing. He spent two and a half months as the youngest patient in the Officers' Wing at the King Hussein Medical City. He subsequently required three corrective surgeries, the last in 1985. Because of his experience, Kamel decided to halt his computer science studies and switched to studying Prosthetic Technology (in Pittsburgh, PA, USA).

When Kamel returned to Jordan in 1988, he decided to dedicate himself to the rehabilitation of others with disabilities and to help them meet not only their medical but also their social needs and to regain self-esteem. In 1996, he decided to work on landmine issues, joined ICBL, and also supported survivors and raised awareness independently. Kamel has since worked on VA for NGOs and the government. He also founded Life Line Consultancy & Rehabilitation (LLCR) in 2007 to raise awareness of the dangers of mines/ERW and advocate for the rights of survivors. LLCR tours schools in mine-affected areas performing an interactive play as part of risk education.

He noted that most survivors have not yet been given what they deserve, which is a chance to participate in decision-making. He says, "The time has come to ask them about their own individual needs, and to respond with efforts, not with words alone. Their desires have long been simple; to be acknowledged is what they mainly need."

Mozambique

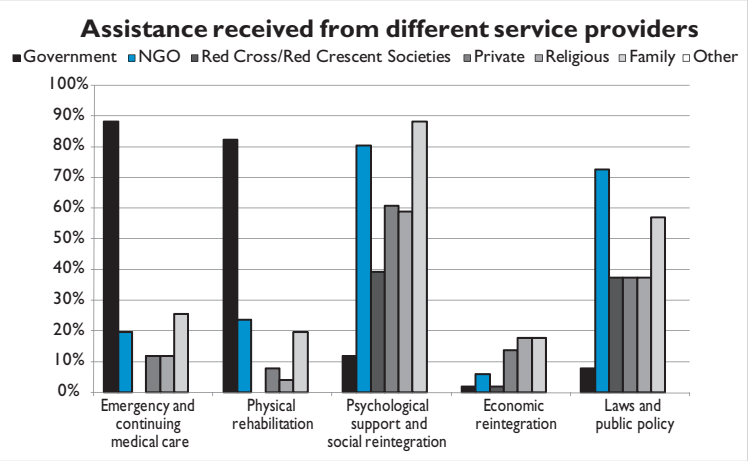
Country indicators

- *Conflict period and mine/ERW use:* Contamination in Mozambique has resulted from the 1964-1974 War of Independence during which both the Portuguese army and the Mozambique Liberation Front used mines, and from the 1977-1992 Civil War.[1]
- *Estimated contamination:* As of May 2008, 12.1 km² of suspected mined areas remained in six provinces and there is additional ERW contamination; the number of people affected is unknown.[2]
- *Human development index:* 172nd of 179 countries, low human development (compared to 171st of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$370 – 199th of 210 countries/areas (compared to US$269 in 2004).[4]
- *Unemployment rate:* 21% (1997 estimate, latest available).[5]
- *External resources for healthcare as percentage of total expenditure:* 56.8% (compared to 50.2% in 2004).[6]
- *Number of healthcare professionals:* Less than four per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention 30 March 2007, had not signed the Optional Protocol as of 30 June 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Mozambique is one of the world's poorest countries, having been devastated by nearly 30 years of violent conflict that ended in 1992. The majority of people live below the poverty line and life expectancy is just under 43 years. Mozambique remains dependent upon foreign assistance for much of its annual budget.[9]

VA country summary

Total mine/ERW casualties since 1964: Unknown			
Year	Total	Killed	Injured
2004	30	3	27
2005	57	23	34
2006	30	14	16
2007	47	22	25
2008	9	3	6
Grand total	**173**	**65**	**108**

- *Estimated number of mine/ERW survivors:* Unknown.
- *VA coordinating body/focal point:* The National Institute for Demining (IND) is the coordinating body, but it cannot fulfill its mandate because it cannot direct ministries. The Ministry of Women and Social Welfare (MoWSW) and the Ministry of Health (MoH) share responsibility for the implementation of disability services, but neither felt VA was part of their mandate.
- *VA plan:* None; but in 2009, the IND requested the inclusion of VA into the National Disability Plan 2006-2010; however, it lacks sufficient resources to be implemented.
- *VA profile:* Since 2004, Mozambique has identified VA as the weakest component of its mine action program and has said there is a need for a stronger commitment. Between 2005 and 2009, VA was not a priority for the government of Mozambique, with the IND saying VA had not been assigned to any government body and that the ministries feel "no responsibility for the Mine Ban Treaty and have no special concern for mine victims."[10] No significant international funding has been spent on VA or the disability sector. In 2008, some progress was noted in services for persons with disabilities in general. Even though in 2005-2009, there was some improvement in bringing healthcare to rural areas, the sector remains weak and heavily dependent on international aid. Specialized services are rare and the entire medical system suffers from staff and infrastructure shortages. Some 30% of the population still does not have access to healthcare and most survivors also face transport and accommodation difficulties. In January 2009, the MoH took over responsibility for the one NGO physical rehabilitation center near mine/ERW affected areas. Since 1999, it had been managing nine other physical rehabilitation centers in regional capitals with substantial international support. During 2005-2009 four centers were upgraded, again with external assistance (two had been previously renovated). However, waiting lists are long because of a lack of trained staff, which also affects quality. In 2009, as in 2005, the vast majority of survivors received no psychological support or economic reintegration, which left



them unemployed and dependent on family support networks. Services remain operated mostly by NGOs with limited resources and reaching a small number of survivors. The MoWSW also operated some projects and was in principle responsible for the community-based rehabilitation (CBR) network. Awareness of survivors' rights and available services has increased, but less progress has been made in enforcing existing legislation, and there has been no funding to implement the disability strategy. Casualty data collection and data on survivors' needs remains insufficient to inform planning or to set specific targets for assisting survivors.[11]

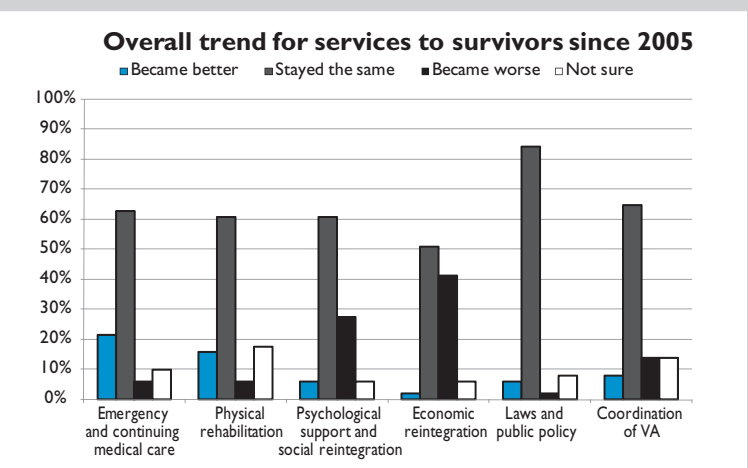
VA progress on the ground

Respondent profile

By July 2009, 51 survivors between 10 and 77 years old responded to a questionnaire about VA progress in Mozambique since 2005: 34 men, 16 women and one boy. Some 63% were heads of households and 66% owned property. Almost half (49%) lived in remote areas without services; another 12% lived in villages with limited services; and 31% lived in the capital or another large city.[12] Just 10% had completed primary school education or higher, while 20% had received no education. Some 16% were unemployed after the incident compared to just 6% before the incident. Of those surveyed, 75% said their income is insufficient. Many were injured prior to 2001. This corresponds to the casualty profile extrapolated from casualty data, indicating that most people became casualties during or shortly after the conflict and that most incidents happened in rural areas.[13] Twelve practitioners from disabled people's organizations (DPO) in the Sofala, Manica and Maputo provinces also responded to a separate practitioner questionnaire.

General findings

Overall, most respondents felt services remained the same over the last five years. In terms of psychosocial support and economic reintegration, a significant number of respondents felt the situation had worsened. Just 25% believed services for female survivors were "equal" to those available to men, and 53% thought they were completely "absent". No one thought they were better, and women responded more negatively than men, with 75% saying services are "absent". Just 10% thought services for child survivors are "sometimes" adapted to their age; 51% were unsure. Practitioner responses corresponded closely to survivor responses.



Some 84% of respondents had been surveyed by government or NGOs three or more times since 2005. Three-quarters felt this had resulted in their receiving more information about services; 65% felt listened to; 63% reported having fewer problems with the bureaucracy; and 49% actually received more services. That same 84% had been given two or more

opportunities to explain their needs to government representatives. These results appear to be more positive than the IND reports, which say casualty and survivor information is under-reported due to difficult terrain, irregular information exchanges, and lack of progress on consolidating data.[14] However, NGOs and DPO networks maintain active ties with their beneficiaries/members and convey their needs to the government. Local authorities and hospitals also maintain this kind of information, but do not systematically report it to the national level.

Emergency and continuing medical care

Nearly two-thirds of respondents (63%) thought that, overall, medical care had stayed unchanged since 2005 and 22% saw improvement. In addition, 24% felt survivors "always" or "mostly" received the healthcare they needed and 33% said "sometimes". However, a significant number of respondents saw progress in just two areas: 41% felt there were more health centers (rising to 57% for those from remote areas) and 37% believed physical access to centers had improved. Just 16% (mostly from urban areas) felt it was easier to get medical care closer to home. This seems to indicate that, although there may be more health centers in rural areas, survivors still feel they are far from their homes. Some 14% or fewer saw improvements in the quality or affordability of healthcare, in better trained staff, or in increased availability of medication, supplies or equipment. Just 4% saw an improvement in the number of first aid workers or the availability of emergency transport. Practitioners responded similarly, with 33% seeing an overall improvement in healthcare and the remainder feeling it had remained the same. Those who saw improvement noted increases in the number of health centers (in rural areas) and better physical access.

Despite significant international assistance since the end of the conflict in 1992, healthcare remained insufficient throughout 2005-2009. Rural centers were unable to provide more than basic assistance, staff and equipment were in short supply, and people had to travel long distances to centers. Only 36% had healthcare available within 30 minutes' travel from their home,[15] and 50% did not have access to adequate assistance. The government acknowledged the lack of staff and infrastructure in May 2009.[16] World Health Organization (WHO) efforts since 2001 to strengthen emergency response seem to have not been very effective.[17]

Physical rehabilitation

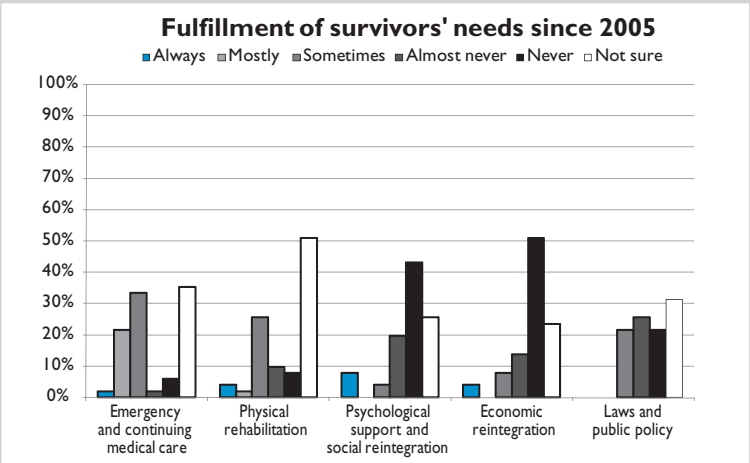
Some 61% of respondents said that, overall, physical rehabilitation services had remained unchanged since 2005; 16% saw an improvement. Half of all respondents (26 people) did not answer or were unsure whether survivors received the physical rehabilitation services they needed. Of the survivors who did respond, 52% felt they only "sometimes" received needed services (25% of total respondents), 36% said this was "never" or "almost never" the case (18% of total respondents); and 12% said services are "always" or "mostly" received (6% of total respondents). Again, the two areas where most survivors saw improvement were an increase in rehabilitation centers (24%) and improved physical access to facilities (41%). Some 22% also found staff better trained and the quality of mobility devices enhanced. Very few respondents (10% or less) felt they could access physical rehabilitation closer to home, that there were more mobile rehabilitation units or more types of mobility devices, or that the waiting lists were shorter. Just 4% thought the government provided more support for physical rehabilitation services. Like the survivors, 16% of practitioners also saw overall improvements to physical rehabilitation services, while 75% felt they had stayed the same.

This perception of more physical rehabilitation centers might be due to the fact that more health centers have started to provide some basic rehabilitation services. The number of centers dedicated to physical rehabilitation has in fact stayed the same since 2000. Renovations to centers possibly also had a positive influence, since by 2009 six (of 10) centers are fully functional. Since just one center is located in a mine-affected area (Gaza) while the others are in regional capitals, survivors would not have felt that services were available closer to home; this center also operates the country's only mobile unit. Throughout 2005-2009 there were shortages of qualified staff, with actual decreases noted in 2006 compared to

previous years,[18] and training targets were unmet for most years, resulting in "long waiting lists that keep getting longer" and patients giving up on receiving services all together.[19] Some short-term training has been given, but a longer-term course, only started in 2008, was not due to finish until 2010. In April 2009, a MoH official noted that few survivors living any distance from orthopedic centers could access services because the MoWSW is no longer able to provide transportation.

Psychological support and social reintegration

More than one-quarter of respondents (27%) thought psychological support and social reintegration services had deteriorated since 2005; 61% felt services remained unchanged. Some 43% believed survivors "never" received the psychosocial support services they needed and an additional 20% found this "almost never" to be the case. Nearly half of all respondents (49%) felt they had become more involved in their communities, while 29% had become involved with psychosocial support activities for other survivors. However, only a few (5% or fewer) saw improvement in the availability of, access to, or quality of services. No respondents said peer support groups had been created or that the government had provided any support for these services, and just 18% thought survivors were considered to be "charity cases" less often. This might explain why only 12% of people felt more empowered. Most practitioners felt psychosocial services had remained the same; 8% saw a decline.



In February 2004, Mozambique recognized the need for "moral support between victims" and called on international donors to support activities in this area.[20] In principle, the MoWSW includes psychosocial support in its CBR program, but no staff has ever received formal training and activities have mostly been left to NGOs with limited means to carry out these activities. One major peer support provider left Mozambique in 2006 because it was no longer cost-effective to work as a stand-alone organization (without local partners) on the issue. Also in 2006 it was reported that there were only 13 psychologists in the entire country, eight of whom were based in Maputo.[21] Since 2004, the government has not mentioned any activities undertaken in the area of psychosocial support. Most respondents were contacted through the DPO network, which might explain why they felt more involved in their communities; many others continued to feel isolated.[22]

Economic reintegration

Some 41% of respondents said opportunities for economic reintegration had worsened since 2005; 51% saw no improvement. Also, 51% felt survivors "never" received the economic reintegration assistance they needed and an additional 14% found this "almost never" to be the case. Some 80% felt unemployment was so high that survivors were the last to be chosen for a job (10% did not answer). The only area where a significant number (51%) of survivors saw improvement was a reduction in educational and professional discrimination. Fewer than 5% of respondents saw improvement on any other progress indicators, such as increased employment opportunities, better access to training programs, more awareness among teachers, more job placement services, or increased government support. Among practitioners, 16% felt economic reintegration assistance had gotten worse and 84% felt it had stayed the same since 2005. The director of one DPO explained that very few people with disabilities in Mozambique work in the formal sector. An NGO representative noted

that the generally low education levels of persons with disabilities are a further obstacle to their finding formal employment.

Since 2004, the government has noted that more funding and facilities are needed for economic reintegration. In subsequent years, it has said there are plans to provide food for work, to encourage the public and private sectors to employ persons with disabilities, to create employment quotas, and to give allowances to those who are unable to generate an income.[23] However, apart from limited government and NGO activities, these plans have not materialized. The fact that Mozambique is one of the poorest countries in the world, with high general poverty and unemployment levels, is a further obstacle, or as one NGO representative commented, "the government just has too many priorities." In 2009, the government reiterated that increasing the sustainability of and capacity for economic reintegration activities is among its biggest challenges for the future.[24]

Laws and public policy

Most survivors (84%) believed the protection of their rights had remained the same since 2005; 47% thought their rights were "never" or "almost never" respected. Nevertheless, 65% felt the general public was more aware of the rights of persons with disabilities; 51% said negative terms about persons with disabilities were used less often; and 49% felt they had received more information about their rights. Some 22% felt discrimination had decreased. More importantly, just 2% felt new policies and legislation had been developed; only 4% said policies were better enforced or that the needs of survivors were included in disability policy. Three-quarters of practitioners indicated that the protection of survivors' rights had remained unchanged. They saw the most progress in rights awareness and information.

These responses confirm the fact that numerous laws do exist to promote disability rights, but their enforcement is weak.[25] As of 2009, no progress had been noted on the approval of the revised disability legislation created in cooperation with disability organizations and submitted in 2005. The various DPO networks all have very limited capacity to carry out advocacy work. While there is a willingness to work with DPOs more often,[26] neither the government nor the DPOs have the resources to put this into practice. International NGOs have increasingly started supporting DPO networks and have spread awareness messages, for example through the radio.[27]

When asked to respond to preliminary survey findings, a government official felt that a deeper analysis of why survivors have not seen more overall change is necessary. The representative believed that, despite the limited national capacity, there has been some progress, and survivors should have received some services, referring to healthcare and physical rehabilitation improvements. However, the representative also noted that some "easy-to-reach" survivors might have received multiple services, while others would not have received any support.

VA process achievements

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

Between 2005 and 2009, Mozambique does not appear to have made significant progress on VA due to coordination challenges, a lack of national and international resources, and the fact that it has many other priorities. The limited progress made in healthcare and in the sustained ownership of physical rehabilitation has mainly come about through broader development

and post-conflict programs, not so much through disability sector activities. One government representative also blamed the lack of progress on an inadequate response from the international donor community, adding that Mozambique had expected to receive additional international assistance by becoming part of the group of 26 countries with significant numbers of survivors and, therefore, the greatest responsibility as well as the greatest needs and expectations for assistance. As one of the poorest countries in the world, an overall lack of financial resources has clearly been an obstacle, but survivors believed a lack of political will was the bigger challenge, with 82% of survivors responding that political will is lacking.

In 2005, Mozambique presented some of its 2005-2009 VA objectives to further the implementation of the Nairobi Action Plan, but these objectives were not SMART. They were never revised and a plan was never developed, even though it was announced in 2006 that a plan might be ready by the end of 2007. Instead, reference has been made to the National Disability Plan 2006-2010, but the IND only requested the inclusion of VA objectives into this strategy in 2009. This involved revision of the objectives for the new disability plan starting in 2010,[28] (i.e., after the 2005-2009 timeframe). The 2006-2010 plan has remained largely unimplemented due to lack of funds. According to NGO representatives, it also remains unimplemented because the government developed it without sufficient information about the needs of persons with disabilities.

Similarly, under the 2005-2009 objectives, a prerequisite for setting specific targets was determining how many survivors there are, where they are, and what their needs are. As of August 2009, this has not happened. For example, in 2008, Mozambique reported that existing casualty data still did not represent "the real situation of the people surviving accidents with mines/ERW in Mozambique."[29] Overall, objectives were too general to be measurable. Progress was limited to the establishment of an inter-sectoral technical group to coordinate disability activities, signature of the UNCRPD, and internationally-backed improvements in the physical rehabilitation sector. Some small-scale economic reintegration activities were reported as well, but it is unclear who has provided these services. Disability was also included in the 2006-2009 Poverty Reduction Strategy Program, which aimed to assist 400,000 persons with disabilities and included a budget, specific objectives and targets; progress on this program is unknown.

While a disability coordination group has been established, Mozambique still identified coordination as one of its main challenges in May 2009.[30] The IND had developed a draft VA policy as early as 2001[31] and has included VA in all its mine action plans, but its involvement over the years has been constricted. Although the IND is, in principle, the coordinating body for VA, it does not have the mandate to direct the implementing ministries; it has seen its role decreased to data collection and fundraising, with the latter also removed from its latest package of responsibilities outlined in the 2008-2012 mine action plan.[32] Nevertheless, the IND does focus primarily on clearance and has found it difficult to integrate VA into its operations. Coordination between the MoH and MoWSW as main implementers is not adequate and neither feels VA is part of their mandate. All three actors have acknowledged that coordination at government level is a problem, but they have also noted that a lack of coordination between the government and NGOs has resulted in an unequal distribution of services. The VA expert representing Mozambique at international meetings has changed at almost every meeting, which is possibly indicative of this lack of institutional ownership and has prevented continuity.

Survivors' responses concur with those of government representatives. Only 22% of survivors know who is in charge of VA/disability coordination and only 16% have seen more government involvement in VA. Just 8% felt the government had improved coordination with NGOs. A mere 2% felt survivors were included in coordination meetings or felt their needs are taken into account when developing national VA plans. Survivors generally did not feel included in the development of VA plans or their monitoring. The vast majority of practitioners (92%) felt coordination had remained the same since 2005. Some 72% believed the government had maintained its efforts, but 28% felt the government has done "nothing". Mozambique's high dependency on international assistance to provide for its most basic needs and its numerous competing priorities are very real issues and thus obstacles for progress in VA.

Conclusions

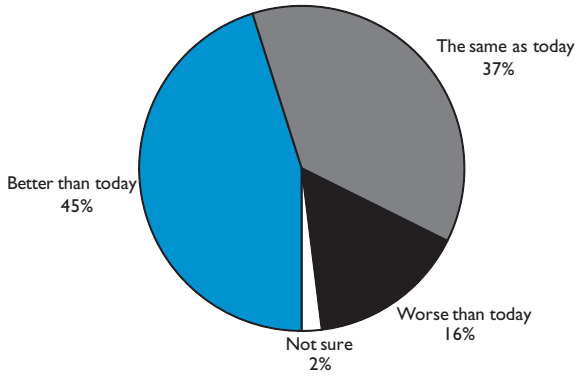
- Access to health and physical rehabilitation services remained difficult for survivors because of a lack of transportation, despite the fact that there were more facilities.
- The vast majority of survivors did not receive either psychosocial or economic reintegration services.
- Survivors did not feel included in VA planning, implementation or monitoring.
- Government and NGO representatives agreed that coordination around VA has not improved since 2005.
- The lack of coordination and national ownership has hampered VA planning and implementation progress, particularly among relevant ministries.
- Insufficient linkages have been made to disability and poverty reduction strategies.
- The competing needs and lack of financial means presented a real obstacle to VA/disability progress.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 45% of respondents felt it would be better than today; 37% felt it would be the same; and 16% felt it would be worse (2% were not sure). To assist in a better future ahead, the following suggestions may be taken into account:

- Urgently develop economic reintegration activities for survivors and other persons with disabilities, strengthen the economic opportunities component of existing development plans, and increase survivors' access to these opportunities.
- Designate a focal point or coordinating body with sufficient authority to raise the profile of VA and ensure its inclusion within a broader disability framework.
- Ensure that responsibility for survivors is internalized in the workings of all relevant government entities.
- Urgently understand the scope of the VA challenge, create a plan as appropriate, and include VA in and strengthen links with existing relevant strategies.
- Reinstate and fund transportation to facilitate much-needed access to services.
- Strengthen DPOs and survivor organizations so they can better negotiate their rights and be more involved in needs-based planning, implementation and monitoring.

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



Rosa José Njango sits outside her small hut
© Luis Wamusse

In her own words: the life experience of Rosa José Njango

In 1981, Rosa José Njango was just 13 years old when she stepped on a mine in the courtyard of her school in Tenga, a small village in Maputo province. She had to travel some of the way to the district hospital in a cart before a car was available to take her. As a result, she lost a lot of blood and both of her legs had to be amputated. Nevertheless, Rosa has since married and had three children. When her husband died, her relatives took her children away from her, claiming she is unable to care for them because of her disability. She now lives alone in a humble hut.

Rosa has never received any psychological, economic reintegration or financial assistance. However, one survivor association has given her some peer support. She dreams that one day she will be able to get custody of her children. Her message to the international community is: "Enough words, now let's move to concrete actions."

In their own words...

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

- Raising awareness of survivors' rights.
- Increasing assistance for medical care and medicines.
- Scholarships and support for economic reintegration.
- For the government to recognize the rights of survivors and support them.
- Economic self-sufficiency.
- Reinforcing psychological support.
- Informing us about progress made in implementing the government's plan.
- Strengthening survivors socially.
- Establishing a compensation fund for survivors.
- Strengthening survivors' organizations so they can help us.
- Moving from theory to practice in social and economic support.
- Supporting survivors in doing advocacy.
- Helping all survivors, especially those in rural areas.

In their own words...

If countries really cared about survivors they would:

- Provide high-level support for non-discriminatory access to services.
- Raise awareness of the rights of survivors and persons with disabilities.
- Coordinate VA to provide services to all.
- Provide physical/psychological rehabilitation services and create conditions for economic independence.
- Provide more medical assistance.
- Provide economic reintegration of all survivors and persons with disability.
- Follow through on the commitments made by the government.
- Build national capacity to respond to survivors' needs.
- Provide specialized attention to child survivors.
- Support survivors' dependents.
- Do a survey to find out more about survivors' concrete situations.
- Respect them more.

In their own words...

Survivors described themselves as: having faith in God, frustrated, having a compromised future, happy, abandoned, suffering, confident, good-tempered, "so sick of thinking about my life", angry, disappointed, unhappy, healthy, lonely, desperate, hard-working, persistent, and fighter.

Nicaragua

Country indicators

- *Conflict period and mine/ERW use:* Nicaragua is contaminated by mines and ERW as a result of armed conflict; the Nicaraguan National Guard used mines in 1978-1979 and the Nicaraguan Army and opposition forces used them from 1981 to 1989.[1]
- *Estimated contamination:* As of 19 May 2009, 10 minefields remain in two departments and affect an estimated 17,500 people.[2]
- *Human development index:* 120th of 179, medium human development (compared to 118th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$1,080 – 161st of 210 countries/areas (compared to US$791 in 2004).[4]
- *Unemployment rate:* 3.9% official rate, but additional underemployment of 46.5% (compared to 22% official unemployment in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 9.3% (compared to 11.5% in 2004).[6]
- *Number of healthcare professionals:* 15 per 10,000 population.[7]
- *UNCRPD status:* Ratified the Convention on 7 December 2007 but not its Optional Protocol, which was signed on 21 October 2008.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Nicaragua is a moderately poor country with the second-lowest per capita income in the Western Hemisphere. Unemployment and underemployment are widespread. Nearly 50% of the population lives below the national poverty line and 80% lives on less than US$2 per day. Nicaragua is dependent on foreign aid, but levels of foreign aid have decreased since their peak during the implementation of the peace process in the 1990s. Recent economic growth has also led some donors to discontinue aid.

VA country summary

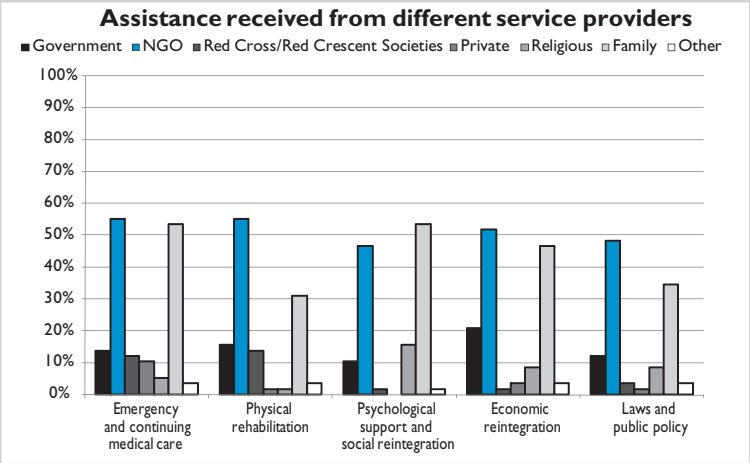
Total mine/ERW casualties since 1980: At least 1,236			
Year	Total	Killed	Injured
2004	7	1	6
2005	15	4	11
2006	7	2	5
2007	15	1	14
2008	3	0	3
Grand total	**47**	**8**	**39**

- *Estimated number of mine/ERW survivors:* 1,145.[9]
- *VA coordinating body/focal point:* The National Demining Commission (NDC) is the coordinating body and the Ministry of Health (MoH) the focal point. The NDC coordinates VA-specific activities and mobilizes resources, but is fairly inactive. The VA focal point position at the MoH was vacant from the end of 2007 until 2009 and thus inactive. VA is only one of the focal point's many responsibilities.
- *VA plan:* None; there is no national disability plan either, but the National Plan on Physical Rehabilitation was under development as of March 2009.
- *VA profile:* Between 2005 and 2009, VA could not be considered a government priority. The Organization of American States (OAS) provides services with international funding (1,107 of 1,145 registered survivors received rehabilitation services and 450 also received socio-economic reintegration). Nicaragua made limited progress towards the development of a sustainable VA national capacity and was still almost completely dependent on OAS services in 2009. Without a full subsidy from the OAS, access to all services remained out of reach for the vast majority of survivors because of the location and cost of services. However, as a lower middle-income country, Nicaragua needs to operate on its own capacity due to a decrease in donor interest. Some progress has been made in improving healthcare and physical rehabilitation for the benefit of the whole population. However, most services remain centralized in the capital and lack qualified staff. Psychological support and social reintegration services are available at physical rehabilitation and vocational training centers but do not exist as a stand-alone service. Through its network, the National Training Institute (NTI) increased its capacity to work with disabled students, but survivors still face challenges in accessing employment opportunities. In light of an expected further decline in international support, the long-term sustainability of VA/disability services is questionable as of August 2009.[10]

VA progress on the ground

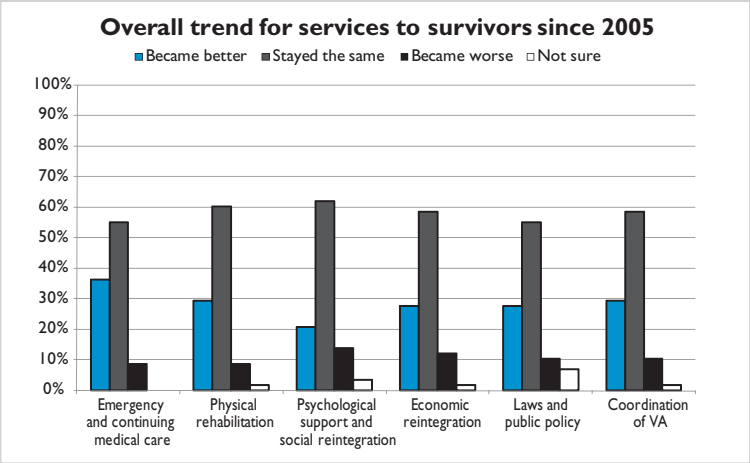
Respondent profile

By July 2009, 58 survivors had responded to a questionnaire on VA progress in Nicaragua: 50 men and eight women. Respondents were between 24 and 64 years old with 66% between the ages of 35 and 50. Some 71% were heads of households and 25% owned property. A majority of survivors (52%) lived in rural areas with limited or no services and 48% lived in the capital or another large city. Just 38% had completed secondary education or beyond (including vocational training) and 10% had received no formal education. Some 31% were unemployed at the time of the survey, as compared to just 14% before the incident. Of those surveyed, 77% said their income was insufficient. This profile corresponds to the casualty profile extrapolated from data: 90% of survivors are men, most of whom were injured during the 1980s conflict, and who often have limited education and economic opportunities.[11]



General findings

The majority of respondents felt that, overall, services had remained the same since 2005, but they did note advances in specific areas. The greatest improvement was seen in the area of healthcare, and the least improvement was seen in psychological support and social reintegration. Respondents living in urban areas were usually more positive than those from rural areas. Some 55% of respondents felt that services for female survivors were equal to those available to men, but 19% thought they were completely absent. Women responded more negatively than men, as 50% said services were absent or much worse. Just 7% of people thought services for child survivors were always adapted to their age level.



While 19% of respondents had been surveyed by government or NGOs at least three times in the last five years, the largest group (40%) had never been surveyed. They reported that survey activity hardly ever produced any concrete results: just 16% felt they faced fewer bureaucratic challenges, 31% received more services, and 33% received a pension more easily. Almost three-quarters of the survivors (74%) said they had never had the opportunity to explain their needs to government representatives.

Emergency and continuing medical care

Approximately 36% of respondents noticed that healthcare had improved overall since 2005. Nearly 40% of respondents noticed that survivors "never" or "almost never" received the medical care they needed; 41% noticed they "sometimes" received the medical care needed; while just two people thought needed care was "always" received.

However, a majority of respondents saw improvements in some specific areas, such as emergency assistance: 64% felt there were more first aid workers and 62% saw an increase in emergency transport. Also evaluated positively were the increased proximity of health centers (by 65% of people), the number of facilities (55%), and the affordability of services (60%). Areas of greatest dissatisfaction were staff capacity, where 41% of people saw improvements, and the availability of medicines and supplies, which 41% and 28% respectively found improved.

These results correspond with government efforts to increase healthcare access through free medical care for all in 2007.[12] It also confirms government reports on upgrades to two regional hospitals near to where many survivors live, improved emergency care, and improved evacuations in mine-affected areas. In 2009, MoH officials also reported an increase in the number of medical professionals being trained. Survivors could not have noticed the impact yet, as this development started in 2007 and training was still ongoing.

Physical rehabilitation

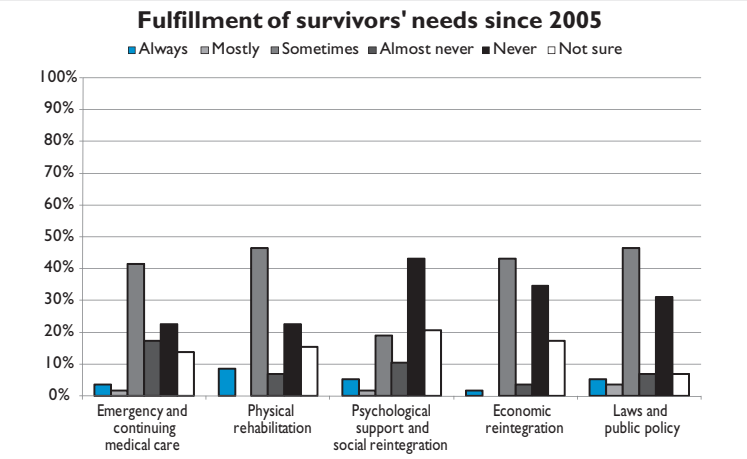
Most survivors (60%) believed physical rehabilitation services had remained the same since 2005, but 9% found they had actually deteriorated. Of those interviewed, 47% thought that survivors "sometimes" get the physical rehabilitation they need. However, 22% found such services were "never" received. When looking at specific areas of progress, 50% believed it was easier to get referrals and that the rehabilitation teams had become more complete. Few respondents saw positive changes in the number or proximity of rehabilitation centers (36%) and the availability of mobile clinics (7%); but 57% noted improvements in transport. Only a few (18%) noticed increased availability of different types of mobility devices or improved device quality (22%). Practitioners working in the physical rehabilitation sector saw an overall improvement, particularly concerning affordability and improved physical access. However, they acknowledged access is limited due to a lack of trained professionals.

The continued centralization of rehabilitation services is key to the survivors' responses, as just one (of four) centers is located outside of the capital, Managua, even though most survivors live in rural areas. The ICRC Special Fund for the Disabled (SFD) also identified centralization as a major obstacle.[13] Because the OAS acknowledged that few survivors from rural areas could independently pay for transport to and lodging at the centers, it included these services in its VA program, resulting in a more positive evaluation of this component. In 2009, the MoH announced plans to open two new rehabilitation centers based on information as to where survivors live. The government said taking over transport and accommodation costs from the OAS would not be sustainable, because then it would have to do this for all persons with disabilities.[14] While additional professionals are being trained and funds were increased in 2008, Nicaragua faces a continuous battle against brain drain, as salary scales are higher in neighboring countries. These measures would have been too recent for survivors to notice impact.

Psychological support and social reintegration

Just 20% of respondents noticed improvements in psychosocial support and social integration over the last five years; 14% thought services had deteriorated. Some 43% said survivors "never" received the psychosocial assistance they needed and 62% asserted it was not a government priority. However, 66% of respondents felt more empowered; 67% felt more involved in community activities; and 60% reported they were no longer considered a "charity case." Of the 58 respondents, 30 reported the creation of peer support groups, which helps explain these positive results. Areas of least progress were the quality of services (34%) and better-trained staff (29%).

As mentioned, the peer support networks, mostly developed by small local organizations, have had a major impact on the positive evaluation of psychosocial services when available. Since 2007, the government has also bestowed increased recognition to those disabled



during the war, which may have helped to elevate their status among the general public. Whereas in 2005 psychological assistance was only available at one center in the capital, by 2008 it was provided at all physical rehabilitation centers and through the NTI. However, such centralized services impact survivors much less than decentralized services would.

Economic reintegration

More than half of those surveyed (58%) felt economic reintegration efforts had remained the same since 2005, and 12% said they had gotten worse. Some 43% said survivors only "sometimes" received the economic reintegration opportunities they needed. The greatest improvements were seen in decreased discrimination (69%), increases in pensions (62%), and increased educational opportunities (52%). A resounding 95% of respondents agreed with the statement that "Unemployment was so high that survivors were the last to be chosen for a job" and few found that employment opportunities had increased (33%). A similar percentage (34%) found training increasingly met market needs, job placement had improved, and employment quotas were better enforced. Just over half thought there was more government support for economic reintegration activities.

Those who felt improvement were likely among the 40% of registered survivors who received OAS support for training and small business establishment. Results also showed that reduced discrimination and more education did not automatically translate into employment, meaning that many survivors seeing improvement in these areas would not necessarily have felt a significant change in their economic situation. While pensions for disabled ex-combatants reportedly increased by as much as 300% since 2007,[15] they remained insufficient and most civilian survivors did not qualify for a pension at all. The capacity of the NTI to provide vocational training was strengthened in 2008 with OAS support but, in 2009, the government acknowledged that "a large majority of mine survivors remain unemployed."[16]

Laws and public policy

Nearly half of all respondents believed the rights of survivors were only "sometimes" respected and 55% of respondents believed their rights situation had remained unchanged since 2005. However, a significant majority noted positive change in specific areas: more awareness among the general public about disability (71%); decreased discrimination (67%); less use of negative terms (69%); and increased access to information about their rights (65%). At the implementation level, 72% felt survivors and their organizations were more involved in the monitoring of disability policy; 64% believed that they were more involved in VA service provision; and 62% believed legislation and policies were increasingly enforced. Practitioner responses confirmed policy advancements, particularly inclusion of survivors in policy-making, greater access to information, and more general awareness.

These positive responses on inclusion are surprising, because survivors have not been included in developing national VA priorities or in monitoring VA implementation. One practitioner offered a possible explanation by noting that this increased awareness and inclusion is related to persons with disabilities in general. This is in line with the greater government focus on broader disability issues, rather than on VA.[17] The government

reported regularly on progress made within the UNCRPD framework and the strengthening of the national disability law. The government's honoring of those disabled during the war has likely had a positive impact as well. Nevertheless, the national disabled people's organization and the National Ombudsman for Disability Rights continued to report widespread discrimination in 2008.

When asked to respond to preliminary findings, a government representative felt mine survivors had received significant attention over the five-year period, especially compared to other persons with disabilities. However, it was acknowledged that Nicaragua had gotten a late start in taking concrete steps due to a lack of international support and a lack of interest (mostly) by the previous government. More significant steps were taken in 2007-2008. However, given that 93% of respondents felt the government did not have the political will to address their needs, it was clear these developments were too recent and needed to be continued.

VA process achievements

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

Nicaragua was actively involved in VA in the run-up to the First Review Conference in 2004 and during the ensuing year, when it was one of the co-chairs for the Standing Committee on Victim Assistance and Socio-Economic Reintegration.[18] It played a crucial role in the promotion of the tools guiding 26 countries with significant numbers of survivors and the greatest responsibility to act in fulfilling their commitment to the 2005-2009 Nairobi Action Plan.

This involvement has not been sustained, nor has it resulted in significant achievements for VA in Nicaragua. NGO representatives felt Nicaragua had failed to develop a sustainable national VA capacity because of its dependency on the services provided by the OAS. A MoH representative claimed the ministry was prepared take over responsibility for the OAS services, but had to identify ways to make them sustainable for the government through decentralization. The positive impressions on the ground were mostly the result of improvements in the broader health and disability sectors, from which survivors have benefited.

Within the Mine Ban Treaty process, Nicaragua presented its VA objectives in 2005 and revised them in 2007. A restructuring within the MoH in 2007 eliminated the position of the VA focal point and much of the work on developing a VA process, including the revised objectives themselves, was lost as a result. As of August 2009, Nicaragua's objectives remained incomplete, largely non-SMART, and not integrated into other frameworks. Half of the objectives related to developing strategies in 2006. The other half related to strengthening national capacities in anticipation of OAS funding ending in 2009.[19] No objectives were related to the implementation of actual activities. In 2009, Nicaragua still did not have a national plan specific to VA or even a general disability plan, and progress towards less dependence on the OAS was slow.

Nicaragua did not include survivors, persons with disabilities, or other representatives from civil society in developing its priorities. The National Demining Commission's (NDC) VA sub-commission, which includes survivor and NGO representatives, met infrequently from 2005-2009, and just once between 2007 and August 2009. The government used these few meetings to disseminate information, not for consultation on VA priorities or planning.

A MoH representative said the government had been tracking VA progress but was not directly linking this progress to the 2005-2009 objectives. Therefore, Nicaragua's efforts to share information about its progress and challenges were limited, especially after 2007. Previous statements mainly provided statistics and information on the challenges faced by the country in general, rather than progress updates on its own stated objectives.

It seems that general measures positively affecting survivors may have started precisely when reporting stopped. Some credit the new administration, which is "more inclined to address social issues"[20] for concrete steps to make healthcare free and to increase the budget for physical rehabilitation services. These steps will benefit survivors and other persons with disabilities more than the 2005-2009 objectives.

In 2004, the government declared that providing socio-economic reintegration assistance to survivors was a "social and moral obligation," but said it did not have sufficient funds and needed support from the international community.[21] Nevertheless, the government did not reflect this as a priority area in its objectives or address it in broader programming.

