FACTSHEETS

How to implement victim assistance obligations?

UNDER THE MINE BAN TREATY OR THE CONVENTION ON CLUSTER MUNITIONS

Concrete actions to improve the quality of life of victims and persons with disabilities

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VICTIM ASSISTANCE FACTSHEETS

INTRODUCTION

Assistance to victims of mine/explosive remnants of war (ERW) is an obligation for States Parties to the Mine Ban Treaty (MBT) and the Convention on Cluster Munitions (CCM). The Cartagena Action Plan and the Vientiane Action Plan include specific commitments that States Parties have agreed on to implement their victim assistance (VA) obligations effectively, in particular to improve the quality of life of victims. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) provides the most comprehensive framework to address the needs & advances the rights of all persons with disabilities (PwD), including mine/ERW survivors. Regional frameworks on disability and development are also relevant, such as the *Incheon Strategy to "Make the Right Real" for Persons with Disability in Asia and the Pacific* and *the African Decade of Persons with Disabilities.*

OBJECTIVE OF THESE FACTSHEETS

The Victim Assistance Factsheets were developed by Handicap International (HI) as a tool to provide **concise information on what victim assistance (VA) is and on how to translate it into concrete actions that have the potential to improve the quality of life of mine/ERW victims and persons with disabilities**. The factsheets target States Parties affected by mine/ERW, States Parties in a position to provide assistance, as well as organizations of survivors and other PwD, and other civil society - and international organizations.

METHODOLOGY

The factsheets build on a review of existing literature on VA, Disability and Inclusive Development, including publications such as the WHO Community-Based Rehabilitation Guidelines, sector and country-specific publications by HI, as well as others by the Anti-Personnel Mine Ban Convention Implementation Support Unit, the ICRC and other organizations. Technical feedback was also solicited from HI's Technical Advisors with contributions from HI field teams. Discussions also took place with survivor and other partner organizations in mine/ERW affected countries. The final content, however, is the sole responsibility of HI and reflects the organization's policy and practice.

OVERVIEW OF THE FACTSHEETS

This package consists of 12 factsheets. Six focus on a specific sector or public policy area that VA is an integral part of and the remaining six are dedicated to cross-cutting issues. With a view to promote synergies between different frameworks, each factsheet makes clear links with development sectors and issues. This approach aims to avoid duplication of efforts and gaps between those done in the context of VA and other development efforts; to promote linkages between similar initiatives and to facilitate an efficient use of resources. More importantly, integrating VA in wider efforts on Inclusive Development will result in more significant and sustainable improvement in the quality of life on mine/ERW victims and PwD, which is the main goal of VA.

THE 12 TOPICS COVERED IN THESE FACTSHEETS ARE:

SECTORS/PUBLIC POLICIES AREAS

1. MEDICAL CARE
2. REHABILITATION
3. PSYCHOLOGICAL & PSYCHO-SOCIAL SUPPORT
4. EDUCATION
5. SOCIAL INCLUSION
6. ECONOMIC INCLUSION

CROSS-CUTTING ISSUES

7. GENDER
8. EMPOWERMENT
9. ACCESSIBILITY & ACCESS TO SERVICES
10. DATA COLLECTION
11. NATIONAL ACTION PLANS, COORDINATION
12. INTERNATIONAL COOPERATION AND ASSISTANCE

HOW TO USE THESE FACTSHEETS

These factsheets have been designed so that they can be used as a package, or on a stand-alone basis. Each factsheet is divided in different sections, including: definition of the VA sector or cross-cutting issue, the international legal & policy frameworks, the main stakeholders, common challenges in low-income countries, a successful project, recommendations, indicators, description of a project or program, and references.

Section 6 of each factsheet lists recommendations for States Parties to the MBT & the CCM. **States affected by mine/ERW** will find examples of what can be done at the national level to improve VA, while **States in a position to provide assistance** can find ideas of what affected States are doing, and can do, on VA; and as such, come across ideas on the kind of policy, plan, programs & projects they may contribute to through international cooperation efforts. In addition, factsheet 12 focuses specifically on how International Cooperation can support VA.

In most sheets, Section 6 on Recommendations & Section 7 on Indicators are subdivided into three parts:

1. Quality of life,
2. Access to Services,
3. Legislation & Policies.

The information is organized in this manner so as to reflect the fact that different interventions have a direct impact on one of these three levels. HI, however believes that advances in access to services & in legislation & policies are important, but that these should ultimately contribute to having a positive, measurable & sustainable impact on the quality of life of victims & PwD.

KEY CONCEPTS

- **ACCESS TO SERVICES:**
  When using the term "access to services" throughout these factsheets, the following six criteria underlie the concept of "access": **availability, accessibility, acceptability, affordability, accountability & good technical quality** *(see factsheet 9: Accessibility/Access to Services).*

- **NON-DISCRIMINATION:**
  In this context, it refers specifically to the fact that no discrimination should be made against or among victims, or between survivors and other PwD. VA efforts should benefit to other PwD, in the same manner as efforts to advance the rights of PwD and their families should include survivors and their families.

- **INCLUSIVE DEVELOPMENT:**
  Ensuring that all groups in situation of marginalization, vulnerability or exclusion (such as most victims and PwD) benefit, contribute to & participate meaningfully and effectively in all development processes.

- **VICTIMS:**
  All persons who have been killed or suffered physical or psychological injury, economic loss, social marginalization or substantial impairment of the realization of their rights caused by the use of mine/ERW. They include those persons directly impacted by mine/ERW as well as their affected families and communities. They are referred to in the factsheets as 'victims'.

- **PERSONS WITH DISABILITIES:**
  According to the CRPD, PwD include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

- **TWIN-TRACK APPROACH:**
  Refers to an approach that promotes Inclusive Development through two complementary and equally important methods:
  - By implementing specific actions that promote the individual and collective empowerment of mine/ERW victims and PwD. *(See factsheet 8: Empowerment)*
  - By eliminating all physical, attitudinal and communication barriers that exclude persons with disabilities from development. *(See factsheet 9: Accessibility/Access to Services)*

We hope that readers will find these factsheets informative and useful, and that they serve as an invitation to learn more about ways in which to contribute to VA and Inclusive Development. Handicap International welcomes all input and comments. Detailed guidelines, technical documentation and good practices on these topics are listed in each sheet.

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Published August 2013

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Victim assistance thematic area: **MEDICAL CARE**
Development sector: **HEALTH**

WHAT IS MEDICAL CARE?

Medical care is one of the components of **Health services.** It is the prevention, **identification, assessment & treatment of health conditions & impairments**. [1] In the context of VA, health services have focused on emergency & continuing medical care. **The goal of emergency medical care** is to provide acute trauma care: first aid, blood transfusions & other **immediate measures** that prevent death and permanent impairments after a person survives an accident. **The goal of continuing medical care** is to **promote the person's full recovery** with measures such as pain management.

Medical care is the first step to ensure a person can survive an accident and minimize the risk and level of permanent impairments as much as possible. Yet, medical care that responds to an injury is only part of the wider health services. Survivors need and have the right to access appropriate medical care even after they have recovered from the initial trauma.

Health services are comprised of the following components: [2]

- **Health promotion:** strengthening the skills of individuals to change the social, economic & environmental conditions to alleviate an injury's impact on health.
- **Prevention:** Primary (avoidance of illness), secondary (early detection and treatment) and tertiary (rehabilitation) prevention measures.
- **Medical care** (including emergency & continuing medical care): Identification, assessment, surgery and treatment of health conditions and impairments.

Quick Facts

- Every year, thousands of people die or are disabled by mine/ERW accidents, in part due to a **lack of immediate access to skilled first aid**.
- PwD, including survivors, often experience **lower levels of health** and face **more difficulties accessing health services** than the rest of the population.
- Women and girls with disabilities, including survivors, suffer a **higher rate of sexual abuse** than other women, and have less access to information on reproductive health. They face **higher risk of HIV infection, unwanted pregnancy & maternal death**.

LEGAL & POLICY FRAMEWORKS

CCM: Art. 5. | **Vientiane Action Plan:** Action #25 & #28.
Cartagena Action Plan: Section IV, para. 12. Action #31.
CRPD: Art. 25 & 26 .
MDGs: Goals 4, 5 and 6.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors and PwD | **Service providers: Hospitals, including emergency medical transport services**, community health centers
Ministries: Health
International organizations: WHO.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- Limited or no healthcare human and material resources (including first aid respondents and safe supply of blood) available in **rural areas**, where the majority of victims live.
- Transportation to healthcare centers is often long and expensive: barriers such as distance and cost tend to make it difficult for **people to access health services regularly**, in particular for children which is needed when they are growing up.
- Few surgeons are trained in **amputation techniques & eyesight saving measures** that are often necessary after a mine/ERW injury.
- Healthcare services often **require payments** that are not affordable for poor persons, such as the majority of survivors.
- In conflict-affected areas, insecurity makes it **difficult or impossible for health services to exist**. Often, there are little to no mobile teams or itinerant services.
- **Lack of female health service providers**, which makes it difficult for female survivors to access these services in certain contexts.
- Insufficient healthcare staff is trained on the rights of PwD or on how to ensure **persons with different types of impairments** can access information on prevention, promotion and medical care & services; as such information about health services **rarely reaches survivors**.

SUCCESSFUL PROJECTS IN ACCESS TO HEALTH

In Afghanistan, the *WHO* collaborated with the *Ministry of Public Health* to build capacities in emergency & essential surgical and anesthesia procedures at regional and provincial hospitals through the Integrated Management for Emergency and Essential Surgical Care program. [3]

In Colombia, the *Ministry of Social Protection*, with support from the *ICRC*, produced a technical guide on emergency medical care and trained surgeons from regional hospitals in mine/ERW affected regions. The *ICRC* and the *Colombian Red Cross* provided community-based first aid training in 12 of the affected regions. [4]

In Thailand, the *Emergency Medical Services System* has expanded to all provinces and local communities, including 27 mine/ERW affected provinces. A network of emergency response teams can be accessed in emergency situations by dialing the emergency hotline and is available throughout the country with the exception of remote communities along the border areas. [5]

WHAT CAN STATES DO?

To improve quality of life:

- **Train local populations** in mine/ERW affected areas on first aid.
- Ensure that survivors and other injured persons receive **follow-up** from both surgical & nursing teams and from rehabilitation professionals.
- Ensure that PwD, including survivors, and their families are **well-informed** on the risks and benefits of surgeries and that they are aware of the cost and duration of the treatment.
- Develop people's skills by providing **health education** & other information to enable them to exercise more control over their health.
- In particular, ensure that girls & women with disabilities, including survivors, have access to **sexual & reproductive health services** on an equal basis with girls & women without disabilities.

To improve access to services:

- Ensure health facilities have **adequate equipment** and **supplies of safe blood & medication**.
- Ensure adequate **trauma surgery & pain management** capacity.
- Guarantee health services are **free or affordable and accessible** to survivors, PwD & other indiviuals in need.
- Implement **disability awareness training** for health professionals.
- Ensure presence of **female health** care providers.
- Develop and support **referral systems** to facilitate access for PwD, especially women & children, to all health services.

To improve access to legislation and policies:

- Legislation & policies on health should be in accordance with the CRPD with subsequent development of **plans & respective budgets** to enable implementation at the local level.
- Ensure legislation & policies include **health promotion, prevention & medical care**.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* Proportion of casualties that survive. * Reduction of time needed to reach medical assistance after an accident. * # of PwD, including survivors, that know the procedure to access health services. * Proportion of girls & women with disabilities, including survivors, accessing health services, compared to women & girls without disabilities. * Reduction of the difference between the male & female fatality rate.

› Access to services:

* # of local people trained in first aid in villages with high incidence of accidents. * # of trained healthcare workers in affected areas. * Increased awareness among healthcare staff on the rights & needs of PwD. * Increased capacity in the areas of surgery & anesthetic in, or close to, affected areas. * # of health programs procedures to reach & include men, women, girls & boys with disabilities.

› Legislation and policies:

* Health-related legislation is in accordance with CRPD and takes into consideration the specific needs of mine/ERW casualties & other victims of trauma. * Health promotion, prevention & medical care policies include measures and a specific budget to include PwD on an equal basis with others.

PROJECT EXAMPLE: TRAINING OF PARAMEDICS IN NORTHERN IRAQ [6]

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KORD center, Souleymaniah, Iraq, 2011.

Identified problems: Most mine/ERW casualties live in rural areas, yet most doctors and medical facilities are located in cities. In Northern Iraq, there was little capacity to provide pre-hospital care for victims of trauma.

Objective: To improve access to pre-hospital care by training a core group of paramedics, who in turn would train first responders at the community level.

Activities: training of 6,000 lay-persons **to be first responders** and of 88 paramedics (1996-2004). All patients were registered with monitoring of time intervals, interventions performed, pre-hospital treatment effect & mortality rate.

Sustainability: The trained paramedics & first responders live and work in the targeted areas, so that the resources stay on-site beyond project duration. All had extensive personal experience responding to people injured & killed by mine/ERW. Retention of paramedics in the program was 72% after 8 years. The project was implemented in cooperation with existing local hospitals & regional health authorities.

Key indicators: 88 paramedics were trained. In turn, they trained 6,000 layperson to be first responders in their own & neighboring villages in basic life support for trauma victims. 2,349 patients received treatment during the period. Of these, 919 persons suffered from mine & other penetrating injuries, and 1,430 from blunt trauma or other medical emergencies. The mortality rate in victims decreased from 28.7% to 9.4%, as did the time interval from injury to first medical help, from 2.4 hours to 0.6 hours. The majority of fatalities were found at the site of injury after they had died. The pre-hospital treatment effect improved significantly.

Duration: Results reported from 1999 to 2005; the project is still ongoing.

Implemented by: Tromso Mine Victim Resource Center in cooperation with Trauma Care Foundation Iraq.

Donor: Norwegian Ministry of Foreign Affairs.

References [1] [2] WHO, UNICEF, ILO, IDDC. *CBR Health Guidelines.* 2010 | [3] [5] GICHD. *Assisting Landmine/ERW survivors in the context of disarmament, disability and development.* 2011 | [4] ICBL. *Landmine and Cluster Munition Monitor.* 2012 | [6] Wisborg, Murad, Edvardsen and Husum. *Prehospital Trauma System in a Low-Income Country.* The Journal of Trauma. May 2008; ICRC. *Care in the field for victims of weapons of war.* 2001 and *Caring for landmine victims.* 2005; Trauma Care Foundation. *Save Lives, Save Limbs.* 2000; Tromso Mine Victim Resource Center. *Annual Report.* 2011; WHO. *Prehospital Trauma Care Systems.* 2005

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Victim assistance thematic area: **REHABILITATION**
Development sector: **REHABILITATION**

WHAT IS REHABILITATION?

Rehabilitation is a process aimed at enabling survivors & other PwD to reach and maintain their optimal physical, sensorial, intellectual and social levels of functioning.
Rehabilitation supports survivors & other PwD in reaching their maximum level of health and wellbeing, in living independently, and in being included in society.

Components of Rehabilitation are:

- **Prosthetics and Orthotics services (P&O):** Production and fitting of prostheses & orthotics to allow a person to walk again or to improve upper limb function. A prosthesis replaces a limb and an orthotic supports or improves sensorial & motor functioning. Prostheses & orthotics belong to the group of **assistive devices,** which also included mobility devices such as wheelchairs and walkers.
- **Physiotherapy:** Use of manual techniques, exercises & basic devices to improve & develop motor and sensory function, as well as control pain.
- **Occupational Therapy:** Therapeutic use of everyday life activities with individuals or in group setting to increase participation at home, school, workplace, community, culture, sport & leisure activities. Aims to address & reduce physical, cognitive, psycho-social and sensory impairments.
- **Speech Therapy:** Treats all disorders of voice, speech and language not related to mental or hearing impairment.

Quick Facts

- In many low-income countries, **only 5–15%** of those people who require assistive devices actually **have access to them**. (1)
- 50% of 114 surveyed countries in 2004 did **not have relevant legislation** on rehabilitation; 48% did **not have policies on assistive devices**. (2)
- An estimated **105 million people**, or 1.5% of the world population, **need a wheelchair**. (3)
- The use of mobility devices improves **opportunities for education & work**, and contributes to improving **health, social participation & overall quality of life**. (4)

LEGAL & POLICY FRAMEWORKS

CCM: Art. 5 para. 1 & 2.H. Art. 6 para. 7. Art. 7 para. 1.K.
Vientiane Action Plan: Actions #25 and #28.
Cartagena Action Plan: Section IV, para. 12. Action #31.
CRPD: Art. 20 & 26.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors and PwD | **Service providers:** Rehabilitation centers & related teams managed by NGO, international NGO, public services | **Ministries:** **Health**, Social Affairs, Education | **National professional organizations** of rehabilitation specialists
International professional organizations such as International Society for Prosthetics and Orthotics (ISPO), the World Confederation for Physical Therapy, and the World Federation of Occupational Therapists | **International organizations:** ICRC.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- **Limited financial resources** for healthcare system and more specifically for rehabilitation services **in rural and remote areas.**
- **No national planning** for the development of rehabilitation and specifically for P&O services; both tend not to be integrated into healthcare programs.
- Some rehabilitation programs might **only focus on physiotherapy & assistive devices**, or on certain type of functional limitation (vision, mobility…) without linkages to other rehabilitation services.
- **Few rehabilitation professionals**, with little or no training on resources at the community-level in particular in mine/ERW affected areas.
- **No proper follow-up** once the rehabilitation service user is discharged
- Little to **no linkage with medical, social & mental health services.**
- Potential **users** do not always know about existing rehabilitation services & processes to access them.
- **Users cannot afford** the actual cost of rehabilitation services or related costs, such as transport, lost income & child care.
- **Users do not participate** in the planning, monitoring and evaluation of services.

SUCCESSFUL PROJECTS IN REHABILITATION

In South Sudan, the ICRC supports the *Ministry of Gender, Child and Social Welfare* in the management & operation of the Juba Physical Rehabilitation Reference Center, which serves as the referral center for the country. To respond to existing challenges, the ICRC:
1. Provided support to cover **the cost of transport** & accommodation for those attending the center, 2. Facilitated the development of a referral system, 3. Supported **outreach visits & information campaigns**. It also donated materials & components to ensure that the Center had the means to provide services. More than 1,440 persons benefited from various services in 2011. The ICRC also provided on-site support, mentoring and scholarships for courses in P&O and supported the Ministry in developing its capacity to implement, coordinate & manage physical rehabilitation activities.(6)

In Mozambique, Handicap International (HI) opened **rehabilitation centers** in the 1980s, together with the ICRC. For 15 years, HI worked in several regions to support or set-up Physical Medicine and Rehabilitation services, mainly P&O centers, and deliver services directly; transit centers were set up to host beneficiaries coming from remote areas and a community-based rehabilitation program was developed. The organization supported in-house and institutional training of rehabilitation profiles. Later on, HI strengthened its partnerships with national authorities to develop the rehabilitation system in the country, through support to policy development, organizational capacity development of service providers and advocacy at the ministry level for resource allocation within the rehabilitation sector.

WHAT CAN STATES DO?

To improve quality of life:

- Facilitate **access to rehabilitation services** that a survivor and other PwD may need, including physical, occupational & speech therapy, P&O and pain management.
- Consider the specific requirements of men, women, girls & boys with regards to the **design, durability & age-appropriateness** of assistive devices.
- Rehabilitation services, including assistive devices, should **meet users' needs & be adapted to local environmental conditions**.
- Ensure follow-up of all users or rehabilitation services, in particular of children whose needs change often while they grow.