The MoH believed that Nicaragua's (limited) involvement in the so-called VA26 process had helped the country to better organize its response to disability in general and had generated some additional international assistance through the OAS and the ICRC-SFD. However, expectations of access to additional international resources for the development of national capacity to complement the OAS program, as expressed by the NDC, did not materialize. In short, improvements have come about despite this lack of additional support and, for the most part, also in spite of a lack of political commitment to the Nairobi Action Plan.

Conclusions

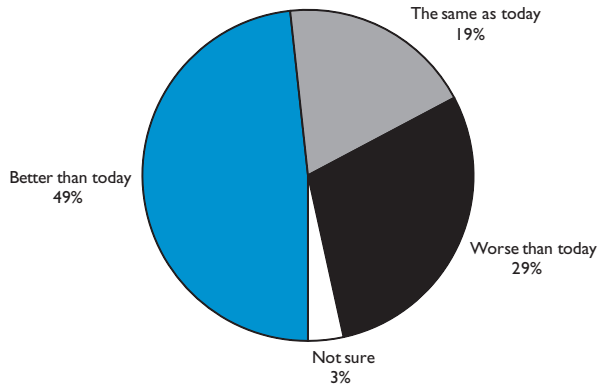
- Progress was either linked to the OAS program, which is not sustainable for the government to take over, or to broader developments started by a more socially-oriented administration.
- Despite being a priority area for survivors, the least progress was noted in improving employment/ income-generating opportunities and access to psychological support.
- Survivors and practitioners signaled the need for more qualified staff and better retention mechanisms to improve the quality of assistance in healthcare, physical rehabilitation, and psychological support.
- Given the low (and declining) number of new casualties, and the lack of attention to VA even as there is general progress in the disability sector, a specialized VA framework might not be an efficient use of resources.
- The channeling of VA funding through the OAS, while efficient, has not fostered a sense of ownership within the government, especially not in direct service provision.

Suggestions for the way forward

When asked about how they saw their situation five years from now, 29% of respondents thought it would get worse, 19% thought it would remain the same and 49% thought it would be better (3% did not answer). To assist in a better future, the following suggestions may be taken into account:

- Ensure greater synergy with UNCRPD implementation plans, including the development of a national disability plan inclusive of the rights and needs of survivors rather than distinct VA plans.
- Investigate options for the cost-effective, sustainable decentralization of services, as transportation/accommodation is not affordable for survivors and its cost is not sustainable for the government.
- Increase involvement of survivors and other persons with disabilities in the development, implementation and monitoring of disability policy, awareness raising, and direct representation in government.

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



Juan Ramon Lopez (left) drawing a map on his palm of a path to a minefield.
© Mike Kendellen

In their own words...

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

- Make assistance accessible.
- Continue OAS (foreign) assistance.
- More and improved prosthetics.
- Support for housing and education.
- Greater NGO/government coordination.
- Medical attention.
- Help persons with disabilities.
- Pensions.
- Professional training.

In their own words...

If countries really cared about survivors they would:

- Treat all survivors equally.
- Donate prosthetics and medicine.
- Provide economic support and training.
- Guarantee support for health care.
- Support prosthetic production.
- Support us psychologically and through group support.
- End wars.
- Increase professional staff for survivors' services.
- Give us jobs.

In their own words...

Survivors described themselves as: independent, entrepreneurial, neglected, abandoned, generous, useful for society, helpful, cheerful, joyful, shy, honest, fine, kind, optimistic, needy because of the disability, hardworking, humble, persevering, capable and strong, tolerant, friendly, responsible.

In his own words: the life experience of Juan Ramon Lopez

In 1979, Juan Ramon Lopez was recruited to join the Contras (the opposition to the Sandinista government in the 1980s). In Honduras, Argentinean trainers taught him how to lay landmines. He was a commander for the Contras known as "Sammy 7" because of the speed at which he ran around and dodged minefields.

When the war ended in the early 1990s, Nicaragua's economy was in a shambles and jobs were scarce. Mines and fighting had damaged the coffee industry, a mainstay of the national economy prior to the war. To restart the coffee business, farmers in Nueva Segovia Department offered jobs to people only if they first cleared mines from the farms. Juan Ramon Lopez accepted these conditions. From 1993 to 1997, he cleared 3,053 mines on six farms with nothing more than an old detector given to him on credit by the coffee farmer. He had two accidents resulting in below-the-knee amputations, but went back to clearance each time. Juan only stopped when the Nicaraguan demining program starting working in the area.

Juan now works as a carpenter but remains involved in demining by serving as an unofficial advisor to the military and has provided information about suspected mined areas along the Honduran border.

Juan has received physical rehabilitation in Managua through the OAS. In March 2009, he received a new prosthetic left foot. The OAS paid for the new foot and the NDC paid for transportation and lodging. As a father of three young children with a low paying job, he did not have the means to travel several hours by bus to Managua for rehabilitation.

Peru

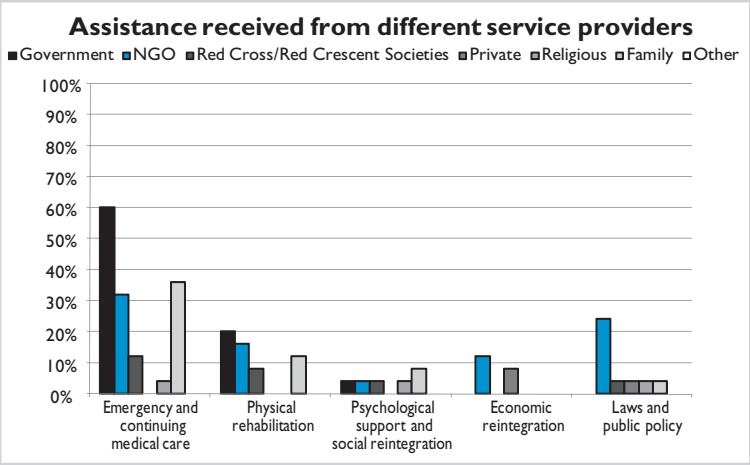
Country indicators

- *Conflict period and mine/ERW use:* The government used mines in the 1980s to protect infrastructure against guerrilla attacks, from 1993-1996 around prisons and police anti-drug bases, and in 1995 along the border during the conflict with Ecuador.[1]
- *Estimated contamination:* In 2009, minefields still remained around three prisons, three police bases, and along the border with Ecuador (334,667m²); at least 500 communities are at risk near mine-contaminated electricity pylons.[2]
- *Human development index:* 79th of 179 countries, medium human development (compared to 85th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$3,990 – 111th of 210 countries/areas (compared to US$2,451 in 2004).[4]
- *Unemployment rate:* 8.4% in metropolitan Lima and widespread underemployment (compared to 13.4% and widespread underemployment in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 1.6% (compared to 1.4% in 2004).[6]
- *Number of healthcare professionals:* 19 per 10,000 population.[7]
- *UNCRPD status:* Ratified both the Convention and its Optional Protocol on 30 January 2008.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Much of Peru's recent economic development has been centered in the capital Lima, while the interior of the country has remained impoverished. Some 30% of the population lives on less than US$2 per day and 53% live below the national poverty level.[9]

VA country summary

Total mine/ERW casualties since 1980: Unknown – at least 426			
Year	Total	Killed	Injured
2004	0	0	0
2005	9	4	5
2006	13	5	8
2007	48	5	43
2008	8	5	3
Grand total	**78**	**19**	**59**

- *Estimated number of mine/ERW survivors:* At least 373.[10]
- *VA coordinating body/focal point:* Contraminas is the coordinating body for VA, but lacks the authority to compel other government entities to act. The Institute for National Rehabilitation (Instituto Especializado de Rehabilitación, INR) is responsible for disability policy and the VA focal point and focuses on physical rehabilitation.
- *VA plan:* None; some general objectives were included in the 2008-2019 mine action plan and there has been a national disability strategy since 2003, but it lacks funds.[11]
- *VA profile:* Between 2005 and 2009, Peru made little progress in VA, and this was recognized as such by the government in February 2009: "The government knows it must emphasize its efforts to improve the planning and implementation of victim assistance."[12] Most services are provided by national organizations; there is a state insurance mechanism for poor people, but this does not cover many services needed by survivors and most persons with disabilities do not have insurance. While services for military survivors are adequate and better than services for civilians, even military survivors sometimes face bureaucratic obstacles. Civilian survivors have to rely on facilitation by the ICRC or the Organization of American States (OAS) to obtain assistance. Survivors are treated within the general healthcare system, which is adequate in Lima, where nearly all public healthcare staff (90%), rehabilitation and psychosocial services are located. In rural areas, where most survivors live, there was no capacity for continuing medical care, prosthetic and orthotic devices, or community-based mental health and social services throughout 2005-2009. The one orthopedic center in the country (Lima) lacked staff with internationally recognized credentials and was hampered by limited supplies and old equipment. Rehabilitation and psychosocial services are not always free of charge and there is a lack of awareness of the need for psychological assistance. Only one survivor organization exists to provide peer support and its capacity is limited. Few survivors have access to economic reintegration programs or government pensions. Since 2008,



survivors have been able to apply for government compensation, but they were only informed of this right in 2009. Disability legislation exists but is not enforced due to funding gaps, particularly with respect to employment quotas.[13]

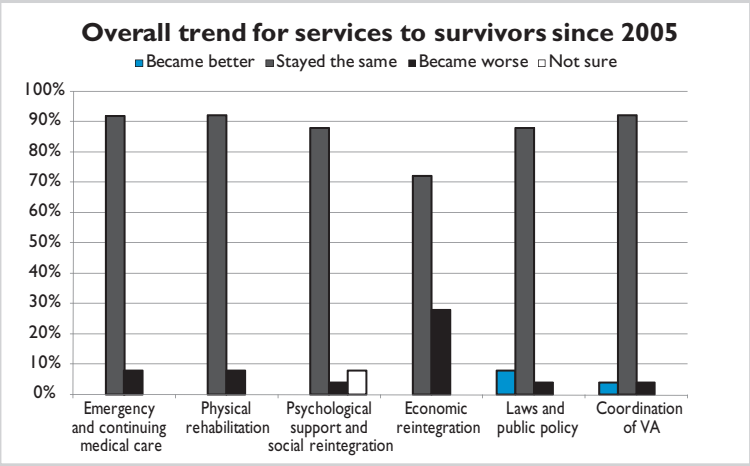
VA progress on the ground

Respondent profile

By July 2009, 25 survivors had responded to a questionnaire about VA progress in Peru since 2005: 24 were male and one was female. All were between 16 and 52 years old, with 64% aged between 35 and 50. Some 76% were heads of households and 28% owned property. Most (68%) of the respondents lived in the capital and 32% lived in rural areas with limited or no services. Nearly all (84%) had completed secondary education or higher. Some 76% were unemployed at the time of the survey, as compared to just 24% before the incident. Incomes are said to be insufficient for 80%, while 20% reported sufficient income. Casualty data confirms that most survivors in Peru are men who were injured prior to 1999, often military personnel. Due to the difficulties in reaching the remote areas where most survivors live, this particular sample over-represents survivors from Lima. As the casualty data indicates, more than 40% of registered survivors live outside the capital.[14]

General findings

Most respondents felt that all services had remained the same over the last five years. No respondents felt they were receiving either more or better services. While the survey sample and female participation is too limited for accurate extrapolation, 84% of respondents felt services for female survivors were "equal" to those available to men, while 16% felt they were "absent". Some 36% felt services for child survivors were "mostly" adapted to their age level; 40% found this only "sometimes" to be the case; and 24% believed it was "never" or "almost never" the case.



Almost all (88%) of the respondents had been surveyed by NGOs or the government at least once since 2005. They felt this survey activity led to more information about services (60%); fewer problems with bureaucracy (56%) and felt listened to (56%). Nearly half (48%) had received at least one opportunity to explain their needs to government representatives. This would correspond to the fact that impact surveys and a pilot needs assessment in Lima have been undertaken (albeit incompletely - the needs assessment only visited 20

people). Other information acquired during impact studies focusing on demining and casualties have not been reported for several years.[15]

Emergency and continuing medical care

Almost all respondents (92%) felt that, overall, the healthcare situation had remained unchanged since 2005 and 8% felt the situation had worsened. Most respondents (60%) felt survivors only "sometimes" received the medical care they needed; 12% said this was "never" or "almost never" the case; 12% said it was "mostly" the case and 16% were not sure. Moreover, 96% of respondents did not believe healthcare for survivors was a government priority; the 4% who believe it is a government priority live in Lima. Areas of some progress, according to a small group of respondents, were the capacity to carry out complex medical procedures (8%) and access to services closer to home (4%). Respondents' comments highlighted problems, such as antiquated equipment, long waiting lists, high costs, lack of capacity for emergency and ongoing medical care, poor maintenance of existing facilities, a shortage of trained professionals, and unaffordable medicines. One survivor living in a village with limited services said: "In my area, there is just one medical center, run by a nurse, and it is completely inadequate."

Some of these responses contrast with the government reports of 2005 and 2008, which claim adequate capacity and a "vast experience in amputation surgery and the care of traumatic injuries."[16] However, the survivors' responses can be explained by the fact that access to healthcare was extremely limited in rural areas and unaffordable for many all over the country from 2005-2009. Despite special health programs for poor and vulnerable people, only 38% of persons with disabilities are covered by insurance.[17] Although emergency care is free, response remains heavily dependent on the location of incidents and can take up to 24 hours. One survivor reported being completely unable to access any medical care whatsoever over the last five years. The government recognizes the limited availability of medicines and equipment and reported on its investments into modern equipment in 2008-2009.[18] This would have been too recent for survivors to notice.

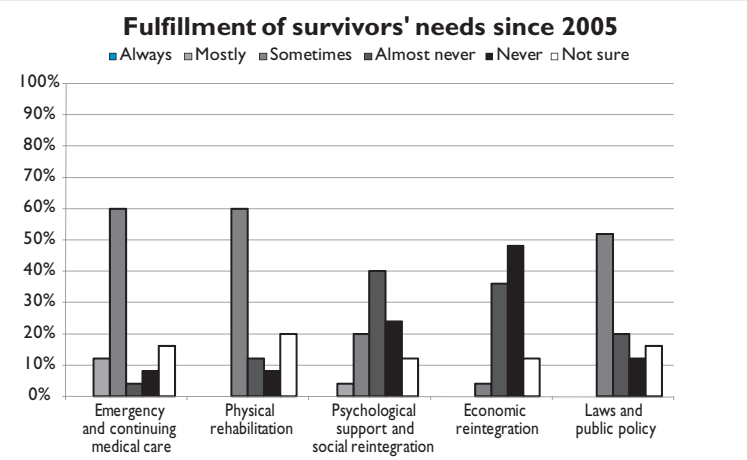
Physical rehabilitation

As with medical care, 92% of respondents felt physical rehabilitation had remained the same and 8% felt a deterioration since 2005. While 60% felt survivors "sometimes" received the physical rehabilitation they needed, 20% found this "never" or "almost never" to be the case (20% were unsure). Again, responses on specific progress indicators were overwhelmingly negative, with a consensus on the statement that it is not easier to get services closer to home, quality has not improved, and assistance is not more affordable. Survivors' comments related mostly to the fact that there is just one orthopedic center (the INR) where the waiting lists are long. Some survivors with amputations said they had never received physical rehabilitation or follow-up care since receiving their first prosthesis immediately after their incident, which in some cases occurred as long ago as 17 years.

In 2005, Peru stated that, "The fundamental limitation [in physical rehabilitation] is that the production of prostheses and orthotics can only be done in the capital, meaning access and costs are issues."[19] Indeed, one center providing mobility devices for children in Lima closed in 2008. Although Peru reported that the INR provides comprehensive services,[20] the ICRC reported quality and productivity concerns in 2009.[21] Some physical rehabilitation is available in regional hospitals, but no efforts have been made to decentralize orthopedic services or to improve the quality of physical rehabilitation. Military personnel receive separate services.[22]

Psychological support and social reintegration

Nearly all respondents (88%) felt psychological support and social reintegration services had remained unchanged since 2005 and 4% felt a decline (8% did not respond). Some 64% said survivors "never" or "almost never" receive the psychosocial services needed; 24% said "mostly" or "sometimes" (the remainder was not sure). Just 4% saw more services, better-quality services, more staff training, the creation of peer support groups, or psychological services being considered as important as other services. No survivors felt empowered or involved in community activities. In their comments, survivors either said they did not know where to access psychosocial services or that they were too far away.



In 2005, Peru recognized that psychological support and social integration services were available through the country's only orthopedic center, that the services are not free, and that "there is no financial support available to assist civilian mine survivors to face issues of post traumatic stress."[23] Despite a government report in 2009 that some survivors have obtained free access to these services,[24] they are still located too far away from survivors. No community-based social activities exist, the capacity of the only survivor organization (AVISCAM) to conduct activities decreased due to management changes in 2008, and there is a general lack of awareness of the need for this kind of service.

Economic reintegration

The least positive results were reported in the area of economic reintegration, as 28% of respondents said the situation had deteriorated since 2005 (72% observed no change). Additionally, 84% believed survivors "never" or "almost never" received the economic reintegration services they need; 4% said they "sometimes" received such services; and 12% were not sure. All respondents felt unemployment was so high that survivors were the last to be chosen for jobs and that economic reintegration was not a government priority. No positive advances were seen in any area. In their comments, survivors highlighted the fact that they do not receive job training and face discrimination. They also noted insufficient enforcement of employment quotas, a generally worsening labor market, and no government efforts to create job opportunities.

In 2005, Peru sought to link survivors to existing economic reintegration programs by 2006.[25] Since then, Peru has only reported on its collaboration with the survivor organization in the area of involving survivors in demining and risk-education programs. The respondents, many of whom are AVISCAM members, reported receiving "occasional" work this way, but none have found permanent employment. The INR is also supposed to provide economic reintegration activities with financial help from NGOs,[26] but it is unknown if any survivors have benefited from this. The National Council for the Integration of Persons with Disabilities (CONADIS) is responsible for general disability issues and underwent restructuring in 2007-2008, which slowed down its activities. In Lima, CONADIS also runs the only training center focused on persons with disabilities, but this was closed from 2002 to 2007 and experienced funding shortfalls in 2008. There was no funding to implement the national disability strategy.

Laws and public policy

Some 88% of survivors felt their rights situation has remained the same since 2005; 8% saw improvement and 4% saw a decline. More than half of all respondents (52%) felt survivors' rights were "sometimes" respected; 32% said this was "never" or "almost never" the case and 16% were unsure. One-fifth of respondents believe laws and policies benefiting survivors were increasingly enforced, or that they and their organizations were more involved in disability monitoring and have a seat in government. Also, 16% felt survivors were more involved in VA activities. However, none of the respondents felt discrimination had decreased or that awareness about the rights of survivors and other persons with disabilities had increased.

While survivors were aware of increased legislative efforts, such as improvements in legislation and development of the disability strategy, they noted a general lack of enforcement. According to one survivor, "there is a lot of interest in helping persons with disabilities, what there is not enough of is money." While Peru has had a national disability strategy since 2003 (Plan of Equality of Opportunities for Persons with Disabilities) and has ratified the UNCRPD, it also acknowledged that

enforcement and implementation of equal rights is inadequate due to insufficient funds and legal difficulties.[27]

When asked to respond to preliminary findings, a government official agreed with the survivors, stating that VA had been "the Achilles' heel of mine action." The representative added that the government knew it had to improve its efforts to strengthen VA planning and implementation, but that these efforts were hampered because many survivors lived in remote locations, making them difficult to reach. The representative also noted that some survivors had refused help.[28]

VA process achievements

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

Since 2005, Peru has made very limited progress in improving the lives of landmine/ERW survivors. This is clear from survivor responses and also the fact that services remain centralized, limited, and often unlinked to broader health, development and disability frameworks. Potential reinforcements in the disability rights area also remain largely unimplemented and thus do not benefit from Peru's implementation of the Nairobi Action Plan as one of the 26 countries with the greatest number of survivors, the greatest responsibility to act, but also the greatest needs and expectations for assistance.

One government representative stated that one aim of becoming part of the so-called VA26 was to raise the profile of VA and to apply pressure internally. While some initiatives have been started in 2009, the representative added that work remains to be done. Survivor respondents also noted a lack of political will. The second aim of joining the informal VA process was to secure increased international technical and financial assistance. This has remained limited to OAS support to provide "prosthetics and that's it" and has overlooked survivors' ongoing needs, according to the representative.

In 2005, Peru developed some objectives for 2005-2006 as part of its commitment to the Nairobi Action Plan. It has not revised them since and no plans to achieve the objectives have been made. That said, all but one objective is related to the development of strategies, directories and databases. Most of these objectives had a 2006 deadline which elapsed without significant progress being reported. Some objectives were repeated with delayed 2008-2009 deadlines in the 2008-2019 mine action strategy, but also remained mostly unachieved.

The objective to create "a strategy to provide direct and appropriate assistance for all registered mine survivors" had a 2009 deadline. This objective is not due to be fulfilled before the end of 2009, which means effective VA implementation and the subsequent improvement of survivors' lives remains problematic. One of the prerequisites for the development of the strategy was better data on survivors, which was still lacking as of August 2009, despite some small-scale attempts. This situation was further exacerbated by the lack of funds in the disability sector and the subsequent lack of progress under the national disability strategy. The disability strategy was developed by CONADIS with participation from persons with disabilities; a multi-sector commission was created in 2009 to ensure the involvement of all relevant stakeholders in implementation and monitoring.

The only objective which implies that some activities must be carried out is the objective of working with survivor groups in order to facilitate access to psychosocial support services.

As seen from the survivor responses above, this objective remains unfulfilled. Furthermore, it completely stalled in 2008 because management changes at AVISCAM reduced that organization's capacity to assist and lobby for the rights of survivors. AVISCAM also reported that cooperation with the authorities on VA had been impossible in 2008.[29]

Ineffective coordination also appears to have been an obstacle to VA progress. The mine action center, Contraminas, was responsible for coordinating VA through its inter-ministerial permanent committee, created in 2006, which met very infrequently. Only in 2009 was the committee expanded to include civil society representatives and started to meet more regularly. However, Contraminas does not have a mandate to direct ministries or to assist ERW survivors. It created a dedicated staff position for VA only in April 2009. In May 2009, an international organization (the Polus Center) was engaged to build national VA capacity.[30] The VA focal point (INR) mainly concentrated on physical rehabilitation; links to CONADIS, which is in charge of general disability issues, appear to be infrequent.

Survivors were invited to participate in meetings, but reported that their presence was "just a formality" and that their input was not considered. This is reflected in survivor responses: 88% did not know who was in charge of VA coordination and 92% saw no improved VA coordination. No respondents thought survivors were involved in planning and 92% did not think their needs were taken into account while developing VA priorities.

Peru has reported on VA at every Mine Ban Treaty-related meeting. Its updates often repeat information from previous years or lack information on activities, except for INR activities (usually about survivors assisted through the OAS). None of the survivor respondents felt well-informed about VA achievements.

The steps Peru started to take in 2009 seem to have come very late in the process as a result of a lack of political will and international assistance. It also is too early to assess whether the 2009 efforts will be sustained.

Conclusions

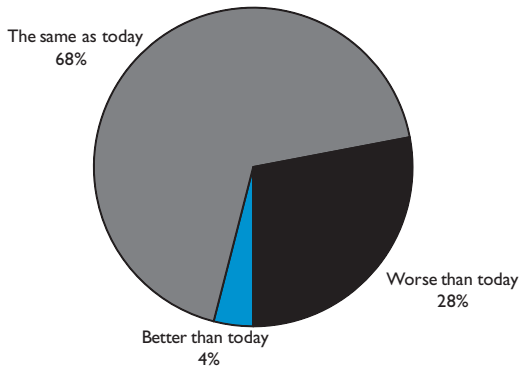
- While many survivors lived in remote areas, almost all services remained located in the capital and no efforts to decentralize services have been made.
- Even though most survey respondents belonged to the survivor organization and were therefore better-connected to services, they have received little psychosocial or economic reintegration support.
- The disability framework has been strengthened but not sufficiently enforced.
- Peru's implementation of the Nairobi Action Plan has been hampered by a lack of action-oriented objectives and plans, as well as a lack of political will and resources.
- There was a clear lack of a body with the mandate and capacity to coordinate VA, as well as insufficient synergies with the disability sector or interaction with civil society.

Suggestions for the way forward

When asked about how they saw their situation in five years, 68% of survivors thought it would remain the same; 28% thought their situation would be worse; and just 4% thought it would be better than today. To assist in a better future the following suggestions may be taken into account:

- Decentralize medical and rehabilitation services by creating or strengthening capacity at existing facilities and by creating mobile units.
- Provide transport and accommodation free of charge for survivors who need to receive treatment in the capital.
- Strengthen disabled people's and survivors' organizations and allocate resources to their activities.
- Support the development of peer-to-peer support networks.
- Expand economic reintegration programs for persons with disabilities and make existing programs inclusive of persons with disabilities.
- Systematically include survivors in VA and disability planning and monitoring.
- Create greater synergies with the body responsible for disability issues.
- Given the low number of survivors and the low profile of VA, explore transferring VA responsibility to the disability committee implementing and monitoring the national disability strategy.
- Allocate adequate resources to the implementation of the disability strategy.

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



Carlos Estrada (right) interviewing a survivor in Sapallanga-Huancayo for this report
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In her own words: the life experience of Huigua Diaz Domingo

After completing high school, Huigua Diaz Domingo started working for the Peruvian National Police. As a police deminer, she had her first mine accident in 1992, which damaged her eyesight and cost her two fingers. However, she did not stop demining. Her second accident in 1995 resulted in an above-the-knee amputation. Since that time she has been unemployed.

Huigua described the medical care at the police hospital in Lima as "very bad." She does not believe medical care has improved since then, adding that access to care is "very complicated." She has not received any support from the government during the last five years. She has only received peer support, rights information and crutches from the survivor organization. Her family of four depends entirely on her husband's income, which she says is not sufficient.

In their own words…

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

- Increasing state support to survivors.
- Focusing on survivors' economic reintegration.
- Increasing capacity to provide specialized medical care.
- Receiving assistance from outside Peru for specialized medical care.
- Giving us what is our due.
- Creating opportunities to work and improving medical assistance.
- Enforcing laws.
- Providing survivors with more information about their rights and about services.
- Raising awareness within the government.
- Giving survivors professional training and an opportunity to work.
- Providing survivors with a pension.

In their own words…

If countries really cared about survivors they would:

- Develop comprehensive assistance programs.
- Increase funds to provide compensation to survivors.
- Raise awareness among employers of the need to employ survivors.
- Provide sufficient funding to give survivors the help they deserve.
- Scrutinize how the government is using international aid.
- Provide the necessary national budget.
- Better monitor the needs of survivors.
- Develop social programs to help survivors.
- Provide information to survivors outside of Lima.

In their own words…

Survivors described themselves as: hardworking, persevering, victim, survivor, accident victim, activist, forward-looking…

Senegal

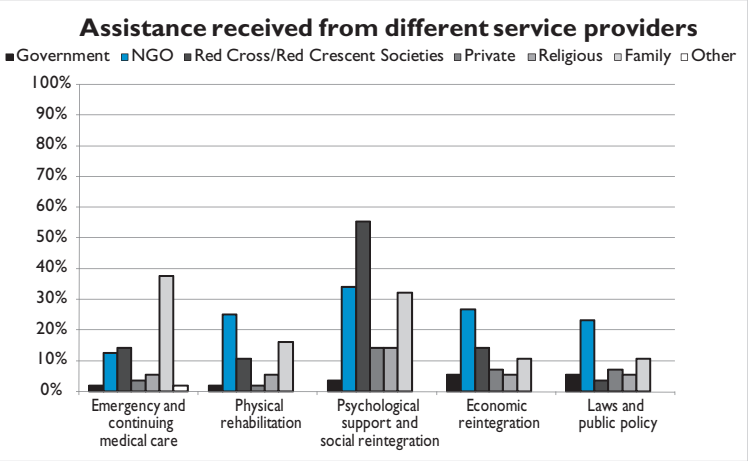
Country indicators

- *Conflict period and mine/ERW use:* Mine/ERW contamination dates back to the conflict around the independence of Guinea-Bissau (1968-1973) and subsequent mining of the border by the Senegalese army. Mines were also used by all parties in the 1982-2004 conflict in Casamance and sporadic use by the armed group Movement of the Democratic Forces of Casamance has been reported since.[1]
- *Estimated contamination:* The 2006 Emergency Landmine Impact Survey of Casamance recorded 149 suspected hazardous areas (11km^2) and 63km of roads or tracks affecting 93 communities (7% of the population).[2]
- *Human development index:* 156th of 179 countries, low human development (compared to 157th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$970 – 168th of 210 countries/areas (compared to US$699 in 2004).[4]
- *Unemployment rate:* 48% (also 48% in 2004).[5]
- *External resources for healthcare as a percentage of total expenditure:* 13.5% (compared to 12.7% in 2004).[6]
- *Number of healthcare professionals:* Four per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention and its Optional Protocol 25 April 2007.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Senegal is a poor country that relies heavily on foreign assistance. More than 33% of the population lives below the national poverty level and the majority (56%) live on less than US$2 a day. High unemployment rates resulted in a migration flow to Europe. Ongoing violence in Casamance has isolated the region and prevented economic growth.[9]

VA country summary

Total mine/ERW casualties since 1988: At least 723[10]			
Year	Total	Killed	Injured
2004	17	0	17
2005	12	4	8
2006	18	8	10
2007	1	0	1
2008	24	1	23
Grand total	**72**	**13**	**59**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 570.[11]
- *VA coordinating body/focal point:* The National Commission on the Implementation of the Mine Ban Treaty and the Senegal National Mine Action Center (Centre National d'Action Antimines du Sénégal, CNAMS) include VA in their mandate but their role is limited and does not involve implementation.
- *VA plan:* None, nor is there a disability strategy. VA is included in the mine action strategy and disability in the national and regional poverty reduction strategies.
- *VA profile:* Most mine/ERW survivors in Senegal live in the restive Casamance region, where services are much more limited than elsewhere in the country. Throughout 2005-2009, Senegal reported it was committed to VA, but at the same time acknowledged that the needs were not being met due to a lack of resources. The mine action center relied on national and international NGOs and the survivor association to implement activities. Civil society and survivors said that VA was not high on the government's agenda.[12] The only international NGO providing VA services since 1999 ended most of its VA activities in August 2008. Years of conflict and intermittent new outbursts devastated infrastructure and prevented access to services. Throughout 2005-2009, emergency medical care was limited and response times depended on the location of the incident; the army provided assistance. Follow-up medical care was only available in the two regional hospitals, which had sufficient capacity but had intermittent equipment and supply shortages. These two hospitals and their satellite centers also provided physical rehabilitation, which just as follow-up medical care was not free of charge, making services unaffordable for many survivors. Material shortages were noted also here, as well as long waiting lists. Psychosocial support has been provided by international organizations and the Senegalese Association of Mine Victims (Association Sénégalaise des Victimes de Mines, ASVM). The government opened a psychiatric center in 2008 but as of 2009 no mine survivors had been assisted. Throughout



2005-2009 economic reintegration and education opportunities for survivors were inadequate because there were few NGO activities and because survivors had difficulties accessing broader programs for all vulnerable groups. Most survivors were said to be unemployed or self-employed and in need of assistance. Military survivors received separate services, which were mostly free of charge and better, but still had gaps. As of 2009, draft disability legislation had not been approved.[13]

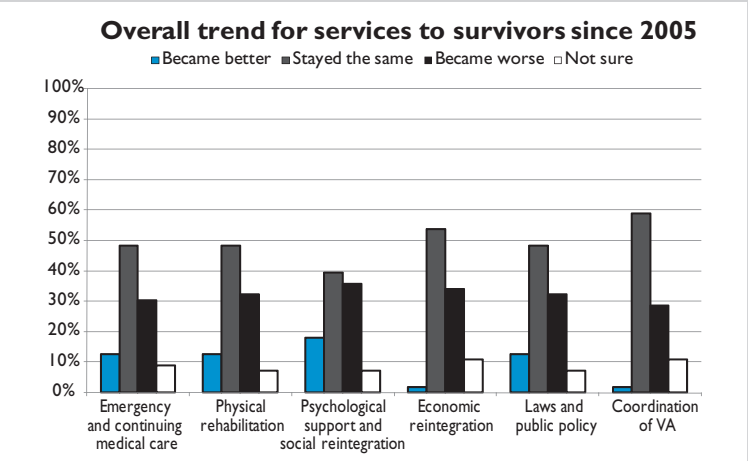
VA progress on the ground

Respondent profile

By July 2009, 56 survivors between 11 and 73 years old responded to a questionnaire about VA progress in Senegal since 2005: 43 men, 11 women, one boy and one girl. Some 64% were heads of households and 14% owned property. Almost half (45%) lived in remote areas without services, 36% in villages with limited services, and 18% in a large city with a variety of services.[14] All were based in the Casamance region where at least 80% of all mine/ERW survivors live.[15] Twenty percent had not received any formal education; 43% had completed primary education or higher; and 23% had attended a few years of primary school.[16] Some 34% of respondents were unemployed after the incident compared to 21% before the incident. More than half (55%) did not feel that their household income was sufficient and the remaining 45% did not respond. This profile corresponds to the casualty profile extrapolated from CNAMS data which indicates that most survivors are men (both civilian and military) injured between 1988 and 2004 in rural areas in Casamance.[17]

General findings

The majority of respondents felt that all services had remained the same over the past five years though a significant number also felt that services had declined, particularly economic reintegration. Just 7% of respondents felt that they received more services in 2009 compared to 2005 and 4% thought that the services were better. Some 30% of respondents believed that services for female survivors were "a bit worse" than those available to men; 14% said services for women were "absent"; and 18% said they were "equal"; 30% of male survivors did not respond. Women responded more negatively (42% thought that services were "a bit worse" and 25% said they were "absent"). Nearly two-thirds of people (63%) were not sure if services for child survivors were adapted to their age; 25% felt they were "never" or "almost never" adapted.



The majority (52%) of respondents had not been surveyed by the government or NGOs since 2005 and 29% had been surveyed three times or more. Some 30% felt that this had resulted in being listened to; 18% said they had received more information about services and had fewer problems with bureaucratic procedures. Most (71%)

had never had the opportunity to explain their needs to government representatives. Respondents were all injured prior to 2005 and would only have had their information recorded by the hospital, NGOs or local authorities at the time of the incident. In 2009, ASVM started collecting information on the needs of survivors but lacked the funds to do this systematically – 177 people were interviewed.[18] In May 2009, Senegal stated that identifying the needs of survivors and setting up a surveillance mechanism were among its main challenges.[19]

Emergency and continuing medical care

Nearly half (48%) of respondents felt that healthcare had remained the same since 2005 and 13% saw improvements. Also, 50% said that survivors "never" or "almost never" received the medical care they needed. Some 36% found that there were more health centers in their area, but responses depended on where the survivors lived. In cities, 50% saw improvement compared to 28% in remote areas. More than a quarter of respondents (27%) found they could access healthcare closer to home (60% in major cities; 12% in remote areas). Another 38% felt that health center infrastructure had improved and 29% said that staff was better trained. Affordability of services and services by more complete teams were a problem with only 18% of respondents seeing progress; 23% saw more emergency transport.

The survivor responses confirm that medical care was most available in the two regional hospitals in Kolda and Ziguinchor, the latter having more capacity and being better-equipped. Staff capacity has remained the same in the two hospitals throughout 2005-2009. In principle, emergency medical care is free of charge, but continued care is not and medication and supplies always need to be paid for. Military survivors received free treatment but free medication was only available in Dakar. First aid was available at some health centers and army posts, as was some emergency evacuation by the military. However, the timeliness of the response depended on the location of the emergency and the quality of the road. Survivors reported in 2009 that often they needed to be taken to hospital by their families and that ambulances were in bad shape.[20] The government also acknowledged that emergency medical vehicles were lacking.[21]

Physical rehabilitation

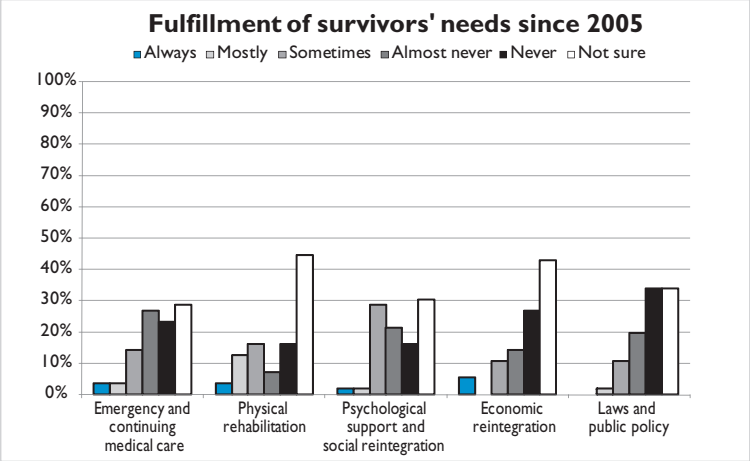
Some 48% of respondents believed that, overall, physical rehabilitation services remained the same since 2005 and 32% thought that services had worsened (40% among respondents in remote areas). The largest group of respondents (45%) was not sure whether survivors received the physical rehabilitation they needed or did not respond; 29% said survivors "sometimes" or "mostly" received these services; and 23% said "never" or "almost never". When looking at specific progress indicators, responses were largely negative: 27% found that more types of mobility devices were available; 23% said staff was better trained or that infrastructure had improved; and 21% found that the quality of physical therapy and of mobility devices had improved and waiting periods had become shorter. Other indicators registered progress rates of 20% or less: 9% found services more affordable and 4% found that free-of-charge repairs were being increasingly provided.

While considered insufficient by NGOs and survivors, the number of rehabilitation services has not increased since 2005. Services were available in Kolda and Ziguinchor hospitals and in two satellite centers, and all had regular material shortages. But bigger obstacles for survivors were that the services were not free of charge for people without insurance (except for military survivors who receive free services); waiting lists were long; survivors lacked awareness about services and needed help from NGOs or ASVM to be able to access services.[22] Particularly since the ASVM fund to cover these costs was discontinued, most survivors were covered by one international NGO working on the issue until the VA program closed in 2008 due to lack of funds.[23] While some respondents saw a decrease in waiting periods, in 2009 the wait for getting a prosthetic limb still averaged 45 days.[24] Training for rehabilitation personnel was provided continuously by an international NGO

between 2005 and mid-2008.[25] In 2009, the government acknowledged that procedures for obtaining replacement devices needed simplification and that raw materials were lacking.[26]

Psychological support and social reintegration

Some 36% of survivors thought that overall psychological support and social reintegration services had deteriorated since 2005 and 39% saw no change. Nearly 29% of respondents thought that survivors "sometimes" received the psychosocial assistance they needed; 21% said this was "almost never" the case and just 2% each said the needed services were "always" and "mostly" received. Some 29% of respondents felt more empowered and thought survivors were considered to be "charity cases" less often in 2009 than in 2005. The same percentage was more involved in psychosocial support for other survivors and 25% were more involved in community activities in general or thought that more peer support groups had been created. Almost 18% thought it was easier to get counseling from a psychiatrist and 13% believed that the government was providing more support for psychosocial services.



Formal psychological support in Casamance was only available through a psychiatrist coming from Dakar a few times per year. Peer support groups and informal psychosocial activities have been carried out by ASVM and NGOs throughout the period, but focused more on individuals, and their activities did not translate into a permanent psychosocial support capacity.[27] All NGO efforts were dependent on external support, and assistance was often just a small part of broader conflict resolution programs. Basic training was also provided to government staff. In 2008, the government opened the Kenia Psychiatric Center (Centre Psychiatrique de Kénia) in Ziguinchor. As of April 2009, no mine survivors had been assisted, so respondents would not have perceived a difference.[28]

Economic reintegration

More than half of the respondents (54%) thought that economic reintegration opportunities had remained unchanged since 2005; 34% saw a decline in services and just 2% saw improvement. While the largest percentage (43%) was not sure, 27% of respondents said survivors "never" received the economic reintegration services they needed; 14% said "almost never"; 11% said "sometimes"; and 5% said "always". Very few specific improvements were observed. One-fifth of respondents saw more educational and training opportunities, as well as teachers better trained in disability issues. Some 18% felt they could access educational and vocational training opportunities closer to home. Few respondents (10% or less) found that employment opportunities, small business loans or pensions had improved.

Between 2005 and 2009 it was acknowledged that economic reintegration opportunities for mine/ERW survivors were limited. Economic reintegration programs for persons with disabilities were integrated in the national poverty reduction strategy and also in the Casamance regional socio-economic development strategy. Some special schools for children with disabilities existed as did some government vocational training, but this was not free of charge. Other income-generating programs targeted all vulnerable groups, but persons with disabilities found it difficult to access them. Already in 2006, it was noted

that development strategies did not pay sufficient attention to the needs of survivors.[29] In May 2009, Senegal acknowledged that one of the main challenges was to facilitate access to employment for survivors. A decree that 15% of those recruited in public offices would be persons with disabilities announced in 2005 did not have implementation legislation to operationalize it as of 2009.[30] In 2008, the Ziguinchor hospital records showed that most survivors were unemployed or self-employed but in need of assistance.[31]

Laws and public policy

Nearly half of respondents (48%) said that the protection of their rights had not changed since 2005 and 13% thought that their rights were better protected. Most respondents (54%) thought survivors' rights were "never" or "almost never" respected and 93% of respondents felt that their rights were not a government priority. Some 34% believed that discrimination had decreased and 29% thought that general awareness about the rights of persons with disabilities had increased. However, only 21% thought that legislation and policies relevant to survivors were developed; 16% thought they had more information about their rights; and 13% thought that laws were enforced better.

In 2005, Senegal pointed to pending legislation for persons with disabilities "which should contribute to the improvement of the situation of persons with disabilities."[32] However, the draft bill has been stuck in parliament since 2005[33] and in May 2009, the government listed its adoption as a remaining challenge.[34]

When asked to respond to preliminary findings showing that few survivors saw overall progress, a government representative disagreed. The representative stated that while perhaps not all needs had been met, awareness had been raised. The person added that the responses received would depend on who had participated in the survey as some survivors had been reached but service provision could be hit or miss, depending on the materials available when any given survivor arrived to seek out assistance.