To improve access to services:

- Ensure that **physiotherapy** is available as soon as possible after the accident to prevent complications, prepare for rehabilitation & facilitate the use of assistive devices.
- If possible, provide assistive devices made of **local materials & which are produced locally**.
- **Train** a sufficient number of **rehabilitation professionals** (physiotherapists, P&O technicians, occupational and speech therapists) in accordance with the needs of the population & their geographic location.
- Ensure quality care & education of professionals for the benefit of patients through **ISPO recognition** - the global standard for P&O.
- Promote the **availability, knowledge & use of assistive devices** amongst survivors, other PwD & their families.
- Develop **mobile & community-based rehabilitations services**.

To improve legislation and policies:

- Ensure rehabilitation is an **integral part of health legislation & policies**, in line with CRPD, by enabling PwD to attain & maintain maximum independence in part through a multidisciplinary assessment of individual needs & strengths.
- Ensure that sufficient resources are allocated for its implementation, including in rural and remote areas.
- Develop a **rehabilitation network** with sufficient coverage, including reference centers, community P&O workshops & mobile teams.
- **Eliminate taxes & duties** on imported rehabilitation materials.
- When international organizations are involved in service provision, ensure national authorities have a clear plan to take over by developing the necessary **technical, human & financial resources** to ensure sustainability.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* # of users receiving treatment and devices. * Reduction of the time between needing a service and accessing it. * # of persons actively participating in developing their rehabilitation plan. * # of users reporting increased social participation after accessing rehabilitation services. * # of persons using their assistive device a year after they first received it.

› Access to services:

* Increase in the # of rehabilitation services provided in rural and remote mine/ERW affected areas. * Level of ISPO accreditation. * % of rehabilitation services with adequate equipment. * # services that are free or affordable. * # of users referred to medical, social or other services. * # of service providers regularly reporting on quality criteria. (affordability, attitude of staff & suitability of devices...). * # of therapists & technicians attending initial or continued professional training, including women. * # of PwD employed in rehabilitation services. * Existence of mechanisms for service users to express their demands. * # of service providers including users in the planning, monitoring & evaluation of the service.

› Legislation and policies:

* Rehabilitation is integral part of healthcare legislation. & policies, and in accordance with CRPD standards.
* Guidelines for physical rehabilitation exist.
* Relevant data for decision-making is routinely gathered.

PROJECT EXAMPLE: ACCESS TO MEDICINE AND REHABILITATION SERVICES IN ALBANIA

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Burmese camps in Thailand, 2011.

Identified problems: Rehabilitation services were not well-developed in the country; no training facilities for rehabilitation professionals.
Objective: To enhance the equal and sustainable access for all to quality Physical Medicine & Rehabilitation services.
Activities: 1. **Training & capacity development** of rehabilitation professionals. 2. Support to develop **rehabilitation services** in one affected region (Kukes Regional Hospital). 3. Support to development of **rehabilitation policy**.
Sustainability: 1. Ensuring ownership by national stakeholders: Ministry of Health, training institutions, local services. 2. Development of local training capacities & training of trainers. 3. Support for the definition of a national action plan on rehabilitation.
Key indicators: * A national physical medicine & rehabilitation strategy and action plan was adopted * 70 physiotherapists graduated at the newly established bachelor programme * 18 doctors completed a one-year course in physical medicine & rehabilitation * 6 trainees participated in P&O training * 399 people received P&O services. * One regional hospital has a well-functioning rehabilitation unit (Physiotherapy, P&O services) * DPOs are active in advocating their rights & monitoring the National Disability Action Plan.
Stakeholders: Albanian Mine Action Executive, Ministry of Health, Nursery Faculty of Tirana, two Belgian Physiotherapy schools.
Duration: end of 2005 – 2010 | **Donor:** International Trust Fund | **Implemented by:** HI

References (1) WHO, UNICEF, ILO, IDDC. *Community-based rehabilitation Health Guidelines.* 2010 | (2) WHO, USAID. *Joint position paper on the provision of mobility devices in less resourced settings.* 2011 | (3) (4) HI. *Policy brief: wheelchair mobility and positioning devices.* 2012; HI. *The sustainability analysis process: the case of physical rehabilitation.* 2012 | (5) ICBL-CMC. *Landmine and Cluster Munition Monitor.* 2012; ICRC. *Understanding the concept of physical rehabilitation.* 2009 | (6) ICRC. *Report of activities.* 2011; ISPO, LSN. *Prosthetics and Orthotics Program Guide: Implementing P&O in low-income settings.* 2006; Landmine Survivors Network. *Surviving Limb Loss.* 2000

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Victim assistance thematic area: **PSYCHOLOGICAL & PSYCHO-SOCIAL SUPPORT**

Development sector: **MENTAL HEALTH & PSYCHO-SOCIAL SUPPORT**

WHAT IS PSYCHOLOGICAL & PSYCHO-SOCIAL SUPPORT?

Psychological and psycho-social support is part of mental health services.

Mental Health is a state of well-being & happiness, whereby individuals recognize their abilities, are able to cope with the normal stresses of life and work & make a contribution to their communities. (1) It is linked to personality traits such as resilience, optimism, ability to deal with difficulties, control over one's life & self-esteem. (2)

Mental Health components are:

- **Psychological support:** Counseling by psychology & psychiatry professionals.
- **Psycho-social support:** Activities such as cultural, sport and leisure whose main aim is to improve psychological well-being.
- **Peer-to-peer support:** The provision of social & emotional support by persons facing similar situations & challenges through one-on-one visits or social support groups.

Mental health services are important for those who survived the shock of a mine/ERW accident, but also for their family, and more generally, affected communities. In the context of VA, **the goal of these services** is to prevent & respond to psychological distress in populations experiencing disabling injuries and the threat of traumas, such as mine/ERW accidents; and to prevent & respond to mental disorders, such as post-traumatic stress syndrome. Mental health services work directly with the person, as well as with his or her environment. They contribute to ensuring that people can find balance & harmony in the environment in which they live.

Quick Facts

- Survivor networks receive extremely **limited support** from national governments while many are the only providers of mental health services **in the form of peer-to-peer support in affected regions**. (3)
- Although the mental health of survivors is crucial to well-being, it remains overlooked by most policies and programs.
- In low-income countries, only 1.54% of the **health budget** is allocated to mental health. (4)

LEGAL & POLICY FRAMEWORKS

CCM: Art. 5 para. 1 and 2.H. Art. 6 para. 7. Art. 7 para. 1.K.
Vientiane Action Plan: Actions #25 and #28.
Cartagena Action Plan: Section IV, para. 12. Action #31.
CRPD: Art. 19, 25 & 26.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors and PwD | **Service providers:** Health centers, peer-to-peer support groups… | **Ministries:** **Health**, Social Affairs | **International organizations:** WHO, the Inter-Agency Standing Committee on Mental Health & Psychological Support in Emergency Settings.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- Mental health including psycho-social support is generally **not considered a priority** amongst other health issues.
- There are very **few professionals** in the fields of **psychology & psychiatry** in affected countries where they tend to be based in big cities.
- Little effort is made to include mental health in larger **health prevention & promotion** activities at community level.
- International cooperation efforts on VA tend to place **insufficient emphasis on support to mental health programs**.
- People living with psychiatric disorders & their families are generally **not sufficiently organized to advocate** effectively for proper care.
- It is difficult to integrate **mental health services into primary health services** as providers of the latter tend to already be confronted with an excessive workload.
- Mental health professionals & peer-to-peer support providers tend to **be predominantly male**, which makes it more difficult for women to access mental health services. Mental health services for children are generally lacking.

SUCCESSFUL PROJECTS ON MENTAL HEALTH & PSYCHOSOCIAL SUPPORT

In Tajikistan, the *Ministry of Labor & Social Protection of the Population* spearheaded regional cooperation efforts to strengthen psychological & peer support. Two *Regional Psychosocial Rehabilitation Conferences* have been organized in Dushanbe in cooperation with the *Tajikistan Mine Action Center* (TMAC) and the UN Afghanistan Disability Support Programme. Tajik survivor organization members also attended a one-week training workshop on peer support by the *Afghanistan Landmine Survivors' Organization* in Kabul, Afghanistan. TMAC and UNDP also provided support to two newly established survivor-run NGOs in Dushanbe & Khujand that promote peer support. (5)

In Uganda, the *Ministry of Gender, Labour & Social Development* produced the kit "*Psychosocial Support for Survivors of Landmines & ERW: A training manual for community level development workers.*" The manual is used to train Community Development Workers & Rehabilitation Officers in affected communities. (6)

WHAT CAN STATES DO?

To improve quality of life:

- Provide individual psychotherapy sessions, set up mobile multi-disciplinary teams, therapeutic discussion groups, peer-to-peer support & therapeutic cultural, sports & leisure activities in affected communities that **positively impact** victims' mental health.
- Together with survivors and PwD establish a **personalized treatment plan** that responds to the specific needs and expectations of each person.

To improve access to services:

- Provide technical, financial & organizational support to new and existing **community-based associations** that provide mental health services, in particular peer-to-peer support. This type of support often is the most effective proximity-service available to victims & PwD in rural and remote areas.
- Train, support & supervise community & social workers, psycho-social counsellors, & other persons that provide mental health services in order **to improve their practice**.
- Create or strengthen **referral systems** so that persons with mental health issues & psychological distress are referred to necessary services.
- Encourage the creation of **forums of discussion & coordination** that include psychologists & psychiatrists, social workers, PwD, victims & their families for the purpose of facilitating an exchange of practices specifically related to challenges faced by victims.
- Support the creation of a national **association of mental health** workers.

To improve legislation and policies:

- In accordance with the CRPD, authorities should develop **policies which ensure respect for the mental integrity** of persons with psychological & psychiatric issues in all public service sectors.
- Any public health policy must contain a significant **section on mental health**, covering prevention, care & follow-up, and include specific actions that contribute to removing the stigma associated with mental illnesses.
- Policies must **reinforce the role of patients & their family** as stakeholders in the health system in their own right, alongside health professionals.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* Increased # of self-referrals by victims & PwD living with psychological distress or psychiatric disorders to mental health services. * Reduction in the prevalence of psychiatric disorders or psychological distress. * Increased participation of victims & PwD in cultural, sports & leisure activities important for them.

› Access to services:

* Improved access for people suffering from psychological distress and/or mental disorders to prevention, screening & mental health services. * Increase in health, social institutions & local associations that ensure continuity in the care management of victims & PwD with psychiatric and/or psychological disorders. * Increase in the # of mental health professionals per 100,000 inhabitants. * Increased # of mental health community workers reaching rural & remote areas. * Increase in the # of peer groups in a given territory. * Increased # of mental health community workers. * Increased # of victims & PwD trained in peer-to-peer support.

› Legislation and policies:

* Abolition of any laws & policies that are discriminatory of persons with mental disabilities. * Increased # number of tools for monitoring & assessing the country's mental health management system. * Existence of CRPD compliant national mental health policies or a national mental health plan, with relevant laws, implementation decrees & budgets.

PROJECT EXAMPLE: PEER TO PEER SUPPORT IN EL SALVADOR [7]

© Jesus Martinez.

Peer support in El Salvador, Red de Sobrevivientes y PcD

Identified problem: Social exclusion and extreme poverty of PwD & their families, including survivors of armed conflict.
Programs implemented by *'the Red'*: 1. Access to **Health:** promotion of **mental health** (self-esteem & self-management), rehabilitation (mobility devices), and prevention (nutrition, preventing infectious disease). 2. Support for **Decent Work**: business training & seed capital. 3. Promotion of **Social empowerment**: training on disability & human rights, leadership, advocacy & legal frameworks; strengthening of community-based organizations & awareness-raising at national level.
Activities: **Peer-to-peer support:** one PwD supports another PwD, based on knowledge, capacities & on similar personal experiences. The Red has a team of field workers with disabilities who visits other PwD to understand their needs & define a personal plan of action in accordance with the person's priorities, potential & environment. The Red notes that although peer-to-peer support certainly contributes to improving mental health, it should not be seen as a substitute for professional psychological support.
Sustainability: Peer-to-peer support has been very successful in improving psychological & socio-economic wellbeing; it promotes sustainability in three ways: 1. **PwD themselves are trained** & improve their own knowledge & capacities, and **share them with their peers**. 2. PwD can use peer-to-peer support with the main goal of **promoting self-esteem & psychological wellbeing**, and also as a methodology to provide support in a **specific sector** (e.g. employment or health). 3. **Collective empowerment** is strengthened via local associations of PwD for advocacy & awareness campaigns.
Key indicators: Around 700 PwD annually trained by peers on health, human rights & business management topics; 100 PwD receive support to start self-employment projects. In 2012, 160 persons received mobility devices. These indicators concern PwD (including survivors) – a larger number actually benefits, such as family members.
Donors: Government of Norway, InterAmerican Foundations, Provictimis Foundation.

References [1] WHO. *Investing in Mental Health.* 2003 | [2] [4] HI. *Mental Health Policy Paper.* 2012 | [3] [5] ICBL-CMC. *Landmine and Cluster Munition Monitor.* 2012 [6] GICHD. *Assisting Landmine and ERW survivors in the context of disarmament, disability and development.* 2011 | [7] Fundación Red de Sobrevivientes y Personas con Discapacidad. *Emails from Jesús Martínez, Director.* April 2013; IFRC, Reference Center for Psychosocial support. *Psychosocial interventions: A handbook.* 2009; WHO, UNICEF, ILO, IDDC. *Community-based rehabilitation Health Guidelines.* 2010

HANDICAP INTERNATIONAL

4

Victim assistance thematic area: **EDUCATION**
Development sector: **EDUCATION, INCLUSIVE EDUCATION**

WHAT IS EDUCATION?

The goal of Education is to ensure **all people are able to learn** what they need & want throughout their lives. **Inclusive Education** is **a process** to increase participation in Education, in a way that effectively responds to the individual needs of all learners, including girls, boys & persons **in situations of vulnerability** (such as victims & children with disabilities - CwD). **Inclusive Education** is a right in and of itself, and a way to facilitate the realization of other rights (like access to health, employment & political participation). Education contributes to the well-being of persons, their families & their communities.

Components of education: [1]

- **Early childhood care & education:** Focuses on survival & development including health, nutrition & hygiene (3 to 6 years).
- **Primary education:** First stage of schooling, should be free of costs & compulsory for all (6 to 15 years).
- **Secondary and higher education:** Beyond the compulsory level, a gateway for a productive & fulfilled life (15 to 24 years).
- **Non-formal education:** Wide range of education initiatives in the community such as home-based learning & community-led initiatives.
- **Lifelong learning:** Takes place throughout the entire life cycle and focuses on knowledge & skills needed for employment.

Quick Facts

- **42% of mine/ERW casualties are children.** [2]
- In situations of conflict, boys may be recruited as child soldiers and miss out on school. At least 5% of these boys will **have impairments** and will be **too old** to attend primary school at the end of the conflict. [3]
- About 72 million children are **excluded** from education globally. One third of them are CwD. [4]
- The level of poverty of a given household often influences children's enrollment in school. In poor households, or in those facing a trauma, **girls often are the first to stop going to school**.

LEGAL & POLICY FRAMEWORKS

CCM: Implicit in the social & economic inclusion components. | **Vientiane Action Plan:** Actions #23, #28. | **Cartagena Action Plan:** Section IV, para 12. Action #31. | **CRPD:** Art. 24 & 26 | **Convention on the Rights of the Child:** Article 28. | **MDGs** #2. | **UNESCO** Education for All Goals.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors, PwD & CwD, DPOs, parents', students' & teachers' associations **Service providers:** Mainstream & special schools, organizations providing informal & non-formal education, teachers associations, teachers' training colleges | **Ministries:** **Education**, Health, Social Affairs | **International organizations:** UNESCO, UNICEF.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- **Lack of understanding** on the part of the family of benefit of school attendance by CwD, in part as a result of lack of support within the family & community.
- **No specific law** to promote inclusive education and no laws that mandate that CwD must go to school.
- **Lack of overall education strategy** at community level, with little to no links between different forms of education.
- **Negative stereotypes** of girls & other marginalized groups such as child survivors & and other CwD that further limit access to education.
- Lack of, or **poor quality of teacher training** – as a result, they might only have a basic level of education and no exposure or training on how to ensure that all children are able to follow lessons and be included in school & community life.
- Lack of **appropriate teaching aids** & other equipment.
- **"Failure to learn"** considered the child's "fault", instead of as a problem with the education system.
- **Lack of hygiene, safety** & access to **sanitation facilities** in schools frequently leads to a high drop-out rate, particularly for girls with disabilities.

SUCCESSFUL PROJECTS ON INCLUSIVE EDUCATION

In El Salvador, Community-Based Rehabilitation (CBR) staff worked with CwD using **learner-centered methods** including games. After a year, teachers became convinced that inclusion was possible if inclusive teaching methods were adopted. The CBR program offered **training** for these teachers in a particular district and paid an itinerant teacher to offer regular, on-site support. The school established the first inclusive system in El Salvador; the *Ministry of Education* paid the training & salary of **3** itinerant teachers to cover all primary schools in that district. [5]

In Sri Lanka, a local **CBR program identified** a number of CwD. A pre-school director showed interest in including them, but said their teachers were not skilled. The program identified **national resources** that provided training on inclusive education & **sponsored** the teachers to attend. Teachers, CBR staff, parents & CwD developed a **plan for inclusion** and also worked with other children & their parents to raise awareness and ensure everyone contributed to the process. [6]

In Togo, *HI*, in partnership with the *Federation of Togolese DPOs* and the *Ministry of Education*, provided **personalized support for CwD** to access education, carried out awareness-raising among parents & communities, strengthened linkages between special & mainstream schools, trained teachers on inclusive education, and provided technical support to improve the accessibility of schools and their education methodologies & tools. A team of mobile teachers & school directors were trained in inclusive education, Braille and Sign Language. As a result, 16 schools became physically accessible, 949 CwD accessed medical & rehabilitation services to improve their autonomy and 318 CwD, previously not attending school were enrolled. A **national working group** on inclusive education was launched. [7]

WHAT CAN STATES DO?

To improve quality of life:

- Provide **direct support to CwD** to enable their school attendance: identification of CwD, referral mechanisms, support access to those health, rehabilitation & social services they may need to facilitate their participation in school.
- **Work alongside family members** to ensure they know in practical terms how to support the child to access and remain in school.
- **Raise awareness** of community members and teachers on disability issues & rights in order to dismantle discriminatory attitudes & practices.

To improve access to services:

- **Challenge attitudes** that consider the CwD as the "problem" instead of looking at external barriers to the child's participation.
- Implement **accessibility measures** at school in terms of the physical structure, means of communication & access to information.
- Create linkages between **mainstream & "special" schools**, where they exist.
- Form school groups that share **itinerant resource teachers** trained on inclusive education and who can share good practices & resources among different schools & provide regular on-site support.

To improve legislation and policies:

- Ensure that all legislation & policies related to education are inclusive of CwD and **in accordance with the CRPD**, i.e.:
  * Complement **teachers' training curriculum** to also include methodologies & techniques on inclusive education. * Develop the education system in such a way so as to enable it to successfully train, recruit & employ **teachers with disabilities**. * Build capacities within the Ministry of Education on **designing inclusive policies**. * Adopt **accessibility norms** for schools.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* Reduction of school drop-out rate among CwD, compared to the average rate. * # of CwD attending school. * # of CwD reporting increased participation in sports & recreation activities. * Improvement in social & academic progress of CwD. * # of CwD finishing primary education. * # of CwD accessing primary school in rural & remote areas (formal education, mobile schools…). * # of PwD involved in the education system as role models, teachers or decision-makers.