VA process achievements

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

Note: Senegal reported casualty data in its 2009 Article 7 Report but did not provide VA information as in previous years.

Senegal declared in 2005 that "it attaches great importance to assistance to mine survivors."[35] VA was included in the mine action strategy and activities, but implementation of activities was delegated to NGOs, DPOs and the regional hospitals. Funding was left almost entirely to the international NGOs, which were dependent on intermittent and decreasing external funding. The international commitment to provide immediate relief has not been matched by long-term capacity building of national authorities or service providers. The government has launched revival plans for Casamance, which to some extent take the needs of persons with disabilities into account. But the region remained the least developed and troubled by conflict thus hampering VA/disability services. According to survivors, the government lacked political will (91%) and it had not increased its involvement (80% saw no progress) or funding (84%).

A government official indicated that the lack of progress was due to coordination challenges and added that, in 2004-2005, VA activities were implemented on an *ad hoc* basis. The representative added that Senegal's expectation when becoming part of the 26 countries with the greatest numbers of survivors and, the greatest responsibility to act, but also the greatest needs and expectations for assistance had been that it would increase

coordination. A second challenge to making progress had been funding, which Senegal had also been expecting as a result of the informal, so-called VA26 process. As of May 2009, the representative did not feel that Senegal had benefited from the VA26 process even though the person felt that the government had demonstrated its commitment to VA and could thus expect international technical and financial assistance.

Already in 2004, NGOs criticized the government for not having a civilian VA program so that international assistance could be sought to supplement Senegal's insufficient national means.[36] VA has since 2005 been under the mandate of mine action authorities, but a functioning mine action center (CNAMS) was established only in 2007. CNAMS recognized that the time it took to set up the mine action framework had caused delays in making progress.[37] However, since its establishment, CNAMS has directed most of its attention to political issues and clearance. Government responsibilities for disability issues are unclear, but the lead ministry for disability appears to be the Ministry of Family, National Solidarity, Women Entrepreneurship and Micro Finance. There also is a presidential advisor on disability. CNAMS does not liaise with either body and added "each ministry acts independently and there is no coordination."[38]

Although CNAMS depends on civil society for implementation of VA activities, NGOs and DPOs said that they were not involved in VA coordination. Few survivors (23%) knew who was in charge of coordinating VA; just 14% saw improved coordination with NGOs; and 18% felt there was better coordination with the disability sector. Survivors were not included systematically in coordination, despite the fact that one of the objectives of CNAMS was to provide technical support to ASVM,[39] nor did the government provide any financial support to ASVM's activities. While survivors (through the work of ASVM) were more involved in VA implementation (29% thought so), just 11% felt that the needs of survivors were taken into account when VA priorities were set. Another 18% thought that survivors were included in coordination and 14% thought that survivors were involved in making plans. Just 7% believed that they received regular information about VA progress.

In 2005, Senegal presented some objectives for the implementation of the 2005-2009 Nairobi Action Plan, but these were not SMART, as no timelines or specific targets were set. No revised objectives or plans have been presented since then. In 2008, some activities planned under the mine action strategy were outlined. But again, these were not specific and not time-bound, and they did not address all components of comprehensive VA (for example, psychosocial support or laws and public policies were not included). In 2008-2009 it was announced several times that a VA plan would be developed, and that it would be presented at the end of 2009 to cover 2009-2014, thus not the period under review (2005-2009).[40]

Conclusions

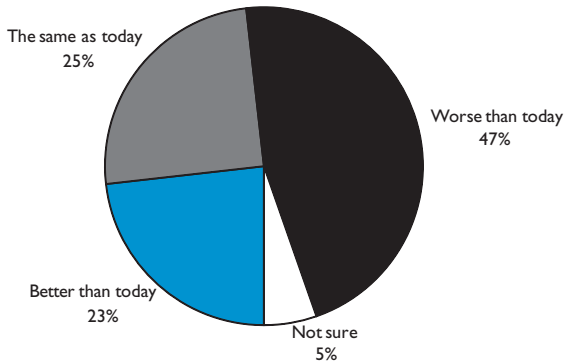
- Senegal remained dependent on the ever-decreasing presence of international organizations to provide VA in Casamance and did not coordinate sufficiently with these organizations.
- Access to services remained problematic, especially for survivors from rural areas due to insecurity, poor road infrastructure, and because of the cost of the services.
- Senegal has not yet developed effective VA/disability coordination mechanisms, and has not linked VA to the disability sector.
- Broader development programs did not take the needs of persons with disabilities sufficiently into account.
- The lack of disability legislation was seen as an obstacle by both the government and survivors.

Suggestions for the way forward

When asked about their expectations for their situation in the next five years, 47% of survivors felt that it would be worse than today; 25% thought it would be the same; and 23% thought it would be better. To assist in a better future ahead the following suggestions may be taken into account:

- Urgently develop, implement and monitor a VA/disability plan with systematic involvement of survivors, NGOs and relevant ministries.
- Ensure that the VA/disability plan complements government development plans and use the VA/disability plan as a tool to guarantee better access by persons with disabilities to the activities under these development plans.
- Identify a clear focal point for VA/disability issues, with a sufficient mandate and capacity to act.
- Ensure that the VA/disability focal point establishes ties between the disability sector (NGOs, DPOs and other service providers) and government bodies in charge of disability issues.
- Ensure that solutions are found to increase national VA capacity, including national funding, while actively seeking continued external funding for the continuation of international NGO activities in the short term.

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



- Start building the capacity of the government and national NGOs to take on the functions that are now being carried out by international organizations.
- Strengthen ASVM, including by providing financial assistance, and include them as equal partners in VA/disability planning, implementation and monitoring.

Elisabeth Nassalang from lower Casamance
© Patrizia Pompili, Handicap International

In her own words: the life experience of Elisabeth Nassalang

In 2000, Elisabeth Nassalang (then 35) went looking for fruit to sell in the fields near her home in Boutoute village, Ziguinchor. She has no memory of actually stepping on the landmine but was later told that this was what caused her to lose her legs. When Elisabeth left the hospital, she went to her father's house since her husband abandoned her and took some of their eight children with him. Elisabeth and her daughters were homeless and had to rely on friends and neighbors. With the help of ASVM, she now has a house and her sons have also come to live with her again.

She started a small shop with micro-credit she received from a Senegalese organization, but the business failed. Again, she has to depend on the charity of her neighbors and occasional help from ASVM. Elisabeth's main concern is for her children and their education, but she also worries about where she will find food from one day to the next.

In their own words…
The main priority for VA in the next five years is:

- Finance our reintegration.
- Restore our homes.
- Train and support survivors.
- Give us access to bank loans.
- Provide free healthcare.
- Create a direct link with survivors.
- Provide social and medical support.
- Fulfill our basic needs such as food.
- Financial compensation for injuries.
- Improve our living conditions.
- Give training in small business management and provide micro-credit.

In their own words…
If countries really cared about survivors they would:

- Put survivors in charge.
- Finance reintegration projects.
- Improve access to healthcare.
- Help us survive.
- Fund our projects.
- Strengthen or review the support system.
- Respect and apply the Ottawa Treaty.
- Listen.
- Support medical and psychological care.
- Ensure free education for young survivors.
- Make funds available for survivors' associations.
- Give comprehensive support.

Serbia

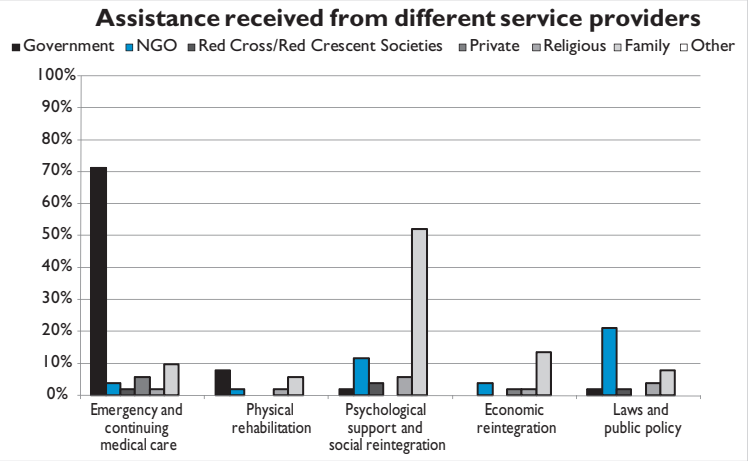
Country indicators

- *Conflict period and mine/ERW use:* During the armed conflict associated with the break-up of the Socialist Federal Republic of Yugoslavia (1991-1999) mines were used by all parties.[1] NATO used cluster munitions in 1999.[2]
- *Estimated contamination:* Contamination with unexploded cluster submunitions was estimated at 15km^2 as of November 2008; just under one 1km^2 remained mine-affected as of June 2009.[3]
- *Human development index:* 65th of 179 countries, medium human development (no ranking in 2004).[4]
- *Gross national income (Atlas method):* US$5,710 – 94th of 210 countries/areas (compared to US$3,198 in 2004).[5]
- *Unemployment rate:* 18.8% (compared to 34.5% in 2004).[6]
- *External resources for healthcare as percentage of total expenditure:* 0.8% (compared to 1.3% in 2004).[7]
- *Number of healthcare professionals:* 63 per 10,000 population.[8]
- *UNCRPD status:* Ratified the Convention and its Optional Protocol on 29 May 2009.[9]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* The 1991-1999 conflict and international economic sanctions reduced the Serbian economy by half. The US maintained sanctions until 2005. The economy has recovered somewhat since, supported by international debt cancellation and aid. Unemployment continues to be a political and economic problem exacerbated by the transition away from a state-managed socialist economy and the economic slowdown.[10]

VA country summary

Total mine/ERW casualties since 1991: Unknown – 1,110 to 3,000			
Year	Total	Killed	Injured
2004	2	0	2
2005	2	0	2
2006	0	0	0
2007	2	0	2
2008	3	1	2
Grand total	**9**	**1**	**8**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 1,110.[11]
- *VA coordinating body/focal point:* VA coordination has been delegated to the Specialized Hospital for Rehabilitation and Orthopedic Prosthetics (SHROP), but is not functioning. Disability issues are distributed among various ministries. The government Council on Disability Affairs met irregularly in between 2005 and 2009.
- *VA plan:* None; mine/ERW survivors are included in the National Strategy for the Enhancement of the Status of Persons with Disabilities 2007-2015.
- *VA profile:* Between 2005 and 2009, little VA progress was noted, and that in only a few areas. Assistance appears to have deteriorated as a result of the economic situation, the lack of resources, and corruption.[12] In 2009, survivors still found it difficult to receive the benefits they were entitled to because of complicated bureaucracy and approval procedures. The state health system provides free emergency medical care and physical rehabilitation, including replacement devices every two years. Mobility devices provided free of charge were of poor quality and more sophisticated devices are unaffordable. While it was recognized in 2005 that survivors required psychosocial support, this is not covered by state health insurance. By 2009, the few existing programs were poor in quality and largely unknown to survivors. Since 2005, the National Employment Service has been responsible for training and job placement for survivors and other persons with disabilities. However, a 2007 assessment noted that "the labor market status of people with disabilities is extremely unfavorable."[13] In May 2009, a government representative noted the need to establish income-generating projects.[14] Most survivors are former military and must survive on pensions, which have been reduced since 2005. Some efforts have been made to strengthen and better enforce the legislative framework and to raise awareness about disability. Few survivors have felt a significant impact from these changes. Since plans to collect and analyze data about



survivors and their needs have not been achieved, accurate information about the number of survivors in Serbia, their needs, or the services received was unavailable.[15]

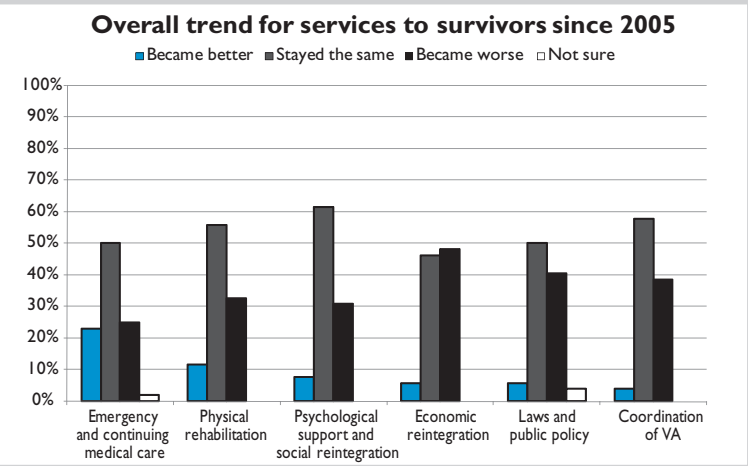
VA progress on the ground

Respondent profile

By July 2009, 52 survivors had responded to a questionnaire on VA progress in Serbia: 90% were men; 6% were women and 4% were boys. Respondents ranged from nine to 65 years old, with 88% between the ages of 34 and 61. Some 81% were heads of households and 27% owned property. Respondents came from Belgrade, Vojvodina, Kragujevac, and Niš: 71% were from the capital or another large city and 29% were from rural areas with limited or no services. Of the adult respondents, 90% had completed at least secondary education. While just 15% of the adult respondents were unemployed prior to the incident, this figure rose to 81% after the incident. Of those surveyed, 85% said their income was insufficient. Most respondents had experienced their incident prior to 2000. This profile corresponds to the casualty profile extrapolated from data gathered by the SHROP and a recent cluster munitions impact survey, which found that most survivors were displaced people from the conflict in Kosovo (1999) or were injured in earlier hostilities in Croatia or Bosnia and Herzegovina (1991-1995).[16] A significant proportion of survivors were military.

General findings[17]

While respondents were able to identify some specific areas where VA/disability services had improved since 2005, overall respondents felt services had remained the same or had even deteriorated. Almost all respondents (94%) said they did not receive more services in 2009 than in 2005 and 92% indicated services were no better than in 2005. The most troubling results were seen in the economic sphere, where almost half of all respondents felt services had gotten worse. Some 73% of respondents felt services for female survivors were equal to those available to men; 15% said they were completely absent. Of the female respondents, two thought services were equal and one said they were absent. Just 6% of people thought services for child survivors were adapted to their age level.



Some 65% of respondents had never been surveyed since 2005, but 25% had been surveyed at least three times. However, 85% reported that this did not lead to their receiving more information about services. Also, 81% said it did not reduce bureaucratic

challenges or make pensions (88%) and services (92%) easier to obtain. Only one-third felt more listened to. This corroborates Serbia's lack of progress in data collection, which has had a subsequent adverse influence on service provision (*see below*).

Emergency and continuing medical care

Some 23% of respondents saw overall improvements in healthcare since 2005, while half said it had remained at the same level. One-third noted that survivors "always" received the care they needed; 25% said such care was "mostly" received; and 6% said appropriate care was "never" or "almost never" received. Specific areas showing the most improvement were: increased physical access to services (56%), more supplies and equipment (50%), and improved capacity to carry out complicated medical procedures (50%). Less than half of all respondents found that service quality had improved, or that it was easier to access services closer to home (35%), or that staff was better trained (35%). One-third noticed increased government support.

The fact that services provided by the government are free was mentioned by 43% of respondents. While the Serbian healthcare system suffered during 1991-1999, efforts have been made since to re-establish a sufficient mechanism. Many survivors were satisfied with healthcare in 2005, which would explain why most did not feel a noticeable difference. Military survivors were especially satisfied with the quality of medical care but sometimes noted that this standard of care was not available to all survivors. No particular improvements or challenges in emergency medical care were mentioned despite reported challenges with rapid evacuation and measures instituted in 2008 to strengthen emergency medical services. This is probably because none of the survivors needed this type of assistance in 2005-2009.

Physical rehabilitation

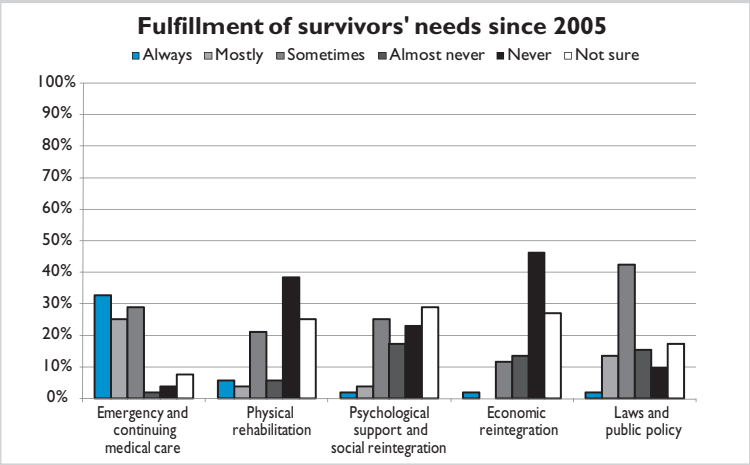
More than half of the respondents said the level of physical rehabilitation had remained the same since 2005. Only 12% saw an overall improvement, while 33% saw a decline. More than 38% of respondents said survivors "never" received the physical rehabilitation they needed and just 6% said that services were "always" received. Similarly, 81% said government support to the sector had not increased and responses to progress on specific areas were overwhelmingly negative. Just 12% said services were available closer to home or that the quality of devices had become better, and 15% said transport to and accommodation at centers had improved. Some 27% said staff was better trained, while 33% said teams now had more complete skills.

Survivors described that basic services were free, but complained that free devices were uncomfortable and that better-quality devices were beyond their means. Despite a government policy allowing replacement of mobility devices every two years, survivors raised concerns about a lack of follow-up care. The complicated bureaucratic procedure to obtain a replacement was an obstacle, exacerbated by difficulties in securing transport to go from office to office to complete the procedure. Several respondents were not aware they were entitled to replacements. One government representative, aware of the survivors' concerns, blamed this dissatisfaction on the "unrealistic expectations" of survivors. This representative stated that while services prior to the war had been "excellent," they were still adequate in 2005-2009, adding that "prosthetics are a luxury, they could use crutches." Throughout the period, the SHROP − where most survivors were treated − reported a lack of materials, long waiting lists, and staff not trained to international standards. In 2009, the government also acknowledged that the level of prosthetic/orthotic services and staff training needed to be "raised."[18] This contradicted the November 2008 report that staff received continuous education.[19] Military survivors were more satisfied, an accurate reflection of the higher quality of services available at the Military Medical Academy.

Psychological support and social reintegration

Some 31% of survivors felt that psychological support and social reintegration had worsened since 2005; 8% noted an improvement; and the remainder said it was unchanged. Only 6% of respondents thought that survivors "always" or "mostly" received the psychosocial support they needed; 40% responded "never" or "almost never"; 25% said "sometimes"; and the rest were unsure. Almost all respondents (90%) noted that psychosocial support was not a government priority. One of the only specific areas where a significant number of people saw improvement was in the increased availability of sports activities (48%). However, just 13% said there were more services; 15% noted improvements in quality; 19% said staff was better trained; and 21% said more peer support groups were available. Some 31% felt there was greater awareness about the need for this type of service, but only 33% felt more empowered or more involved in community activities. Lastly, 37% believed there was now less stigma in seeking psychological support.

Several of the respondents who said the situation had deteriorated ascribed this to a lack of political will to follow through on commitments, such as an election promise to build psychosocial support centers. As of July 2009, these had not been established. While the government acknowledged in 2004 that psychosocial support services were lacking and outlined plans to improve services,[20] they were still found to be inadequate in 2007. The services are not covered by health insurance.[21] There was only one peer support group in all of Serbia, mostly working with Serbian refugees from Bosnia and Herzegovina and Croatia.[22] Many respondents were also unaware of services or of the fact that such services might be useful for their recovery. Others paid for private-sector services or found support through their family networks.



Economic reintegration

Just 6% of respondents said economic reintegration activities had improved since 2005; 48% said they had worsened; and 46% felt they had remained the same. Only one respondent said survivors "always" received the economic reintegration they needed; 60% found this "never" or "almost never" to be the case. Nearly all people (92%) said this sector was not a government priority. Very few respondents saw positive advances in any specific area. The most positive response came from the 23% who felt that educational and professional discrimination against survivors had decreased. In all other areas, improvement rates were very low: survivors were the last to be chosen for a job (92% thought this) and employers and teachers lacked awareness (88% each thought so). Few saw more employment opportunities (12%). Only 10% said it was easier to get loans; 10% believed vocational training better met market demand; and 10% said job placement services had increased. This clearly reflects the personal situations of the respondents, 81% of whom were unemployed after the incident.

Survivor responses reflect the situation of all persons with disabilities in Serbia. In 2009, the World Bank reported that just 13% of persons with disabilities in Serbia were employed. Of the 23,000 persons with disabilities registered with the National Employment Service, only 300-400 are able to find a job annually.[23] The most common explanation, given by survivors and government alike, is related to high general unemployment and the economic crisis. Survivors also noted that their average ("old") age made them unemployable; that the government had eliminated pensions for those with paying jobs; and that it was impossible

for survivors to qualify for bank loans. Despite government reports on the integration of survivors' needs into poverty reduction, health, and disability strategies, it has never reported on progress in this field.[24]

While survivors receive disability pensions (at higher rates for military survivors), these pensions have been reduced since 2005 and, in December 2008, the government found that 70% of persons with disabilities lived in poverty, despite receiving a pension, compared to 11% of the general population.[25] In 2009, the government recognized that economic reintegration was still a challenge and called on the international community to support projects to create economic opportunities.[26]

Laws and public policy

Half of respondents said the protection of their rights had remained the same since 2005, while 40% felt they were less protected. Some 42% said their rights were only respected "sometimes"; 25% said this was "never" or "almost never" the case. Very small percentages of survivors felt that new policies and legislation had been developed (15%); that existing policies were better enforced (23%); that survivors had increased access to information (19%); or that there was greater awareness (25%). Just 12% indicated that survivors or their representatives were more involved in planning, implementation and monitoring of VA or disability issues. Some respondents said they simply did not know what their rights were; others noted increased awareness about disability but added that mine/ERW survivors "were never mentioned." Respondents felt current laws were inadequate or existed "only on paper." One person said, "Theoretically, things are better. Practically, things are worse."

Since 2005, Serbia has made some progress in enforcing existing legislation and in passing new laws, such as the Law on Professional Rehabilitation and Employment of Persons with Disabilities (2009). It also ratified the UNCRPD and its Optional Protocol at the end of May 2009. These advances occurred during/after surveying and would not have impacted results.

These results differ quite significantly from the government statement in May 2009 saying that, "Since the year 2004, the situation for landmine survivors is much better now than before."[27] When asked to respond to preliminary findings, a government representative was not sympathetic, stating that survivors were used to getting everything for nothing and that this had affected their expectations.

VA process achievements

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

At the First Review Conference of the Mine Ban Treaty in December 2004, Serbia set itself the ambitious goal "to create an integrated system… for the social reintegration of all mine victims within three years."[28] Steps towards achieving this goal included establishing a database, providing mobility devices, and creating jobs for survivors. Between 2005 and 2009, Serbia has made little progress, mainly because the casualty and service database – planned since 2004[29] and a prerequisite for much of its VA implementation – has not been established as of August 2009. In May 2009, Serbia repeated that, "a large obstacle to… assisting persons with disabilities is that the exact number of anti-personnel mine survivors still… has not been determined."[30]

One government representative said Serbia became one of the 26 countries with significant numbers of survivors and, therefore, the greatest responsibility to act, but also the greatest needs and expectations for assistance because it had expected it would receive international assistance as a result. Throughout 2005-2009, Serbia made it clear that its achievements would be dependent on international technical and monetary assistance. As early as 2004, it even detailed that €300,000 per year would be needed from international donors, albeit without a concrete plan of how this money would be used.[31] However, Serbia has not benefited much from international assistance. This lack of assistance was further exacerbated by a deepening economic crisis due to Serbia's transition away from a socialist economy with free, comprehensive services for all and government funding shortfalls curtailing these services.

In 2005, Serbia presented its largely non-SMART objectives and revised them in 2006-2007. A time-based plan was reportedly developed but had not been presented as of August 2009. The fulfillment of many objectives was linked to a better understanding of the scope of the problem through a casualty and service provision database and several needs assessments, which would form the basis for plan development and improved coordination. Adequately functioning state systems already in place ensured the *de facto* achievement of some of the objectives, particularly for medical care. The only other objectives directly relating to implementation of activities for survivors were: the initiation of vocational training and an income-generating project, on which no progress has been reported; and better implementation of disability legislation, on which progress has been reported but only minimally felt by survivors and persons with disabilities.

As of August 2009, there was no real VA/disability coordinating body. The SHROP was delegated by the Ministry of Health to become the focal point, but remained mainly focused on its own activities and did not liaise systematically with the various ministries dealing with disability (education, health, justice and labor, employment and social affairs). There were no other platforms to bring together representatives of these ministries for VA/disability planning. In May 2009, Serbia announced plans to develop a council to monitor the implementation of the Strategy for Improving the Status of Persons with Disabilities, which should indirectly advance coordination on VA issues.

Among survivors, just 4% said VA coordination had improved since 2005; 38% thought it had actually gotten worse; and 58% felt it had remained the same. Just 17% felt the government coordinated better with NGOs; 12% saw improved coordination with the disability sector; and 6% believed survivors or their families were included in coordination meetings. Survivors have not been included in VA/disability policy-making, implementation or monitoring. Only 12% of survivor respondents believed the needs of survivors had been taken into account while developing VA priorities and just 4% thought survivors had actually been included in planning exercises.

There is no VA/disability progress monitoring mechanism in Serbia. At the international level, Serbia reported regularly on VA, usually reiterating the obstacles posed by the lack of a functioning data collection mechanism and international funding. In 2007-2009, it repeated its claims of improvements in medical care and physical rehabilitation without beneficiary statistics or other progress indicators. Domestically, just 10% of survivor respondents felt regular information on VA achievements was provided by the government.

While each of these factors is important, there is also an apparent lack of political will to prioritize the needs of survivors (and persons with disabilities), include them in planning and coordination processes, set realistic goals for progress, and take national responsibility for working towards these goals. Serbia does not appear to have made use of the tools put at its disposal by the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration to develop its VA priorities to promote the importance of VA/disability nationally and internationally. This is evidenced by many survivor respondents saying they believed services had declined since they first needed care after their incidents, or saying they were among the "lucky" few.

Conclusions

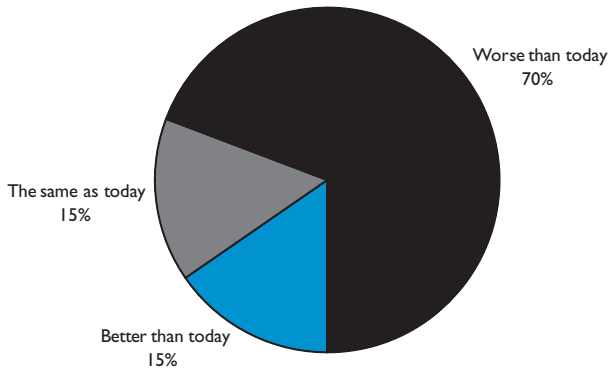
- On the key issue of economic reintegration, only deterioration has been noticed.
- Serbia still depends on its socialist healthcare system, which has been increasingly strained due to the different economic orientation Serbia is now taking.
- The quality of physical rehabilitation has not improved, nor has the bureaucratic process, and survivors noted a decline in follow-up care.
- While there was more disability awareness, this has not led to any concrete improvements in the lives of survivors.
- Mechanisms for government/civil society coordination that include survivors have not been established.

Suggestions for the way forward

Some 70% of respondents felt their situation would be even worse over the next five years because of the political and/or economic crisis, the lack of change thus far, and their own declining health. Just 15% felt the situation would be better, but half of them reasoned that "the situation is so bad now that it cannot get worse." To assist in a better future ahead the following suggestions may be taken into account:

- Develop a functioning disability coordination mechanism, ensuring survivor inclusion, and elevate its prominence to ensure greater authority to enforce implementation.
- Equalize the treatment of civilian and military persons with disabilities.
- Focus on social reintegration to extract survivors/persons with disabilities from isolation and engage them in their communities and activities destined to benefit them.
- Increase economic opportunities, especially training and employment, but also provide an incentive for taking on paid work by allowing survivors and other persons with disabilities to earn a certain income before reducing pensions or cutting them.
- Find ways to increase national VA/disability funding while absorbing the backlash of the disintegration of the socialist model and strengthen international fundraising efforts with increased transparency.

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



From left to right, Jovica Pavlovic, Radisa Milivojevic, Miodrag Novakovic and Milan Spasic, all were injured by mines/ERW in Serbia, just like Nikola Lunic.

In his own words: the life experience of Nikola Lunic

In 1992, former Yugoslav Army member Nikola Lunic stepped on a landmine in Drnis (Croatia), injuring both of his legs. Lunic was evacuated to Serbia where, as a member of the military, he received prompt medical care and physical rehabilitation. Afterwards, he stayed in Serbia as a refugee of war, leaving behind friends, family and property in Croatia. While Lunic received a disability pension, he still needed to find a job to support his family.

As a trained mechanic, Nikola was unable to find work in this area because of high general unemployment. However, as a self-declared optimist, he finally managed to find a job at the Institute of Rehabilitation in Belgrade. At first, people around him thought he was crazy because his starting salary was lower than his pension. Even today his income is not enough, but he has continued working to support his family.

This job gives Nikola a great deal of insight into the government support available for physical rehabilitation. He noted that while a lot exists in theory, "Rights are obtained only if you are persistent enough to go through the bureaucracy." Lunic says that if his country really cared about survivors, it would include survivors and other persons with disabilities when defining their needs, and would solve their problems through strong, enforced laws.

In their own words…

If countries really cared about survivors they would:

- Provide assistance regulated by law.
- Improve the law.
- Improve quality of life and employment.
- Organize seminars with full participation about psychological support; provide information about laws and other issues concerning survivors; and publish a bulletin.
- Provide more realistic disability allowances and employment.
- Resolve the housing problem.
- Ensure survivors' rights.
- Apply the existing laws and regulations and raise awareness of disability issues through the media.
- Show more social equity.
- Consult victims more often.
- Enable survivors to solve problems and not have politicians be in charge of the issue.
- Change attitudes towards survivors and disabled persons and show more respect.

In their own words…

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

- Full protection under the law.
- Providing places to gather and socialize, as most survivors have too much free time.
- Address housing problems, the education of children, and psychosocial support.
- Educate the government about our needs.
- Education of survivors and of providers of services.
- Physical and psychological rehabilitation.
- Better healthcare in specialized centers.
- Provide better economic status to all, as well as better healthcare.
- More accessible psycho-physical rehabilitation.
- Solving victims' financial problems.
- Employment and housing.
- Favorable loans in order to solve the housing problem.
- Better prosthetics.

In their own words…

Survivors described themselves as: persistent, communicative, strong, stable, honest, responsible, forgotten, quiet, unsuitable, optimistic, society's waste, humanist, unpredictable.

Sudan

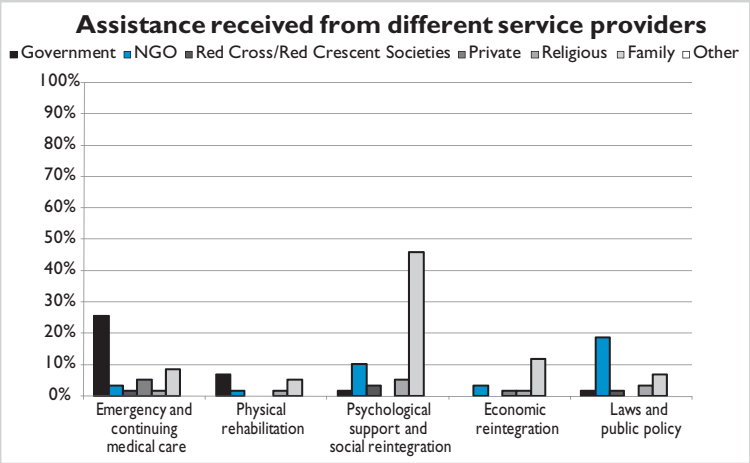
Country indicators

- *Conflict period and mine/ERW use:* Sudan is contaminated with mines, cluster submunitions and other ERW as a result of 20 years of internal conflict (1985-2005) all of Sudan's borders are also mined, with some dating back to World War II.[1]
- *Estimated contamination:* As of 2009, the precise scale of contamination in Sudan remains unknown, although 19 of the 25 states are said to be affected. The ongoing Landmine Impact Survey has identified 190 affected communities in 18 states.[2]
- *Human development index:* 147th of 179 countries – low human development (compared to 139th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$1,130 – 159th of 210 countries/areas (compared to US$706 in 2004).[4]
- *Unemployment rate:* 18.7% (2002 rate).[5]
- *External resources for healthcare as percentage of total expenditure:* 6.4% (compared to 5.1% in 2004).[6]
- *Number of healthcare professionals:* 12 per 10,000 population.[7]
- *UNCRPD status:* Ratified the Convention and its Optional Protocol on 24 April 2009.[8]
- *Budget spent on disability:* Unknown, but the VA budget for 2009-2011 is estimated at US$4.3 million.[9]
- *Measures of poverty and development:* Despite being rich in natural resources and having enormous agricultural potential, Sudan is one of the poorest countries in the world, due to decades of conflict as well as economic sanctions. Until the economic recession in 2008, Sudan's economy was growing fast and foreign investment increasing. However, investment and prosperity are concentrated around the country's capital Khartoum. It is estimated that some 60% of the population in northern Sudan and 90% in the south live on less than US$1 per day. Infrastructure is either non-existent or very weak in all parts of the country.[10]

VA country summary

Total mine/ERW casualties since 1964: At least 4,211			
Year	Total	Killed	Injured
2004	101	34	67
2005	121	31	90
2006	140	38	102
2007	91	28	63
2008	65	19	46
Grand total	**518**	**150**	**368**

- *Estimated number of mine/ERW survivors:* Unknown, at least 2,809.
- *VA coordinating body/focal point:* The National Mine Action Center is the VA focal point in northern Sudan and the Ministry of Gender, Social Welfare and Religious Affairs is the focal point in southern Sudan; coordination is effective but, particularly in the south, national capacity is still being built.
- *VA plan:* The National Victim Assistance Strategic Framework 2007-2011 set strategic objectives; the subsequent Victim Assistance National Work Plan September 2007-August 2009 was the practical tool for the first implementation period.
- *VA profile:* Sudan's infrastructure is devastated by years of conflict and often lacked even the most basic services, particularly in southern Sudan. Political divisions and continued conflict hamper equal service delivery in all parts of the country and have, until 2006, made a unified VA response impossible. With strong international impetus, national VA coordination and planning have improved significantly since 2007, and relatively stable international funding has led to increased project implementation (to 2011). While Sudan is heavily dependent on external support for many of its basic needs, the ongoing conflict in Darfur diverts many international resources from other parts of the country. Service provision is centralized and often limited to the main cities, with all types of service provision more devastated in southern Sudan. The lack of services leads to a lot of preventable deaths and disabilities. Healthcare coverage and quality is variable and in most rural areas basic to non-existent. Many health centers are in bad physical condition, lack supplies and equipment, and are both under-staffed and lacking qualified personnel. Physical rehabilitation is functioning well in the two main cities in northern and southern Sudan, but less so in the government satellite centers or in NGO centers. Although treatment is free of charge, distances and waiting periods are long, and transport and accommodation costs prohibitive. Since 2007, more focus has been placed on psychosocial support and economic reintegration of mine survivors through international



funding but overall services of both types were severely lacking and there was no national support mechanism or policy in place for either. Services were mainly carried out by NGOs. Local, community-based organizations became more active and gained capacity. Owing to the availability of increased funding, several new organizations became involved. However, local NGO activities usually remained small-scale and very dependent on international funding. Broader programs were often not accessible for survivors or other persons with disabilities or did not meet their needs. New disability legislation and policies have been developed and approved in late 2008, making it too early to measure their impact. Previous measures were not adequately implemented or monitored; general awareness about disability was also lacking, resulting in discrimination against persons with disabilities. The lack of accurate information about mine/ERW casualties and the needs of survivors were considered to be an obstacle throughout 2005-2009.[11]

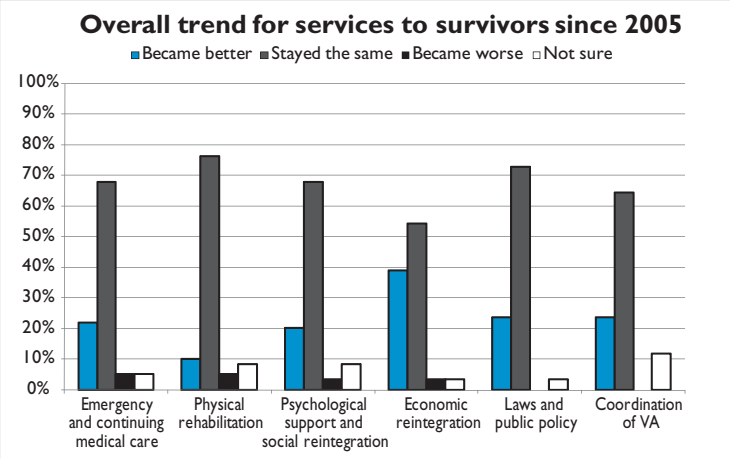
VA progress on the ground

Respondent profile[12]

By July 2009, 59 survivors between 25 and 67 years old responded to a questionnaire on progress in VA since 2005 in Sudan: 56 men and three women. Some 86% were heads of their household and 46% owned property. More than half (53%) lived in villages with limited services; 19% lived in the capital, Khartoum; and 17% lived in remote areas without services. Respondents came from all over the country, but slightly more came from the northern parts. One-fifth of respondents had received secondary school education or higher and the same number had not received any form of formal education. No one was unemployed prior to the incident, but many were injured while they were members of the armed forces (government or opposition), just three people were unemployed after their incident, but most had been able to establish a small business. This is most likely because those interviewed were beneficiaries of the organizations participating in the survey. Almost all respondents had changed jobs after the incident, and they said this was because of their disability or because they were discharged from the army. Some 61% of survivors said that their income was insufficient. The profile of respondents corresponds with some of the limited information available about casualties in Sudan. The vast majority of casualties are men, who were injured either while traveling or engaging in military activity. As among questionnaire respondents, most casualties had to change employment due to their incident, but on average the loss of livelihoods is around 42%, which is much higher than among the sample of respondents.[13]

General findings

Overall, the majority of survivors thought that their situation had changed little in the last five years. Least progress was seen in physical rehabilitation, whereas the impact of more recent projects focusing on economic reintegration resulted in a more positive response. Nevertheless, a large percentage of survivors said that the needed assistance was never received, reflecting the fact that much of the population of Sudan as a whole does not have access to even the most basic services. Practitioners were much more positive, but this is related to the fact that they contributed to projects directly targeting survivors. Some of these projects were small-scale and would have only reached a small group of survivors, others were too recent, while for some of the more quality- and training-oriented projects, it would have taken longer for effects to become noticeable to survivors. Just 17% of



survivors thought that they received more services in 2009 than in 2005 and 19% thought that the services were better. Few people (15%) also thought there were fewer gaps in services.

Just over 42% of respondents had never been surveyed by NGOs or the government in the past five years and 10% had been surveyed three or more times. For 14% of respondents, this survey activity resulted in receiving more information about services; 8% felt they had also received more services; and 7% said they had fewer bureaucratic difficulties as a result. Just 12% said they had had a chance to explain their needs to government representatives in the last five years. These responses confirm the fact that data collection in Sudan is limited and incomplete, due to the vastness of the country, the lack of capacity and resources, as well as conflict. A comprehensive needs assessment or comprehensive data collection has not been achieved, despite being identified as key to effective service provision throughout 2005-2009 and prior to that. However, a Landmine Impact Survey has been ongoing since 2007 and several small-scale VA/disability needs assessments were conducted in 2007 as well.

Most of the male respondents were not able to respond to the question on whether services for women were equal, better, or worse than those available for men. Of those who did answer (10 men), 60% thought that services for women were "better" and 30% thought they were "absent". None of the women thought that females had better access to services.[14] Nearly half of respondents (47%) said that services for children were "never" adapted to their age.

Emergency and continuing medical care

Most survivors (68%) thought that, overall, medical care had remained the same since 2005 and 22% thought it had become better. Almost all of those seeing improvement lived in Khartoum or another large city. The largest group of respondents (37%) said that survivors "never" received the healthcare they needed and just 7% said that survivors "mostly" received the needed services. One-fifth of respondents found that the government had increased its support for healthcare. Few respondents saw progress in any specific area. Most advances were felt in improved quality of medical care (27%), improved infrastructure (25%) and better trained staff (also 25%). Areas of least progress were: the availability of first aid and of medical teams with more complete skills (14% each) and the ability to carry out complex medical procedures (12%). Just 7% thought that there was more emergency transport. The majority of practitioners (57%) thought that healthcare had improved since 2005. They identified the same areas of most progress: better infrastructure and more qualified staff. These were also the two areas where practitioners felt the government had increased its efforts the most.

Sudan's health infrastructure was severely damaged by years of conflict. Throughout 2005-2009, it has been reported that healthcare in Sudan is limited and unequally distributed – particularly in southern Sudan, mainly for political reasons. Within the framework of large international projects more rural health facilities have been built, efforts have been made to train more staff and information about emergency care has been distributed to community health workers.[15] However, the sector still depends heavily on NGOs implementing services and international support to fund government centers. The war-injured from Sudan could also receive medical assistance at the ICRC hospital in Kenya, until the ICRC ceased this support in mid-2006, but this does not appear to have influenced responses.

Since 2005, basic medical care is free of charge for registered survivors under the national health insurance scheme, even though other people need to pay contributions to benefit from insurance. But most centers were ill-equipped and under-staffed and there were very few surgeons or specialized medical staff. Follow-up care is only available in a few large cities and coordination between health centers was lacking. Emergency transport was not available in many parts of the country and distances to health centers were long.[16]

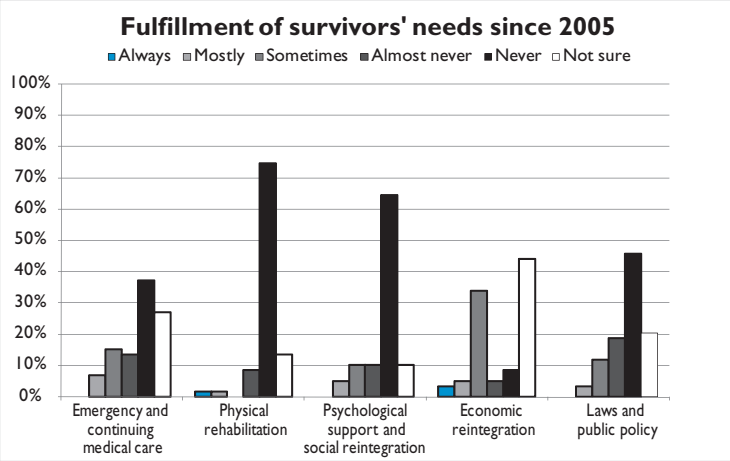
Physical rehabilitation

More than three-quarters of survivors (76%) thought that, overall, rehabilitation services had remained the same since 2005 and 10% saw improvement. However, 75% of respondents also thought that survivors "never" received the assistance they needed. Responses were no more positive in major cities. Some 12% of survivors thought that the government provided more support to the physical rehabilitation sector. Responses were overwhelmingly negative, as fewer than 20% of respondents found advances on any of the progress indicators. Areas of most progress were better trained staff and better quality of physical therapy (19% saw improvement). Areas of least progress were: the availability of mobile workshops to carry out small repairs (2%), the inclusion of transport and accommodation in services (5%) and the availability of services closer to home (7%). Practitioners, again, were much more positive, with 71% seeing improvement, particularly in the increased number of centers and better trained staff. Practitioners thought that least progress was made on the inclusion of services and transport to services.

Government bodies were the main service providers but they needed extensive assistance from international organizations (mainly the ICRC). Although many VA/disability activities in Sudan traditionally focused on physical rehabilitation, the responses of the survivors clearly reflect the challenge of the centralization of services in Khartoum (north) and Juba (south). Some satellite centers also existed in state capitals. Throughout 2005-2009, it was reported regularly that these were functioning below capacity due to staff and material shortages and a lack of technical support. The ICRC resumed its support to three satellite centers in 2008. Mobile workshops were virtually non-existent. Even though their deployment had been announced by the National Authority for Prosthetics and Orthotics since 2005, mobile workshops were only established in 2008.[17] Services provided by NGOs were smaller scale and of variable quality. While physical rehabilitation was made free of charge in 2003, accommodation and transportation was not (apart from in Juba and Nyala) and, considering the long distances, this was a major obstacle for survivors. Waiting periods remained long throughout 2005-2009 (up to four months). However, with significant international support, substantial progress was made in training staff in prosthetic-orthotic techniques starting in 2005 and in physiotherapy, which might be the reason for the slightly more positive survivor response on quality issues. Although the first students only graduated in 2008, this and the inauguration of the new rehabilitation center in Juba in December of the same year definitely influenced the more positive results of practitioners.[18] The center in Juba was to replace referral of southern Sudanese survivors to Kenya which ended in mid-2006.

Psychological support and social reintegration

More than two-thirds of survivors (68%) believed that psychological support and social reintegration services had, overall, remained the same since 2005. According to 64%, survivors "never" received the psychosocial support they needed and just 5% thought that survivors "mostly" received the psychosocial assistance needed. The areas with most positive responses were an increased awareness about the importance of psychosocial services and less stigma around seeking counseling (24% agreed with each point). However, this did not result in respondents feeling more empowered (20% thought they were) or more involved in community activities (19% was). Just 10% believed that survivors were seen as "charity cases" less often in 2009 than in 2005 and 5% thought that peer support groups had been created. Again, the majority of practitioners saw improvement in psychosocial support.



Indeed, providing psychosocial support was a component integrated in VA activities implemented under a Human Security Trust Fund (HSTF) grant in 2007-2008 – although the main focus of the projects was economic reintegration. While covering all parts of Sudan, the projects remained small-scale and limited to "pilot projects" dependent on external funding for further project implementation. Three survivor groups were also established in northern Sudan in 2007-2008[19] and, in southern Sudan, some networks of former combatants existed. But none of these were well-structured or active. Despite these efforts, it was reported throughout 2005-2009 that psychosocial support was insufficient. Some NGOs provided psychological assistance to the war traumatized in general, but often survivors did not access these. Government health staff was not well-trained or well-aware of psychosocial support or discrimination issues.[20] In 2009, Sudan acknowledged that more technical and financial support was needed to strengthen psychosocial support.[21]

Economic reintegration

Some 39% of survivors found that, overall, economic reintegration opportunities had improved since 2005 and 54% felt the situation had remained unchanged. Just 8% of respondents thought that survivors "never" received the economic reintegration they needed, which is significantly less than for other types of services; 34% said services were "sometimes" received. However, few survivors saw improvement on any of the specific progress indicators. Most progress was seen on increased access to vocational training (20%). Some 19% saw improvement in: decreased discrimination in educational and employment opportunities and increased availability of economic opportunities (micro-credits, small loans, etc.) specifically targeting survivors. Least progress was seen in job placement (10%), enforcement of employment quota (8%), and access to bank loans (5%). Of those answering the question (49), 96% thought that unemployment was so high that survivors were the last to be chosen for a job. Again, more than half of practitioners (57%) saw improvement in economic reintegration, particularly in the increased availability of vocational training and economic opportunities specifically for survivors. Like the survivor respondents, they saw least improvement in the enforcement of employment quota and job placement.

The more positive response of the survivors is likely because they have been beneficiaries of vocational training and income-generating projects implemented by the organizations assisting in gathering responses for this report. Progress has also been made through the HSTF grant in 2007-2008 and another significant grant for 2008-2011 under which several local organizations conduct economic reintegration projects. These projects aimed to reach some 3,000 survivors by 2011. As of 2008, some 650 people had been reached.[22] However, all of these projects were completely dependent on international funding. Additionally, more systematic economic reintegration projects for persons with disabilities were severely lacking and often persons with disabilities were discriminated against in broader economic reintegration activities. Vocational training centers for the general public were located only in large cities, and several organizations providing vocational training for survivors or persons with disabilities lacked capacity. Job placement and employment services were inefficient and employment quotas were not enforced. A lack of awareness among employers, a lack of knowledge about services among survivors, and high general unemployment were further obstacles.[23]

Laws and public policy

Almost three-quarters of survivors (73%) believed that the protection of their rights had remained the same since 2005 and 24% saw improvement. Nearly half (46%) thought that the rights of survivors were "never" respected and another 19% said this was "almost never" the case. Most progress – albeit only 22% – was seen in the less frequent use of negative terms about persons with disabilities. Some 20% also thought that discrimination had decreased and 19% said that there was more awareness about the rights of persons with disabilities. Just 12% thought that laws and policies relevant to survivors were better enforced in 2009 than in 2005. All practitioners said that laws and public policies for survivors and persons with disabilities had improved in the last five years.

Both survivors and practitioners show a different side to the same situation. Indeed, Sudan ratified the UNCRPD and has stated repeatedly that it will base further disability legislation on this convention.[24] New legislation, which identifies mine/ERW survivors as a specific target group, was approved by the Council of Ministers in the second half of 2008 in northern Sudan.[25] This legislation also took into account the work that had already been done under the VA framework. In the south, disability policies had also been developed but not approved as of end July 2009.[26] These developments clearly influenced the responses of practitioners. However, these positive developments would have been too recent to have an impact on the lives of survivors. Throughout 2005-2009, it has been reported consistently that previous legislation had not been implemented or monitored effectively and that there was a general lack of rights' awareness.

When asked to respond to preliminary results, one government representative agreed "100%" that there were still many gaps and that more support was needed. One UN representative also confirmed that much remained to be done because of the chronic poverty and a general lack of opportunities and development in Sudan. However, this person added that in certain rural areas and states, positive changes have been made for physical rehabilitation and social reintegration. More importantly, the number of actors and VA/disability activities on the ground had increased and had provided concrete support to a significant number of persons (several hundred).

VA process achievements

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

Note: Sudan was one of the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration in 2006-2007.

In 2004, Sudan stated that its aim was to develop a sustainable national capacity to provide VA. Its priorities were gathering adequate data on survivors' needs, providing psychosocial support capacity at an early stage, decentralizing trauma care and physical rehabilitation, and cost-effective economic reintegration linked to peace-building and poverty reduction initiatives.[27] One of the key factors to achieving these goals was improved coordination.

Between 2005 and 2009, Sudan has, with continuous UN support, made progress in establishing coordination mechanisms in a very complex political context. But Sudan's dire development situation and ongoing conflict have limited progress in actual service provision. Targeted VA projects have benefited a number of survivors and these projects have also engaged more local actors. Even though VA activities have in theory been integrated into the work of relevant ministries, more long-term sustainable changes to, for example, the healthcare and economic support networks, were beyond the scope of the VA program. Nevertheless, it was scheduled that VA/disability issues would be under complete national management by 2011.

As one of the 26 countries declaring responsibility for the greatest numbers of survivors but also with the greatest needs and expectations for assistance, Sudan expected to receive technical support to build national government and NGO capacity. One government representative added that this technical support had been received but that, in addition, Sudan also benefited from increased international funding and more focused attention from the UN mine action program. This, in turn resulted in more awareness in the government and realistic national VA planning. One UN representative added that there was more awareness in and outside of the country and that Sudan had received more funding as a result of the VA process between 2005 and 2009.

This international funding dedicated to VA has stimulated the implementation of projects since 2007 and the acquirement of multi-year funding to 2011 should assure the implementation of core planned activities.

A national VA officer had been recruited at the UN Mine Action Office (UNMAO) in 2003 to develop a plan of action.[28] Throughout 2003-2009, this person liaised closely with government and NGO stakeholders, identified projects, supported fundraising, and mostly raised awareness of VA/disabilities. However, progress in strategy development, the creation of more systematic coordination platforms and the integration of VA in the work of the relevant authorities only gained momentum in early 2007.[29] This was in part due to the improved political situation since the signing of the Comprehensive Peace Agreement (2005) but more so due to the recruitment of an external specialist since early 2007 to provide the necessary technical support.

As part of its commitment to the implementation of the 2005-2009 Nairobi Action Plan, Sudan developed some general objectives in 2005. Through a process of stakeholder meetings, which included some survivors, these objectives were revised considerably in 2007 and the Victim Assistance Strategic Framework 2007-2011 was developed for strategic guidance. For practical implementation, the Victim Assistance Work Plan September 2007-August 2009 followed. Components dealing specifically with survivor inclusion, advocacy and fundraising were added.[30] A work plan for the next period is under development, as is a review of the 2007-2009 period.

In 2007, Sudan stated that "All objectives and targets have been designed to be achievable, measurable, time-bound and to be incorporated into the work and financial plans of the relevant ministries and commissions."[31] The most significant progress made since the kick-start of VA activities was the establishment of focal points in both the north (National Mine Action Center) and the south (Ministry of Gender, Social Welfare and Religious Affairs), as well as regular coordination platforms. Until early 2007, this coordination was lacking and irregular, while VA efforts were mostly focused on northern Sudan.

Throughout 2007-2008, the first priority was to build national capacity, which as of August 2009 was increasingly successful in northern Sudan, where both authorities and NGOs have been involved for much longer in the issue. In southern Sudan, constant UNMAO support remained needed as of August 2009. Due to more regular coordination and assessment the number of implementing actors also increased, particularly on the NGO side. Despite, in theory, being integrated in ministries' budgets and work plans, coordination with other relevant ministries was still limited and financial commitments of the government to VA were still an issue. Survivor responses indicated the same challenge as just 12% of survivors thought that the government had allocated more funds to VA/disability.

Even though survivors were included in the strategic planning workshops, they are generally not organized in associations, making effective lobbying for their rights and needs, as well as their systematic inclusion into planning, implementation and monitoring, challenging. This was evidenced by survivor responses to coordination questions. Some 15% knew who was in charge of VA/disability coordination and also 15% thought that the needs of

survivors had been taken into account when setting VA priorities. Just 3% thought that survivors were included in VA coordination; 8% thought they were involved in planning; and 20% thought that they were involved in implementation of VA/disability activities.

Overall, progress is being made on implementation of the project thanks to the international funding. While effectively targeting survivors, this approach might be less sustainable in the long term, as it is project-oriented, usually limited to "pilot projects" at first, and implementing organizations selected under one grant might not be under the next. A UN representative also noted that partners did not use the 2007-2009 work plan "as much as planned." The plan was mostly used for resource mobilization purposes.

Additionally, several of the objectives in the VA strategy and work plan had been identified as key issues prior to 2004 and have been elaborated from earlier plans, and some remained unfulfilled as of August 2009 (for example, nationwide data collection). Additionally, some of the progress made under the plans still needed time for survivors to feel its impact. This and the poor general development context in Sudan probably led 83% of survivors to say that the government lacked the political will to make VA/disability progress. However, one representative added, "No matter the support provided there will always be a margin of (justified) discontent."

Conclusions

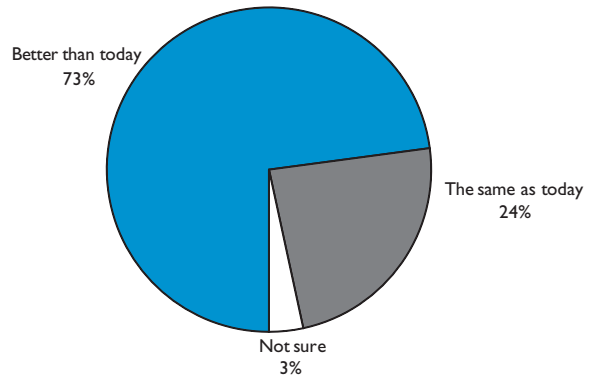
- Service provision remained limited and often out of reach of survivors, particularly in areas broader than can be addressed by the VA/disability sector, such as healthcare and economic opportunities in general.
- Psychosocial support and peer support groups were absent, and the few survivor group initiatives did not have capacity nor did they appear to link to disabled people's organizations (DPO).
- The experience of having benefited directly from economic reintegration opportunities likely influenced survivors' responses but they were also aware of the much less favorable general employment and economic conditions.
- Although physical rehabilitation received the most significant international support for years, survivors perceived it as inadequate.
- International funding and better coordination had a direct positive result on activity implementation, even though projects remained relatively small-scale.
- While several "pilot projects" directly targeting survivors were successful, systematic links with the disability, health and development sector remained insufficient to guarantee long-term sustainability.
- Due to increased attention and coordination, an achievable work plan was developed, under implementation and regular assessment.
- Implementation of the work plan progressed but many actions were taken too recently for survivors to see an immediate effect.

Suggestions for the way forward

When asked about how they saw their situation in five years, 73% of survivors thought it would get better and 24% thought it would remain the same (the remainder did not respond). To assist in building a better future, the following suggestions may be taken into account:

- Continue the regular coordination platforms and also increase coordination between the two platforms.
- Use the review of the achievements of the first work plan to make adjustments as appropriate to the second work plan (2009-2011) and the strategic framework.
- Find mechanisms to establish nationwide data collection for the use of casualty information and data from several needs assessments in planning.
- Despite increased government involvement, improve inter-ministerial coordination and involvement, to raise their financial contributions and the inclusion of survivors in broader economic, social and health policies.
- Use the VA process experience to strengthen activities and increase attention to the disability sector as a whole.
- Establish survivor organizations, link them to active DPOs, and provide capacity building so that survivors and their representatives can take more systematic and substantial part in planning, implementation and coordination.
- Ensure that the community-based NGOs can make their work more sustainable in the long term by increasing national support and by providing project proposal writing and fundraising training as needed.
- Investigate the option of organizing the community-based NGOs into a more formal community-based rehabilitation network that can also provide more systematic psychosocial support.
- Find ways to decentralize physical rehabilitation activities, and to include some basic activities in a more complete package of community-based actions.
- Strengthen first aid and emergency response mechanisms, by establishing more formal links with medical NGOs and organizations to ensure inclusion of mine/ERW survivors and to reduce preventable disability until the national network has more capacity.

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



Salih (middle) at the vocational training center
© Friends of Peace and Development Organization

In their own words…

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

- The priorities should cover all the different sectors (from emergency medical care to public and political participation). That is because you are dealing with communities, not individuals.
- Financial support and social reintegration (several).
- Social care and monthly allowances.
- Supply prosthetics.
- Subsidised housing (several).
- Job creation schemes, such as micro loans.
- Provide employment (several).
- Support the education of survivors' children (several).
- Survivors are productive so help them find jobs.
- More rehabilitation and reintegration services.

In their own words…

If countries really cared about survivors they would:

- Ratify the UNCRPD treaty and implement its obligations.
- Take care of the affairs of survivors and their families.
- Assign a government official to take care of survivors' problems and to resolve them.
- Help reintegrate survivors and ensure that ministries would appoint officials to take care of survivors, and create jobs.
- Financial support and employment opportunities (several).
- Provide survivors with their basic needs (numerous).
- Open up more centers to supply prosthetics at affordable prices.
- Provide healthcare.
- Subsidised housing.
- Provide survivors and their families with moral and material support.

In their own words…

Respondents described themselves as: integrated, powerless, aspire to a better future, patient, accepting of my situation, disabled person...

In his own words: the life experience of Salih

Salih (35) from Laffa in Kassala State (eastern Sudan) had his incident when his truck drove over an antivehicle mine near the border with Eritrea in 1999. Salih did not know the road had been mined nor were there any warning signs. He was in a coma for 25 days and when he woke up, he noticed that his lower left leg had been amputated, his right one had been broken.

Salih still does not remember very well what happened that day and he is also not able to venture into noisy or crowded places. His wife left him because he was not able to work anymore. However, then he came into contact with a local NGO (Friends of Peace and Development Organization) who selected him for one of their socio-economic empowerment projects. Salih took an intensive course to become a mechanic at the Kassala Vocational Training Center. This enabled him to find a job again. "I am employed as a normal, equal human being and earning a salary, which makes me feel productive and independent again," he says.

Tajikistan

Country indicators

- *Conflict period and mine/ERW use:* Contamination results from the 1992-1997 civil war: from Soviet and Uzbek mine-laying along the borders, and Soviet cluster munition use.[1]
- *Estimated contamination:* Contamination is estimated at 50km^2; the affected population is unknown.[2]
- *Human development index:* 124th of 179 countries, medium human development (compared to 116th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$600 – 182nd of 210 countries/areas (compared to US$415 in 2004).[4]
- *Unemployment rate:* 2.6%, unofficial rates are much higher and up to 40% (compared to 2.0% official rate in 2004).[5]
- *External resources for healthcare as a percentage of total expenditure:* 6.4% (compared to 9.7% in 2004).[6]
- *Number of healthcare professionals:* 70 per 10,000 population.[7]
- *UNCRPD status:* Non-signatory as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Tajikistan is one of the poorest countries of the former Soviet Union. It lacks sufficient public service delivery and the population suffers from persistently low incomes and economic hardship worsened by regular energy shortages. The poverty rate was high with about half of the population living below the poverty line (US$41 per month), and 17% living in extreme poverty.[9] Life expectancy in 2008 was 65 years, ranking Tajikistan 166th in the world.[10]

VA country summary

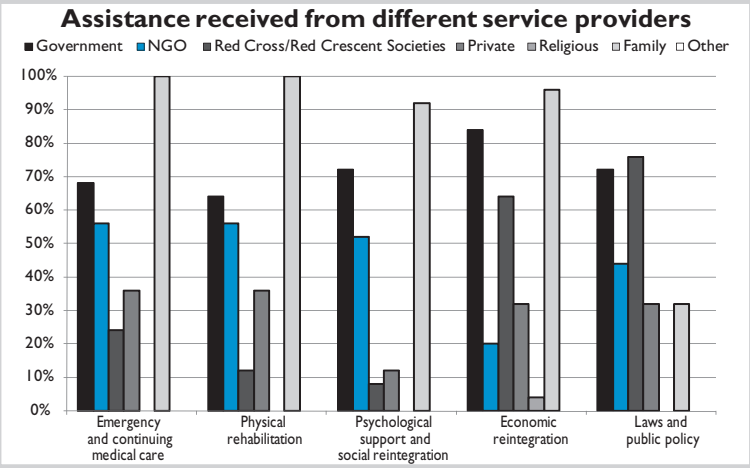
Total mine/ERW casualties since 1992: At least 802			
Year	Total	Killed	Injured
2004	19	7	12
2005	20	6	14
2006	21	6	15
2007	20	9	11
2008	13	9	4
Grand total	**93**	**37**	**56**

- *Estimated number of mine/ERW survivors:* At least 448.[11]
- *VA coordinating body/focal point:* Tajikistan Mine Action Centre (TMAC) VA officer, who is a medical doctor and psychologist.
- *VA plan:* The 2005-2009 VA objectives and plan were developed as part of the commitment to the Nairobi Action Plan and adopted by the government (Commission on Implementation of International Humanitarian Law) in July 2006.
- *VA profile:* In 2004, there were no dedicated programs assisting mine/ERW survivors,[12] but this changed with the inclusion of VA in the mine action strategy and the recruitment of the VA officer in 2005. Many services in Tajikistan are state-run and free. Some improvements have been noted since 2004 when medication and supply shortages were chronic and most facilities were said to be run-down. However, particularly in mine/ERW affected areas, infrastructure remained poor and response capacity low due to under-funding. Tajikistan's VA/disability sector did not receive a lot of international support. In mine/ERW-affected areas, the mountainous terrain severely hampered access to services. According to a TMAC needs assessment in 2008, the large majority of survivors were in need of long-term medical care, physical rehabilitation, psychological support and economic reintegration. Between 2005 and 2009, the government gradually took on more responsibility for the National Orthopedic Center (NOC) resulting in sole government responsibility by January 2009. Psychological support was neglected and only available through a disability association. Economic reintegration projects, while carried out based on identified needs and by national operators remained small-scale and were either not funded or were under-funded for most of 2005-2009. Disability legislation has been in existence since 1998 but remained implemented inadequately due to funding constraints. In 2009, new legislation in line with the UNCRPD was under development. Casualty and service provision data collection remains incomplete but has expanded every year since 2006.[13]

VA progress on the ground

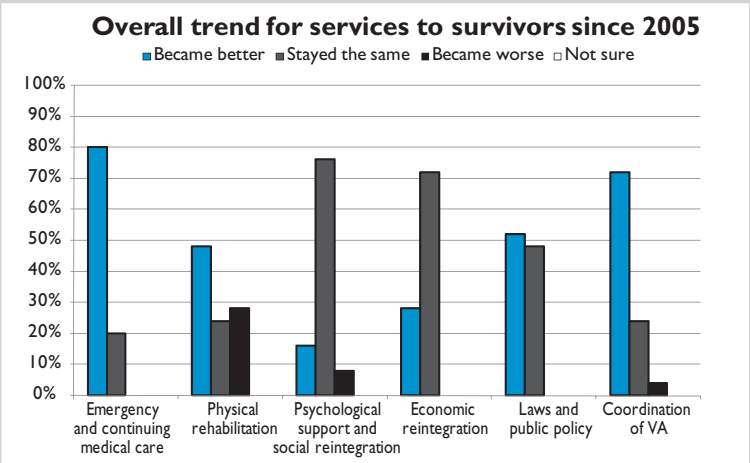
Respondent profile

For Tajikistan, 25 responses were received by July 2009; all of the respondents were men between 20 and 53 years old, 13 of whom headed a household. Thirteen had completed at least secondary education, including three people through specialized education, and eight more continued onto higher education. Fifteen owned property, but 17 were unemployed at the time of the survey, including five who had been employed before the incident. Income was insufficient for 18 of the respondents. Most survivors (17) lived in villages with some services, six lived in remote areas without services, and just two lived in the capital or a large city with a range of services. Most respondents (60%) suffered their incident prior to 1999.



General findings

Overall, survivors reported that over the past five years, progress had been made in VA; 80% said they now receive more services and 56% also found the services improved. This indicates that Tajikistan's implementation of the Nairobi Action Plan has had positive results, despite the obvious challenges remaining. Some 68% of respondents felt services for female survivors were equal to those available to men; 25% thought they were "a bit worse."[14] Most were not sure whether services for child survivors were adapted to their age level (44%), but 36% said such services "never" or "almost never" were.



Almost all respondents (92%) had been surveyed at least three or four times since 2005, leading to survivors saying they felt listened to and, more importantly, had received more services. They also noted that they had been provided with more information about services and found it easier to obtain a pension. Practitioner responses also indicated that data collection had improved. This corroborates Tajikistan's reported efforts on conducting needs assessments, expanding data collection and expanding needs-based programming for economic reintegration (albeit on a small scale).[15]

Emergency and continuing medical care

Some 80% of survivors found that, overall, healthcare services had improved over the past five years (80%). However, many (68%) also believed survivors only "sometimes" receive the care they need. The greatest improvements − 80% or more − were seen in increased first-aid capacity, emergency transport, and government support. Also, more than 80% reported physical access to health centers was better and referrals were improved (80%), as was the capacity to carry out complex medical procedures (80%). On the downside, the vast majority of respondents (96%) did not feel they could get the assistance they need closer to home. Additionally, just 12% or fewer responded that progress had been

made in improving the availability of medication, supplies and equipment. Responses from practitioners indicated that healthcare had improved and government efforts had increased despite these gaps.

This would appear to corroborate the Ministry of Health's efforts, in cooperation with TMAC, on improving emergency response. It also confirms TMAC's assessment that continuing medical care is lacking, particularly in mountainous affected areas where facilities are difficult to reach and in bad shape. However, six mobile hospitals were deployed in late 2008, which might not have been noticed by survivors yet.[16]

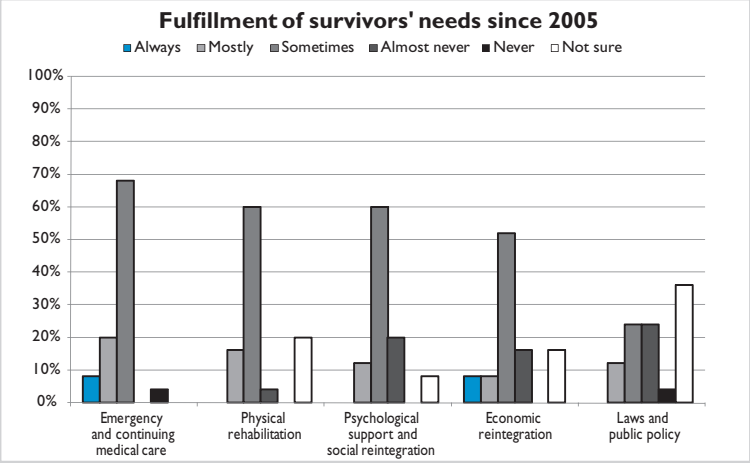
Physical rehabilitation

Less than half (48%) of survivors noted an overall improvement in physical rehabilitation services since 2005. Worryingly, 28% observed that services had become worse. Some 60% noted that survivors "sometimes" received the assistance needed. When looking at specific areas of improvement, 92% noted quality improvements, closely followed by more affordable physical rehabilitation (80%), as well as better transport, accommodation and food provisions (88%). Three-quarters of respondents also found staff was better trained, rehabilitation teams were more complete, and more types of devices were available. Fewer people (52%) found waiting periods had become shorter or that it had become easier to obtain replacement devices (56%). The least progress was reported in bringing services closer to respondents (33%).

These results are consistent with the improvements people receiving treatment at NOC in the capital would have felt versus the lack thereof for those assisted at NOC's satellite centers, which are in poor condition. The increased satisfaction with quality is consistent with ongoing government and ICRC efforts to improve devices and training.[17] All people treated at NOC would have received free transportation, accommodation and three hot meals a day, explaining overall satisfaction in this area,[18] despite continued centralization of services. Perceptions about the treatment period may have been distorted by the creation of a waiting list at the NOC in 2008, due to reduced staff capacity.[19] Prior to this, there had not been any waiting lists since at least 2006.[20] This capacity issue, particularly increasing the number of trained professionals, was identified by practitioners as the area of least improvement. This is likely related to the changing situation, during which the government gradually assumed complete responsibility for the sector (albeit it with continued support from the ICRC). Overall, practitioners asserted government efforts were either increased or had been maintained at the very least.

Psychological support and social reintegration

As acknowledged repeatedly by Tajikistan, survivor opinions confirmed the lack of any significant progress in psychological support and social reintegration for survivors. While 76% of respondents thought these services had stayed the same, only 8% reported that the situation had deteriorated since 2005. This probably is because services did not exist in the first place. Some 20% of respondents felt survivors "almost never" received the psychosocial support they needed and 60% felt it was "sometimes" received. The specific areas where a narrow majority of survivors observed improvement were related to improved societal beliefs, with some 56% reporting that survivors were no longer considered to be "charity cases" and that they had become more involved in community activities (52%). The only other area showing a majority positive response (56%) was the perception that there were more social workers. For all other specific actions, such as increased formal counseling opportunities, establishment of peer support groups, better trained staff, or better-quality services, less than 25% of people saw progress. Almost all respondents (90%) said services were not available closer to home and that social stigma around seeking psychological counseling had decreased (80%). Practitioners echoed this and noted slightly increased services because they had either been involved in them or had seen them first-hand.



These responses are not surprising, as there are no psychological support services or peer support groups in rural areas and there is a lack of qualified staff in the country. General psychological assistance is only provided by the National Union for Disabled People and *ad hoc* at some rehabilitation facilities. Capacity-building activities only started in 2009 and guidelines were still under development as of May 2009.[21] Tajikistan's limited efforts to provide training to social workers and organize summer camps for survivors since 2005 have had a somewhat positive influence on results. However, as of May 2009, no funding had been found for the 2009 summer camp and the activity remained a one-off event not organized close to the homes of survivors.

Economic reintegration

Just over one-quarter of survey participants (28%) found economic reintegration services improved since 2005; the remainder saw no change (72%). Just 8% of people noted that survivors "always" received the economic reintegration assistance needed. Most importantly, all respondents felt survivors were still the last to be chosen for a job, despite recent economic improvements. Just 4% of respondents found that training programs for survivors better met market demands. Very few people also noted increased employment (8%) or educational opportunities (24%), although survivors reported better access to economic reintegration programs not specifically designed for them (68%). The only overall positive response (92%) in the economic sphere was an increase in pensions. Practitioner responses showed little improvement overall, but confirmed better access for survivors to services not designed specifically for them.

These results confirm the necessity of the small-scale economic reintegration programs and local income-generation projects, supported by TMAC, which have experienced funding challenges since 2006.[22] Almost 200 survivors received some form of assistance through income-generation projects since the beginning of the Tajikistan's VA program in 2005.[23] Results also highlight that high general unemployment, particularly in rural areas, remains a serious obstacle. The positive response on pensions is solely due to an increase in the minimum pension from US$10 to US$17 in July 2008. Despite the improvement the pensions available remained low and insufficient.[24]

Laws and public policy

Some 52% of respondents felt survivors' rights were better protected compared to 2005. Most of the progress reported concerned more positive perceptions among the public: 88% said negative terms about persons with disabilities were used less; 84% found awareness about the rights of survivors had improved among the general public; and 76% noted decreased discrimination. Survivors were also increasingly able to access information about their rights (80%). Those interviewed also noted increased survivor involvement in policy-making (76%) and service provision (80%). However, 80% said they were not at all better represented through participation in government.

This result appears to contradict the employment discrimination results. It also shows the importance of awareness raising and needs-based VA, which is being carried out by TMAC in a context with a relatively weak legal disability framework. Work on improving 1998 disability legislation has been discussed since 2005, but had not been concluded as of August 2009, nor had the UNCRPD been signed.

When asked how they would respond if survivors in Tajikistan were to say that their situation had stayed the same over the last five years, TMAC answered that Tajikistan had been doing its best to provide services required to as many survivors as possible in comparison to the problems and needs. Work had been carried out to increase services, particularly in affected areas, and to improve the quality of services. TMAC was also working to improve its coordination with survivors' organizations and to involve them in planning, implementation and monitoring. However, it was also acknowledged that the mobilization of resources for long-term sustainability, capacity development, and the holistic approach to the rehabilitation of survivors remained challenging.

VA process achievements

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

Throughout 2005-2009, Tajikistan has demonstrated significant dedication to achieving the Nairobi Action Plan and has made good use of the tools put at the disposal of the 26 countries with significant numbers of survivors and, therefore, the greatest responsibility to act but also the greatest needs and expectations for assistance. Tajikistan's expectations when entering the so-called VA26 process were that the scope of the VA challenge in Tajikistan would be recognized, that the survivors' living situations would improve, that a national action plan would be developed and that more international financial and technical support would be received.

Tajikistan developed mostly SMART objectives, which it presented in 2005 and revised in 2006. A subsequent plan, developed in broad stakeholder consultation and in part based on NGO needs assessments and their discussions with survivors, was presented in 2007.[25] The plan was reviewed and adjusted in 2008 after a stakeholder workshop.[26]

TMAC was assigned to coordinate VA activities, with its VA officer as the focal point. Continuity in this position has had a demonstrably positive effect on Tajikistan's commitment, its systematic liaison with other stakeholders, and its international participation. Survivor responses also showed they had experienced improvements in VA coordination. Nearly all (92%) survivors reported they were aware of who is responsible for VA coordination; many (88%) also believed the needs of survivors were included in the development of the VA plan; and 88% estimated the government had increased its contribution to VA. In late 2008, a survivor was recruited as a VA assistant at TMAC. The practitioners' responses likewise revealed that Tajikistan's commitment to the Nairobi Action Plan contributed to better coordination between government and NGOs and increased survivor participation.

Tajikistan was one of only a very few countries directly reporting progress against the plan in 2007-2008. At international forums, updates on achievements focused on the real needs of survivors, and Tajikistan was one of the only States Parties that attempted to estimate state expenditure on government health services with respect the percentage of survivors as recipients.[27]

Despite TMAC's close liaison with other governmental and non-governmental stakeholders and its efficient planning and reporting, the budgetary needs for full implementation of the plan were never met between 2005 and 2009. This is evidenced by the fact that only 32% of survivors saw fewer gaps in services despite better coordination, strongly indicating that more resources are needed to match the improved coordination efforts. Between 2005 and 2009, state funding was insufficient, international donors seem to have focused

elsewhere, and fundraising capacities at TMAC needed reinforcement. It is likely that the planning could have better factored in this lack of resources. While TMAC's specific focus on survivors and their families has been beneficial in many ways for survivors, it may have inadvertently narrowed the possibilities for the program to draw on international assistance and resources available for broader health, disability and development initiatives. To take full advantage of such opportunities, it would have been useful for the program to have been included more in the broader disability sector by sharing both the resources and the responsibilities for funding and program implementation.

Some objectives, particularly those committing to assisting half of the known survivors in the period, were probably too ambitious given the resources at hand.[28] These objectives were not changed in the 2008;[29] whereas some objectives could have aimed for a more incremental approach in areas where almost no services existed, such as in the field of psychosocial support.[30] Several less ambitious objectives were concerned with establishing directories and were completed by 2008.[31] While directories are a useful first step to connect survivors to services, they do not address the actual lack of services.

While making good use of the VA26 process, in many areas Tajikistan lacked both the capacity to battle general development obstacles and lacked the national and international resources for VA to exploit the benefits of the country's planning and increase in knowledge.[32] However, at the same time Tajikistan reported that international assistance has gradually started to increase and that it has benefited from the opportunity to attend the international events related to VA within the framework of the Mine Ban Treaty. Domestically, Tajikistan better understood the challenge, showed improved coordination and increased awareness, and started to receive more national funding.

Conclusions

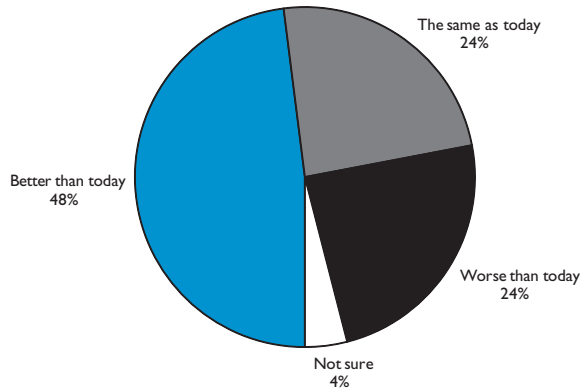
- Responses in Tajikistan have shown that when there is nothing to begin with, small steps can register high on the scale of measuring progress.
- Tajikistan's survivors' great "expectations of assistance," were generally ignored by the donor community, despite the country having stepped up to the challenge of self-identifying its responsibility to survivors and creating and monitoring a SMART action plan.
- Survivors continued to receive physical rehabilitation, although a waiting list grew during the handover to national capacity. However, the high value given by respondents to quality improvements and the provision of transport and lodging underscored the impact more day-to-day comfort can have.
- Needs for psychological support remained high, in part because of the near non-existence of these services prior to 2005.
- Economic reintegration has seen the least progress and was the area that most concerned respondents, despite needs-based planning and TMAC fundraising efforts.
- Effective coordination has contributed to better VA implementation and to a greater sense of survivor inclusion, but this needed to be matched with both national and international support for sustainability.

Suggestions for the way forward

When asked how they see their situation five years from now, 48% of respondents thought it would be better, 24% thought it would get worse, and the rest thought it would stay the same (4% non-response). To assist in a better future, the following suggestions may be taken into account:

- Continue support for establishing the necessary services for mainstreaming of VA, as Tajikistan has benefited from the VA26 process but is not yet in a position to fulfill the basic needs of most survivors.
- The international (mine action) community needs to make adequate, short-term contributions for Tajikistan to build long-term capacity and sustainable economic support activities.
- Continue to improve state services provided through relevant ministries, and increasingly include survivors.
- Strive for hand-over processes, such as those implemented in the physical rehabilitation sector, when relevant.
- Establish a survivor-run organization with peer support capacity for which core funding and technical resources are made available.

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



Davlatali Saidov in front of his house
© Tajikistan Campaign to Ban Landmines

In his own words: the life experience of Davlatali Saidov

Davlatali is a young man from Vanj District who lost his arm to a mine incident in May 2003. He was just 12 years old when it happened. He went with a group of friends and was running ahead of everyone, but suddenly he tripped and fell down on his hands. Davlatali does not remember what happened next, as he fell unconscious. He does not know how he got to the hospital but only remembers the shock of not having his left arm anymore when he woke up.

When Davlatali was discharged from the hospital he had nightmares all the time and felt too ashamed to visit relatives or go to family gatherings. He also hated it when people were staring at his arm, which was not there anymore. In 2005, he got a prosthetic arm from the NOC. It was hard fitting it at first, as it made the pain more severe. Today Davlatali is a 2nd grade student of a special boarding school giving vocational training to children with disabilities. His dream is to have his own small business and to get married.

In their own words...

If countries really cared about survivors they would:

- Develop psychological support services.
- Provide more financial support.
- Improve economic reintegration support programs.
- Support income generation for survivors.
- Increase pensions.
- Pay more attention overall to the needs of the disabled.
- Execute existing laws.

In their own words...

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

- Improve economic reintegration.
- Pay more attention to quality of [survivors'] lives.
- Assign more funds.
- Provide free services.
- Increase pensions.
- Provide good-quality support free of charge.
- Increase and develop medical and physical [rehabilitation] services.
- Develop psychological support services.

In their own words...

Survivors described themselves as: young, disabled, blind, expendable, joyful, teachers, healthy, students, youths, at peace, and alive.