› Access to services:

* # of teachers trained on how to include CwD in mainstream education. * # and types of accessible teaching tools available. * # of schools implementing accessibility standards, including for sanitation facilities. *# of disability awareness sessions for all children at school to welcome CwD as equal peers. * Positive change in knowledge & attitudes of teachers and community members regarding inclusive education. * Existence of coordination mechanisms involving national authorities, teachers, parents, associations of parents & DPO.

› Legislation and policies:

* The Ministry of Education generates statistics on the number of CwD in school. * Change in Knowledge-Attitudes-Practices of decision-makers in the educational system. * Existence of inclusive education action plans (at local, national, regional levels) in accordance with the CRPD.

PROJECT EXAMPLE: INCLUSIVE EDUCATION FOR CHILDREN WITH DISABILITIES IN ETHIOPIA

Freetown, City Center, Sierra Leone, 2007.

Identified problem: CwD face physical, attitudinal & communication barriers to attend and remain in school.
Main objectives: 1.To reinforce the capacities of teachers & other education service providers to include CwD in their programs 2. To increase the awareness of the families of CwD on the benefit of education for their child.
Activities: 1. **Capacity building** of teachers & other relevant stakeholders to improve the quality of instruction for CwD. 2. Promotion of a **more active role of DPOs** in inclusive education. 3. **Awareness raising** activities among families of CwD. 4. **Technical support** for schools to develop or improve accessibility features, adapted equipment & training materials. 5. Identification & dissemination of **lessons learned & best practices** with the Ministry of Education and USAID to promote upscale & replication.
Sustainability: Project based on the national & regional education system & schools. It trains government Education officials, local teachers & DPO members so they have improved knowledge & skills beyond project duration. It ensures linkages with the Ministry of Education and will disseminate lessons learned & good practices to promote replication & inform policy-making.
Key indicators: Half-way through the project: 6 schools have undergone an accessibility audit and carried out recommended adaptations; 80 teachers have improved their practices after following training; 80 officials of the Bureau of Labor and Social Affairs and the Regional Education Bureau have increased their knowledge on inclusive education tools, methods & approaches; 210 DPO members have improved their skills to support CwD & PwD to access education.
Duration: Two years (ongoing).
Implemented by: HI, partners: Ministry of Education & DPOs.
Donors: USAID, Charleville-Mezières Cooperation.

References (1) *EFA Global Monitoring Report.* 2010 | (2) ICBL-CMC. *Landmine and Cluster Munition Monitor.* 2012 | (3) (4) (5) (6) WHO, UNESCO, ILO, IDDC. *Community Based Rehabilitation Education Guidelines.* 2010 | (7) HI. *Le système d'enseignants itinérants – projet Education Inclusive au Togo.* 2011; World Vision UK. *Education's Missing Millions: including disabled children in education through EFA FTI processes and national sector plans.* 2007; Atlas Alliance. *Inclusion Education where there are no resources.* 2002; HI. *Lessons learnt for the inclusive education of disabled children in Cambodia.* 2009; HI. *Inclusive Education Policy Paper.* 2012; UNESCO. *Embracing Diversity: Toolkit for creating learner-friendly environments.* 2004; *Overcoming Exclusion through Inclusive Approaches in Education.* 2003; *Understanding and Responding to Children's Needs in Inclusive Classrooms: A Guide for Teachers.* 2001

HANDICAP INTERNATIONAL

5

Victim assistance thematic area: **SOCIAL INCLUSION**
Development sector: **SOCIAL INCLUSION, SOCIAL WORK**

WHAT IS SOCIAL INCLUSION?

Social inclusion is the result of supporting someone to gain direction in his/her life & to realize his/her goals, find a place within his/her family, and participate in community life. It may be seen as too "difficult" or unnecessary, but **social inclusion** often is the cornerstone of quality of life, as it generates a sense of human dignity, belonging & self-worth.

The goal of social inclusion activities is to increase a person's self-reliance by gaining insights about him/herself and how to mobilize his/her own resources, both internal & external (e.g. family, neighbors, community). It values each person and promotes human development principles, where persons take an active role in the process of planning their life.

The main components of social inclusion are: [1]

- **Personalized social support:** Provision of tailored guidance in order to help someone to reduce the physical, social & emotional barriers faced in the effort to increase participation in a chosen area of his/her life; and to develop a project to engage in a social role or daily activity that is important for the person (e.g. being a student or a mother, looking after a home, working).
- **Relationships & family life:** Ensuring persons have positive relationships by changing negative attitudes on the part of family & community. It also aims to prevent and address violence against victims & PwD.
- **Cultural, sports & leisure:** Improving participation in such activities as a vehicle for personal expression, well-being & health; contributes to challenging negative community attitudes and to raising awareness about the rights and capacities of victims & PwD.

Quick Facts

- Survivors face **social exclusion** or are abandoned after the accident because of prevailing community beliefs (e.g. that the person brings bad luck).
- Many PwD are **excluded from relationships & family life** as a result of negative attitudes.
- Women with disabilities have a **lower marriage rate** than men with disabilities.
- Women & girls with disabilities are particularly **vulnerable to abuse and rape** in their families & communities.

LEGAL & POLICY FRAMEWORKS

CCM: Art.5, para. 1; Art.6, para. 7.
Vientiane Action Plan: Actions # 25, # 28.
Cartagena Action Plan: Section IV, para. 12.
CRPD: Art. 19, 21, 23, 28, 30.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD (DPOs); their families, friends & neighbors
Service providers: Social & health services
Ministries: **Social Affairs**, Women & Children / Gender, Youth & Sports…
International organizations: International Federation of Social Workers.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- Many victims & PwD **lack information** on existing services. Even when information is available, it often is not enough. Most victims & PwD, in particular those most vulnerable, require **personalized support** to be empowered and to move forward, approach & receive the services they need.
- As a result of being excluded from daily life, victims & PwD often have **poor self-esteem** which reinforces the cycle of exclusion as a result of their reluctance to take part in social activities & events.
- Children with disabilities, including child survivors, may **not receive equal love**, affection, stimulation & opportunities as others.
- Women with disabilities, including female survivors, are **often excluded** from certain social roles, such as marriage & parenting. They often face double discrimination as a consequence of being a woman and being disabled.
- **Family members** may feel that being related to someone with a disability brings shame, so they do not encourage or allow their participation in cultural, sports, leisure and other social activities.
- DPOs, in which membership is a means to increase social participation, may inadvertently **discriminate** against women with disabilities as men with disabilities tend to lead DPOs, leaving little to no space for the voice of women with disabilities.

SUCCESSFUL PROJECTS THAT PROMOTE SOCIAL INCLUSION

In Bosnia and Herzegovina, **sport & leisure activities** have been recognized as a way to facilitate social inclusion and psychological well-being of PwD. There are clubs of sitting volleyball, wheelchair basketball, football & athleticism for, and inclusive of, men & women with disabilities. In Republika Srpska, the *Secretariat for Sport and Youth* has a focal person to promote sports & physical activity for PwD. The government has an annual budget allocation for inclusive sports. [2]

In Mozambique, in 2011, *RAVIM (Landmine Survivors Assistance Network)* and *HI*, in coordination with the *Ministry of Women & Social Action* and the *National Institute on Social Assistance*, are implementing a project to facilitate **social inclusion** of PwD & CwD. To date, 328 persons, of which 118 are children, have been identified, supported to define their needs & priorities, and referred to accessible services. In addition, 65 service providers have been trained on accessibility, the rights of PwD and on which steps to take to facilitate access of PwD to health & social services.

WHAT CAN STATES DO?

To improve quality of life:

- Support victims & PwD to identify their **needs, skills, priorities, resources & interests** and to develop & implement a feasible plan of action to achieve their goals (e.g. education, employment, social life).
- Support victims & PwD to identify **opportunities to participate** in community life (e.g. join local groups such as survivor organizations, DPOs or others for the general population).
- **Work with families** so they learn how to better support and empower a family member with a disability and on how to advocate together for their rights.

To improve access to services and social activities:

- Identify community workers that can be trained to provide **personalized social support at local level** (CBR, social & health workers, others…)
- Include personalized social support as part of the **regular training program** of social & health workers.
- Identify, map and disseminate **information on services** in the community.
- Support service providers to ensure victims & PwD can access their services.
- Work with **leaders in the community** to encourage them to raise people's awareness about the rights of victims & PwD; to challenge discrimination; and to create opportunities for community discussions on disability.
- Work with **associations** so that they become interested & knowledgeable about how to include PwD in their activities, in particular women groups so that women with disabilities are included in their activities.
- Train **sports & cultural associations** on the rights of PwD and on easy adaptations to their equipment, game rules & physical facilities.

To improve legislation and policies:

- Include personalized social support, inclusive culture, sports & leisure activities as well as key elements related to community life in **national action plans** to assist the victims & disability.
- In compliance with the CRPD on freedom of expression and opinion, ensure the **voice of PwD** is taken into account in policy fora.
- Encourage and inform local, national and international stakeholders on how to include victims & PwD in their **culture, leisure & sports policies & programs**.
- Undertake a review of current laws and policies that may contain **discriminatory approaches or barriers** to social inclusion of PwD.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* # of persons having developed a personal plan of action. * # of persons reaching their plan's objectives. * # of persons reporting increased participation in decision-making within their families. * # of persons reporting increased participation in social activities that they value. * # of persons participating in cultural, sport or leisure activities.

› Access to services & social activities:

* # of persons receiving personalized social support. * # community members or leaders accepting that PwD can marry & have children. * # of families encouraging and supporting their members with disabilities to socialize & develop relationships outside the home. * # of spiritual & religious centers that count PwD among its members. * # of cultural, sports or leisure venues taking measures to reach out to PwD. * # of cultural, sports and leisure centers adapting their equipment/communication/game structure or rules to include PwD.

› Legislation and policies:

* Culture, leisure & sports policies & programs specifically are inclusive of PwD. * National resources are mobilized to implement inclusive culture, sport & leisure policies. * Discrimination on the basis of disability in family law is abolished. * Policies indicate how to safely adapt activities, equipment & venues to be inclusive.

PROJECT EXAMPLE: SOCIAL INCLUSION OF VICTIMS IN UGANDA

© Nicolas Axelrod / Handicap International

Happy Child project for mother and child, Siem Reap, Cambodia

Identified problems: Victims & PwD face important barriers to participate on an equal basis with other people in social & work life. | **Main objectives:** 1. To **support the authorities** in achieving their VA obligations as per the MBT & the Cartagena Action Plan. 2. To **identify victims** in the two most affected regions, and **improve their access** to **social & livelihood services**. | **Activities:** A) **Policy:** Enhance VA coordination by organizing multi-stakeholders workshops with the Ministry of Gender, Labor & Social Development. B) **Personalized support:** Provide individual support to enable victims to define needs & priorities and develop a plan to reach their goals. C) **Access to services:** Map health, psychosocial and livelihood services and support them to become accessible (awareness raising & training). Within social activities, a focus was given to **sport & leisure** activities, which was a priority for self-help groups. D) **Empowerment:** Support self-help groups to start & improve their capacities and activities related to sport & leisure (easy adaptations to sport & leisure rules and equipment to make them accessible).
Sustainability: Based on various elements including: 1. Responding to the identified needs of the Ministry and mobilizing local stakeholders 2. Improving national coordination by mobilizing several national stakeholders through workshops. 3. Providing training to social & livelihood service providers & self-help groups in the target areas to ensure they are accessible beyond project duration. 4. Providing personal support to ensure an improvement in the quality of life of victims.
Key indicators: * 2448 victims & 1230 PwD were identified. * 900 victims & PwD received personal social support. An impact study assessed food intake, housing conditions, savings, skills, self care & mobility at the end of the project: 93% of the respondents said that at least one of these 5 dimensions improved, and 24% reported improvements in 4 or 5 dimensions. * 20 service providers became more inclusive of survivors & other PwD. *20 self-help groups were trained to improve their social activities. * **4 coordination meetings** at national level and 1 at local level.
Duration: 18 months | **Implemented by:** HI; partners: Uganda Landmine Survivors Association, MoGLSD.
Donor: AusAid.

References (1) HI. *Personalized social support: Thoughts, method and tools for proximity social services.* 2010 | (2) GICHD. *Assisting Landmine/ERW survivors in the context of disarmament, disability and development.* 2011; Intl Association of Schools of Social Work. *Social work in the context of political conflict.* 2008; Inclusion International. *Supporting children with disability- parent and family information kit.* Right to Play. *Harnessing the power of sport for development: recommendations to governments.* 2008; WHO, UNICEF, ILO, IDDC. *CBR Guidelines, Social Inclusion Component.* 2011

HANDICAP INTERNATIONAL

6

Victim assistance thematic area: **ECONOMIC INCLUSION**
Development sector: **EMPLOYMENT AND SOCIAL PROTECTION**

WHAT IS ECONOMIC INCLUSION?

Economic inclusion means that all persons, without discrimination, can benefit from, participate in, and contribute to, the economic development of their communities. Its **goal** is to guarantee all persons have enough income to ensure adequate standards of living through employment & social protection. It increases the income of a person & her family, and improves social participation & psychological well-being. Economic inclusion benefits a single person as well as the collective development of her family & community. Most victims & PwD mention economic inclusion as their first priority.

The main components of economic inclusion are: [4]

A) Employment:

- **Self-employment:** A person who works for herself instead of for an employer. It is often the main option available in low-income countries, but not the best one for everyone.
- **Waged employment:** A person carries out a paid job under contract. Employment requires **skills development:** Technical & professional skills, business management skills & core life skills (goal-setting, time management, communication…). In addition, **financial services** (savings, credit, insurance and money transfers) are of particular importance for self-employment.

B) Social protection: is comprised of social insurance & social assistance and is composed of measures that provide a safety net for persons in situation of vulnerability and which ensure minimum living standards including food, clothing, housing, water & sanitation.

Quick Facts

- A survey of 1,645 survivors in 26 countries showed that **economic inclusion is the sector where most say their situation has worsened over the years**. 74% said their household income was insufficient. [1]
- **Less than 20% of PwD work**. Their exclusion from work deprives societies of up to 1.94 USD trillion per year (total annual value of global GDP lost in relation to disability). [2]
- **82% of PwD live on less than 1 USD/day**. [3]
- 80% of PwD live **in isolated rural areas**.
- **Women with disabilities are 50% less likely** than men with disabilities **to be employed**. [4]

LEGAL & POLICY FRAMEWORKS

CCM: Art.5, para 1 & 2.H. Art.6, para 7. Art. 7, para 1.K.
Vientiane Action Plan: Actions #25 & #28.
Cartagena Action Plan: Section IV, para 12. Action #31.
CRPD: Art. 27, 24. **MDG** #1.
ILO Convention 159, Vocational Rehabilitation and Employment.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD | **Service providers:** Vocational training centers, Business Development Services, microfinance providers, social services, employment centers, Chambers of Commerce, trade unions, entrepreneurial groups, public & private employers, NGO & other organizations working on livelihoods & entrepreneurship development | **Ministries:** **Labor**, Agriculture, Social Affairs, Finance and/or relevant authority on Microfinance, Development Planning, Office on Poverty Reduction
International organizations: **ILO**.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- Employment programs often **focus on urban or semi-urban areas**, instead of rural & isolated areas where the majority of victims & PwD live.
- Programs may focus on **facilitating access to one service** (eg. training centers) instead of looking globally at all the services people may need to develop an economic activity successfully (microfinance, business development support, linkage to markets…)
- **Vocational training is not always market-led.**
- There is little knowledge on how to **adapt the workplace for a PwD**, whereas being creative and gathering ideas from other PwD in the community often suffices if there is no professional support on site.
- **Prejudices remain strong** among families, employers & service providers regarding the skills & competitiveness of victims & PwD. Long-term coaching is necessary to change knowledge, attitudes & practices but tends to be lacking.
- Economic inclusion projects may **overlook** possibilities for **waged employment**.
- **Government social protection mechanisms** are minimal in low-income countries.
- Often, **a gender analysis is not included** in economic inclusion programs, which may lead to, or reinforce, discrimination against women.
- **Families of persons killed by mine/ERW** are often overlooked by livelihood programs.

SUCCESSFUL PROJECTS IN ECONOMIC INCLUSION

In Ethiopia, the *Ethiopian Center for Disability and Development* (ECDD), supported by the ILO, provides **training on disability for business, industry & public sector organizations**. In rural areas, it works with *DECSI*, a microfinance provider. DECSI now includes PwD as a result of the research, advocacy & training of the ECDD and the *Tigray Disabled Veterans Association*. In 2010, 900 persons (5% of DECSI's clients) were PwD; DECSI now has a monitoring system to measure improvements in this area. [5]

In Nicaragua, the **microfinance institution** *ProMujer* reached out to **local DPO** & **to social services** to include women with disabilities in their microfinance services. *ProMujer* includes women with disabilities in communal banks, and also provided services to a communal bank organized by 30 women with disabilities. Participants also attend sessions on reproductive health & prevention of domestic violence. [6]

In the Philippines, **650 members** of the *National Federation of Co-operatives* are PwD. They produce mainly school chairs & desks for the *Ministry of Education*. Their business motto is *"We do not want you to buy our products out of pity but because they are a better deal"*. [7]

WHAT CAN STATES DO?

To improve quality of life:

- Support victims & PwD to develop a **relevant & feasible plan of action** towards employment.
- Programs should ensure that financial services and training workshops are **as close as possible** to target communities & its members.
- Program support should not finish once the person starts a business or is employed- follow up should be ensured for **at least 6 months**.
- Programs are more successful when, instead of focusing on an individual, the **family is also considered** in planning & managing the economic activity, as well as in money management training and in the process of accessing capital.
- A special focus should be placed on **women of working age** as they encounter greater barriers to economic inclusion, and because of their key role in improving the living conditions of their families.

To improve access to services:

- Work with **mainstream services** such as microfinance institutions & vocational training centers to support them in identifying the barriers they face to become accessible to and inclusive of PwD.
- Propose **coaching for these services** over a period of time to ensure they improve their practices & policies in aspects such as knowledge of rights, non-discriminatory attitudes and practices from the organization's staff, accessibility in terms of physical structures & communications, reasonable accommodation & affordability.
- Partner with **employers** to carry out an analysis of their recruitment procedures, possible adaptations in the workplace to increase accessibility & training for staff to include PwD.

To improve legislation and policies:

- Legislation & policies on employment and poverty reduction should be **in accordance with the CRPD**. These should be followed by plans & budgets for implementation at local level.
- **Employ PwD in the public sector.**
- Ensure victims & PwD can actively participate in **economic policy-making & planning** at national, regional and local level.
- Establish and maintain policies & programs on **social protection** and those that support PwD seeking a job.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* Increase in household income. * Increase in profits of disabled entrepreneurs. * Improvement in technical and business skills. * # of people remaining in a job after one year. * # of active business one year after start-up. * Better capacity to access a nutritious diet all year round. * Reported increase in self-confidence and social participation. * Better capacity to manage household income. * Increase in the coverage of victims and PwD in social protection programs.

› Access to services:

* # of services including victims as beneficiaries. * # of victims completing vocational training/receiving loans or grants. * # of victims being employed. * # of awareness raising and training sessions on disability and inclusion for mainstream service providers.

› Legislation and policies:

* Discrimination in labor law on the basis of disability is abolished. * National legislation on employment is in accordance with CRPD standards. * Poverty reduction policies include specific measures for victims & PwD. * Resources are allocated at local level to promote economic inclusion. * Victims & PwD actively participate in policy & decision-making at community level.