Thailand

Country indicators

- *Conflict period and mine/ERW use:* Thailand is affected by mines and ERW resulting from conflicts along its borders with Cambodia, the Lao People's Democratic Republic, Myanmar, and Malaysia.[1]
- *Estimated contamination:* According to the 2001 Landmine Impact Survey, 2,557km² of suspected mine-affected areas affected more than 500,000 people. In 2009, Thailand estimated 547.9 km² suspected mined areas remained.[2]
- *Human development index:* 78th of 179 countries, medium human development (compared to 76th of 177 in 2004) [3]
- *Gross national income (Atlas method):* US$2,840 – 127th of 210 countries/areas (compared to US$2,463 in 2004).[4]
- *Unemployment rate:* 1.2% (compared to 2.2% in 2004).[5]
- *External resources for healthcare as a percentage of total expenditure:* 0.3% (also 0.3% in 2004).[6]
- *Number of healthcare professionals:* 32 per 10,000 population.[7]
- *UNCRPD status:* Ratified on the Convention on 29 July 2008, its Optional Protocol had not been signed as of 1 August 2009.[8]
- *Budget spent on disability:* Unknown.
- *Measures of poverty and development:* Although Thailand has experienced rapid progress in human development in recent decades, people whose incomes remained tied to the domestic market, such as small-scale farmers, have received fewer benefits and poverty remained a real concern for them. Some 10% of the population was living below the poverty line.[9]

VA country summary

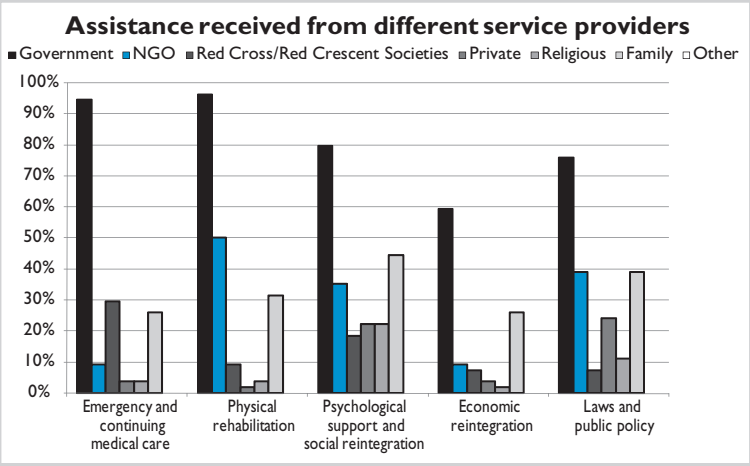
Total mine/ERW casualties to 2009: 4,060			
Year	Total	Killed	Injured
2004	28	7	21
2005	43	4	39
2006	26	4	22
2007	19	0	19
2008	26	3	23
Grand total	**142**	**18**	**124**

- *Estimated number of mine/ERW survivors:* 1,252.[10]
- *VA coordinating body/focal point:* The responsibility for VA coordination changed from the Thailand Mine Action Center (TMAC) in 2004-2007 to the Ministry of Public Health in 2008, as chair of the sub-committee on VA, established under the National Committee on Humanitarian Mine Action.
- *VA plan:* The Master Plan for Mine Victim Assistance 2007-2011 is an inter-ministerial plan to guide the development of individual plans by ministries, but it has few specific goals.
- *VA profile:* Thailand increased services for survivors during 2005-2009 by building on broader frameworks in the health, disability and employment sectors. Throughout the period under review, a community-based rehabilitation (CBR) network improved health centers and hospitals, and a new emergency service network significantly improved medical care for survivors. Healthcare for survivors was generally considered to be adequate in 2009, whereas in 2004 shortages in personnel and supplies had been reported at the community level. The availability of prosthetic and orthotic devices increased because of the better-functioning state system and through NGOs; physical rehabilitation was also largely adequate. Psychological support and economic reintegration services mostly remained inaccessible to survivors or inappropriate for their needs despite being generally more available. Substantial new legislation and policy measures to protect the rights of persons with disabilities were introduced in 2007-2008, but discrimination, especially in employment, remained problematic. Mine/ERW survivors from Myanmar and Cambodia also receive services in hospitals in Thailand's border provinces, and/or from international NGOs (in refugee camps for Burmese refugees). These survivors are not included in Thailand's strategic VA planning. Data collection on new casualties led by TMAC remained inadequate and incomplete throughout 2005-2009. NGOs completed a national mine/ERW survivor survey and needs assessment in 2009.[11]

VA progress on the ground

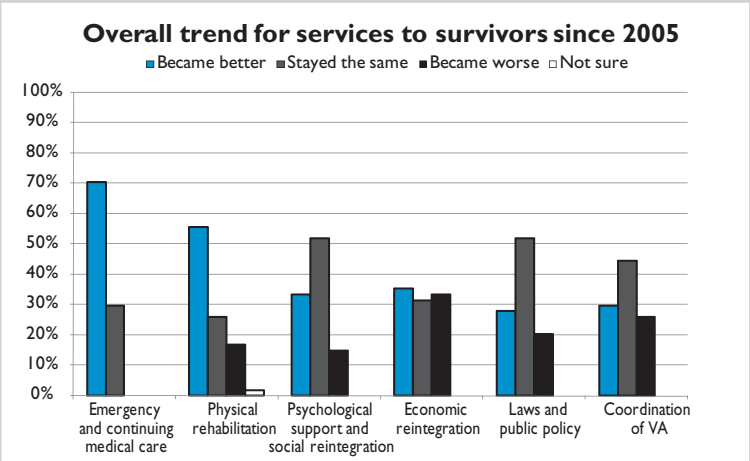
Respondent profile

By July 2009, 54 survivors had responded to a questionnaire about VA progress in Thailand since 2005: 46 men, five women and three adults whose gender was not reported. The vast majority of respondents (83%) had started primary school. Only 9% had reached secondary school level and 7% had not received formal education. Some 85% of respondents were heads of households and 87% owned property. Nearly all respondents (94%) lived in villages with limited services and just 4% lived in a large city with a variety of services. All respondents were employed before the incident (83% farmers) but 15% were unemployed afterwards and just 59% remained farmers. Nearly all respondents (96%) found their household income insufficient. This corresponds with the results of the nationwide survivor survey which reported that most survivors are men (93%), living in a rural border province region, with a low education background and having a low monthly household income. Most survivors were civilians.[12]



General findings

Overall, a significant percentage of survivors saw progress in service provision compared to 2005; most progress was definitely seen in medical care and least in economic reintegration. Some 41% of survivors responded that they had received more services in 2009 than in 2005 and 43% reported that services were better than those provided five years ago. Most (63%) believed that services for child survivors were "always" adapted to their age. While female participation was too limited for accurate extrapolation, 81% of respondents thought that services for female survivors were "equal" to those available to male survivors; 13% said services were "better". Of the five female respondents, three said "better" and two said "equal".



Nearly all respondents (91%) had been surveyed by NGOs or authorities in the past five years and almost a quarter (24%) had been surveyed four or more times. Some 46% of respondents thought that this survey activity had resulted in their receiving more services; 39% found they had received more information about services as a result; and the same percentage (39%) said that they had less difficulty obtaining a pension. This last response is concerning given that assistance in obtaining pensions is the key goal of most social support visits paid to survivors.[13]

Emergency and continuing medical care

Most respondents (70%) believed that, overall, healthcare had improved since 2005 and the remaining 30% said services had stayed the same. According to 61%, survivors

"always" received the healthcare they needed and another 26% replied "mostly". Nearly three-quarters (72%) felt that the government provided more support to healthcare. The greatest progress was felt in reducing the cost of services (89% saw improvement). Some 81% of respondents also found that the quality of healthcare had improved and that they could receive services closer to home. Better-trained health staff was seen by 78% of survivors and 74% found that more complex procedures could be carried out. Another 70% reported increased emergency transport and 65% said there were more first aid workers. Practitioners found that healthcare progress was made in similar areas: increased first aid workers and emergency transport, as well as more affordable services.

These responses correspond with Thailand's rapid expansion of primary healthcare services throughout districts of Thailand since 2005, its reform and expansion of the emergency response mechanisms – even though full coverage was only foreseen by 2011. Responses are also indicative of recent infrastructure improvements to village health centers and the development of a health volunteer system. Thailand also invested in training health staff and free medical assistance was provided to registered persons with disabilities.[14] This all resulted in adequate medical care for mine/ERW survivors by 2009, whereas it had still been considered inadequate at the community level in 2004. However, Thailand recognizes that further increases in the number of health staff are still needed.[15]

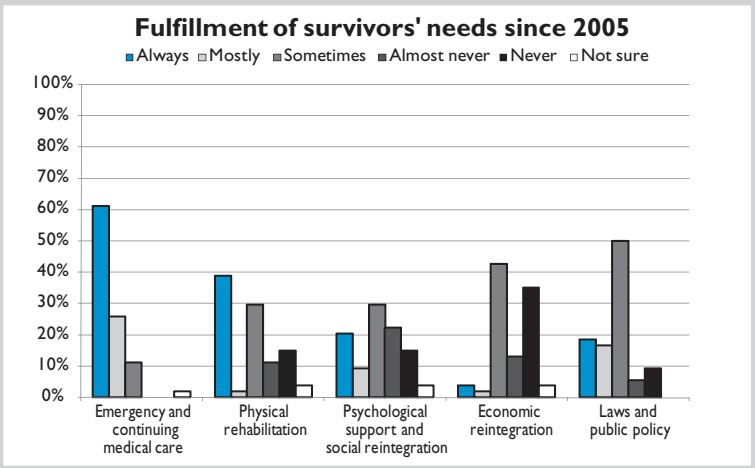
Physical rehabilitation

More than half of respondents (56%) thought that, overall, physical rehabilitation had improved since 2005; 26% said it had stayed the same; and 17% saw a deterioration. Some 39% felt that survivors "always" received the physical rehabilitation they needed and 30% said this was "sometimes" the case. A majority of respondents (63%) believed that the government provided more support to physical rehabilitation in 2009 than in 2005. Most improvement was recorded in the quality (87% agreed) and variety (72%) of mobility devices. Some 70% reported that it was easier to get free replacement devices, that rehabilitation staff was trained better, and that the waiting period to obtain a device had become shorter. More than half of respondents (57%) noted that they could obtain services closer to home or that there were more mobile workshops. Practitioners found that physical rehabilitation for survivors had remained unchanged and that the government had "maintained its efforts."

All public hospitals, mainly supplied by the Sirindhorn National Medical Rehabilitation Center, were capable of providing prosthetic and orthotic devices; some mobile units also existed. In 2007, Thailand also reported that the health system was able to reimburse the cost of treatment for all survivors.[16] However, transportation costs could be prohibitive; for example, the 2009 survivor survey noted that some 43% of respondents saw distance to the centers and transportation costs as a problem.[17] The NGO Prosthetic Foundation also provided free mobility devices through its main center in Chiang Mai and some 16 satellite and mobile workshops; many of those assisted here were unable to get coverage through the national health insurance scheme.[18] In 2009, Thailand stated that studies showed that 67% of people were satisfied with the prosthetic-orthotic assistance they received.[19] However, the survivor survey noted that maintenance of devices was the main concern for survivors due to the long distances to centers.[20]

Psychological support and social reintegration

More than half of the respondents (52%) thought that, overall, psychological support and social reintegration services had remained unchanged since 2005 and 33% saw improvement. Some 30% thought that survivors "sometimes" received the psychosocial services they needed; 22% said that survivors "almost never" received the needed services; but 20% said they "always" did. The greatest progress was not seen in the actual services, but in individual and community attitudes: 67% of respondents felt more involved in community activities and 56% felt more empowered. Just 22% reported more opportunities for psychological counseling and 20% said peer support groups had been created. According to



30% of respondents, there were more social workers. Some practitioners saw improvements mainly because there were more or better-trained psychiatrists, social workers and counselors. It is likely that practitioners, through their work, have more contact with institutions providing psychological support than survivors living in rural communities.

The responses, in part, show that many rural survivors in farming communities are likely unaware of existing psychosocial services or of their importance and would be unlikely to seek this type of assistance. However, psychosocial assistance activities were also limited. A few survivor groups existed and some social inclusion support was provided informally such as during the course of other services in some hospitals and through the CBR network, but was dependent on the awareness and goodwill of the staff.[21] Rather than counseling, the role of social workers and of CBR volunteers is to assist survivors in applying for disability pensions and certificates which give access to medical and social benefits. The lack of psychological support services was a major concern for more than three-quarters of survivors in the national survey.[22]

Economic reintegration

Responses to progress in economic reintegration for survivors since 2005 were split in almost equal thirds: 35% reported progress, 33% deterioration and 31% no change. However, 35% of respondents found that survivors "never" received the economic reintegration assistance they needed and 43% indicated that the needed assistance was "sometimes" provided. Almost all survivors (98%) thought that unemployment was so high that survivors were the last to be chosen for a job. Just under half of all respondents (48%) believed that the government provided more support for economic reintegration. The most progress was seen in the provision of vocational training for survivors and awareness of disability issues among teachers (56% saw an increase). Some 54% found that services were available closer to home. While 35% of survivors believed that they had better access to income-generating and training programs not specifically targeting them, just over a quarter (26%) saw improvement in these programs actually meeting market demand. Only 9% reported that job placement services increased. Although Thailand has strict employment quotas, only 20% thought these were better enforced.[23] Despite intensive state efforts in registering persons with disabilities, including survivors, for pensions (of US$15 per month), only 15% of respondents thought that pensions had improved. Practitioner responses indicated that economic reintegration had improved, mostly in the areas of micro-credit, employment opportunities and vocational training including programs not designed specifically for survivors. Unlike survivors, most practitioners also thought that employment quotas were enforced more often.

The differences between practitioners and survivors probably indicate that, although economic reintegration services have increased, opportunities might not reach survivors in rural areas. The government launched some pilot income-generating projects through the CBR network and vocational training was free for persons with disabilities. However, projects reached limited numbers of survivors and services did not appear to fully address their needs. Additionally, even if survivors found employment, there often was salary discrimination and discriminatory hiring policies also existed.[24] Thailand acknowledged that some 71% of survivors have never received training and that training was inconsistent with their work in agriculture. Thailand also recognized that, despite efforts, coordination with local survivor groups remained limited.[25]

Laws and public policy

Some 52% of respondents reported that, overall, the enforcement of the rights of survivors had stayed the same; and 28% saw improvement since 2005. Half of respondents felt that their rights were "sometimes" respected and 19% said this was "always" the case. A majority of survivors (59%) thought that the needs of survivors were better included in disability legislation and policy; and 52% believed that they had more access to legal recourse when their rights were violated. Half of the respondents also believed that legislation and policies relevant to survivors had been developed, but fewer (39%) thought that legislation was better enforced. Some 44% also agreed that the public was more aware about the rights of persons with disabilities. Yet, only 39% of respondents believed that discrimination against survivors had decreased. Practitioners also noted progress in laws and public policies relevant to survivors but found that the government had "maintained its efforts" rather than increased them.

In 2007-2008, Thailand introduced new laws and made public policy changes with the aim of improving the lives of persons with disabilities. Key among these measures was the Persons with Disabilities Empowerment Act of 2007 and some sections of the Thai Constitution of 2007, which specifically prohibit discrimination and grant access to services to persons with disabilities. In the same year, legal protection for the rights of persons with disabilities was improved as the Ministry of Social Development and Human Security increased the importance of the Office for the Empowerment for Persons with Disabilities.[26] Thailand's signature and ratification of the UNCRPD is reported to have contributed to progress in these areas as well.[27] NGOs and disabled people's organizations were active in raising awareness throughout 2005-2009, and already in 2003 Thailand hosted a series of meetings to facilitate the drafting process of the UNCRPD.[28]

When asked how they would respond if survivors were to say that their situation stayed the same over the last five years, a government representative's answer was pragmatic, stating that if survivors were referring to basic needs or essential services such as food, housing or prostheses, then Thailand would seriously explore further processes for assistance to address those needs. However, if the issues were about more than basic needs Thailand could not act on these, as all people have different expectations.

VA process achievements

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

In 2007, Thailand stated that its "victim assistance programme may not be without its flaws, but we are confident that we are on the right track."[29] As one of the 26 countries with the greatest numbers of survivors and, therefore, the greatest responsibilities, "but also the greatest needs and expectations for assistance," Thailand realized that it was primarily responsible for assisting survivors. But it also believed that Thailand's so-called VA26 status was a way to obtain international technical support and funding to reach appropriate standards of assistance. While Thailand did not find it had received such support, substantial progress has been made, through efficient use and optimization of existing mechanisms, particularly for medical and physical rehabilitation assistance. One government representative thought that a key accomplishment was that while Thailand had improved healthcare for all citizens, it was also able to ensure the same access to services for persons with disabilities (including survivors).

The Thai ministries involved in the VA process also found that it was a useful tool to call for stakeholder meetings and increased information sharing to improve VA. Through the process, the ministries were also able to increase linkages with the broader disability sector and take advantage of developments there.

In 2008-2009, Thailand assumed the role of co-chair of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, which together with its presidency over the Fifth Meeting of States Parties in 2003, seems to have influenced progress in national VA measures.

As part of its commitment to implementing the Nairobi Action Plan, Thailand presented its 2005-2009 objectives in 2005, but there were few objectives and they were not SMART. In February 2007, the Master Plan for Mine Victim Assistance 2007-2011, which had been ready since December 2005, was adopted. This plan was meant to guide relevant ministries in developing their own plans; the 2005-2009 objectives were not actually used.[30] Although the VA master plan lacks strategic detail and timeframes for implementation, it does set some standards for ministries to meet. Reportedly, ministries and NGOs carried out their responsibilities mindful of the master plan in the period between its development and its adoption.[31]

TMAC was initially in charge of coordinating VA. While TMAC did not allocate a budget to VA or implement any service provision, it spearheaded the development of the master plan and convinced government agencies to integrate VA into the National Socioeconomic Development Plan (2007-2011). TMAC also liaised with relevant stakeholders and, to a limited extent, with survivor representatives on these issues. In 2008, coordination responsibilities shifted to the Ministry of Public Health as chair of the sub-committee for VA under the National Committee on Humanitarian Mine Action which had already been established in March 2003. The sub-committee includes representatives from key ministries and NGOs, and meets biannually. It was subsequent to this readjustment that Thailand started to state that coordination had improved.[32]

TMAC's limited coordination and the fact that most developments beneficial to survivors were carried out as part of the broader mechanisms, appear to have influenced survivor responses. Just 28% knew who was in charge of coordinating VA, and just 30% thought that VA coordination had improved. Some 31% thought that survivors had been involved in coordination and 41% indicated that the needs of survivors were taken into account in the plans.

Conclusions

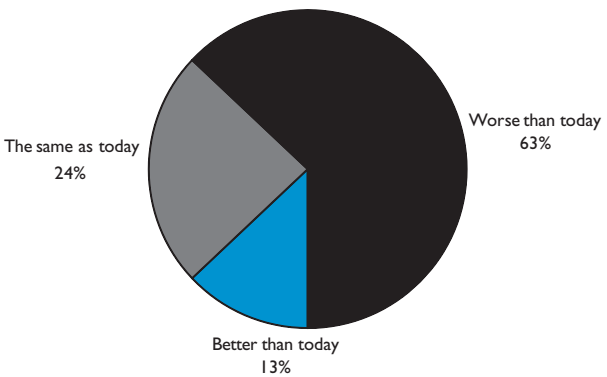
- Services and their availability improved for survivors due to broader initiatives in the health and disability sectors.
- Thailand's participation in the VA26 process led to it feeling the need for increased coordination and the more systematic integration of VA in other relevant frameworks and the ministries' work.
- There were few or no specific projects for survivors, even though they might have been useful in the short term to reinforce the weaker economic reintegration and psychosocial support components.
- Economic and psychosocial services were insufficient and did not appear to address the specific requirements of survivors in rural environments.
- The CBR network was a useful tool for expanding services, but it has not reached its potential for economic reintegration and psychosocial support.
- Survivors and their representatives were not included systematically in activities.
- The national survivor survey is likely to increase the expectations of survivors, and also provides an excellent starting point for implementing further assistance.

Suggestions for the way forward

When asked what they thought their situation will be like in five years, 63% of respondents replied that it would be worse than now; 24% thought it would stay the same; and only 13% thought it would be better.[33] To assist in a better future ahead the following suggestions may be taken into account:

- Use the results of the survivor survey to improve planning and take specific strategic action on the issues identified as problematic by survivors.
- Include survivors and their representatives in planning based on their needs, but also ensure their inclusion in relevant broader coordination and planning frameworks.
- Extend the CBR program to systematically include psychosocial support activities and to involve survivors and local survivor and disabled persons' groups.
- Link the economic reintegration needs of survivors more to existing programs and seek to duplicate useful lessons learned from integration of VA in the health and rehabilitation sectors.
- Build the capacity of local survivor organizations to implement community-based projects.
- Devise a strategy to increase the rural incomes of survivors or to subsidize their costs so that they can withstand market fluctuations.
- Ensure that economic reintegration activities better meet market demand.
- Increase awareness about services and establish stronger referral mechanisms between services.

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



Chob in his furniture workshop
© Loren Persi

In his own words: the life experience of Chob

Chob is a farmer and a carpenter living very close to the Thai-Cambodian border. He lost his leg to a landmine while collecting vegetables almost 15 years ago. Chob received a prosthetic leg from a national NGO after the incident. He does not have the prosthesis repaired or replaced often. The last time he had a new device was three years ago at a local hospital. He noticed improvements in the quality when he went, but it took a long time to make the device. He was not able to make a living while he was waiting for his new leg.

Chob prefers to work for himself rather than face the discrimination he knows exists when working with others. He has been actively involved in a local group in his village maintaining a system of revolving micro-credit loans started by an NGO seven years ago. The group includes several persons with disabilities, some of whom are mine survivors. Over the years, projects have come through the village surveying survivors and offering the hope of vocational training or start-up equipment, but these hopes have always been disappointed. Just one NGO provides basic relief packages to survivors from time to time – Chob received one once. Chob sees that some small practical adaptations would make a big difference to survivors in the area, for example adjustments to motorcycles for those who lost their legs.

In their own words…

The priority for VA for the next five years is:

- Provide more support.
- Budgets to start economic projects.
- It's too hard to say any one thing.
- Education for the children of survivors; it is too late for us.
- Donate to demining to release the land for use.
- Grants for children's education.
- Survivors need to have a better income.
- Increase our pensions.
- Give more physical rehabilitation, as there are not enough services now.

In their own words…

If countries really cared about survivors they should:

- Follow up on surveys with the appropriate assistance for survivors.
- Make the 500baht [US$15] monthly pension universally available to all survivors.
- Increase the pension to make it adequate for survivors.
- Get information from survivors and act on it.
- Create a budget for survivors to find work and for their children to study.
- Just do what they said they would do.
- Income and jobs.
- Give special rights for survivors.
- Provide good coordination.
- Push to improve the economic support plan.
- Donate for more physical rehabilitation.
- Take care of the survivors' families.

Uganda

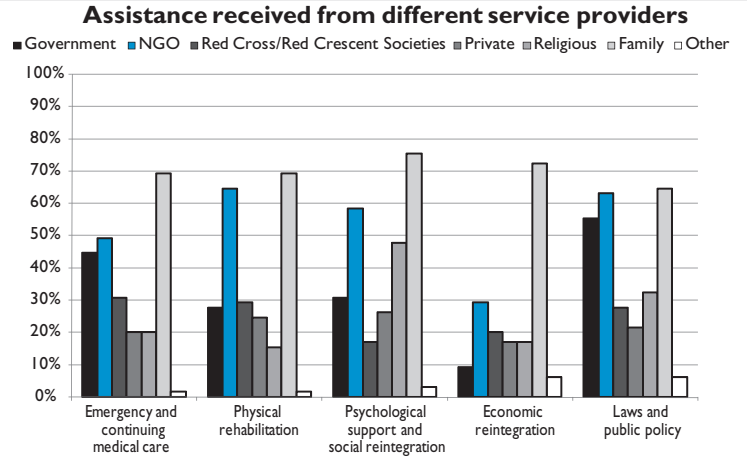
Country indicators

- *Conflict period and mine/ERW use:* Uganda suffers from ERW and some nuisance mine contamination as a result of four decades of conflict. Mines were used by government forces in the early 1980s and by resistance forces since then.[1]
- *Estimated contamination:* There are only a few suspected mined areas or ERW-contaminated areas throughout the country, but fears of existing mine contamination and ERW contamination impede development and the return of internally displaced persons (IDPs).[2]
- *Human development index:* 154th of 179 countries, low human development (compared to 146th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$420 – 189th of 210 countries/areas (compared to US$272 in 2004).[4]
- *Unemployment rate:* 3.5% official rate, but additional underemployment of at least 17% (unknown in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 28.5% (compared to 23.5% in 2004).[6]
- *Number of healthcare professionals:* Eight per 10,000 population.[7]
- *UNCRPD status:* Ratified both the Convention and its Optional Protocol on 25 September 2008.[8]
- *Budget spent on disability:* A budget line supposedly exists for VA at the Office of the Prime Minister (OPM) and there is a national disability budget, both of unknown size.[9] Sources indicate the government might be "reluctant" to spend money on disability.[10]
- *Measures of poverty and development:* Uganda is a poor country, devastated by decades of conflict. Some 35% of the population lives below the poverty line and income inequality continues to increase despite relative stability leading to economic growth. Average life expectancy is less than 53 years of age.[11]

VA country summary

Total mine/ERW casualties since 1986: Unknown – at least 1,414			
Year	Total	Killed	Injured
2004	31	5	26
2005	40	11	29
2006	50	11	39
2007	23	10	13
2008	16	10	6
Grand total	**160**	**47**	**113**

- *Estimated number of mine/ERW survivors:* Around 864.[12]
- *VA coordinating body/focal point:* The *de facto* coordinator is the Ministry of Gender, Labour and Social Development (MoGLSD), but divisions of tasks are unclear.
- *VA plan:* Uganda Comprehensive Plan of Action for Victim Assistance 2008-2012; disability is also included in several other relevant strategies.
- *VA profile:* Although Uganda showed increased national ownership for VA between 2005 and 2009, it continues to depend heavily on external resources, technical advice and international NGOs for VA implementation. Uganda's health and social infrastructure suffered from years of conflict, particularly in mine-affected areas. Many mine/ERW survivors are IDPs and were initially assisted through services in or around IDP camps. Increased IDP return in recent years has created challenges to providing similar, adequate services in all parts of Uganda. NGOs carried out most of the service provision in mine/ERW-affected northern Uganda in 2009. Very limited government or NGO services continue to be available in western Uganda. Throughout 2005-2009, it was reported that health facilities were ill-equipped and under-staffed. Few survivors have access to physical rehabilitation. Only two centers were available in mine/ERW-affected areas in 2005-2009; one was run by an international NGO and in the other the ICRC resumed support in 2008. Long distances and accommodation challenges are even greater obstacles to accessing services. Throughout the period, very limited opportunities for psychosocial support and economic reintegration existed, particularly in remote, uninformed western Uganda. Activities were mainly carried out by national and international NGOs, which did expand the variety of their services. The few government initiatives that exist were under-funded and too expensive for survivors. Since 2004, survivors have been assisted by NGOs and disability organizations to form associations and become self-sustaining. By 2009, these associations had been increasingly successful in negotiating their own demands, but still depended on international NGO support. Throughout the period under



review, the government highlighted the survivor associations' importance, but was not able to aid them. Uganda has a well-established disability sector with a Minister of State for Disabled Persons, a National Council for Disability (NCD), and a national disability strategy in place even before 2005 – all of which lack funding to carry out activities. Persons with disabilities are represented at various government levels. Disability issues have been mainstreamed into the various relevant strategies and, since 2005, legislation has been strengthened and developed, implementation has lagged. As of August 2009, Uganda does not have complete or reliable data on mine/ERW casualties or services received by survivors, despite promises to develop a complete database dating back to 2005.

VA progress on the ground

Respondent profile[13]

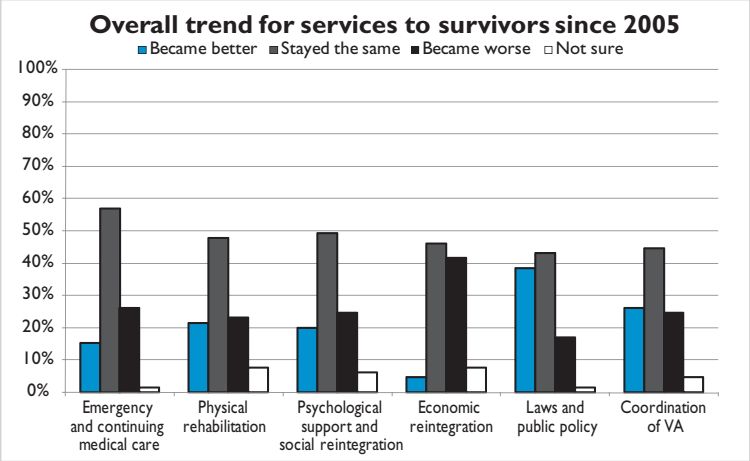
By July 2009, 65 survivors between 13 and 70 years old had responded to a questionnaire on VA in Uganda: 71% were men, 26% were women, and boys and girls accounted for 1.5% each. Some 66% were heads of households (including 41% of the women) and 83% owned property. Respondents came from mine-affected areas in the north and in the west; some had moved back to their area of origin after being displaced for years. Nearly half of the respondents (49%) lived in remote areas without services; 42% lived in villages with some services; just 8% lived in the capital or a large city with a variety of services (one person did not answer this question).

Some 69% of people had not gone further than primary school, and nine people have never received any education. Just 29% (35% of them women) went on to secondary education or higher. Ten people were unemployed at the time of the survey, including eight who had lost their job as a result of their incident; one person said he was a beggar. Most of those employed had to change their employment after their incident. The vast majority (85%) said their income was insufficient. Some 11% were military or police; most experienced their incident prior to 2000. The respondents' profile corresponds to the recorded casualty data, which indicates that the vast majority of casualties were young civilians injured in the late 1990s.[14]

General findings

The vast majority of respondents felt that, overall, services had stayed the same since 2005 in most sectors, while around 25% saw deterioration. Some 86% said more services were not available, and 75% said services had not improved. Responses were not more positive for those living in urban centers. Just over one-third (34%) thought services for women were "equal" to those for men (44% of women respondents thought this). Almost 68% of people said services for children were "never" or "almost never" adapted to their age level, 11% said they were "sometimes" adapted, and the remainder were not sure.

More than half of respondents (54%) had been surveyed by NGOs or authorities at least four times since 2005, while for 22% this survey was their first. More than half (52%) said previous surveys had resulted in more information about services and in their feeling listened to. However, 86% said being surveyed did not lead to fewer bureaucratic difficulties, and 77% said it did not result in more services. Most people had also received a chance to explain their needs to government representatives more than once.



This corresponds to the government's efforts to include persons with disabilities in local government and to involve survivors in workshops and meetings. These results also confirm government reports about their surveys and needs assessments, the information from which has not yet been consolidated and is not usable for planning purposes. NGO survey activity is a result of patient registers, so it would have covered many people already receiving treatment.

Emergency and continuing medical care

Most respondents (57%) said healthcare had stayed the same overall since 2005, while 26% said it had deteriorated. Some 37% said survivors "never" received the healthcare they needed, while 11% said survivors "almost never" receive the necessary services. More than three-quarters (78%) said healthcare for survivors was not a government priority. Responses to specific progress indicators were overwhelmingly negative, and respondents reporting improvement never exceeded 25%. Better equipment and supplies at facilities were reported by 9% of respondents only; more complete medical teams, more emergency transport, or an increased ability to conduct medical procedures were reported by just 11% each; more first aid workers or medication available was reported by 12% each; more affordable healthcare was reported by 14%; healthcare closer to home, better quality healthcare, better trained staff or better physical access were reported by 17% each; more health centers were reported by 18%; and 22% reported improved infrastructure. Practitioners' responses were similar, with 50% indicating the situation had stayed the same and 17% seeing deterioration. Improvements were seen in more centers, better infrastructure and quality. Practitioners saw the least progress in emergency care and said government efforts had been maintained but not increased.

These responses confirm reports since 2005 of a dire healthcare situation as a result of conflict. As in 2005, the government noted in 2008 that emergency response capacities are inadequate, facilities ill-equipped,[15] and lack of trained staff is "one of the most critical factors limiting the delivery of a minimum package of services."[16] The VA plan is said to link to a comprehensive health strategy for 2005-2009/2010 which aims to decentralize health services and includes specific measures for persons with disabilities. Survivor responses indicate this has not been achieved. In its VA plan, Uganda also committed to improving emergency capacities by 2009; plan implementation only started in mid-2009 due to a lack of resources.

Physical rehabilitation

Nearly half of all respondents (48%) felt the physical rehabilitation situation had remained the same since 2005; 22% saw improvement, and 23% saw deterioration.[17] Some 42% felt survivors "never" or "almost never" received the physical rehabilitation they needed, while 35% said needed assistance was received only "sometimes". In addition, 88% said physical rehabilitation was not a government priority. Responses were again negative on specific progress indicators. Only 2% report more centers; 5% said it is easier to get replacements; 6% said more types of mobility devices or rehabilitation closer to home were available; 8% reported shorter waiting periods; 11% reported better infrastructure or more mobile workshops; 13% reported transport and accommodation being increasingly included as part of services; and 15% reported that physical rehabilitation teams were either better trained or more complete. Half of all practitioners saw an improvement in physical rehabilitation, but attributed this to NGO activities. In quite a few areas practitioners saw

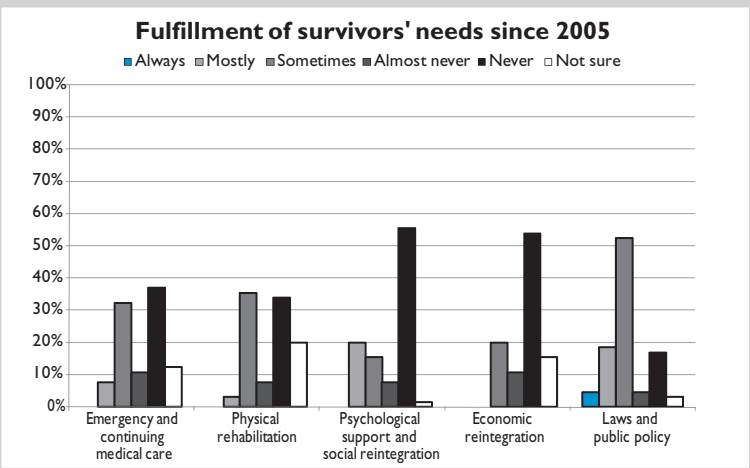
reduced government efforts, particularly as concerned enhancing quality, making teams more complete, or upgrading infrastructure at centers.

These responses confirm that physical rehabilitation needs are not being met, particularly in western Uganda. The government estimated in 2008 that just 25% of persons with disabilities had access to services.[18] There were no reports of increased physical rehabilitation capacity in 2005-2009; in fact, one center closed in 2006.[19] Government services were not free and were of lower quality than NGO services, and most staff was not trained to international standards. In 2009, the main NGO service provider reported difficulty in keeping up with ever-increasing demand, adding that local governments do not respect commitments to cover transport and accommodation costs, which are a challenge for most survivors. In late 2008, the ICRC resumed its support to a center in western Uganda which it had previously handed over to the government in 2002.[20] The existence of a government CBR strategy and network apparently has not improved responses.

Psychological support and social reintegration

Nearly half of all survivors (49%) said that, overall, the psychological support and social reintegration situation had remained the same since 2005. One-quarter saw deterioration and 20% saw improvement.[21] Some 55% of respondents said survivors "never" received the psychosocial assistance they needed, while 83% thought it was not a government priority. Some 43% said they were increasingly involved in community activities and psychosocial support activities for other survivors; women were even more involved (50% in community activities and 44% in psychosocial support for others). Some 29% of survivors felt more empowered. About 29% also noted more peer support groups and 28% said they were no longer considered to be "charity cases." The least progress was seen in the quality and availability of counseling. Again, practitioners' responses concurred with survivors' responses; 50% of practitioners said the situation was unchanged, while 33% saw improvement. Those who saw improvement were directly involved in supporting survivor associations. Psychosocial support was the only area where practitioners saw increased government support, particularly in awareness raising, reducing the stigma around this type of service, and including more survivors in service provision.

The more positive responses on psychosocial support as compared to other sectors is in large part due to the existence of survivor associations. These organizations existed throughout 2005-2009 (and prior to that) and had become increasingly organized and capable of defining their own strategies and resources by 2009. Since 2004, the government has stressed the importance of these associations and the need to strengthen and structure them under an umbrella organization. However, capacity-building and financial support have been left largely to non-governmental actors. Formal structures for psychosocial support remain weak due to a lack of awareness, culturally sensitive methods, trained staff and structures at community level. In 2009, Uganda noted negative attitudes to such support still persist. This was underscored by the survivor responses, indicating that awareness raising efforts have not paid off yet.



Economic reintegration

Nearly 42% of survivors said economic reintegration opportunities have worsened overall since 2005; just 5% said they had improved. Additionally, 54% felt survivors "never" received the economic reintegration assistance they needed, while 20% said the needed assistance was "sometimes" received. Nearly 91% said economic reintegration was not a government priority and 85% said unemployment was so high that survivors were the last to be chosen for a job. The greatest improvement was noticed in access to programs not specifically targeting survivors (49%) and in decreased educational and professional discrimination (46%). However, just 15% saw more economic or employment opportunities, only 12% saw better enforcement of employment quotas, and just 5% had less difficulty in getting bank loans. Some 23% said there was more vocational training, but just 22% of them said such training increasingly met market demand. In this area, practitioner responses differed significantly from survivor responses, with 50% of practitioners saying the economic integration situation had stayed the same and 33% seeing improvement. However, they did not attribute this improvement to increased government support overall. One respondent said: "Plans are there, meetings are held, and these are all beautiful, but implementation is still dependent on funds coming from donors through NGOs."

Again, these results confirm the lack of progress reported by the government between 2005 and 2009. Economic reintegration activities were mostly carried out by NGOs. In 2009, as in 2005, Uganda reported there were inadequate resources for vocational training.[22] Construction of new training centers was ongoing as of 2008 and support to existing ones had been reinforced, but quality issues remained and admission was fee-based.[23] The government had difficulty covering costs for survivors, thus limiting their access. No system to track employment after training exists. High general unemployment is an obstacle, as is the low education level of survivors, according to a government representative. Representatives of survivor and disability organizations remarked that the main problem was the lack of survivor inclusion in program design and the absence of "positive discrimination" for survivors in program implementation.

Laws and public policy

Some 38% of survivors felt their rights situation had improved since 2005, while 43% said the situation was unchanged. More than half (52%) said survivors' rights were "sometimes" respected, 18% said this was "mostly" the case, and 17% said this was "never" true. Some 77% said the rights of survivors were not a government priority. Unlike other sectors, a majority of respondents saw improvement in some specific areas here. Two-thirds saw improvement in the representation of persons with disabilities in government and said negative terms describing persons with disabilities were being used less. Some 62% also said discrimination has decreased, and 55% were aware that new legislation and policies relevant to survivors had been developed. However, just 37% felt these laws and policies were actually enforced. Most practitioners (83%) saw an overall improvement in the rights situation since 2005. The greatest progress was reported in developing legislation (100%), while the least progress was reported in including survivors in policy-making (33%); 67% thought discrimination had decreased.

These responses confirm the steps Uganda has taken to develop and strengthen disability legislation, its ratification of the UNCRPD, and its work to start implementing the national disability strategy. Five seats are reserved for persons with disabilities in parliament, and two of the people first elected as disabled representatives were re-elected on the ordinary ballot in 2006. Persons with disabilities are also represented at local levels.

When asked to respond to preliminary survey results, a government representative felt a lot of work had been done and that survivors would not say the situation had remained the same. The representative added: "We have given them physical rehabilitation, we have mobilized NGOs to carry out psychosocial support and economic reintegration, and we have helped them resettle and integrate into their communities."

VA process achievements

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

National ownership of VA increased in Uganda between 2005 and 2009 and VA has evolved from being a "mere NGO program"[24] to a government responsibility. However, the government lacked both the funding and staff capacity to effectively facilitate VA implementation and remained heavily dependent on external funding and advice, usually through NGOs.

Throughout 2005-2009, Uganda reported that its main priority for VA was to develop an integrated approach in which VA would be included into existing health, disability, poverty reduction, and peace-building frameworks. While this may ensure long-term sustainability, for 2005-2009 it appears to have resulted in a lack of concrete improvements for survivors. Several disability-related frameworks were already in place prior to 2005, but their impact on facilitating improved coordination or implementation of Uganda's commitment to the Nairobi Action Plan remains unclear. Additionally, Uganda does not appear to have applied its integrative approach systematically.

In 2004, Uganda identified the main goals of what more than three years later would become its VA plan. These goals were: collection of baseline data; government capacity building; increased coordination, decentralization and improvement of rehabilitative services; and increased psychosocial and economic reintegration activities.[25] In June 2005, it presented some of its 2005-2009 objectives, plans, and the means for their implementation saying it would not "isolate [survivors] in a separate program."[26] Uganda released largely SMART objectives in November 2005, but it was not until 2007 that it "recognized that while there were many laws and policies, we needed a comprehensive plan of action to operationalize existing policies…"[27] This then resulted in the Comprehensive Plan for Landmine Victim Assistance 2008-2012 (budgeted at nearly US$3 million),[28] which integrated strategic goals from the poverty eradication, social development and health sector plans and was supposed to support the broader disability sector.[29]

Already in 2000, Uganda had a disability strategy in place, and health and other sectoral plans already included provisions for persons with disabilities prior to 2005. However, the government focal point for disability and VA was unable to explain how these plans interacted in practice. Several of these plans remain largely unimplemented due to a lack of funding and capacity. In addition, some operators noted that new plans and programs for war victims in general are under development but do not include the advances made under the 2008-2012 VA plan and are likely to result in duplication. A monitoring mechanism for the VA plan has been developed but is not used because the NCD, which was appointed to monitor the VA plan, receives less than US$1,000 per year in government support to carry out the task.[30]

While an integrated approach should increase national sustainability, in practice it has not had a beneficial impact on the coordination and implementation of assigned responsibilities. Coordination has changed hands several times, moving from the Ministry of Health (2004-2005) to the mine action center and OPM (since 2006) – although in 2009 the mine action center noted it was responsible for all parts of mine action *except* VA. MoGLSD has *de facto* claimed the focal point role since 2008, but its relation to the MoH and other governmental stakeholders is unclear. Neither the inter-ministerial committee on disability

(in place at MoGLSD prior to 2005), nor the NCD coordinating all disability activities[31] were assigned responsibility to become the VA focal point, and it is not clear why.

In principle, implementation is split between the two main ministries, but how they actually divide execution of tasks is unclear as well. Some even say delays in implementing the VA plan for 2008-2012 are being caused by government stakeholders not wanting to take responsibility for the tasks assigned to them. Practical coordination and survivor inclusion work better at local level, particularly through the efforts of some survivor organizations. These ambiguities were reflected in the survivor responses. Just 35% said they knew who coordinated VA; 46% said the government is better-coordinated with NGOs than previously; 29% said the government provided regular information on VA achievements; and only 8% said the government allocated more funds to VA.

Since 2006, Uganda has noted the importance of strengthening survivor groups, their organization into a national federation, and their inclusion in policy-making. Progress in inclusion has been reported by the survivor organizations, but it remains unsystematic. Just 29% of survivor respondents thought survivors were included in coordination, 34% thought the needs of survivors had been taken into account when developing plans, and 31% thought survivors had been involved in developing plans. One organization has been identified to grow into the national federation. This organization has tried to fulfill its role, but has not received formal assistance to achieve its task. The first meeting of the national federation was held in July 2009 and a president and vice-president elected.

The implementation of the 2008-2012 VA plan did not start until June 2009 because funding had been blocked since 2007 and a technical advisor was needed. This has resulted in little demonstrable improvement in survivors' lives. According to a well-informed source, part of the problem is that the roadmap and funding strategy for 2008-2012 seem to have been developed mostly by the UN or an external advisor without taking the real capacity in the country into account. Funding promises were based on this and did not include any resources for capacity building of district/level staff to actually implement the 2008-2012 plan, which resulted in the MoGLSD struggling to get programs into place with insufficient capacity. Funding was only unblocked in 2009, with the message that the money needed to be spent by year-end if more funding was to follow.

All actors agreed Uganda's main achievement during 2005-2009 was the development of the VA plan, which has already helped guide the actions of some NGOs in order to avoid duplication. However, one practitioner noted: "Government has put plans, legislation, documents, and coordination systems in place, but has not allocated a budget for the survivors, nor has [it] been very pro-active in ensuring that all the good efforts written down are being implemented." However, others noted that because of fighting in the north, all the work there had been done by NGOs, some of which started to leave before the government "got itself organized" to expand activities into these areas. Neither the government nor the NGOs have focused on western Uganda.

A government representative noted that being part of the group of 26 countries with significant numbers of mine survivors and therefore the greatest responsibility to act, but also the greatest needs and expectations for assistance, has brought Uganda recognition as a country with this particular problem and has probably resulted in financial gains. The person further noted that being part of the group gave Uganda the courage not to lag behind.

Conclusions

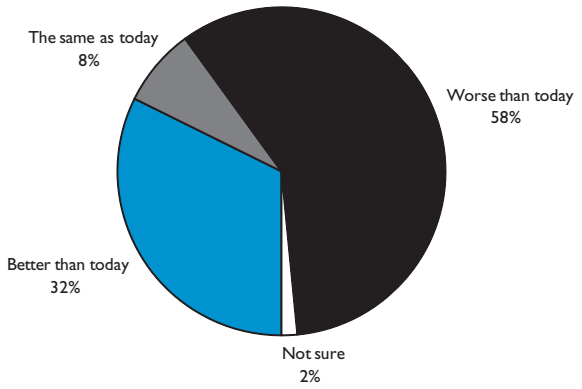
- Legislative improvements have been made, but fewer advances in service provision have been made.
- Activities were largely implemented by NGOs and funded by international donors.
- Challenges and weaknesses (capacity, unequal national coverage, funding, inadequate data) pinpointed early on were not solved between 2005 and 2009.
- The existence of a relatively well-established, albeit under-funded, disability sector prior to 2005 does not appear to have had a direct impact on VA progress.
- The importance of survivor inclusion was recognized early on and acted upon, but needs further strengthening.
- Implementation of a clear plan of action has been delayed because of dependency on external financial and technical resources.

Suggestions for the way forward

When asked about how they saw their situation in five years, 58% thought it would get worse, 8% thought it would remain the same, and 32% thought it would be better.[32] To assist in a better future ahead, the following suggestions may be taken into account:

- Urgently address the needs of survivors by implementing the VA plan for 2008-2012.
- Continue efforts to integrate VA into disability and to streamline practical interactions with development, health, and social sector plans to avoid duplication.
- Diversify funding for the 2008-2012 VA plan to avoid further delays.
- Define clear government responsibilities and divisions of tasks.
- Focus more planning and government funds on western Uganda.
- Intensify and clarify linkages to broader economic reintegration programs for conflict-affected and resettlement areas.

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



- Allocate sufficient long-term national funds for the survivor national federation and groups, and continue to include them more systematically in relevant planning and implementation processes.
- Increase budgets to enable the NCD to carry out activities and monitor the VA plan.

Patrick Omule
© Margaret Arach Orech

Lilly Akullu and her daughter
© Margaret Arach Orech

In her own words: the life experience of one woman now working for the National Union of Disabled Persons of Uganda (NUDIPU)

This 46-year-old, describing herself as a "professional, results-oriented disabled lady," experienced her incident in 1989 in Karamoja, when she was traveling. After initial treatment she was referred to the main hospital in Kampala, where bone-setting and skin grafting saved her leg. These services were not free of charge and put a heavy financial burden on her. She now walks with a limp. She needs orthopedic shoes to walk more easily, but cannot afford them. As a university graduate, she was working as a teacher prior to her incident, but she had to change jobs afterwards due to discrimination and her disability. She thus became a community worker and needs to supplement her salary by working for NUDIPU.

As someone involved in disability and VA activities, she said the main achievement of the last five years has been the development of the comprehensive VA plan. However, in her assessment, many services have not improved over the last five years because of the conflict and displacement. She added that the main priority for VA for the next five years is economic reintegration, as there are no specific programs to access micro-credit or vocational training. She further noted a "lack of implementation of most of the policies in place." She concludes by saying: "Much as Uganda is a part of the Mine Ban Treaty, victim assistance is not yet quite felt on the ground."

In their own words...

Respondents described themselves as: professional, result-oriented, disabled lady, coordinator of landmine survivor group, female survivor who has had both legs amputated, needing immediate help, having many dependents, hard-working man who cannot use a prosthesis due to topography, combatant abandoned by the government…

In their own words...

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

- Economic reintegration.
- Increasing physical rehabilitation and economic empowerment.
- Survivor resettlement.
- Providing school materials and fees for school-going survivors.
- Strengthening and lobbying for assistance for survivors' basic needs.
- Financial empowerment of survivors / survivor groups.
- Providing survivors with capital.
- Housing compensation.
- Assisting female survivors in earning a living.
- Creation of a landmine survivor center.
- Building for survivors and empowering their businesses.

In their own words...

A diverse range of opinions were expressed in survey responses and some respondents chose to include comments about services, such as:

Patrick Omule, 49, of Lira said the main achievement since 2005 has been: *"Organizing survivors and sensitizing them… The existence of survivor groups made a huge difference… at least we now have people to talk to who are close to home."*

Lilly Akullu, a married woman with eight children, said: *"I am only spoken to, but with no material benefit… The quality of prostheses is poor and we need to be taken to another district to get them… I only hear psychosocial support programs on the radio… Loans should be made available for survivors, and survivors' children's education should be supported… The capacity of survivor groups should be built so that our information is used correctly."*

Yemen

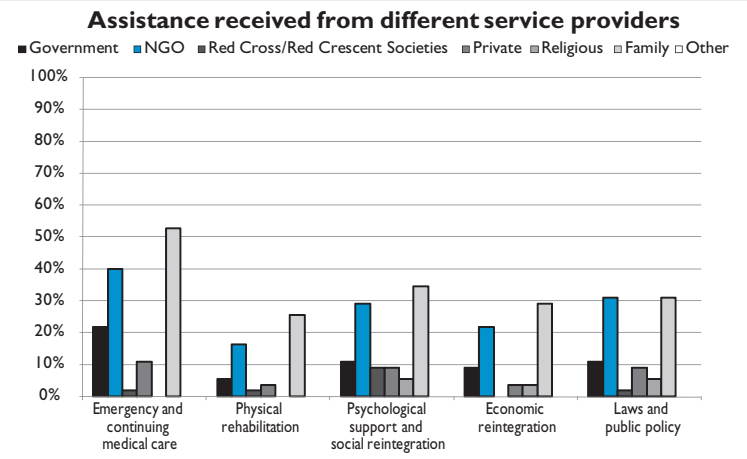
Country indicators

- *Conflict period and mine/ERW use:* Yemen is contaminated by mines and ERW, particularly in the south and the border between north and south due to conflict since 1962 (1962-1975 in the north; 1963-1967 in the south; 1970-1983 leftist guerilla conflict; 1994 separatist war; 2004-ongoing Shi'ite insurgency in the north).[1]
- *Estimated contamination:* As of August 2008, an estimated 243 km² was suspected of mine/ERW contamination.[2]
- *Human development index:* 153rd of 179 countries, low human development (compared to 149th in 2004).[3]
- *Gross national income (Atlas method):* US$950 – 169th of 210 countries/areas (compared to US$615 in 2004).[4]
- *Unemployment rate:* 35% (compared to 35% in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 24.6% (compared to 15% in 2004).[6]
- *Number of healthcare professionals:* 10 per 10,000 population.[7]
- *UNCRPD status:* Yemen ratified both the Convention and its Optional Protocol on 26 March 2009.[8]
- *Budget spent on disability:* Unknown; the VA program received government funding (matched with international funding), but it was inadequate and was cut in 2008.
- *Measures of poverty and development:* Yemen is one of the poorest countries in the Middle East, dependent on declining oil reserves. Some 45% of the population lives below the poverty line. Development is hampered by rapid population growth and increasing unemployment. Even though it is one of the "least developed countries," it received little development assistance until a US$5 billion aid plan was launched in 2006 to help Yemen reach its Millennium Development Goals; it was otherwise unlikely to reach all but one goal.[9]

VA country summary

Total mine/ERW casualties since 1962: At least 5,068			
Year	Total	Killed	Injured
2004	18	9	9
2005	35	9	26
2006	18	7	11
2007	26	5	21
2008	22	10	12
Grand total	**119**	**40**	**79**

- *Estimated number of mine/ERW survivors:* Unknown, but at least 2,445.
- *VA coordinating body/focal point:* The VA department of the Yemen Executive Mine Action Center (YEMAC) coordinates VA without any systematic connection to other relevant bodies.
- *VA plan:* VA is included in the mine action plans and a four-phased assistance program is followed.
- *VA profile:*[10] Between 2005 and 2009, VA was implemented by YEMAC in much the same way it has been since 2001. The YEMAC program consists of four phases: visiting mine/ERW survivors, medical examination of their needs, medical and physical rehabilitation assistance, and socio-economic reintegration. The socio-economic reintegration component, delegated to an NGO and started in September 2004, has been defunct since 2005 due to a lack of funding and capacity. Psychosocial support is not provided as it was not considered a priority, nor is there funding for it. In essence, YEMAC covers the cost of treatment, transport and accommodation of mine/ERW survivors who receive services through the regular health and rehabilitation networks; it also provides emergency evacuation. All services are centralized in the main cities (Sana'a, Aden and Ta'izz), whereas survivors almost always live in remote, rural areas requiring them to travel long distances and spend time away from home. This is especially problematic for women, who often need a male caretaker to accompany them. Basic healthcare is free of charge, but ongoing medical care and medication are not. Hospitals in major towns are not well-equipped or staffed, but can perform the necessary procedures. Physical rehabilitation centers are dependent on international support, which has decreased significantly since 2005, compelling the ICRC to expand its support in 2007. Economic opportunities for persons with disabilities and survivors were limited throughout the period, pensions were insufficient, and discrimination remained prevalent. The disability sector in Yemen is relatively well-developed and coordinated, but lacks



financial and human resources. Again, most services are urban-based, while community-based rehabilitation (CBR) is "virtually non-existent," resulting in only 1.5% of persons with disabilities having access to services and women with disabilities having even less access.[11] Mine/ERW survivors were almost never integrated into or aware of broader disability programs. There also have been reports of survivors being seen as "special cases" already receiving assistance elsewhere.[12]

VA progress on the ground

Respondent profile

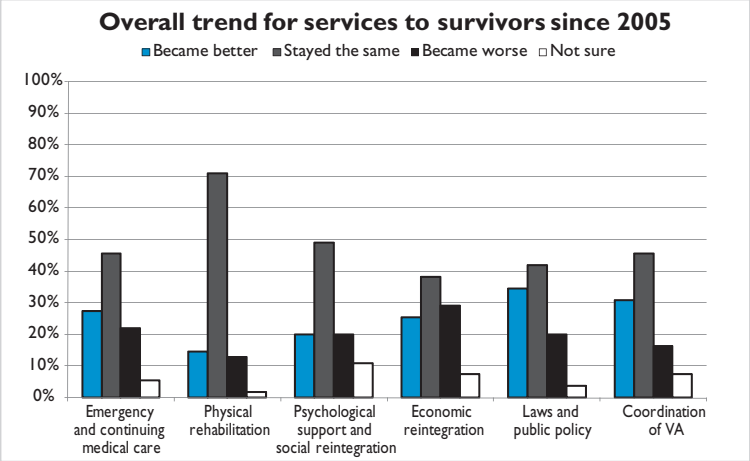
By July 2009, 55 survivors had responded to a questionnaire on VA progress in Yemen since 2005: 32 men, 18 women, three boys and two girls. Respondents ranged from 14 to 80 years old, with 55% between the ages of 21 and 40. Thirty people (55%) were heads of households and just 18% owned property. Respondents came from the mine-affected areas in al-Dhale, Ibb, Abyan, Lahej and al-Bayda, but also from Aden, Ta'izz and Sana'a. Most people lived in villages with limited services (30 or 55%), five lived in remote areas without services and 19 lived in a large city or the capital. One woman did not have a fixed residence and had to move between different family members.

Just 11% of respondents said their income was sufficient; 78% said it was insufficient and the rest did not respond. Just one person had been unemployed prior to the incident; 15 had been in school at the time (including three who were still minors at the time of the survey). After the incident, five said they were unemployed and 23 did not provide an answer.[13] Those who responded to the question all said their disability was the reason for them losing or changing their job. Almost half of the respondents (45%) were illiterate and only 33% made it past primary education. Most people experienced their incident when young. The respondents' profile corresponds to the casualty profile in Yemen, where most incidents occur in remote areas, often to young people. Women and children form a significant proportion of casualties as they are traditionally in charge of tending animals or collecting wood and food; girls are at particular risk.

General findings

Overall, the vast majority of respondents felt services had remained the same and had been limited since 2005, particularly in the area of physical rehabilitation and economic reintegration. Three-quarters of respondents did not feel there were more services, and 73% did not think services were better compared to 2005. People living in major cities noted more improvement (32% compared to 22% elsewhere). Some 16% thought services for women were "absent" compared to those for men; 20% thought women's services were "worse"; 31% thought services were "equal"; and 31% thought women's services were "better" than services for men.[14] Women and girls responded more positively than men: 35% of women and 35% of girls said women's services were "equal" or "better". Some 58% said services for children were "never" or "almost never" adapted to their age level, a finding that should be accurate, as many respondents were young when they experienced their incident.

Nearly 31% of respondents had never been surveyed by the government or NGOs since 2005; 15% had been surveyed three or more times. Some 65% said this had resulted



in their receiving more information about services. But it only led to 38% actually receiving more services, while just 27% reported less difficulty getting a pension or feeling listened to. Some 36% had been given a chance to explain their needs to government representatives. These results are surprising given the set-up of the YEMAC VA program, as recorded survivors are systematically interviewed to determine whether they need services. According to YEMAC, 2,033 files had been opened to March 2009 and 81% of these had received services (there are fewer than 2,500 recorded survivors in Yemen).[15] However, these results correspond to reports from government and survivors that not all of those identified in the Landmine Impact Survey of 2000 had been visited or assisted and that it was challenging to receive follow-up care after the first treatment.[16] It might also mean that respondents have been visited prior to 2005 but not since.

Emergency and continuing medical care

Nearly half of all respondents (45%) felt medical care had stayed the same since 2005; 27% saw progress; and 22% saw deterioration.[17] Most of those seeing progress lived in cities; none were from remote areas. More than half of all respondents (55%) thought survivors "never" or "almost never" received the medical care they needed and 29% found this "sometimes" to be the case. Nearly one-quarter thought complicated medical procedures could be carried out more than before. For the remaining progress indicators, fewer than 15% of respondents saw improvement in areas such as more suitable medication or equipment in facilities, better trained staff, better physical access, more emergency transport and first aid workers, or easier referrals. The least progress (4%) was noted in receiving healthcare closer to home, while only 5% thought government support for healthcare had increased. Half of the practitioners also thought that medical care had remained the same and none thought there were more centers in mine-affected areas. At best, practitioners thought that the government had maintained its efforts.

These results correspond with the situation in Yemen, where healthcare in rural areas is scarce and difficult to reach, particularly for persons with disabilities. Complex procedures need to be carried out in the main cities (mostly Sana'a, Aden and Ta'izz) and are not free of charge. A general lack of human resources, medication and equipment was reported throughout the period.[18] The only service provider for mine/ERW survivors is the YEMAC VA program, which has to group people together for transport to one of the main cities, provide them board and lodging, and cover the cost of their treatment. These results also confirm a 2006 Geneva International Centre for Humanitarian Demining (GICHD) evaluation finding that, "most [survivors] had not heard of the Yemeni Landmine/UXO Victim Assistance Program and are managing the best they can without adequate medical… support."[19] Emergency and basic care is free in principle, but many survivors report having to pay. YEMAC has tried to provide emergency evacuation but most survivors did not see progress in this area, either because of problems with the terrain and a lack of more general improvements by the government, or simply because they did not need this type of assistance. A Ministry of Public Health and Population (MoHP) evaluation of the health infrastructure and subsequent improvements scheduled for 2006 has not yet been undertaken.

Physical rehabilitation

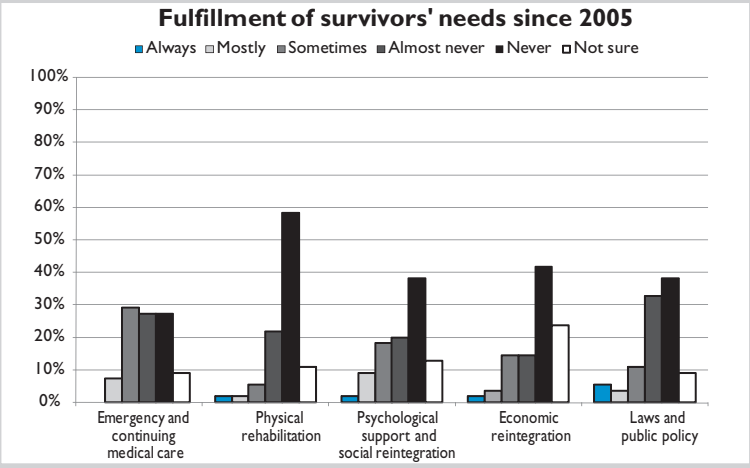
The vast majority of people (71%) said physical rehabilitation has remained unchanged since 2005 (15% reported improvement; 13% reported deterioration; one did not respond).

However, 58% believed survivors "never" received the physical rehabilitation they needed and 22% found this "almost never" to be the case. Overwhelmingly, survivors did not perceive progress in any of the specific progress indicators. The area where most progress was seen (albeit by just 13% of respondents) was in the quality of mobility devices. Fewer than 10% saw progress on all other indicators, such as better trained staff, better facilities, better physical therapy, or shorter waiting lists. The option of accessing services closer to home and the availability of mobile workshops scored 5% or less in terms of progress. Again, practitioners concurred, as 75% thought that physical rehabilitation had remained unchanged. A majority thought that, overall, the government had reduced its efforts, particularly in infrastructure, follow-up, and replacement devices.

This can be explained by the fact that the YEMAC program has not changed fundamentally since 2001. Therefore, those receiving assistance through YEMAC would have received the same services as before. Physical rehabilitation is only available in the main cities and in one mine-affected, remote area (al-Mukalla in Hadramawt governorate), making it difficult to reach the centers. In 2005, Yemen assessed that there was no need for community rehabilitation workers, and thus no efforts have been made to bring services closer to the people.[20] The absence of positive responses for specific progress indicators can be explained by the challenges the physical rehabilitation sector has faced since 2004. This is in part due to unclear government responsibility for physical rehabilitation, in which both the MoHP and the Ministry of Labor and Social Affairs provide financial support to the sector. However, each ministry provides insufficient support and it is impossible to obtain simultaneous funding from the two ministries. Challenges are also due to the departure of two international NGOs that supported the sector in 2005-2006. This resulted in funding gaps, personnel losses, a lack of materials in the Aden and Tai'zz centers, and the ill-functioning of the physiotherapy units in Aden due to a lack of staff capacity. Both ministries declined responsibility for taking over the Aden center, resulting in the ICRC expanding its operations to cover the center in mid-2007. Again, a MoHP assessment scheduled in 2006 was never conducted.

Psychological support and social reintegration

Nearly half of all respondents (49%) said psychological and social support services had remained unchanged since 2005; 20% saw improvement and 20% saw deterioration.[21] Just 11% said survivors "mostly" or "always" received the psychosocial support they needed. However, compared to medical and rehabilitation assistance, more people saw improvement in individual areas for this type of support. Some 35% thought psychosocial services were now considered equally important to other services and 31% believed there is less stigma associated with seeking this type of support. Also, 25% believed survivors were no longer considered as "charity cases"; 27% had become more involved in community activities; and 15% had actually become involved in psychosocial activities for other survivors. Three-quarters of practitioners found that psychosocial services had deteriorated and they usually thought that the government "did nothing" to improve the sector.



While the survivor responses are not overly positive, they are at odds with the total lack of government support for survivors in this area. While there are some counseling centers in Aden and Sana'a, no survivors have been assisted through them. Between 2005 and 2009, YEMAC did not conduct psychosocial activities due to lack of funding. YEMAC further noted

throughout 2005-2009 that psychosocial support was not a priority because survivors received this support in the family network.[22] The 2006 GICHD evaluation "emphasized that mental health care needs were sometimes as important as physical health needs" and needed to be incorporated into services.[23] Therefore, the positive responses in this area are likely related to the fact that the two national organizations conducting the survey also carry out activities in these communities, and some respondents are either members or beneficiaries of these organizations. A CBR network also exists, but its does not work specifically with mine/ERW survivors, has many competing priorities, and needs strengthening, as it mainly works through volunteers.

Economic reintegration

Among respondents, 29% believed economic reintegration opportunities had become worse since 2005 and 38% thought the situation remained unchanged. Some 42% of people found that survivors "never" received the economic reintegration opportunities they needed, while 15% said this was "almost never" the case. Just 5% said survivors "mostly" or "always" received the opportunities they needed. Nearly all survivors (95%) thought they would be the last to be chosen for a job, while just 10% thought economic reintegration of survivors was a government priority. One-fifth said employment quotas were better-enforced. Less than 15% of respondents saw improvements on other progress indicators, such as decreased discrimination, higher pensions, vocational training better meeting market demand, more educational or employment opportunities, increased awareness, or better-trained teachers. Half of the practitioners thought that economic reintegration opportunities had deteriorated since 2005.

This corresponds with the challenges YEMAC has faced in creating a successful economic reintegration component. In 2004 YEMAC supported the creation of an NGO (the Yemen Association for Landmine and UXO Survivors, YALS) for this purpose, but this organization has faced financial and capacity challenges ever since a one-off Japanese grant ended at the end of 2005. A small number of people have continued to be trained, but far fewer than the 500 survivors to whom YEMAC aimed to provide economic opportunities in 2005-2009.[24] Several other organizations work on vocational training and economic reintegration for persons with disabilities and occasionally include survivors, but YEMAC does not appear to refer people to these centers (for example, in Aden where it does refer people for physical rehabilitation but not for economic reintegration). Other initiatives exist through the Social Fund for Development (SFD), a semi-autonomous body with a wide variety of programs for vulnerable groups, but survivors' access in affected areas appears to be limited. Rising unemployment (since 1994) and the lack of opportunities in rural areas were further obstacles for survivors and other persons with disabilities. Only an estimated 12% of persons with disabilities were employed and 0.07% had received government support to access education.[25] Pensions were insufficient and only received by some 10% of persons with disabilities. Most of the survivors responding more positively in the survey had received support through the NGO to which YEMAC delegated its economic reintegration work.

Laws and public policy

Some 35% of respondents said their rights were more respected compared to 2005, while 42% said the situation had remained the same. However, 71% thought survivors "never" or "almost never" had their rights fulfilled. When looking at specific areas of progress, 38% thought awareness of survivors' rights had increased, 33% thought discrimination had decreased, and 25% said they received more information about their rights. The areas of least progress were enforcement of legislation (15% saw improvement) and government representation (7% saw improvement). Practitioners were much more positive, as 75% saw progress. They noted improvement in the development of new policies and decreased discrimination. Least progress was perceived in the enforcement of legislation.

This relatively positive response is likely not linked to YEMAC's activities, as it has never focused on rights issues or awareness raising. Such efforts were left to NGOs, which have been active on the issue and have increased their efforts since Yemen signed the UNCRPD, particularly Save the Children. The SFD ran awareness campaigns and a large disability project was started by the World Bank with the aim of assisting the government in creating a disability strategy. YALS' limited activities have also aimed to lobby for the rights of survivors and to increase awareness.

When asked how they would respond if survivors in Yemen were to say that their situation had stayed the same over the last five years, YEMAC said this would be "a credit to YEMAC as it has managed to maintain the level even when there was no money and no capacity."

VA process achievements

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

Note: Yemen actually provides VA information in Form I of its Article 7 transparency report, not in Form J.

Between 2005 and 2009, Yemen continued the VA program it has been running since 2001. The VA program is run exclusively by the VA department of the mine action center YEMAC, and is not integrated with any other disability, health or development initiatives in the country. In May 2009, the YEMAC director said the VA program was barely functional due to a severe funding problem.

Yemen's main reason for becoming part of the 26 countries with the greatest numbers of survivors and, therefore, the greatest responsibility to act, but also the greatest needs and expectations for assistance was to increase its receipt of international financial support. However, in May 2009, YEMAC said it had "not gotten anything" out of the VA26 process. Throughout 2005-2009, YEMAC's VA program operated on decreasing international funding and limited national funding. The funding allocated constituted a minimal part of the center's entire mine action budget. No international funding has been allocated to VA since 2007. In 2008-2009, the government funding to YEMAC was cut by 50% due to the economic slowdown; the reduced budget was earmarked for mine clearance, according to YEMAC.

As part of its commitment to the implementation of the Nairobi Action Plan, Yemen presented its largely SMART objectives in November 2005. Plans were detailed in 2007, but were restricted to the implementation of the four-phase program that has been in place since 2001. In 2009, YEMAC reiterated there was no reason to change the program, because "we think it is a good approach, tangible for survivors." Yemen has remained substantially below achieving its target to assist 500 people per year (and 2,000 in 2005-2009) in the first three phases, assisting 1,638 people since 2001. Fewer than 500 survivors have received economic reintegration support.[26] Survivors' responses also seem to indicate that the centralized, largely medically-oriented program does not fulfill their more varied needs. Just 15% said their needs were taken into account when setting VA priorities.

Some of the objectives relate to work to be implemented by ministries, such as assessment of the health and rehabilitation sector, implementation of a disability strategy, and the establishment of vocational training centers. However, YEMAC has never reported on these, stating in 2008 that it "was solely responsible for achieving the 2005-2009 objectives."[27] Coordination with ministries and other organizations is limited to referral of survivors. Nevertheless, several international assessments urged YEMAC to connect with other social and development programs more often.[28]

Over the years, YEMAC's coordination with other bodies has actually decreased. YEMAC's own Victim Assistance Advisory Committee – which prior to 2005 was an active body comprised of NGOs and government stakeholders – first started to reduce the participation of NGOs to such a low point that they were no longer invited in 2007. Secondly, it began to meet "only when needed," which was very irregularly. The committee does not have decision- or policy-making capacity. Centralized YEMAC management has, since 2005, also made it difficult for NGOs to obtain independent funding for VA/disability projects and has caused some international organizations to leave.[29]

Survivor responses reflect this. Only 44% knew who was in charge of VA; some 27% thought coordination with NGOs had improved since 2005, and 22% reported more coordination with the disability sector. Only 7% thought survivors or their representatives were included in VA coordination. Practitioners agreed: 75% saw no improvement in VA coordination or the government's coordination with NGOs. None of the practitioners thought that the needs of survivors were taken into account when developing plans or survivors were included in planning.

It should be noted that the successes YEMAC has scored are almost solely dependent on the efforts made by its top management, as already noted in evaluations in 2005.[30] This was also acknowledged by YEMAC itself in 2009, which said the head of the YEMAC VA department lacked capacity and needed to be more proactive. The capacity of the relevant ministries was said to be fair, but not adequate in all areas due to limited budgets.

Yemen has been increasingly active on disability issues because of the increased capacity of the SFD and because of a World Bank support project to develop the disability sector. The SFD is considered to be one of the most effective poverty alleviation networks in the region and the only public institution that supports both policy reform and service delivery for disability. There also are other disability coordination mechanisms, such as the Rehabilitation Fund and Care of Handicapped Persons (Disability Fund), a disability union, and several disabled people's organizations, most of which are well-coordinated. However, they lack government support and human resources. The completion of a disability strategy has also been pending ever since the first version forwarded to the Prime Minister in 2005 was deemed insufficient because it lacked a thorough situational analysis.

YEMAC said in 2009 that it had tried to approach the World Bank and SFD for more cooperation, but that there are no clear prospects for the near future. It added that SFD and the Disability Fund only assist those registered with them and that very few survivors are registered. Several NGOs have expressed interest to YEMAC in integrating mine/ERW survivors into their activities more, particularly social and economic activities. In 2008, YEMAC reported it aimed to close its VA program by 2014, but it is unclear if any transition mechanisms are in place.[31]

Conclusions

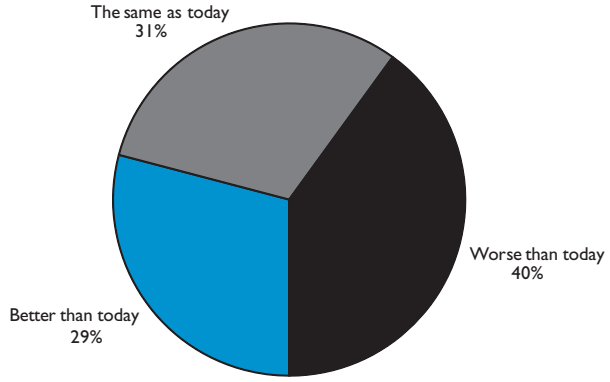
- YEMAC's VA program has been beneficial for the survivors it managed to reach, but its geographical scope and program range were too narrow.
- No changes have been made to the YEMAC program to cover the more varied needs of survivors.
- Economic reintegration activities were insufficiently supported.
- The departure of international NGOs which found Yemen a difficult place to work in and secure funding for has negatively impacted VA activities.
- Not enough linkages have been sought with civil society and with the broader disability, social assistance or development sectors.
- National funding for VA and for disability was insufficient and, in the rehabilitation sector, complicated by unclear responsibilities between key ministries.

Suggestions for the way forward

When asked about how they saw their situation in five years: 40% of survivors thought it would get worse, 31% thought it would remain the same, and just 29% thought it would be better. To assist in a better future ahead, the following suggestions may be taken into account:

- Decentralize the VA program, strengthen its follow-up capacity, and reorient it toward a less medical approach.
- Proactively find (international) funds for economic reintegration and ensure that survivors are more systematically referred to other service providers.
- Integrate VA and the YEMAC experience in broader disability, health and development strategies; actively seek survivor inclusion in existing programs; and ensure sufficient VA capacity at YEMAC in the meantime.
- Ensure that survivors are eligible for programs for persons with disabilities or vulnerable groups, for example through SFD.
- Ensure inclusion of the needs of survivors in the disability strategy under development.
- Allocate sufficient national funds to VA and to disability more broadly.
- Include survivors more systematically into VA, as well as into general disability planning and implementation.
- Increase interaction with civil society while guaranteeing its independence.

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



Ahmed Naji (middle) being interviewed
© Gamila Muhammad Awad

Saleha in her village
© Gamila Muhammad Awad

In their own words…

Respondents described themselves as: patient, suffering a complex, depressed, strong-willed, determined to overcome illiteracy, perseverant, frustrated, ambitious, and persistent.

In their own words…

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

- Care for us and coordinate with us.
- Improve the living standards of survivors.
- Collect our information and integrate us into society.
- Provide follow-up care.
- Offer us jobs and housing.
- Training and rehabilitation.
- Provide repairs for prosthetics near our homes.
- Give us better work opportunities.

In their own words…

If countries really cared about survivors they would:

- If they did, I would answer this question.
- Support the survivor association [YALS] so it can do more for us.
- Give survivors their full rights.
- They do not but I wish they would.
- Offer us a decent income.
- Be earnest and honest in their concern.
- Give us a chance to get a job.
- Increase their economic, social and cultural status.
- Give them their rights in terms of employment and involve them in decisions.
- Help us make a living.
- Visit us and take our needs into consideration

In their own words…

A diverse range of opinions were expressed in survey responses and some respondents chose to include comments about services, such as:

Yahya Abdu Muhammad was tending his herd in the mountains when he set off a landmine that led to the amputation of one of his legs. He says:
"I received initial medical care only, no follow-up. Ten years later, I made the eight-hour journey to Sana'a to get a prosthetic leg which cost 50,000 riyals (US$250). I would like to have a service like this closer to home and free of charge."

Saleha Bint Muhammad, a 72-year-old widow, noted:
"Since my injury while herding sheep in 1982, I have suffered from headaches and vision difficulties. As a woman, I do not get the support I need. I feel men get more opportunities."

Ahmed Naji lost his both legs in an antipersonnel mine incident while in the army. He lives in a very mountainous area in al-Dhale. He said:
"I have been given a wheelchair, but I cannot use it in this area. I feel weak, as I am unable to move and services are inaccessible."

Gamila, one of the interviewers, added:
"Most male survivors had big families to support but hardly any income. The female survivors interviewed were usually illiterate and had been injured while herding. All survivors found it tiring and costly to go to the post office to collect their small pensions, but they think people in even more remote areas are not receiving services from anyone. Although the survivors said they need health, educational, social and psychological services, what they want above all are work opportunities suitable to their disability and to live in dignity and with respect in their community."

External support for victim assistance (VA) – donor states' efforts

The Mine Ban Treaty (MBT) states that all States Parties "in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims…"[1] Thus far, this report has focused on those primarily responsible – the affected states. But it is also clearly recognized that these affected countries are not in a position to address their needs with national resources and capacity alone. So, while they had the greatest responsibility to act, they also had the greatest needs and expectations for assistance.[2] The Nairobi Action Plan (action #36) calls on other countries to "promptly assist those States Parties with clearly demonstrated needs for external support…and ensuring continuity and sustainability of resource commitments."[3]

When asked about their expectations for entering the informal VA process 18 of the 26 countries with significant numbers of survivors answered that they had expected increased access to international technical and financial assistance. Just two, Albania and Croatia, did not answer the open question about their expectations in this way.[4] Of the 18 who did expect increased support, 14 did not feel that they received it and two (Burundi and Nicaragua) were unsure, stating that international assistance had been received but government officials were not sure this was because more attention was given to VA. While Albania had not explicitly expected increased funding, it added that being part of the informal group of 26 had assisted it in acquiring more aid.

Twenty-nine main donor states or regional organizations received questionnaires asking them about trends in their support for VA and their perceptions of global patterns in this area since 2005. Questionnaires did not ask donors to provide monetary figures nor to differentiate funding for projects that targeted mine/ERW survivors from integrated funding, such as development aid, which aimed to address the rights and needs of persons with disabilities. By July 2009, 14 donors completed questionnaires and three others responded in another format.[5]

While the sample size is too small for accurate statistical representation, there was clear agreement that external support for VA was insufficient and that there was no effective mechanism to monitor this support. The majority of respondents indicated that they had increased their support to VA since 2005 but just 14% felt that international donor contributions to VA were sufficient. The two most cited reasons for why funding was deemed to be insufficient were the continued high levels of needs and competing public health priorities in countries with inadequate healthcare systems. The issue of competing priorities can be connected to increasing trends to integrate assistance for mine/ERW survivors into broader development frameworks, which should also benefit survivors.

This integrated approach has made it difficult for many donors to demonstrate their support for VA and, thus, to hold them accountable for their commitments to the MBT. All three states responding in an alternative format stated that their VA support was mainstreamed into other development assistance (such as healthcare) and could not be tracked. This inability to track support and the wide variety of broader development projects that should benefit survivors have been a consistent challenge in estimating how much resources are allocated to VA. The co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration stated, in 2009, that "very little [information] was provided regarding efforts that will ultimately benefit landmine survivors through integrated development cooperation."[6]

While donors have had difficulty providing data or tracking external support to VA, all respondents felt that they were at least "sometimes" in a position to provide international assistance to VA.

Asked when affected states would be able to cover all VA needs with national funds, no donor respondents felt they already could. Most donors said that affected countries would only be able to cover their own VA needs in 10 years or more, or would never be fully able to. One respondent pointed out that most donor states were currently unable to meet all of the needs of their own disabled population and, thus, it was unrealistic to expect affected states to be able to do this any time soon. Most donors estimated that national contributions in 2009 accounted for 50% or less of VA costs.

Handicap International staff member conducting interviews in Colombia
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Global victim assistance (VA) progress on the ground

Respondent profile

A diverse range of survivors were surveyed in 25 of the 26 relevant States Parties and 1,561 survivor responses were analyzed as of July 2009 (84 additional responses could not be used). The demographic composition of all the respondents matched closely with global trends among survivors. In a small number of countries, obtaining a completely representative sample was constrained by the limitations of in-country project partners and/or political or security limitations (Guinea-Bissau, Burundi and Peru). Due to similar but more severe constraints, it was not possible to survey any survivors in Eritrea without endangering partners or research team members.

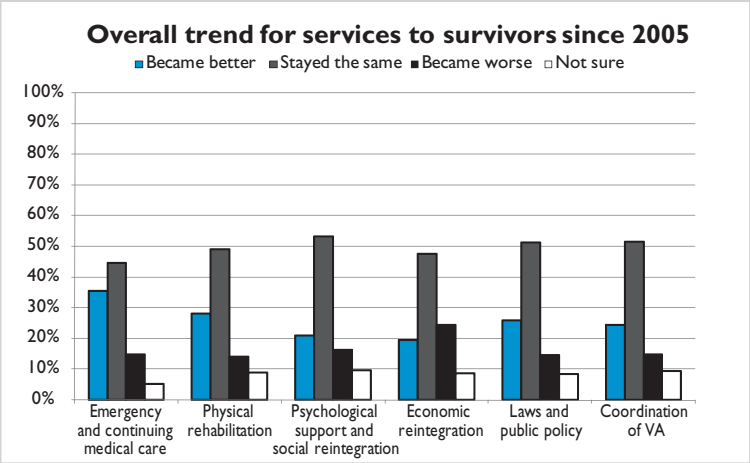
Although adults were slightly over-represented, as it would be too difficult and inaccurate to interview young children, a significant number of adults had experienced their incident while in childhood. Men made up 86% of respondents, women 11%, boys 2% and girls 1%. Respondents resided in all types of living areas: 39% lived in villages with some limited services, 20% in large cities, 20% in the country's capital, and 16% in remote areas without services.[1] Most people (71%) were heads of households and 44% owned property. Almost 20% of respondents had not received any formal education and just 38% had started secondary education or higher.

Just 8% of survivors were unemployed prior to their incident. After the incident, this rose to 25%, with many more just not answering the question or noting that their work was "limited", "occasional", "a bit of everything" or "whenever they could". Those who became unemployed mostly gave their disability as the reason. Among working survivors, most had to change jobs and many could no longer even work as subsistence farmers, the main occupation in many of the countries, for example, in Cambodia or Thailand. It needs to be noted that the majority of respondents was interviewed through survivor organizations and disabled people's organizations of which they were members or through NGOs where they worked or were beneficiaries (often of economic reintegration projects). This would have affected the response on unemployment and it is certain that the unemployment rate among survivors and persons with disabilities in general is much higher. For example, in Sudan 42% of survivors lost their livelihood, in Afghanistan unemployment of persons with disabilities is estimated at more than 70% and in Eritrea just 10% of persons with disabilities have a job. Nearly three-quarters of respondents (74%) thought that their household income was insufficient. It is likely that the survey also over-represented survivors who are part of peer support networks and that, in general, many survivors were more isolated than those surveyed.

General findings

Over two-fifths of respondents (42%) had never been surveyed by the government or NGOs in the last five years, and 30% had been surveyed three or more times. Results varied significantly across countries. In some countries, such as Albania, survivors were regularly consulted about their needs. In others, such as DRC, this survey was the respondents' first in at least five years. Just 28% of survivors thought they had received more services as a result of these surveys.

About 32% of survivors thought that services for children were "never" adapted to their needs. Although female participation was too limited for accurate extrapolation, some 44% of survivors thought that women had "equal" access to services as men, but the second largest group (20%) thought that services for females were completely "absent". Just 10% thought that women received better services than men. Overall, women responded more negatively to this question: 34% thought that services were "equal"; 23% said services were "absent"; and 9% said "better".



Overall, just one-quarter of all respondents thought that they were receiving more services in 2009 than in 2005. Some 28% thought that services were better in 2009 compared to 2005.

Emergency and continuing medical care

The area of most progress was emergency and continuing medical care. But still less than two-fifths of all respondents (36%) saw progress. While responses varied significantly across countries, generally the areas of most satisfaction were: improved infrastructure of health facilities (44% thought so), and an increased number of health centers (41%). Nevertheless, fewer people thought that they could get the medical care they needed closer to home. Issues of least progress were: the availability of sufficient supplies and equipment at health centers (29%), medical teams with a more complete set of skills and the availability of emergency transport and medication (33% for all).

In many cases, there was indeed an increase of medical facilities and better infrastructure due to broader development projects in the health sector, such as in Thailand. However, more specialized medical care was highly centralized in capitals and a few major cities in each country, for example, in Yemen. While efforts were made to train more staff, they were often not willing to work in rural areas. Emergency response mechanisms were lacking throughout and response effectiveness was often hampered further by bad road networks or insecurity, for example, in Colombia. Basic care was also generally free of charge, but continued medical care, medication and transport and accommodation were not, making services effectively inaccessible for survivors, which is a major obstacle, for example, in El Salvador.

Physical rehabilitation

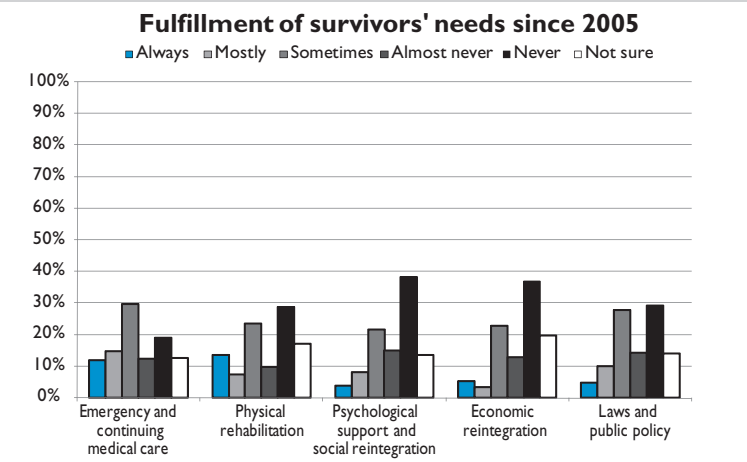
Just 28% of survivors globally believed that physical rehabilitation had improved since 2005; most thought that the situation remained unchanged. Just 24% of survivors thought that the government now provided more support to physical rehabilitation than in 2005. Areas of most progress were the quality of mobility devices (39% thought so) and better trained staff (also 39%). Much less progress was seen in the number of physical rehabilitation facilities, the possibility to get services closer to home and the availability of mobile

workshops to provide repairs or some other basic services. For each of these, just 18% of survivors saw advances.