PROJECT EXAMPLE: ECONOMIC INCLUSION OF PERSONS WITH DISABILITIES IN LAOS

Johnson Bwambale, 50 years old, Kanyampara trading center, Munkunyu Subcounty, Uganda.

Identified problem: Increasing household's income is a priority for most PwD, including survivors, in Laos, yet many barriers exist for them to access waged employment and self-employment.
Objectives: 1. To increase the access of PwD **to waged employment** 2. To support PwD to start or expand **income-generating activities** through access to credit, technical & business skills training, & business development support.
Activities: a) **Waged employment**: Establishment of a job placement center; capacity development of the Laos Disabled People Association (LDPA) to support job-seekers with disabilities; awareness raising & partnerships with employers; personal support for PwD to apply, enter & remain in waged employment.
b) **Self-employment**: Personalized support for PwD to develop business plans, access technical & business skills training, and access capital (mix of grants and microfinance); capacity building of the staff of LDPA and Offices of Labor & Social Welfare in target districts.
Sustainability: Project designed & implemented with LDPA; participation & capacity building of the Offices of Labor & Social Welfare, awareness raising & training of employers, coaching of PwD to facilitate the sustainability of their employment.
Key indicators: Self-employment: 312 persons accessed loans; 202 participated in technical training; 97 in business development training; and 236 in training on financial education. Waged employment: 66 persons employed; 172 employers share job announcements with LDPA.
Duration: 42 months. **Implemented by**: HI, LDPA.
Donor: USAID, Belgian Cooperation, European Union.

References (1) HI. *Voices from the Ground: Mine/ERW survivors speak out on victim assistance.* 2009 | (2) ILO. *The price of exclusion.* 2009; ILO. *Assisting disabled persons in finding employment.* 2005 | (3) World Bank. *Poverty and disability, a literature review.* 1999 | (4) (7) WHO, UNICEF, ILO, IDDC. *Community-based rehabilitation Livelihood Guidelines.* 2010 | (5) ILO. *Ethiopia: Disability Inclusion Support Services Case Study.* 2010 | (6) HI. *Good practices for the economic inclusion of persons with disabilities.* 2006; CDPO. *Report on good practices in inclusive agricultural skill training.* 2011; ILO. *Disability in the Workplace: company practices.* 2010; *Placement of job-seekers with disabilities: an effective service.* 2003; *Training for success: A guide for peer-to-peer training.* 2008

HANDICAP INTERNATIONAL

7

Victim assistance cross-cutting issue: **GENDER**
Development sector: **GENDER**

WHAT IS GENDER?

« Gender » is a set of **roles, rights, responsibilities, characteristics & qualities** that a specific society associates with being **male or female**. Institutions, ideologies, religion & values all shape attitudes about gender. Notions related to gender change over time and vary among different cultures. In contrast, « sex » refers to the biological characteristics of men & women.

Women & men experience **the same conditions differently**. Indeed, the prevalence of poverty & economic dependence is higher among women. Generally, women have limited power over their sexual & reproductive lives, are more likely to be victims of violence than men, and lack influence in decision-making.[1]

The goal of a gender approach is to achieve **gender equality**: ensure girls, boys, women & men among victims & PwD all bring their experience, knowledge & interests into the development agenda; and that they contribute to and benefit equally from improvements in their quality of life. This involves working with girls, boys, women & men to analyze and, if necessary, change attitudes, behaviors, roles & responsibilities at home, school, in the workplace & the community. Unless a gender approach is used, unequal access to resources is likely to continue undermining the right to freedom and the quality of life of both men & women in the long run. Improvements in quality of life of all on an equal basis benefits society as a whole.

Quick Facts

- Girls, boys, women & men are all direct & indirect victims of the physical, psychological, social & economic consequences of mines/ERW; but they are affected differently by this threat.
- In 2011, **90% of casualties** where the sex was known were **male**. **Child casualties** accounted for **42%** of all civilian casualties for whom the age was known. [2]
- After a mine/ERW accident, the **female fatality rate is 43%**, whereas that of men is 29%. [3]
- Women with disabilities often face **greater discrimination** than their male counterparts when accessing services. [4]
- Women & girls with disabilities suffer a higher rate of **sexual abuse** & have less access to information on **reproductive health**. [5]
- Men outnumber women in paid employment. Jobs taken by women are less secure than those of men; **women earn less** and **have less social protection** than men. [6]

LEGAL & POLICY FRAMEWORKS

CCM: Art.5, para 1. Art.5, para 7. Art.7, para 1.K. | Vientiane Action Plan: Actions #22 & #30. | Cartagena Action Plan: Section III, Action #19. Section IV, para 12, Action #29. Section V, Action #41. | CRPD: Art. 3, 6 & 16. | MDGs: Goal 3. | Convention on the Elimination of All Forms of Discrimination Againt Women. | The Beijing Platform for Action, Section 143) E. | UN Security Council Resolution 1325.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors, PwD, women & women with disabilities.
Service providers in all sectors relevant to VA.
Ministries: Gender, all Ministries.
International organizations: **UNWOMEN**.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- **Few Ministries & service providers** have an explicit **gender approach** to their policies, programs & recruitment processes.
- Often, women represent a **smaller proportion of employees** in health, rehabilitation, social & employment services - therefore some women may be discouraged or feel less comfortable to approach & use these services.
- Affected areas are often remote. The time & cost involved in reaching the services in main cities often results in **women not being able to reach them**, as they cannot be away from their family or spend limited income on transport & accommodation.
- In some countries, some men developing **mental health & substance abuse** issues following a mine/ERW accident have been reportedly become aggressive and engage in **domestic & sexual violence** directed at their family members. Female survivors, as are other women with disabilities, are more likely to become victims of domestic violence than other women. [7]
- In contexts where men are expected to support the family financially, the **psychological impact of loss of income** due to a mine/ERW accident is believed to be more greatly suffered by men.[8] Female survivors may face different psychological challenges. Those with visible injuries or impairments may be **abandoned** and lose all **prospects of marriage**. Others may be expected to **continue with the same household & productive roles** with little to no support.
- When men are injured or killed by mines/ERW, the responsibility to **earn an income** and to **ensure the survival and well-being** of the family & children often falls upon women, who may also become the main caregiver of the survivor.

SUCCESSFUL PROJECTS THAT PROMOTE GENDER EQUALITY

In Bosnia and Herzegovina, *Landmine Survivors Initiatives* (LSI) includes a **gender approach throughout its work**. LSI endeavors to identify & reach female survivors, a difficult task since information about women is not prioritized by the men-driven war veterans' organizations that LSI cooperates with. LSI ensures adequate resources are allocated to support female survivors in reaching their recovery objectives. For instance, LSI Outreach Workers, who are male, may be substituted by a female Social Worker. LSI implements initiatives specifically to empower women (convening female-only survivor meetings to discuss the rights of PwD, peer-to-peer support & economic empowerment). Wives of survivors are included in the process of recovery & inclusion of their husbands. LSI also makes sure that the voice of women is properly valued regarding when opening or expanding small family businesses. [9]

In Tajikistan, the *UN Mine Action Coordinator* supported the establishment of a network of **80 female heads of households covering 331 villages**. They acted as focal points in remote areas or in areas where the security situation is sensitive, including border areas. They received remote support to conduct community-based VA awareness activities in their villages. [10]

WHAT CAN STATES DO?

To improve quality of life:

- Projects & programs should include survivors (mostly **men & boys**) but also **indirect victims** - their caregivers & family members (mostly **women & children**).
- Ensure services respond to the **diverse needs** of men & women, boys & girls. In health services, make sure there is **female professional staff & privacy** for patients during their physical examinations. In vocational & business training, make sure the **timing allows** for the participation of both men & women.

To improve access to services:

- Collect data & report on # of victims (men, women, boys & girls) accessing services, including those targeting **women** (such as safe pregnancy & maternal health) & **children** (such as vaccination campaigns).
- Invest in **analyzing the roles** of different groups of victims & PwD including women & men, and their level of **access to & control over resources**.
- Ensure **gender balance** among health workers & counselors to best address the specific needs of women, girls, boys & men.
- Make arrangements to **provide suitable accommodation** so that women & child survivors are able to access services, particularly if they must travel from home.
- Consult and involve men & women in the design, implementation, monitoring & evaluation of **programs & policies**.

To improve legislation and policies:

- Ensure the **budget** allows taking a gender approach to plans & programs: allocation of public resources should reflect the needs & rights of men & women; and, if necessary, **specific initiatives to empower women** should be implemented.
- Assess the **needs & contributions** of men, women, boys & girls in existing revenues, expenditures & allocations. If necessary, adjust the budget to benefit all groups.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

› Quality of life:

* Increased participation of women & men with disabilities in decision-making at family & community level.
* Reduction in the mortality rate of female mine/ERW casualties. * Reduction of maternal mortality among female survivors. * Reduction in domestic violence among victims.

› Access to services:

* Percentage of women, men, boys & girls accessing health, mental health, rehabilitation, social & economic services. * # female survivors accessing sexual & reproductive health services as compared to the general population.
* # of female versus male staff members. * # of programs providing support for women with disabilities who are victims of abuse.

› Legislation and policies:

* Abolition of laws and policies that discriminate on the basis of gender. * Existence of baseline data disaggregated by sex & age. * A budget for women empowerment initiatives exists.

PROJECT EXAMPLE: GENDER APPROACH IN CAMBODIA [11]

Kanha at school, Bun Rany Hun Sen Primary school, Memot, Kampong Cham.Cambodia, 2011.