Physical rehabilitation is often only available in major cities while most survivors live in rural areas, for example, in Peru. If transportation and accommodation was provided, this positively affected the responses of survivors, as occurred in Tajikistan. In the majority of countries, the physical rehabilitation sector remained heavily dependent on international support – in some cases, it is almost entirely run by international organizations, such as in Cambodia. In countries where this international support ended, service provision declined and was expected to decline further, as is the case in Angola. These international organizations also ensured continuous training and improvement in devices, which increased the daily comfort of survivors significantly, for example, in Nicaragua. NGOs and international organizations were usually also the ones providing transport and accommodation coverage.

Psychological support and social reintegration

Just 21% of respondents thought that psychological support and social reintegration services had improved since 2005. The area where the least survivors, just 19%, saw improvement was in the level of government support. Most advances were made by survivors themselves or with the support from family, friends, and to a lesser extent NGOs: over time, they had started to feel more empowered (45% felt this way) and had become more involved in community activities (47%).



These two advances had little to do with any actual improvements on the ground, as services were often chronically lacking, stigmatized or virtually non-existent. The fact that many respondents were part of peer support groups influenced responses. Nevertheless, just 23% thought that this much-needed support mechanism had become more widespread, for example, in Mozambique, where no one thought this was the case. The importance of psychosocial support was not often recognized, as in Chad. Services were small-scale and provided by NGOs usually not targeting mine/ERW survivors, as in Burundi. Few well-trained staff existed and just 24% of survivors saw improvement in that situation. This, for example, was the case in Serbia where services were, in theory, available in social centers but staff had only basic skills.

Economic reintegration

Economic reintegration is the area where most respondents (24%) thought the situation had worsened and just 19% saw improvement. More worryingly, just 9% of survivors thought that they would not be the last ones to be chosen for a job. Most progress was seen in the level of educational and professional discrimination (37% thought it had fallen). Around 29% of survivors thought their access to education had increased and 25% thought the same about vocational training opportunities. But for the vast majority, this did not translate into actual employment opportunities (16% saw an improvement) or the means to set up their own business (15%). Employment quotas and job placement mechanisms for persons with disabilities were totally ineffectual, for example, in Bosnia and Herzegovina or Jordan. Just 13% thought that employment quotas were enforced more often and 15% thought that job placement services had improved since 2005.

Economic reintegration initiatives were usually carried out by NGOs and remained small-scale. Nevertheless, when survivors had accessed these initiatives, this very strongly influenced their response, for example, in Ethiopia or Sudan. Survivors generally had insufficient access to the economic reintegration activities of broader development programs, for example, in Senegal. Often survivors' education levels were too low to be able to enroll in skills training, for example, in Colombia. Entry fees for training and education were a challenge in several countries, as was transportation and accommodation if it was not covered by NGOs.

Laws and public policy

About a quarter of respondents (26%) found that the protection of their rights had increased since 2005. Overall the areas of most progress were increased awareness about the rights of persons with disabilities (43% saw improvement), for example, in Jordan, and the less frequent use of negative terms about persons with disabilities (45%), as in Uganda. While survivors in many countries noted that laws and policies relevant to them and other persons with disabilities had been developed, they saw less progress in the actual enforcement of these laws and legislations (33% saw progress), for example, in Croatia. In other countries, such as Iraq and Afghanistan, the lack of effective disability legislation was seen as a severe obstacle.

VA process achievements as seen by survivors (coordination and inclusion)

The 26 relevant States Parties increased their focus on strengthening coordination mechanisms in 2005-2009. But overall, just 39% of survivors knew who was in charge of VA/disability coordination in their country and only 24% thought that coordination had improved. Often, coordination did actually increase and improve but for many survivors this had not been translated into more effective service provision, for example, in Sudan. In other countries, such as Bosnia and Herzegovina, coordination was lacking throughout 2005-2009.

Some 35% of survivors thought that coordination with NGOs had improved and 37% thought that more links had been established with the disability sector in general. This was for example the case in Uganda or in Afghanistan. However, in countries like Yemen or Guinea-Bissau, these linkages were missing completely and severely hampered the sustainability of VA provision.

Just 21% of respondents thought that survivors were included in VA/disability coordination and just 26% thought that VA plans and priorities were based on the actual needs of survivors. Some of the notable exceptions were Tajikistan and Albania which consistently tried to conduct needs-based programming and include survivors in coordination. However, both have a relatively small-scale problem. Some 38% of respondents thought that survivors were involved more often in the implementation of VA/disability activities. However, this percentage is likely too high as many respondents were NGO, DPO or survivor organization members. Just 17% thought that they received regular information about achievements in the VA/disability sector, despite the fact that nearly all of the 26 countries reported at least once a year at international MBT meetings, possibly indicating a greater focus by governments to provide updates abroad than in their own countries.

Overall, progress made by the 26 states has been strongly influenced by their national technical and financial capacity and country context, but also by their level of political will. Most survivors (65%) acknowledged that their governments did not have sufficient resources, but at the same time, just 22% thought that their governments had actually increased their national contributions to VA/disability since 2005. Some 34% of survivors thought that their governments had become more involved in VA, but just 15% thought that there had been sufficient political will to ensure improvement to the lives of survivors.

ICBL Ambassador Tun Channareth making a statement in May 2009
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Conclusion

Under the Mine Ban Treaty's (MBT) Nairobi Action Plan for 2005-2009, States Parties committed to "do their utmost" to enhance the care, rehabilitation and reintegration efforts for survivors during the period 2005-2009. Understanding the achievements and challenges of the past five years of victim assistance (VA), which make up half of the MBT's lifetime so far, is key to planning for the future.

For the first time, *Voices from the Ground: Landmine and Explosive Remnants of War Survivors Speak Out on Victim Assistance* provides a review of progress in VA – as seen by the people directly affected – against the commitments made by States Parties. The report findings are a rare porthole to the views and opinions of the people who the processes of VA are designed to serve. Responses, while often not technically informed, are founded in deep personal knowledge of VA by those experiencing the reality on the ground with its progress, successes and the problems.

This report sets benchmarks against which future progress can be measured. *Voices from the Ground* provides more than statistics. It lays down a challenge for States Parties to incorporate these findings into their actions so as to make good on their commitments to survivors. More importantly, it serves as a powerful reminder that survivors' voices need to be at the forefront of planning, implementation, monitoring and reporting on VA.

For the purpose of the Nairobi Action Plan, VA is divided into inter-related and equally important, but clearly distinct pillars. These became the framework against which this report measured progress.[1] However, for survivors these provisions are an inextricable part of their daily lives, rather than a series of steps they need to go through. Rather than thinking about each type of service separately, survivors attach more importance to whether all types of services are suitable, reachable, affordable, qualitative and non-discriminatory. What matters is that girls, boys, women and men can access the services and rights they need, when and where they need them.

Definitely, VA is a long-term commitment which cannot be completed in the limited timeframe under review (2005-2009). It is acknowledged that the number of survivors, the capacity to assist, and the developmental and political context of the 26 States Parties with significant numbers of mine survivors and "the greatest responsibility to act, but also the greatest needs and expectations for assistance" varies greatly. No matter how significant their numbers, mine/ERW survivors and other persons with disabilities are seen by most countries as a small issue among many competing priorities. However, under the MBT process, these 26 states declared that they felt responsible for this small but important group and were determined to improve their lives by compiling a set of activities which they could successfully complete in five years. While the international community should have felt a pressing obligation to assist, it could not replace the real and sustainable sense of ownership and political will these 26 countries needed to experience in order to face the challenge and find solutions to it.[2]

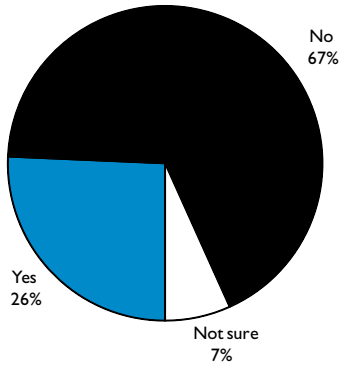
Ultimately, VA is valued by what is actually delivered to improve the lives of survivors, their families and communities. Bearing that in mind, a number of important lessons can be drawn from this survey.

Lesson 1: Survivors know best what they need, so always include them in coordination, planning, implementation and monitoring of VA/disability issues.

Many of the 26 States Parties have taken seriously the Nairobi Action Plan's call "to ensure better understanding of the breadth of the victim assistance challenge they face..." They started needs assessments, organized stakeholder workshops and engaged in lengthy consultative processes to develop plans.

In many cases, this task was done so thoroughly that several of the 26 countries acknowledged that planning had been their greatest achievement of the last five years. The co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration equally stated that for 2005-2009, "the most identifiable gains have been process-related and the real promise of the Convention is to make progress on the ground, in the lives of individual survivors."

The needs of survivors are taken into account while developing a national VA action plan



To make progress on the ground, an accurate and effective understanding of the challenges in VA necessarily includes the concerns of survivors themselves. In most countries, survivors were not adequately consulted about VA issues and survivors' needs were not included in planning. As mentioned before, just 26% of survivors thought that VA/disability priorities were set based on their needs and only 21% believed that survivors actually participated in coordination.

Efforts to seek information from survivors, while undertaken, were usually not systematic. Equal participation of survivors and their organizations in many countries was also hampered by their limited financial, human resource and logistical capacities and the lack of assistance to facilitate their participation. In some cases, the voices of survivors were considered to be too militant or inconvenient.

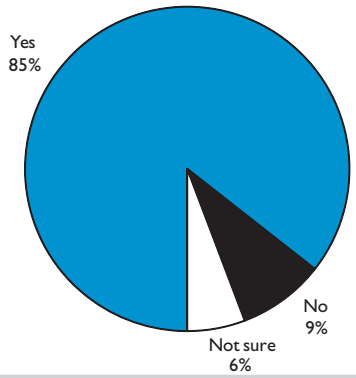
Inclusion of survivors in issues affecting them also needs to be extended beyond the scope of VA. They need to be involved more often in broader disability planning as well as relevant health, social and development planning. This is the only way to ensure that survivors, as one among many vulnerable groups in most of the 26 countries, can also benefit from these broader and, in some cases, more advanced programs. To make sure that these broader programs are adjusted to the needs of survivors is the only way to ensure adequate long-term assistance to survivors, as survivors will continue to need support after many of the other provisions of the MBT are completed.

Lesson 2: Survivors need more than basic medical care and rehabilitation to make their lives whole. Ensure that all types of services are equally developed and accessible when and where needed.

While most survivors received initial medical care and basic rehabilitation services, specialized services and follow-up care were out of reach for most. One of the most common reasons for this was the centralization of nearly all specialized services in major cities and a lack of attention to the reinforcement of community capacities. An equally important obstacle was cost, not only the cost of the actual service, but also the cost of transport to get to faraway places and to leave work behind for a significant amount of time. In other cases, services simply did not exist or were not open or adapted to survivors.

States and civil society alike have come to accept that VA is not just a medical issue, but a series of interlinked, equally important services and rights. However, national governments and international supporting organizations have not been able to put this theory into practice as they continued to focus their attention mainly on medical and rehabilitation issues throughout 2005-2009. Most of the States Parties were able to present advances in the health sector, usually unrelated to their VA efforts. National governments displayed much less investment in the physical rehabilitation sector, which however, remained the predominant focus of international organizations.

Unemployment was so high that survivors were the last to be chosen for a job



The importance of psychosocial support services was sadly undervalued. It was either left to the family support network or almost seen as a "luxury item" for those who could afford to think about it. Psychosocial activities were lacking in the majority of community or center-based services and peer support mechanisms remained underdeveloped. More awareness is needed, as are technical and financial resources, to expand and build capacity of community-based and peer support networks

Being economically active again and independent is the area survivors find most important for their healing process. But in all 26 countries, survivors were most pessimistic about their income, their employability and their future economic prospects. Nearly all survivors were convinced they were the last to ever get a job. General high unemployment and low educational levels of survivors were often called in as reasons for the lack of employment and educational opportunities for survivors. But equally, specially designed programs did not meet market demands, and general programs were not inclusive of survivors.

Lesson 3: Progress is about coordination, monitoring and the practical use of the resources states have, rather than those they would like to have.

Many countries face huge challenges in delivering the services that survivors need, while ongoing conflict damages and drains scarce resources. But regardless of security, economic, and development indicators, the survivors' assessment of progress was more positive in countries where adequate coordination mechanisms had been set up.

For many states in 2005-2009, the main achievement was the development of coordination mechanisms and a strategic framework, but plan implementation started too recently for it to have a direct positive impact on survivor responses. Nevertheless, just the process of formulating a plan in broad stakeholder consultation helped guide the actions of NGOs and ensured that ongoing activities were included in the plan.

Of course, with several states only just starting to implement their plans at the end of the period under review (2005-2009), a real risk exists that they will make little proactive effort to implement the plan or allocate sufficient budget to it.

In many of the 26 states, implementation of the plan was not monitored adequately, as more often than not monitoring systems were not in place or not in use. Throughout 2005-2009, states' reporting has been disconnected from the objectives they set for themselves. Initiatives were mentioned but no indication was given whether there was any greater benefit for survivors over time.

Civil society, including the ICRC and the ICBL, have repeatedly asked for more standard and rigorous monitoring and reporting to provide "all States Parties with a sense" that progress is being made but also to ensure that a focus is kept on VA because it can demonstrate "that it is an area of implementation that merits increased investment."[3]

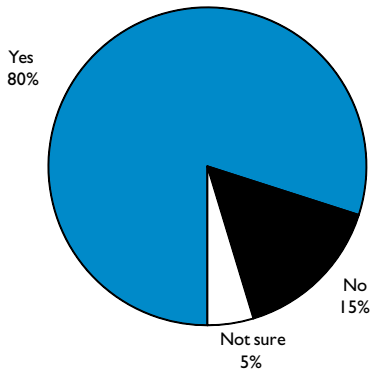
It is likely that international resource mobilization will become an even greater challenge in the years ahead and states will be expected to increase their own national investment. In some cases, coordination of VA-specific initiatives proved to be extremely effective, for example, in Albania and Tajikistan. But analysis revealed that several States Parties had developed complex, stand-alone VA plans and projects, while overlooking existing resources in the disability, health, social, and development sectors. Sustainable progress and more effective use of resources can be achieved by incorporating VA into disability or other relevant planning while keeping any special needs for survivors in mind. This was successfully undertaken in just a few countries, such as Afghanistan, where a process that started as a VA effort became the roadmap for the disability sector as a whole.

The UN Convention on the Rights of Persons with Disabilities should provide synergies for a more systematic and sustainable approach by putting VA into a more elaborate legal framework for persons with disabilities in general. The MBT needs to re-establish its pioneering leadership by building on and extending the more specific language of the Convention on Cluster Munitions.

Lesson 4: Those responsible for coordination need to be in the best position to get the job done.

Not only does coordination need to exist, those in charge of coordinating VA/disability issues also need to have the capacity, knowledge and authority to effectively fulfill the role. Additionally, continuity in the coordination and sufficient interaction with the broader disability and other relevant sectors are needed. In many countries, the mine action center, ministry or other organization designated with the VA coordination position lacked many of these attributes. To the detriment of implementation, VA often simply was not a priority compared with their other tasks. In many cases, focal points or coordination mechanisms did not have the authority to direct or even engage relevant ministries, let alone entice resources out of them.

There was a lack of political will from the government



A focal point or coordinating body with sufficient authority is needed to raise the profile of VA. But more importantly, it is needed to ensure the access of survivors to suitable programs in the broader disability and other relevant frameworks. For some States Parties, future action may require the transfer of the VA coordination role to a ministry responsible for disability issues.

Lesson 5: The international community needs to continue to listen to affected states and provide them with more and better financial and technical assistance.

The international community has to promptly assist those States Parties that can clearly demonstrate they need external support for VA and to ensure that sufficient resources are committed for the long term.

During 2005-2009, most of the 26 States Parties found that they had received insufficient international technical and financial support. Several of those states have done the groundwork for VA, including assessing the needs of survivors and making plans, but have not received sufficient donor assistance to adequately implement their plans. In some cases, this seriously stalled a solid process, such as in Tajikistan and Uganda. In other instances, it has meant that much-needed activities for survivors could not even be started, such as in Guinea-Bissau. Some other countries have clearly evidenced that sustained and multi-year funding can result in direct progress, for example, Sudan.

Future perspectives

Although some of the lessons learned are not very different from the challenges identified in 2004 and which the Nairobi Action Plan meant to address, they have been confirmed by survivors' own experiences. In many cases, although acute needs were recognized, little improvement was experienced on the ground.

While it needs to be fully acknowledged that VA is a long-term endeavor with limited resources and dependent on the general developmental state of a country, it cannot be accepted that the challenges faced in 2009 "likely will be the same as those to be faced in 2014,"[4] as noted in May 2009.

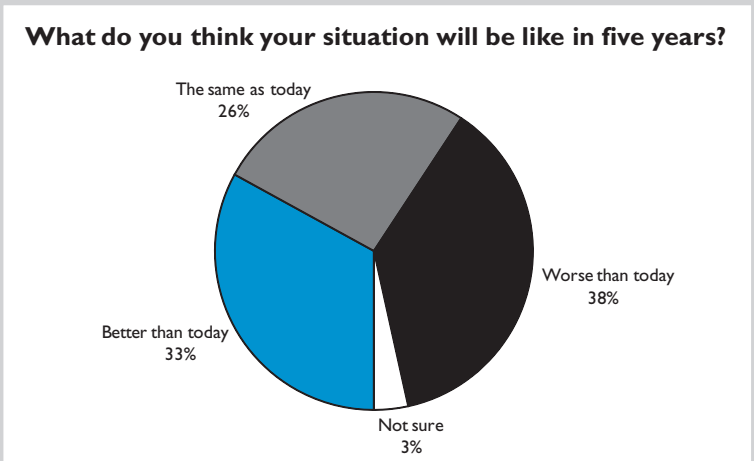
In 2009, it is time to move beyond this cliché that some immeasurable progress is being made but that an even more immeasurable lot remains to be done. Survivors have spoken out clearly, and, together with the states' own reporting and civil society monitoring, have set a clear benchmark of where the work needs to start immediately after the Second Review Conference in November-December 2009. If affected states and the international community are to fulfill their promise to tangibly improve the lives of survivors, donors must increase, or at least maintain, their financial and technical support, and enhance its effectiveness. Without waiting any longer, affected countries must increase their ownership, **implement measurable actions and include survivors** and other persons with disabilities in the activities whose only progress indicator is the positive impact on the lives of those they are meant to benefit.

Survivor Corps staff member meeting one of the survey participants in Jordan
© Survivor Corps Jordan

Suggestions for the way forward for progress-oriented victim assistance (VA)

When asked about how they saw their situation in five years:

- 38% of survivors thought it would be **worse** than today.
- 33% of survivors thought that it would be **better** than today.
- 26% of survivors thought that it would be the **same** as today.



These results send out unambiguous warning signs that, based on the last five years, two-thirds of survivors do not really believe in their governments' and the international community's ability to make progress. It also shows clearly that States Parties' status reports about their efforts to fulfill the core aim of the Mine Ban Treaty (MBT) might have little direct relationship with what survivors are experiencing on a daily basis.

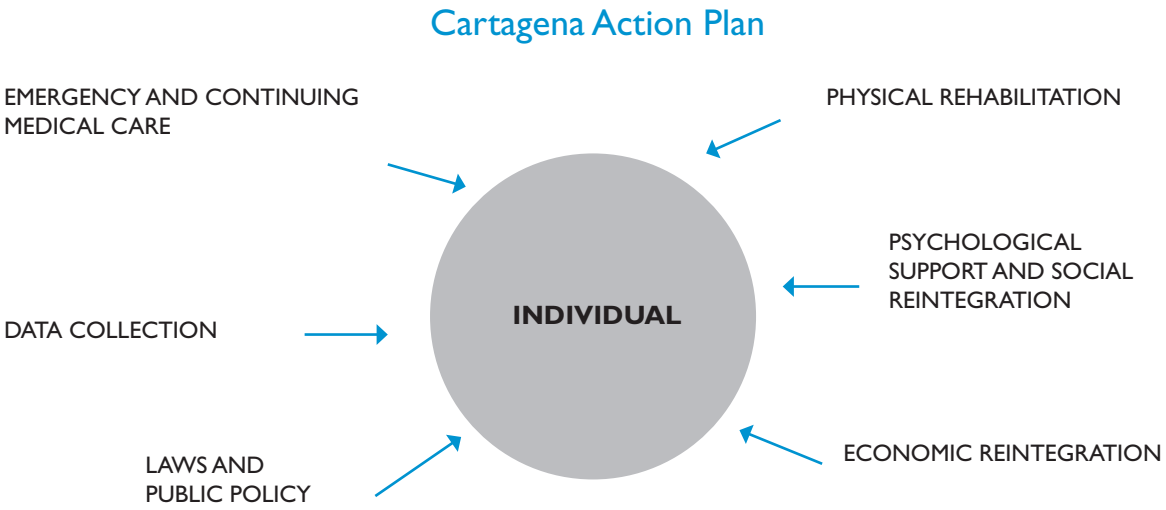
Core aim of the MBT:
End the suffering caused by antipersonnel mines

- For VA, "ending the suffering…" means: bringing about a demonstrable improvement to the lives of survivors and their full and equal participation in society.
- Improvement is achieved by implementing activities within the context of the legal framework of the MBT and coherent with other relevant frameworks.[1]
- The guide to implementation of VA for the MBT is the Action Plan.
- To be able to show progress, actions need to be measurable and timely.
- The measurable and timely actions need to be monitored.
- Monitored results (progress and lack thereof) need to be reported transparently.

In 2005-2009, the majority of survivors indicated that their situation had remained unchanged. This means that states did not provide what is important for survivors, their families and affected communities ('victims')[2] or were not able to demonstrate that progress had been made to the citizens for whom it declared responsibility.

What is important for the 'victim'?

- Equal access to and input into services, the full exercise of their rights and participation in the decision-making process when and where needed.



What is important for VA in the MBT context?

- **Demonstrating progress**: States must be able to prove that victims receive appropriate services and that their equal rights are respected, when and where they need them, no matter under which framework this assistance is provided.
- **Non-discrimination:** VA functions within the broader context of disability and development. VA actions should address the needs and rights of persons injured by other causes and other persons with disabilities. If existing disability, development or poverty reduction frameworks are in place, states must demonstrate that victims are assisted through these and/or modify them if they are not.
- **Synergy:** The scope of MBT VA cannot duplicate or replace the relevant broader human rights frameworks. More systematically, VA actions must coordinate with and build on these comprehensive frameworks, such as the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the Convention on Cluster Munitions (CCM), or poverty reduction strategies to ensure efficient use of resources in implementation, capacity building, monitoring, reporting, and funding because the outcome of this will be "greater than the sum of each part."[3]
- **Scope:** Many of the challenges for VA are commonly faced by developing countries. Rather than being paralyzed by the extent of these challenges, such as competing priorities or weak bureaucratic structures, States Parties should look for creative solutions fitting within the scope of their VA obligations and use their experience to contribute to their country's development goals.[4]

Unlike for other provisions, the MBT is very vague and unspecific for VA as it does not prescribe what exact obligations States Parties need to complete and by when. It is obvious that VA cannot have deadlines and that it requires a cross-cutting approach. But much more needs to be done to make VA truly measurable and show real progress in the lives of those affected rather than continuing the decontextualised situational updates observed over the last five years.

To States Parties committed to see "the full and effective participation and inclusion of mine survivors, and the families of those killed or injured, in the social, cultural, economic and political life of their communities"[5] we present the following suggestions. These issues can only be addressed in the context of the future action plan.

The way forward:
Three main actions at two levels (national and international) with a clearly measurable structure[6]

The actions below apply in a non-discriminatory manner to persons injured by other causes and other persons with disabilities and in particular to victims of other explosive ordnance. It is acknowledged that policies, resources, demography and development levels **differ** among states and that States Parties might operate in a context of underdevelopment and poverty, conflict and **competing priorities**. The actions, therefore, allow States Parties to decide national priorities and to take a progressive approach to implementation by whatever means are appropriate.

The actions ensure the development and implementation of **measurable and sustainable** strategies and ultimately the **mainstreaming** of victim assistance in **disability-related policies, as well as development and poverty reduction strategies. Without delay,** adequate **age- and gender-sensitive** assistance, including medical care, physical rehabilitation, psychological support, and social and economic reintegration, must be provided in accordance with applicable national and international policies and standards. Each State Party must collect and report reliable data on the victims and on the services they have received.

To make measurable progress in advancing the full and effective participation and inclusion of mine survivors, and the families of those killed or injured, in the social, cultural, economic and political life of their communities, States Parties shall at:

National level

Action 1: Take full national ownership of sustainable strategies for victim assistance by:

- Mobilizing sufficient **political will** to ensure victim assistance advancements.
- Seizing every opportunity to increase **awareness** of action on victim assistance in all relevant sectors.
- Guaranteeing systematic victim **participation** in policy- and decision-making at all levels.
- Establishing effective and continuous national victim assistance **coordination**.
- Annually providing precise and transparent victim assistance **progress reports**.

The following specific measures shall be taken to make steady progress toward **action 1**:

- Without delay, designate an **actively functioning focal point** with a clear mandate and authority within the government for coordination of victim assistance efforts.[7]
- If not known, **assess the needs and priorities** of victims and the extent of current service provision, as soon as the focal point is established. Periodically update results.[8]
- Based on the assessment results, **develop a national plan** with *SMART* objectives,[9] including all relevant VA components, and/or **amend existing relevant national strategies** to include victims.
- In conjunction with the national plan, develop a **budget** for the implementation of the plan in its entirety. Allocate sufficient national and international resources including by diversifying funding sources and mainstreaming activities into general development frameworks.
- As soon as the focal point is established, develop or amend implementing **laws and policies** with the aim of protecting victims' **rights** as necessary.
- In conjunction with the national plan, implement, and if needed establish, an **accountable and transparent mechanism to monitor** annual progress under the plan. The mechanism reports back to the focal point at regular intervals.
- Both nationally and internationally, disseminate **annual progress reports** detailing progress made against each objective in the national plan, progress compared to the previous year, challenges and proposed solutions. Progress reports shall also be used as a means to share good practices.
- Throughout the process, guarantee regular **inter-ministerial, inter-sectoral and inter-agency** coordination through involvement and empowerment of all stakeholders to avoid service

provision duplication and gaps, and share good practices.
- Consult with **victims** and their organizations on an **equal basis to others**, for decision-making, coordination and monitoring.
- Systematically present information and positive role-models to **raise awareness** of the rights and capacities of victims and persons with disabilities as equal participants in society.

Action 2: Provide barrier-free services to victims and protect their equal rights by guaranteeing:

- **Needs-based** assistance to women, men, girls and boys.
- **Timely access** for victims to appropriate services, including ensuring that those injured by landmines become survivors.
- Acceptable **quality** standards of services rendered to victims.
- **Effectiveness** of services rendered to victims.
- Systematic victim **participation** in victim assistance implementation.
- **Continuous training and capacity building** for assistance implementers.

The following specific measures shall be taken to make steady progress toward **action 2**:

- While respecting privacy, **use up-to-date victim data**, including information on injury, socio-economic situation and services received, which is registered in a central surveillance mechanism.
- Always ensure that victims are not barred from immediate access to services by making services, medication and devices available at **affordable cost**, also for the poorest. Establish subsidy programs if needed.
- Always guarantee **physical access** by developing, promulgating and monitoring the implementation of minimum standards and accessibility guidelines for facilities and services open or provided to the public and using universal design.
- Increasingly overcome **geographical distance barriers** by cost-efficiently strengthening community and emergency response in mine-affected areas,[10] and by providing transport and accommodation for the victim and, if necessary, for their care-takers.
- Carry out a **formalized referral system** consisting of mainstream and specialized services, in which governmental, non-governmental and private services coordinate and apply non-contradictory and non-discriminatory operating procedures.
- Ensure staff adherence to nationwide and internationally recognized minimum **quality standards** and systematically establish holistic teams with a variety of skills and appropriate to the cultural context.
- Assure **continuity of services** by recruitment based on qualifications, continuous staff learning/skill development, local and national staff retention through fair and competitive wages (comparable across government, private and non-governmental sectors), and psychological support for staff.
- Make available, in adequate quantities, **medication, supplies and materials** through central store management according to minimum standards, using internationally approved, but local production options and generic cure alternatives.
- Throughout service provision, include **victims** and their organizations on an **equal basis to others**, in service implementation, as well as treatment assessments and decisions.
- Guarantee that victims know their rights and available services through **up-to-date service directories** in formats accessible for different types of disabilities and educational levels.

International level (international cooperation)

Action 3: Seize every opportunity to support national victim assistance efforts by:

- **Sustaining** attention to victim assistance.
- Engaging in coherent international and regional **cooperation**.

- Guaranteeing systematic **victim** participation.
- Annually providing **precise information** on victim assistance support.
- Taking the necessary steps to increase sustainability through sharing of **expertise**.

The following specific measures shall be taken to make steady progress toward **action 3**:

- Sustain adequate levels of **long-term financial and technical support** to affected countries by providing multi-annual financial and in-kind contributions.
- Inform and encourage **funding mechanisms** for development, post-conflict recovery, humanitarian aid and human rights to **include victim assistance** within their funding mandate.
- Publicly disseminate standardized **annual funding reports** detailing resources (directly or indirectly) dedicated to victim assistance, ways in which spending is monitored, and output of contributions.
- Systematically ensure the effective and continuous **participation** of health, rehabilitation, social services, employment and disability rights **experts**, **victims and their organizations** and officials in Convention-related activities at regional and international level.
- Rationalize and ensure **efficiency in international reporting** obligations by using a standard progress reporting format in synergy with other relevant frameworks.
- S**upporting agencies** seize every opportunity to emphasize recruitment, training and retention of local staff for all aspects of planning, implementation, resource mobilization and monitoring, with the aim that local resources **replace** the supporting agency as soon as appropriate.

Definitions and scope of victim assistance (VA)

- *Casualty:* An individual who has been injured or killed as a result of a landmine or ERW incident. This definition excludes deaths and injuries caused by other sources, such as small arms, fireworks, and commercial explosives not used for a military purpose.
- *Community-based rehabilitation:* A multi-sectoral approach to rehabilitation which has five major components: health, education, livelihood, social support, and empowerment. In the context of this report, the approach usually refers to enhancing the quality of life for persons with disabilities (including mine/ERW survivors) and their families by improving access to basic needs, ensuring inclusion and participation, and increasing community decision-making and accountability.
- *Mine Ban Treaty (MBT):* The Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction (18 September 1997).
- *Mine/ERW survivor:* Any individual who has been directly injured by an explosion of a landmine or an explosive remnant of war (including cluster submunitions) and has survived the incident.
- *Non-response:* Failure to obtain a measurement in a survey question.
- *Peer support:* In this context, peer support involves connecting mine/ERW survivors in need of help with others who have overcome a similar experience.
- *VA26:* This informal term, used mainly among NGOs, is a short way of referring to the 26 States Parties to the MBT recognized as having significant numbers of mine survivors and the greatest responsibility to act, but also the greatest needs and expectations for assistance. This group is not exclusive and does not need to fulfill different obligations compared to other States Parties. Nevertheless, these 26 countries have, with the help of the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, engaged in an informal process to determine what measurable progress they could achieve between 2005 and 2009. This process involved, among others, the articulation of concrete VA objectives, plans to achieve these objectives, and means to implement these plans.
- *Victim:* Rarely used in this report, victim refers to those who have been injured or killed by a mine/ERW explosion, their families who suffer emotional, social and financial loss and the communities that lose access to land and other resources due to the presence of mines/ERW.

The pillars of victim assistance most often include, but are not limited to the following:[1]

- *Data collection and management:* Includes, in this context, the collection of information about persons killed or injured in mine/ERW incidents or about other persons with disabilities (personal data, incident data, service data, etc.), the verification of this data, its storage in an information management system and its use for planning purposes.
- *Emergency medical care:* Includes first aid, and transportation, to respond effectively to landmine and other traumatic injuries.
- *Continuing medical care:* Includes surgery, pain management, and additional medical care to assist in the rehabilitation of survivors.
- *Physical rehabilitation:* Includes physiotherapy, production and fitting of prostheses, pre- and post-prosthetic care, repair and adjustment of prostheses, provision and maintenance of assistive devices and wheelchairs, and rehabilitative assistance for persons with audiovisual disabilities.
- *Psychological support and social reintegration:* Includes community-based peer support groups, professional counseling services, sports, and the activities of disabled people's organizations.
- *Economic reintegration:* Includes skills and vocational training, literacy training, income-generating projects, small business loans, and job placement.

- *Laws and public policies:* Includes, in this context, the national and international laws, policies and strategies aimed at protecting the rights and needs of persons with disabilities, including mine/ERW survivors.
- *VA process achievements:* Some of the achievements in the informal process of the 26 relevant States Parties have been tabulated to provide a quick overview. The definitions of indicators marked in the VA process achievements table are as follows:

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

- *Form J with VA:* If marked "YES", this means the State Party submitted Form J of its annual Article 7 report and included information relevant to VA. In accordance with Article 7 of the MBT, each State Party is obliged to report to the Secretary-General of the UN. Reporting must be updated by the States Parties annually, covering the previous year. States Parties may use Form J to report voluntarily on other relevant matters and they are encouraged to use that form to report on activities undertaken with respect to Article 6 of the MBT and in particular to report on assistance provided for the care and rehabilitation, and social and economic reintegration, of mine survivors.
- *ISC VA statement:* If marked "YES", this means that the State Party made an intervention during the intersessional Standing Committee on Victim Assistance and Socio-Economic Reintegration meeting in the corresponding year. This meeting is part of the intersessional work program – informal meetings created to ensure systematic implementation of the MBT and to engage the broad international community in open discussion to advance the MBT.
- *MSP VA statement:* If marked "YES", this means that the State Party made an intervention on VA during the annual Meeting of States Parties to the MBT in the corresponding year. It was decided that these formal meetings would be held annually until at least the Second Review Conference in 2009 to "consider any matter with regard to the application of implementation of (the) Convention."
- *VA expert:* If marked "YES", this means that a designated health, rehabilitation or social services professional or official was included in the State Party delegation at either MSP or ISC meetings or both in that year, in fulfillment of Action #39 of the Nairobi Action Plan.
- *Survivor on delegation:* If marked "YES", this refers to a State Party fulfilling Nairobi Action Plan "Action #38: Ensure effective integration of mine victims in the work of the Convention, inter alia, by encouraging States Parties and organizations to include victims on their delegations" in the corresponding year by including a mine/ERW survivor on their national delegation at either MSP or ISC meetings or both in that year.[2]

Abbreviations and acronyms

AXO	Abandoned Explosive Ordnance
CBR	Community-Based Rehabilitation
CIA	Central Intelligence Agency
CCM	Convention on Cluster Munitions
DPO	Disabled People's Organization
ERW	Explosive Remnants of War
GICHD	Geneva International Centre for Humanitarian Demining
GNI	Gross National Income
HDI	Human Development Index
HI	Handicap International
ICBL	International Campaign to Ban Landmines
ICRC	International Committee of the Red Cross
ICRC-SFD	International Committee of the Red Cross - Special Fund for the Disabled
IDP	Internally Displaced Person
IED	Improvised Explosive Device
IMF	International Monetary Fund
IMSMA	Information Management System for Mine Action
ISC	Intersessional Standing Committee Meetings (to the Mine Ban Treaty)
LIS	Landmine Impact Survey
LSN	Landmine Survivors Network
MAC-MACC	Mine Action Center/Mine Action Cell - Mine Action Coordination Center
MBT	Mine Ban Treaty
MDG	Millennium Development Goals
MoE	Ministry of Education
MoH-MoPH	Ministry of Health - Ministry of Public Health
MSP	Meeting of States Parties (to the Mine Ban Treaty)
NAP	Nairobi Action Plan
NATO	North Atlantic Treaty Organization
NGO	Non-Governmental Organization
NPA	Norwegian People's Aid
OAS	Organization of American States
PRSP	Poverty Reduction Strategy Paper
SMART	Specific, Measurable, Achievable, Relevant and Time-Bound
UK	United Kingdom
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNMAS	United Nations Mine Action Service
US	United States of America
UXO	Unexploded Ordnance
VA	Victim Assistance
WB	World Bank
WHO	World Health Organization

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Notes

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1 The content of this publication is the sole responsibility of Handicap International vzw-asbl (HI) and can in no way be taken to reflect the views of the sponsors, in-kind donors, or the Central Intelligence Agency (CIA) whose country maps were used.

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9 UNDP-BiH, "Eradicate extreme poverty and hunger," 11 February 2009, http://www.undp.ba/index.aspx?PID=32&RID=1; UNDP, "2008 Statistical Update – Bosnia and Herzegovina," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_BIH.html; and CIA, *The World Factbook – Bosnia and Herzegovina*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/BK.html, accessed 11 July 2009.

10 "Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 111. The situation was no clearer in 2009 due to ongoing work in creating a unified national database.

[11] Bosnia and Herzegovina is divided into two political divisions called entities: the Bosniak-Croat Federation of Bosnia and Herzegovina and the Republika Srpska. Each entity has its own government, parliament, and health and social systems.
[12] 7% non-response rate.
[13] BHMAC, "Mine victims: Bosnia and Herzegovina, 10 April 2009," (translation) http://www.bhmac.org/ba/filedownload.daenet?did=474, 10 May 2009.
[14] No questionnaire responses have been received from VA/disability practitioners in Bosnia and Herzegovina.
[15] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 182.
[16] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 195.
[17] 2% non-response rate.
[18] "Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 114-115.
[19] Statement of BiH, Seventh Meeting of States Parties, Geneva 19 September 2006; and statement of BiH, Eighth Meeting of States Parties, Dead Sea, 21 November 2007.
[20] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 226.
[21] "Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 114.
[22] 7 % was not sure.
[23] ICBL, *Landmine Monitor Report 2002*, Washington, DC, August 2002, p.126.
[24] ICBL, *Landmine Monitor Report 1999*, Washington, DC, April 1999, p. 567.
[25] Statement of BiH, Eighth Meeting of States Parties, Dead Sea, 21 November 2007.
[26] Article 7 Report, Form J, 2005, 2006, 2007 and 2008; and statement of BiH, Ninth Meeting of States Parties, Geneva, 28 November 2009.
[27] 5% non-response rate.
[28] "Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 119.
[29] US Department of State, "2008 Country Reports on Human Rights Practices: Bosnia and Herzegovina," Washington, DC, 25 February 2009; and email from Radojka Kela, Chief of Department for Normative and Legal Business, Ministry of Labour and Protection of Veterans and Disabled Persons of RS, Banja Luka, 5 May 2009.
[30] Statement of BiH, Ninth Meeting of States Parties, Geneva, 28 November 2009.
[31] "Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 114-117.
[32] BiH did organize cross entity representation from the health ministries at Mine Ban Treaty meetings, which could have been a positive first step.
[33] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of Victim Assistance in the Context of the AP Mine Ban Convention in the 26 Relevant States Parties 2005 – 2008," Geneva, 28 November 2008.

Burundi

[1] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, pp. 234-235; ICBL, *Landmine Monitor Report 2008*, Ottawa, October, p. 194.
[2] Statement of Burundi, Standing Committee on Mine Clearance, Mine Risk Education and Mine Action Technologies, Geneva, 27 May 2009.
[3] UNDP, "2008 Statistical Update – Burundi," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_BDI.html, accessed 21 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 142.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; and UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 21 July 2009.
[5] CIA, *The World Factbook – Burundi*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/BY.html; and 2004 http://www.umsl.edu/services/govdocs/wofact2004/geos/by.html, accessed 21 July 2009.
[6] WHO, "Detailed Database Search: Burundi," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 21 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95-96; The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
[8] UN, "Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 21 July 2009.
[9] CIA, *The World Factbook – Burundi*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/BY.html, accessed 21 July 2009.
[10] Email from Jean-Baptiste Hatungimana, Director *ad interim*, Humanitarian Department for Mine/UXO Action (Direction de l'Action Humanitaire contre les Mines et Engins non explosés, DAHMI), 28 May 2009; and "Fact sheet – Burundi: Actions de prise en charge des Personnes en Situation de Handicap (PSH) et Assistance aux victimes de la guerre" ("Fact sheet – Burundi: Actions to take care of Persons with Disabilities (PWD) and Assistance to war victims"), presented at the Intersessional Standing Committee Meetings, Geneva, May 2009. DAHMI reports that survivors represent 84% of all casualties.
[11] Email from Jean-Baptiste Hatungimana, Director *ad interim*, DAHMI, 28 May 2009.
[12] Statement of Burundi, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[13] See Burundi chapters in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 183-187.
[14] In total, 80 questionnaires were received but only 25 were complete enough for analysis and/or fitted survey criteria.
[15] The association works for former combatants from both sides of the conflict and was formed as part of the peace process. Only the members disabled by mines/ERW participated, although there are many more other members. Most of their activities relate to broader development issues, and disability is only one of the topics addressed by the association.
[16] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 211.
[17] No practitioner responses were received.
[18] ICBL, *Landmine Monitor 2008*, Ottawa, October 2008, pp. 197-198; and email from Jean-Baptiste Hatungimana, Director *ad interim*, DAHMI, 28 May 2009.
[19] Statement of Burundi, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[20] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 200; and ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 242.
[21] Statement of Burundi, Standing Committee on Victim Assistance and Socio-Economic reintegration, Geneva, 26 May 2009.

[22] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 201; and ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 243.
[23] Statement of Burundi, Standing Committee on Victim Assistance and Socio-Economic reintegration, Geneva, 26 May 2009.
[24] HI, "Annual Report 2006 and Action Plan 2007," Bujumbura, 11 January 2007, p. 14.
[25] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 212.
[26] Statement of Burundi, Ninth Meeting of States Parties, Geneva, 28 November 2008.
[27] Statement of Burundi, Standing Commitee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008.
[28] HI, "Annual Report 2006 and Action Plan 2007," Bujumbura, 11 January 2007, p. 14.
[29] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 244.
[30] Statement of Burundi, Ninth Meeting of States Parties, Geneva, 28 November 2008.
[31] Statement of Burundi, First Review Conference, Nairobi, 29 November-3 December 2004; and statement of Burundi, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 16 June 2005.
[32] Draft "National Victim Assistance Strategy for Burundi" provided by Akiko Ikeda, (then) VA Officer, UNMAS, New York, 12 July 2005.
[33] Kerry Brinkert, (then) Manager, Implementation Support Unit Geneva International Centre for Humanitarian Demining, "Making sense out of the Anti-Personnel Mine Ban Convention's obligations to landmine victims," Geneva, 31 March 2006, pp. 6, 8.
[34] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 214.
[35] Email from Jean-Baptiste Hatungimana, Director *ad interim*, DAHMI, Bujumbura, 28 May 2009.
[36] Statements of Burundi, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 24 April 2007 and 3 June 2008.
[37] 4% non-response rate.

Cambodia

[1] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 248; and HI, *Circle of Impact: The Fatal Footprint of Cluster Munitions on People and Communities*, Brussels, May 2007, p. 23.
[2] Statement of Cambodia, Standing Committee on Mine Clearance, Mine Risk Education and Mine Action Technologies, Geneva, 28 May 2009; and Article 5 Deadline Extension Request, 30 April 2009, Phnom Penh, p. 44.
[3] UNDP, "2008 Statistical Update – Cambodia," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_KHM.html, accessed 28 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 141.
[4] World Bank (WB), "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; and UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 28 July 2009.
[5] CIA, *World Factbook – Cambodia*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/cb.html; and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/cb.html, accessed 28 July 2009.
[6] WHO, "Detailed Database Search: Cambodia," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 28 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95-96; The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
[8] UN, Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 28 July 2009.
[9] "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009.
[10] CIA, *World Factbook – Cambodia*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/cb.html, accessed 28 July 2009.
[11] Casualty data 1979-May2009 provided by Cheng Lo, Data Management Officer, CMVIS, Phnom Penh, 19 June 2009.
[12] Austcare, "Assessment of Landmine Survivors and Victims Needs, Banteay Meanchey and Oddar Meanchey Provinces, Kingdom of Cambodia," Phnom Penh, July 2007, pp. 2, 46.
[13] See Cambodia chapters in *Landmine Monitor Reports*, 1999-2008; "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 119-125; and Kingdom of Cambodia, "National Plan of Action for Persons with Disabilities, including Landmine/ERW Survivors 2009-2011, Phnom Penh, February 2009 (hereafter Cambodia National Plan 2009-2011).
[14] Interviews were conducted by the ICRC, Jesuit Services Cambodia and Disability Development Services Pursat.
[15] 3% non-response rate.
[16] See for example also, Tom Hunter, "Mine victims say they are forgotten," *Phnom Penh Post* (Kampong Thom), 24 February 2009, http://www.phnompenhpost.com/index.php/2009022424372/National-news/Mine-victims-say-they-are-forgotten.html, accessed 28 July 2009.
[17] Cambodia National Plan 2009-2011, pp. 13-14; and "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009.
[18] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 220; and Cambodia National Plan 2009-2011, pp. 18-19.
[19] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 228.
[20] "The 3-Year Physical Rehabilitation Working Project (Review of responsibilities to be completed in 2008)," Phnom Penh, 26 March 2009.
[21] Interviews with service providers April 2009.
[22] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, pp. 227-228.
[23] Cambodia National Plan 2009-2011, p. 19.
[24] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 236.
[25] Cambodia National Plan 2009-2011, pp. 22-24; and "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009.
[26] Statement of Cambodia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009; Cambodia National Plan 2009-2011, pp. 25-26, 31; and "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009.
[27] Cambodia, Article 7 Report (for calendar year 2008), Form J, 28 April 2009.
[28] "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009. These figures were incomplete and likely subject to change.
[29] "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009.
[30] The Common Statute of Civil Servants, Chapter II Recruitment of Civil Servants: Article 11; 5° states that employees "must satisfy the

conditions of physical aptitude for the exercise of the function as required by guidelines and applicable regulation." See Cambodia National Plan 2009-2011, p. 40.

[31] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 272.

[32] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 221; and ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 272.

[33] Statement of Cambodia, Sixth Meeting of States Parties, Zagreb, 30 November 2005.

[34] "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 119-125; and Cambodia National Plan 2009-2011.

[35] CMAA, "Mine Action: 1992-2003," Phnom Penh, 29 April 2004, p. 6.

[36] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 271.

[37] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 226; and "Status of Victim Assistance in Cambodia," draft of the report to be presented at the Second Review Conference in November 2009, June 2009.

[38] Monitoring of the plan will be conducted through visits to relevant ministries and operators to collect their information. The status report questionnaire developed by the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration for the purpose of the Second Review Conference is used as a template.

[39] Cambodia National Plan 2009-2011, p. 8.

[40] Cambodia National Plan 2009-2011, p. 8.

[41] Cambodia National Plan 2009-2011, p. 8.

[42] Interview with Chan Rotha, Deputy Secretary-General, CMAA, Phnom Penh, 6 April 2009.

[43] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 271.

[44] Interviews with HI, Phnom Penh, 10 April 2009; UNICEF, Phnom Penh, 7 April 2007; VI, Phnom Penh, 6 April 2009; and CWARS, Phnom Penh, 5 April 2009.

Chad

[1] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 230.

[2] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 230; and ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 275.

[3] UNDP, "2008 Statistical Update – Chad," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_TCD.html, accessed 29 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 142.

[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 29 July 2009.

[5] CIA, *World Factbook – Chad*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/cd.html, and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/cd.html, accessed 29 July 2009.

[6] WHO, "Detailed Database Search: Chad," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members.

[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95-96. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.

[8] UN, "Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, as accessed on 1 August 2009, delays in updating the webpage were noted.

[9] World Food Programme, "Chad," http://www.wfp.org/countries/chad; and CIA, *World Factbook – Chad*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/cd.html, accessed 29 July 2009.

[10] Statement of Chad, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009; interview with Assane Ngueadoum, Advisor for Strategic Planning and Operations, CND, Geneva, 28 May 2009; and ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 284.

[11] See Chad chapter in *Landmine Monitor Reports*, 1999-2008; and ICRC, "Annual Report 2008," Geneva, 27 May 2009, p. 90.

[12] Statement of Chad, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.

[13] Statement of Chad, Ninth Meeting of States Parties, Geneva, 28 November 2008.

[14] WHO, "Health Sector Needs Assessment," 10 December 2007, p. 10.

[15] Médecins sans Frontières (MSF), "As MSF treats wounded in N'Djamena, Chad, tens of thousands of people flee the city," 2 May 2008, http://www.msf.org/msfinternational/invoke.cfm?objectid=E8F9C7BD-15C5-F00A-2567C2D2EF28C0D3&component=toolkit.article&method=full_html, accessed 29 July 2009.

[16] Interview with Assane Ngueadoum, CND, Geneva, 28 May 2009; ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, pp. 237-238; and MSF, "Chad: MSF continues emergency medical aid amidst fresh fighting," 18 June 2008. http://www.msf.org/msfinternational/invoke.cfm?objectid=B9C059E3-15C5-F00A-25D56BC57888DA72&component=toolkit.article&method=full_html, accessed 29 July 2009.

[17] Interview with Assane Ngueadoum, CND, N'Djamena, 20 April 2009.

[18] ICRC, "Physical Rehabilitation Programme: Annual Report 2008," Geneva, 7 May 2009, p. 22.

[19] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 284.

[20] Notes from *Voices from the Ground* survey in Chad, 23 April 2009.

[21] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 285; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 238.

[22] Statement of Chad, Ninth Meeting of States Parties, Geneva, 28 November 2008; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 238.

[23] Interview with Assane Ngueadoum, CND, N'Djamena, 20 April 2009.

[24] Survey Action Center, "Landmine Impact Survey, Republic of Chad," Washington, DC, 2002, p. 34.

[25] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 243.

[26] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 285; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 238.

[27] Statement of Chad, Ninth Meeting of States Parties, Geneva, 28 November 2008.

[28] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 238.

[29] UN, "2009 Portfolio of Mine Action Projects," New York, 4 December 2008, p. 86.

[30] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 238; and ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 244.

[31] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of Victim Assistance in the Context of the AP Mine Ban Convention in the 26 Relevant States Parties 2005-2008," Geneva, 28 November 2008, p. 11.

[32] Presentation of Chad, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 24 April 2007.

[33] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 239.

[34] Statement of Chad, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008.

[35] Statement of Chad, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009; interview with Assane Ngueadoum, CND, Geneva, 28 May 2009; and statement of Chad, Ninth Meeting of States Parties, Geneva, 28 November 2008.
[36] Interview with Assane Ngueadoum, CND, Geneva, 28 May 2009.
[37] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 231.

Colombia

[1] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 256.
[2] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 256.
[3] UNDP, "2008 Statistical Update – Colombia," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_COL.html, accessed 26 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 140.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 26 July 2009.
[5] CIA, *The World Factbook – Colombia*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/co.html, and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/co.html, accessed 26 July 2009.
[6] WHO, "Detailed Database Search: Colombia," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 26 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95-96. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population will be unlikely to achieve adequate coverage.
[8] UN, "Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 26 July 2009.
[9] PAICMA, "Política Nacional de Accíon Integral contra Minas Antipersonal 2009-2019" (National Strategy for Integral Action Against Antipersonnel Mines 2009-2019") Bogotá, 2008, p. 133 (hereafter PAICMA National Strategy 2009-2019).
[10] CIA, *The World Factbook – Colombia*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/co.html, accessed 26 July 2009.
[11] PAICMA, "Victimas por Minas Antipersonal 1990-06/2009," http://www.accioncontraminas.gov.co/index.html, accessed 26 July 2009.
[12] HI, "Minas Antipersonal en Colombia: El Camino Hacia la Rehabilitación e Inclusión Social" ("Antipersonnel Mines in Colombia: The Road to Rehabilitation and Social Inclusion"), Medellín, October 2007 (hereafter 2007 HI rehabilitation in Colombia); and ICRC, "Encuesta sobre Conocimientos, Actitudes y Prácticas (CAP), Observaciones y Recomendaciones, Departamentos de Antioquia, Meta y Tolima" ("Study about Knowledge, Attitudes and Practices (KAP), Observations and Recommendations, Departments of Antioquia, Meta and Tolima"), Bogota, May 2007, pp. 6-8; and email from Godofredo Torreblanca Cardenas, ICRC, 8 September 2008.
[13] PAICMA response May 2009; and PAICMA National Strategy 2009-2019, p. 78.
[14] PAICMA response May 2009; and Colombia, Article 7 Report (for the period from 1 January 2008 to 31 March 2009), Form J, 30 April 2009.
[15] PAICMA National Strategy 2009-2019, p. 80
[16] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, pp. 270, 274; ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 319, 322; and 2007 HI rehabilitation in Colombia.
[17] PAICMA National Strategy 2009-2019, p. 79.
[18] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 270; and ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 285.
[19] PAICMA, "Resumen Ejecutivo del Perfil del Proyecto "Fortalecimiento del Sistema de Rehabilitación Integral de Personas con Discapacidad, Especialmente víctimas de Accidentes con Minas Antipersonal" ("Executive Summary of the Project Profile "Reinforcement of the System of Integral Rehabilitation of Persons with Disabilities, particularly victims of incidents with antipersonnel mines"), Bogotá, 2008, pp. 1-2; and 2007 HI rehabilitation in Colombia.
[20] Field trip observations, April 2008.
[21] PAICMA response May 2009; and PAICMA National Strategy 2009-2019, p. 80.
[22] European Commission, "Ficha descriptiva del proyecto," (Project description"), Bogotá, 5 March 2008.
[23] 2007 HI rehabilitation in Colombia; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 271.
[24] PAICMA National Strategy 2009-2019, pp. 80-81.
[25] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 321.
[26] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 286.
[27] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 271.
[28] Survivors and the families of those killed by these devices can claim one-time government compensation and reimbursement of treatment costs within one year of the incident under various legislative frameworks implemented by the Agencia Presidencial para la Acción Social y la Cooperación Internacional (Acción Social) and the Solidarity and Guarantee Fund (Fondo de Solidaridad y Garantía, FOSYGA) of the Ministry of Social Protection. In October 2007, Decree 3990 to streamline procedures entered into force.
[29] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 271; and PAICMA response May 2009.
[30] Colombia, Article 7 Report (for the period from 1 January 2008 to 31 March 2009), Form J, 30 April 2009.
[31] See for example: PAICMA, "Plan estratégico y operativo del programa presidencial para la acción integral contra las minas antipersonal (PAICMA) en el año 2008" ("Strategic and operational plan of the presidential program for the action against antipersonnel mines (PAICMA) for the year 2008"); Bogotá, February 2008; statement of Colombia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 9 May 2006; and ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 283.
[32] For example, while the inclusion of transport and accommodation costs in the *ruta de atención* is addressed, PAICMA's role is limited to lobbying for this. PAICMA National Strategy 2009-2019, pp. 119-130.
[33] PAICMA, "Seminario Internacional de Asistencia a Víctimas" ("International Seminar on Victim Assistance"), http://www.accioncontraminas.gov.co/documentos/seminariovictimas/seminario.html, accessed 26 July 2009.
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[2] Statement of Croatia, Standing Committee on Mine Clearance, Mine Risk Education and Mine Action Technologies, Geneva, 27 May 2009; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 302.

[3] UNDP, "2008 Statistical Update – Croatia," hdrstats.undp.org/en/2008/countries/country_fact_sheets/cty_fs_HRV.html, accessed 9 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 139.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 9 July 2009.
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[10] Casualty data provided via email by Kristina Ikic Banicek, Adviser for International Cooperation and Donations, CROMAC, Sisak, 19 June 2009.
[11] As part of its commitment to the Nairobi Action Plan, Croatia developed objectives for 2005-2009, but no plans to achieve these objectives.
[12] Statement of Croatia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 29 May 2009.
[13] See Croatia chapter in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 131-140.
[14] No questionnaire responses have been received from VA/disability practitioners in Croatia.
[15] Statement of Croatia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 29 May 2009; and interview with Dijana Plestina, Advisor to the Ministry of Foreign Affairs (MFA), Geneva, 28 May 2009.
[16] Interview with Dijana Plestina, Advisor to the MFA, Geneva, 28 May 2009.
[17] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 310.
[18] Interview with Dijana Plestina, Advisor to the MFA, Geneva, 28 May 2009.
[19] US Department of State, "2008 Country Reports on Human Rights Practices: Croatia," Washington, DC, 25 February 2009.
[20] Statement of Croatia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 29 May 2009.
[21] Statement of Croatia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 29 May 2009.
[22] Croatia even championed the idea of having a landmine survivor serve as permanent advisor to the committee's co-chairs.
[23] Statement of Croatia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 29 May 2009.
[24] "Mid-Term Review of the Status of Victim Assistance in the 24 Relevant States Parties," Dead Sea, 21 November 2007, pp. 25-26.

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[13] "Final Report of the Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 145.
[14] See the DRC chapter in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 141-145.
[15] Questionnaire responses were provided through the mine risk education network supported by HI and by the ICRC.
[16] "Final Report of the Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 140-141.
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34 ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 290; and DRC, Article 7 Report (for calendar year 2008), Form J, 27 May 2009.

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15 3% non-response rate.

16 27% non-response rate.

17 ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 347.

[18] While children only constitute a small percentage of overall casualties, they were the largest casualty group in 2008 and are particularly vulnerable to ERW incidents − the only type of incident in El Salvador since it was declared mine-free in 1994.
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[20] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 347.
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[22] Gabriel Labrador Aragón, Heridas de guerra en tiempos de paz ("War injuries in peace times"), *La Prensa*, 27 July 2008, http://archive.laprensa.com.sv/20080727/septimosentido/1102772.asp, accessed 23 June 2009.
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[27] CONAIPD, "Outcome Document from National Multi-Stakeholder Review of Victim Assistance, Plan de Accion Nairobi: El Salvador," 19 November 2008.
[28] Interview with José Francisco Cortez González, Ministry of Foreign Affairs, Nairobi, 2 December 2004.
[29] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 365; and ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 407.
[30] Statement of El Salvador, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[31] Email from Lourdes Barrera de Morales, Executive Director, CONAIPD, Geneva, 20 July 2009.
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Eritrea

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[14] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, pp. 348-349.
[15] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 423.
[16] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 381; ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 369; and US Department of State, "2008 Country Reports on Human Rights Practices: Eritrea," Washington, DC, 25 February 2009, http://www.state.gov/g/drl/rls/hrrpt/2008/af/119000.htm, accessed 24 July 2009.
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[24] Statement of Eritrea, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008.

[25] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of Victim Assistance in the Context of the AP Mine Ban Convention in the 26 Relevant States Parties 2005-2008," Geneva, 28 November 2008, p. 13.

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[11] See Ethiopia chapter in *Landmine Monitor Reports*, 1999-2008; "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 33; and MoLSA, "Status of Victim Assistance in Ethiopia," Geneva, 3 June 2008.
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[18] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 898.
[19] MoLSA, "Status of Victim Assistance in Ethiopia," Geneva, 3 June 2008.
[20] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 384; MoLSA, "Status of Victim Assistance in Ethiopia," Geneva, 3 June 2008.
[21] MoLSA, "Status of Victim Assistance in Ethiopia," Geneva, 3 June 2008; Article 7 Report (for calendar year 2008), Form J; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 384.
[22] However, Ethiopia participated in the Review Conference as an observer state and was not included amongst the 23 counties highlighted by the Standing Committee on Victim Assistance and Socio-Economic Reintegration in the final conference report; See "Final Report, First Review Conference," Nairobi, 29 November-3 December 2004, APLC/CONF/2004/5, 9 February 2005, pp. 9, 33.
[23] Statement of Ethiopia, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008; and ICBL, *Landmine Monitor Report 2007*, pp. 392, 395.
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Guinea-Bissau

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[5] CIA, *The World Factbook – Guinea-Bissau*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/PU.html; and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/pu.html, accessed 15 July 2009.
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[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 98. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
[8] UN, "Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, as accessed on 1 August 2009, delays in updating the webpage were noted.
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[11] Statement by Amália Luis Mendes, Ministry of Economy, Finance and Regional Integration, Ninth Meeting of States Parties, Geneva, 28 November 2008.

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[20] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 385.

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[13] 2% non-response rate.

[14] Information Management and Mine Action Programs, "Landmine Impact Survey: The Republic of Iraq, 2004-2006, Washington, DC, August 2007, p. 8-136.

[15] See Iraq chapter of *Landmine Monitor Reports*, 2005-2008; Medact, "Rehabiltation under fire: Health care in Iraq 2003-2007," London, 2008; ICRC, "Iraq: no let-up in the humanitarian crisis," Geneva, March 2008; and ICRC, "Annual Report 2008," Geneva, 27 May 2009, p. 345. The ICRC supported some 77 hospitals in all governorates.

[16] 3% non-response rate.

[17] ICRC, "Physical Rehabilitation Programme: Annual Report 2008," Geneva, 7 May 2009, p. 62.

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[19] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 453; and HI, *Circle of Impact: The Fatal Footprint of Cluster Munitions on People and Communities*, Brussels, May 2007, pp. 112-113.

[20] WB, "International Reconstruction Fund Facility for Iraq – World Bank Iraq Trust Fund Report to Donors," Washington, DC, 31 December 2008, p. 22.

[21] Kerry Brinkert, (then) Manager, Implementation Support Unit Geneva International Centre for Humanitarian Demining, "Making sense out of the Anti-Personnel Mine Ban Convention's obligations to landmine victims," Geneva, 31 March 2006, pp. 6, 8.

[22] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of Victim Assistance in the Context of the AP Mine Ban Convention in the 26 Relevant States Parties 2005-2008," Geneva, 28 November 2008, p. 14.

[23] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 451; and ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 454.

[24] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 456.

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2008, p. 22.
[26] 4% non-response rate.

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[2] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 461.
[3] UNDP, "2008 Statistical Update – Jordan," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_JOR.html, accessed 13 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 140.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 13 July 2009.
[5] CIA, *The World Factbook – Jordan*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/JO.html; and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/jo.html, accessed 13 July 2009.
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[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 98. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
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[12] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009; and see Jordan chapter in *Landmine Monitor Reports*, 1999-2008.
[13] Information and casualty data provided by email from Adnan Telfah, Head MRE/VA Department, NCDR, 31 May, 4, 21, 22 and 25 June 2009.
[14] While children are only a small group of casualties, the percentage of child casualties per year is increasing. In 2009, they were the largest casualty group.
[15] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[16] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[17] 10% non-response rate.
[18] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 470; ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 472; and ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 490.
[19] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[20] 2% said worse and 13% non-response rate.
[21] 6% non-response rate.
[22] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[23] US Department of State, "2008 Country Reports on Human Rights Practices: Jordan," Washington, DC, 25 February 2009; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 468.
[24] Statement of Jordan, Ninth Meeting of States Parties, Geneva, 27 November 2008.
[25] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of Victim Assistance in the Context of the AP Mine Ban Convention in the 26 Relevant States Parties 2005-2008," Geneva, 28 November 2008, p. 14.
[26] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008.
[27] Kerry Brinkert, (then) Manager, Implementation Support Unit Geneva International Centre for Humanitarian Demining, "Making sense out of the Anti-Personnel Mine Ban Convention's obligations to landmine victims," Geneva, 31 March 2006, pp. 6, 8.
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[29] Statement of Jordan, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 23 June 2004.
[30] NCDR, "National Mine Action Plan 2005-2009," Amman, June 2005, pp.13-15; and statement of Jordan, Standing Committee on Mine Clearance, Mine Risk Education and Mine Action Technologies, Geneva, 14 June 2005.
[31] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 469.
[32] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, pp. 465-466 and 469.

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[2] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 525.
[3] UNDP, "2008 Statistical Update – Mozambique," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_MOZ.html, accessed 20 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 142.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 20 July 2009.
[5] CIA, *The World Factbook – Mozambique*, https://www.cia.gov/library/publications/the-world-factbook/geos/mz.html, accessed 20 July 2009.
[6] WHO, "Detailed Database Search: Mozambique," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 20 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 100. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population will be unlikely to achieve adequate coverage.
[8] UN, "Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 20 July 2009.
[9] CIA, *The World Factbook – Mozambique*, https://www.cia.gov/library/publications/the-world-factbook/geos/mz.html, accessed 20 July 2009.
[10] Interview with Mila Massango, Head of International Affairs, Fernando Mulima, Head of Planning and Information, and Antonio Belchoir Vaz Martin, Head of Operations, IND, Maputo, 20 April 2009.

[11] See Mozambique chapter in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 164-167.
[12] 8% non-response rate.
[13] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 532.
[14] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 532.
[15] WHO, "Mozambique's Health System: Country Profile," www.who.int/countries/moz/areas/health_system/en/index1.html, accessed 20 July 2009.
[16] Statement of Mozambique, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[17] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 448.
[18] ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 540.
[19] Interview with Sergio Nhantumbo, Director, Orthopedic Center, MoH, Maputo, 22 April 2009.
[20] Statement of Mozambique, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 10 February 2004.
[21] ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, pp. 538, 541.
[22] Interviews with Ivete Dengo, Head of the Social Department, Mozambique Red Cross, Maputo, 20 April 2009; Cidia Montiero, Director, POWER, Maputo, 21 April 2009; and Eufemia Amela, President, Mozambican Association of Disabled Women, Maputo, 21 April 2009.
[23] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 595; presentation by Mozambique, workshop on Advancing Landmine Victim Assistance in Africa, Nairobi, 31 May-2 June 2005; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 534.
[24] Statement of Mozambique, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[25] US Department of State, "2008 Country Reports on Human Rights Practices: Mozambique," Washington, DC, 25 February 2009.
[26] Interview with Macario Dubalelane, Coordinator for Disability, MoWSW, Maputo, 22 April 2009.
[27] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 541.
[28] Interviews with Mila Massango, Head of International Affairs, Fernando Mulima, Head of Planning and Information, and Antonio Belchoir Vaz Martin, Head of Operations, IND, Maputo, 20 April 2009; and interview with Macario Dubalelane, Coordinator for Disability, MoWSW, Maputo, 22 April 2009.
[29] Article 5 Deadline Extension Request, Maputo, 6 May 2008, p. 13.
[30] Statement of Mozambique, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[31] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 596.
[32] IND, "Plano Nacional de Acção Contra Minas, 2008-2012" ("National Mine Action Plan, 2008-2012"), Maputo, 12 February 2008, p. 10.

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[1] Elizabeth Beery Adams, "The History of Demining in Nicaragua," *Journal of ERW and Mine Action*, Issue 5.2, August 2001, http://maic.jmu.edu/journal/5.2/focus/nicaragua.htm; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 545.
[2] Statement of Nicaragua, Standing Committee on Mine Clearance, Mine Risk Education and Mine Action Technologies, Geneva, 27 May 2009; and statement of Nicaragua, Managua Workshop for an America Free of Mines, Managua, 25 February 2009.
[3] UNDP, "2008 Statistical Update – Nicaragua," http://hdrstats.undp.org/en/2008/countries/country_fact_sheets/cty_fs_NIC.html, accessed 8 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 141.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; and UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 8 July 2009.
[5] CIA, *The World Factbook – Nicaragua*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/NU.html; and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/nu.html, accessed 8 July 2009.
[6] WHO, "Detailed Database Search: Nicaragua," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 8 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 100. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
[8] UN, Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 8 July 2009.
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[10] See Nicaragua chapter in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 168-173.
[11] See also, presentation by Dr. Carlos Jarquin, Director General of Health Services, MoH, Managua Workshop for an America Free of Mines, Managua, 25 February 2009.
[12] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 553.
[13] Presentation by the ICRC-SFD, Managua Workshop for an America Free of Mines, Managua, 26 February 2009.
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[15] Office of the President, "Informe de Comisión de Paz y Reconciliación" ("Report of the Peace and Reconciliation Committee"), Managua, 11 July 2008, www.elpueblopresidente.com/ACTUALIDAD/2090.html, accessed 8 July 2009.
[16] Presentation by Dr. Carlos Jarquin, Director General of Health Services, MoH, Managua Workshop for an America Free of Mines, Managua, 25 February 2009.
[17] Interview with Dr. Carlos Jarquin, Director General of Health Services and Guillermo Gosebruch, Specialist in Psychiatry, MoH, Managua, 25 March 2009.
[18] Statement of Nicaragua, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 10 February 2004.
[19] The end of OAS funding has been expected every year since 2007 along with expectations to complete clearance, but every year it has been extended. Continued OAS funding is also expected for 2010.
[20] ICRC SFD, "Annual Report 2008," Geneva, April 2009, p. 31.
[21] Statement of Nicaragua, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 10 February 2004.

Peru

[1] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, pp. 568-569.

[2] Statement of Peru, Standing Committee on Mine Clearance, Mine Risk Education and Mine Clearance Technologies, Geneva, 27 May 2009; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 569.
[3] UNDP, "2008 Statistical Update – Peru," http://hdrstats.undp.org/en/2008/countries/country_fact_sheets/cty_fs_PER.html, accessed 13 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 144.
[4] World Bank, "Gross national income per capita 2008, Atlas method and PPP," 1 July 2009, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf; and UN Statistics Division, "Per capita GNI at current prices – US Dollars," http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A103%3BcurrID%3AUSD%3BpcFlag%3A1, accessed 13 July 2009.
[5] CIA, *The World Factbook – Peru*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/PE.html; and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/pe.html, accessed 13 July 2009.
[6] WHO, "Detailed Database Search: Peru," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 13 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 100. The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage. The estimate for Peru is from prior to 2000.
[8] UN, "Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 13 July 2009.
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[10] Casualty data provided by email from Juan Miguel Grau, VA Consultant, Contraminas, Lima, 10 June 2009.
[11] The Plan of Equality and Opportunities for Persons with Disabilities 2007-2016 was extended in December 2008 to cover the period 2009-2018.
[12] Interview with Wilyam Lúcar, General Coordinator, Contraminas, Managua, 26 February 2009.
[13] See Peru chapter in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 173-176.
[14] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 575.
[15] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 575.
[16] "Final Report of the Sixth Meeting of the States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 174; and statement of Peru, Ninth Meeting of States Parties, Geneva, 27 November 2008.
[17] Government of Peru, "Plan De Igualdad De Oportunidades Para Las Personas Con Discapacidad 2009-2018" ("Plan of Equality of Opportunities for Persons with Disabilities 2009-2018"), Lima, 23 December 2008, p. 11.
[18] Statements of Peru, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008 and 26 May 2009.
[19] "Final Report of the Sixth Meeting of the States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 174.
[20] Statements of Peru, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 3 June 2008 and 26 May 2009; and statement by Dr. Juan Daniel Guillen Cabrejos, General Director, INR, Managua Workshop for an America Free of Mines, Managua, 24 February 2009.
[21] ICRC Special Fund for the Disabled, "Annual Report 2008," Geneva, April 2009, p. 33.
[22] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, pp. 577-578.
[23] "Final Report of the Sixth Meeting of the States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 175.
[24] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 578; and statement of Peru, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[25] "Final Report of the Sixth Meeting of the States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 175.
[26] Statement of Peru, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[27] Presentation by Dr. Guillermo Vega Espejo, President, CONADIS, Managua Workshop for an America Free of Mines, Managua, 25 February 2009; and statement of Peru, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.
[28] This is also reported in Landmine Monitor; see ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 580.
[29] Email from Carlos Estrada, (then) President, AVISCAM, Lima, 10 March 2009.
[30] Interview with Wilyam Lúcar, General Coordinator, Contraminas, Geneva, 26 May 2009.

Senegal

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[6] WHO, "Detailed Database Search: Uganda," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 10 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 102; The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
[8] UN, Convention [on the Rights of Persons with Disabilities] & Optional Protocol Signatories & Ratification," http://www.un.org/disabilities/countries.asp?id=166, accessed 10 July 2009.
[9] Statement of Uganda, Seventh Meeting of States Parties, Geneva, 19 September 2006; and statement of Uganda, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 24 April 2007.
[10] Email from Julius Kamya, Executive Secretary, National Council for Disability (NCD), 29 June 2009.
[11] International Monetary Fund, "Uganda: Poverty Reduction Strategy Paper," Washington, DC, August 2005, p. xv, http://www.imf.org/external/pubs/ft/scr/2005/cr05307.pdf, accessed 10 July 2009.
[12] Casualty data 1986-2009 provided by email from Femke Bannink, Project Coordinator, Association of Volunteers in International Service (AVSI), 18 June 2009.
[13] Questionnaires were completed through several survivor organizations in three different regions and at the ICRC-supported rehabilitation center.
[14] Casualty data 1986-2009, provided by email from Femke Bannink, Project Coordinator, AVSI, 18 June 2009.
[15] Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 209-210; and MoGLSD, "Status of Victim Assistance in Uganda," Geneva, 3 June 2008.
[16] MoGLSD, OPM and MoH, "The Uganda Comprehensive Plan of Action for Victim Assistance 2008-2012," Kampala, November 2007, p. 21.
[17] 7% non-response rate.
[18] Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 209-210; and MoGLSD, "Status of Victim Assistance in Uganda," Geneva, 3 June 2008.

[19] ICRC, "Physical Rehabilitation Programme: Annual Report 2008," Geneva, 7 May 2009, p. 29.
[20] ICRC, "Physical Rehabilitation Programme: Annual Report 2008," Geneva, 7 May 2009, p. 29.
[21] 6% non-response rate.
[22] Statement of Uganda, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009; and Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 214-215.
[23] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 760.
[24] Response to questionnaire by one international practitioner.
[25] Statement of Uganda, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 23 June 2004.
[26] Statement of Uganda, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 16 June 2005.
[27] Statement of Uganda, Eighth Meeting of States Parties, Dead Sea, 27 November 2007.
[28] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, pp. 720-721.
[29] MoGLSD, OPM and MoH, "The Uganda Comprehensive Plan of Action for Victim Assistance 2008-2012," Kampala, November 2007, pp. 10-12.
[30] Email from Julius Kamya, Executive Secretary, NCD, 29 June 2009.
[31] ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 845.
[32] 2% non-response rate.

Yemen

[1] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 749; and ICBL, *Landmine Monitor Report 2004*, Washington, DC, October 2004, p. 866.
[2] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 749.
[3] UNDP, "2008 Statistical Update – Yemen," http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_YEM.html, accessed 18 July 2009; and UNDP, *Human Development Report 2004: Cultural Liberty in Today's Diverse World*, New York, 2004, p. 141.
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[5] CIA, *The World Factbook – Yemen*, 2008, https://www.cia.gov/library/publications/the-world-factbook/geos/YM.html; and 2004, http://www.umsl.edu/services/govdocs/wofact2004/geos/ym.html, accessed 18 July 2009.
[6] WHO, "Detailed Database Search: Yemen," http://apps.who.int/whosis/data/Search.jsp?indicators=%5bIndicator%5d.%5bHSR%5d.Members, accessed 18 July 2009.
[7] WHO, "World Health Statistics 2009," Geneva, 2009, pp. 95, 102; The WHO estimates that countries with less than 23 healthcare professionals (physicians, nurses and midwives) per 10,000 population are unlikely to achieve adequate coverage.
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[10] See Yemen chapter in *Landmine Monitor Reports*, 1999-2008; and "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, pp. 217-224.
[11] WB, "Yemen, an Integrated Approach to Social Sectors – Towards A Social Protection Strategy," Sana'a, 29 June 2007, pp. 31-32.
[12] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 622; notes from victim assistance session at YEMAC/ICBL workshop, Sana'a, 3 February 2007.
[13] This included 10 people who had given their occupation prior to the incident, indicating that they were now also unemployed.
[14] 2% non-response rate.
[15] Article 7 Report (for period from 31 March 2008 to 31 March 2009), Form I, 31 March 2009.
[16] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 758; and ICBL, *Landmine Monitor Report 2007*, Ottawa, October 2007, p. 745.
[17] 6% non-response rate.
[18] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 757; and Final Report of the Sixth Meeting of States Parties / Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 218.
[19] B. Pound *et al.*, "Departure of the Devil: Landmines and Livelihoods in Yemen," *GICHD*, Geneva, 2006, p. 33.
[20] "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 220.
[21] 11% non-response rate.
[22] "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 221; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, p. 757.
[23] B. Pound *et al.*, "Departure of the Devil: Landmines and Livelihoods in Yemen," *GICHD*, Geneva, 2006, p. 33.
[24] "Final Report of the Sixth Meeting of States Parties/Zagreb Progress Report," Part II, Annex V, Zagreb, 28 November-2 December 2005, p. 221.
[25] WB, "Yemen, an Integrated Approach to Social Sectors – Towards A Social Protection Strategy," Sana'a, 29 June 2007, pp. 55, 132; and ICBL, *Landmine Monitor Report 2008*, Ottawa, October 2008, pp. 757, 759.
[26] Article 7 Report (for period from 31 March 2008 to 31 March 2009), Form I, 31 March 2009.
[27] ICBL, *Landmine Monitor Report 2008*, Ottawa, October 208, p. 759.
[28] B. Pound *et al.*, "Departure of the Devil: Landmines and Livelihoods in Yemen," *GICHD*, Geneva, 2006; and GICHD, "Mid-Term Outcome Evaluation for Strengthening National Capacity for Mine Action in Yemen-Phase II," Geneva, 2005.
[29] ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, p. 622; ICBL, *Landmine Monitor Report 2006*, Ottawa, July 2006, p. 795; ICBL, *Landmine Monitor Report* 2008, Ottawa, October 2008, p. 759; and interview with two NGO representatives in November 2008.
[30] GICHD, "Mid-Term Outcome Evaluation for Strengthening National Capacity for Mine Action in Yemen-Phase II," Geneva, 2005, p. 24; and ICBL, *Landmine Monitor Report 2005*, Ottawa, October 2005, pp. 622-623.
[31] Response by Head of VA Department, YEMAC, Sana'a, 3 August 2008.

External support for victim assistance (VA) – donor states' efforts

[1] Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, Article

6.3, http://www.apminebanconvention.org/overview-and-convention-text/.

2 "Ending the Suffering Caused by Anti-Personnel Mines: Revised Draft Nairobi Action Plan 2005-2009," APLC/CONF/2004/L.4/Rev.1, 5 November 2004, p. 5.

3 "Ending the Suffering Caused by Anti-Personnel Mines: Revised Draft Nairobi Action Plan 2005-2009," APLC/CONF/2004/L.4/Rev.1, 5 November 2004, p. 6.

4 Bosnia and Herzegovina, Colombia, DRC, Eritrea, Ethiopia, and Iraq did not respond.

5 Questionnaires were received from Australia, Austria, Canada, the Czech Republic, the European Community, Finland, Ireland, Italy, Japan, Luxembourg, Norway, Spain, Switzerland, and the United States. Written information, not in the questionnaire format, was provided by Denmark, Sweden and the United Kingdom.

6 Co-chairs, Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 26 May 2009.

Global victim assistance (VA) progress on the ground

1 Some 2% said they were located "other" living areas and 2% did not respond to the question (1% variation due to rounding of numbers).

Conclusion

1 These are: data collection, emergency and continuing medical care, physical rehabilitation, psychological support and social reintegration, economic reintegration and laws and public policy, to which coordination may be added.

2 Two of these countries, Iraq and Jordan, only started the informal process two years after the other 24 countries in 2007, but this was not reflected in the responses the survivors from these countries gave.

3 Notes for ICRC intervention under agenda item "Towards the Second Review Conference and beyond," Standing Committee on Victim Assistance and Socio-Economic Reintegration, Geneva, 29 May 2009.

4 Statement by the Co-Chairs, Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Towards the Second Review Conference and beyond," Geneva 29 May 2009.

Suggestions for the way forward for progress-oriented victim assistance (VA)

1 Most notably the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the Convention on Cluster Munitions (CCM).

2 This approach serves everyone covered by the definition of a victim. The commonly accepted definition of a victim encompasses not only the directly affected individuals, but also their affected family and community. The MBT concentrates first on the directly affected individual, then the family and later the community, either through a trickle-down effect for the group as a whole or individually through community-based programming.

3 ICRC, "Delivering on the promises: a meeting of practitioners, survivors and experts. Priorities for implementation of victim assistance commitments in the context of the Mine Ban Convention, the Convention on Cluster Munitions and the Protocol on Explosive Remnants of War," recommendations from Oslo meeting 22-24 June 2009, draft version 24 July 2009.

4 According to the "Draft 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, 17 July 2009, pp. 25-26 (point 119), some of the main challenges include: disability rights often not seen as a priority by policy-makers; weak capacity to address disability issues at all levels; limited or lack of inclusion of persons with disabilities in decision-making processes; limited disability-related data for planning purposes; services not meeting needs in terms of both quantity and quality; limited or lack of accessibility to services and opportunities in rural areas; weak state structures and, hence, weak bureaucratic, human resource, technical and financial capacity to develop, implement and monitor objectives, national plans, and legislation in a transparent manner; inadequate resources to build government capacity to provide services in rural areas; lack of sustainability of national ownership, interest and will when faced with other competing priorities; and, inadequate long-term international cooperation and assistance in both the provision of financial resources and technical support and in linking of resources to identified needs.

5 "A Shared Commitment: Draft Cartagena Action Plan 2010-2014 – Ending the Suffering Caused by Anti-Personnel Mines," 17 July 2009, p. 4.

6 SMART (specific, measurable, achievable, relevant and time-bound) objectives and plans were the core of activity in the last five years, but they were not included in the action plan. Through this we have established a minimum set of organizational/structural criteria needed for a start to successful VA: responsibility, assessment of the scope, measurable objectives and plans with clear timeframes, coordination, a connection between planning and the national budget, monitoring and reporting.

7 Focal point in this context does not refer to a specific person but to a position integrated in the relevant body's hierarchy, budgeted, and with a clear mandate and space for independent decision-making to ensure sustainability and continuity.

8 The lack of a complete assessment cannot be used as an obstacle to service implementation.

9 SMART: specific, measurable, achievable, relevant and time-bound.

Definitions and scope of victim assistance (VA)

1 For more detailed and comprehensive information see, "A Guide to Understanding Victim Assistance in the Context of the AP Mine Ban Convention," Geneva, October 2008, pp. 6-11.

2 "Ending the Suffering Caused by Anti-Personnel Mines: Revised Draft Nairobi Action Plan 2005-2009," APLC/CONF/2004/L.4/Rev.1, 5 November 2004, p. 8.

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Aynalem in school
© Gaël Turine/ VU for Handicap International, 2008

Aynalem making injera (typical Ethiopian bread)
© Gaël Turine/ VU for Handicap International, 2008

Aynalem Zenebe from Ethiopia was seven years old when she lost her leg in an ERW incident. At the time, she was too young to realize the consequences, but now Aynalem has become an advocate for the rights of survivors. Her full story can be found in this report.

Aynalem getting a check-up at the physical rehabilitation center
© Gaël Turine/ VU for Handicap International, 2008

An eventful 10 years have passed since the entry into force of the Mine Ban Treaty, which aimed to put an end to the suffering and casualties caused by antipersonnel mines. The treaty offered the fundamental promise that the lives of hundreds of thousands of survivors, their families and communities would improve. The hard work of advocates from affected communities and their supporters at the national and international levels has ensured that victim assistance has remained at the forefront of the Mine Ban Treaty agenda throughout.

Voices from the Ground is the first study to convey, in a systematic manner, the voices of the large, diverse group of people living with the daily impact of mines and explosive remnants of war. More than 1,500 survivors and 150 practitioners participated in the study, which was conducted in 26 affected countries which have declared not only that they have a responsibility toward the greatest number of survivors, but also the greatest needs and expectations for assistance. This study aims to improve the understanding of how those directly affected have experienced the victim assistance activities provided in their countries between 2005 and 2009. Their evaluation of the efforts by these 26 states and the international community to improve the lives of those affected should take center stage in any discussion on ensuring the effective provision of victim assistance in future.

Austrian Federal Ministry for European and International Affairs

NORWEGIAN MINISTRY OF FOREIGN AFFAIRS

International CAMPAIGN TO BAN LANDMINES