Identified problem: In Cambodia, as in many other countries, PwD face discrimination. More specifically, women with disabilities in rural areas face what UNESCAP refers to as « triple discrimination »: being female, poor & having a disability. The barriers they face to exercise their rights & respond to their needs are complex, and if a gender approach is not included in projects, such barriers will remain – or even be reinforced.
Objectives of the project: 1. To provide tailored-support to men & women who are victims & PwD to start their own business & improve their quality of life. 2. To train authorities & services to include PwD.
Gender approach: The project: 1. Used **participatory approaches** to ensure women & men had equal voice & opportunities, and took into account their different roles & responsibilities. 2. Made **accommodations** so that the timing of the vocational & business trainings made it accessible to both men & women. 3. Collected, disaggregated & reported on **data by sex, age & socio-economic indicators** based on quality of life criteria, as defined by men & women. 4. Ensured **staff included both men & women** in all capacities. 5. Planned for 45% of all the beneficiaries of the project to be women –49% was achieved. 6. Facilitated access to health services for women, including **safe pregnancy & reproductive health**; and to **domestic violence prevention programs**, beneficial both for men & women.
Sustainability: The field officers working for a local NGO include PwD on staff; is based in the most affected province and takes a gender approach throughout its work. Local authorities & service providers were trained to ensure PwD accessed their services. Individual support was provided for a year following business start-up to increase chance of success.
Key indicators: 560 persons participated in the project. 78% increased their income in the first year. 100% reported an increase in overall quality of life (including income, access to food, school, health services and social participation). Women & the most vulnerable men reported the most significant improvement in quality life. Women in particular valued the fact they had more choices to find an eligible husband & start a family.
Duration and donor of the project: 30 months, funded by the European Union.
Implemented by: HI and the local NGO OEC. Cambodian DPO joined in the second phase.

References [1] UNESCAP *Incheon Strategy to Make the Right Real for Persons with Disabilities in the Asia Pacific.* 2012 | [2] ICBL, CMC. *Landmine and Cluster Munition Monitor.* 2012 Report | [3] [7] [8] Swiss Campaign to Ban Landmines. *Gender and landmines: from concept to practice.* 2008 | [4] Committee on the Elimination of Discrimination against Women. *Recommendation 18 – Disabled Women.* 1991 | [5] UNHCHR. *Thematic study on the issue of violence against women and girls and disability* . 2012 | [6] UNDP. *Factsheet MDG Goal 3 : Promote gender equality and the empowerment of women.* 2010 | [9] Landmine Survivor Initiatives Website (accessed March 2013) and email exchanges. March 2013 | [10] UN. *Gender guidelines for Mine Action Programs.* 2010 | [11] HI. *Good practices from the project Towards Income Generating Activities.* 2010; UNDP, UNIFEM. *A guide to gender-sensitive indicators in basic service delivery.* 2009

HANDICAP INTERNATIONAL

8

Victim assistance cross-cutting issue: **EMPOWERMENT**
Development sector: **EMPOWERMENT**

WHAT IS EMPOWERMENT?

Empowerment is a process through which persons build their confidence, capacity & self-esteem to understand and claim their rights, make decisions, speak out & participate in all aspects of community life.[1] Its **goal** is to ensure victims & PwD can exercise self-determination and enjoy their rights & responsibilities on an equal basis with others. **At the individual level**, it allows a person to take responsibility for his or her own life and to take action to enjoy his or her rights – such as participating in the community with choices equal to others. **At the collective level**, the growth of a democratic, representative movement of victims & PwD is a fundamental condition to ensure that governments, service providers & the society at large respond to their needs & rights. It also helps ensure that they are involved & actively participate in the planning, implementation & monitoring of legislation, policies & programs that concern them.[2] Individual and collective empowerment of victims & PwD is one of the two tracks of the twin track approach to inclusive development.

Components of empowerment are:

- **Individual empowerment:** The tailored or personalized support that is necessary for the most vulnerable victims so that they can strengthen their self-determination & achieve their life goals. This process enables a person to build his or her capacities & decision-making powers by developing self-confidence, self-esteem, a sense of initiative & by gaining control over his or her own life.[3]
- **Collective empowerment:** Process through which groups of victims & PwD, such as survivor organizations & DPOs, associations, self-help groups & federations created and led by PwD, develop their capacities to represent & mobilize their peers; advocate for change in policies & practices; monitor human rights; empower their members. Such organizations play an essential role in promoting inclusive societies where the rights of victims & PwD are fully realized.[4] DPOs, including survivor organizations, also play an essential role in increasing access to services.

Quick Facts

- Empowerment is a complex & long process; it is not something that can happen in a few days, or that can be given to someone. [5]
- Empowerment involves having access to information to ensure people are better equipped to take advantage of opportunities, access services, exercise their rights, negotiate effectively, & hold duty-bearers accountable. [6]

LEGAL & POLICY FRAMEWORKS

Vientiane Action Plan: Implicit in Actions #30, #31 #32.
Cartagena Action Plan: Section IV, Action #23.
CRPD: Implicit in Article 3.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD, other civil society organizations such as those of women **Service providers** in all sectors relevant to VA | **Ministries: Social Affairs** or ministry in charge of Disability & VA, all other ministries for advocacy | **International networks:** International Disability Alliance, International Disability and Development Consortium, Disabled People's International **International organizations:** Secretariat for the CRPD and other relevant UN agencies.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- Many PwD experience **disempowerment in the family & the community**. They may be strongly supported by their families but also over-protected; or rejected and excluded from community life, which reinforces the sense of being victims instead of agents of change.
- Staff in public services and other service providers may **not be aware of the rights of victims & PwD** and not know in practical terms how to make reasonable accommodations to ensure access to their services.
- Government staff may not know that it is their responsibility to ensure the **informed & active participation** of victims & PwD. They may not know how to go about eliciting such participation, or tend to dialogue with one person or organization without knowing to what extent the person or organization is actually **representative & accountable**.
- In some countries, DPOs are relatively new stakeholders in civil society and thus often **need to improve their capacity** in terms of representation, democratic governance, mobilization of members, information & knowledge sharing, and sustainability strategies.

SUCCESSFUL PROJECTS THAT PROMOTE EMPOWERMENT

In Colombia, one local government, realizing many of its CBR programs lacked community ownership, supported the establishment of the **Foundation of Persons with Disabilities** *FUNDISCA*, to facilitate the empowerment of PwD by training and encouraging them to assume leadership roles within the CBR program and to play an active role in planning & controlling their own lives. FUNDISCA mobilized PwD, parents, caregivers, displaced persons, indigenous people, community members & community leaders. It has 218 members & 20 CBR staff who promote self-esteem, family inclusion, access to services & dialogue with local authorities. [7]

In Uganda, the *Ugandan Landmine Survivor Association* (ULSA) has worked since 2005 to **build the capacity of survivors through psycho-social support & leadership training** by establishing social & economic support mechanisms such as peer-to-peer support, exchange visits, recreational activities, livelihood projects & a referral system to medical & rehabilitation services. ULSA raises awareness on the MBT, the CCM & the CRPD and collects and disseminates information on mine action. ULSA's partners include the National Union of Disabled Persons in Uganda, the *National Council for Disability & the Ministry of Gender, Labour & Social Development*. Since its inception, ULSA has worked with over 400 survivors & PwD. This includes direct support to survivors in the regions of Kasese, Lira and Agago/Pader as well as leadership training to over 40 leaders in 10 districts of Uganda. [8]

WHAT CAN STATES DO?

To improve individual empowerment:

- Provide **personalized social support** to victims to identify their needs & resources and develop a plan of action to achieve their goals.
- **Work with families** so they learn how to support & empower a family member with a disability, and how to advocate together for their rights.
- Support victims to **join local organizations** of survivors and/or PwD, & other groups for the general population.

To improve collective empowerment:

- Support DPOs to carry out **self-assessments** to identify the areas in which they require capacity development.
- Develop the **organizational capacities** of DPOs by training its members at local, regional & national level. This may include project management skills & resource mobilization, which remain a challenge for most DPOs, but also advocacy to influence legislation & policy-making, awareness-raising, public speaking, mobilization of the media, and how to use these tools in a strategic manner according to advocacy goals.
- Provide information on **training opportunities** in areas such as human rights, the CRPD & national human rights monitoring.
- Support DPOs to strengthen their function as **representative organizations**: governance, dissemination of information & accountability.
- Support the organization of **study tours or exchange trips** between DPOs including targeted visits, sharing information & replication of practices upon return.
- Facilitate the **representation of victims & PwD** in all aspects of implementation and monitoring of the MBT, the CCM & the CRPD at local, regional, national & international level.
- Ensure organizations of victims & DPOs know about and can actively participate in **policy-making & program planning, monitoring & evaluation** at national, regional & local level – not only on VA, but on all processes & sectors that concern them, along with other members of civil society.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

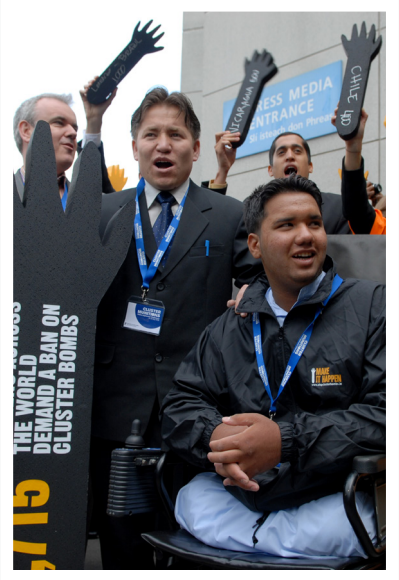
› Individual empowerment:

* Victims & PwD report an increase in self-confidence & participation in their families & communities. * Victims & PwD have the capacity to reach their goals. * # of victims & PwD knowing their rights & how to claim them. * Victims & PwD report increased access to services in their communities. * Victims & PwD join representative groups & organizations.

› Collective empowerment:

* % of DPO members & staff who have improved capacity in project management, advocacy, human rights fundraising & diversity of funding sources by the time of the end of the project. * Improved organizational capacity of the DPO: frequency of meetings, transparent decision-making mechanisms, audits. * Existence of clear mechanisms to share information between the DPO staff & its members, and amongst a DPO network. *A comprehensive advocacy plan is implemented in a coordinated manner among DPO & other civil society organizations. * DPO are members of # of formal decision-making structures & committees. * DPO actively participate in # of meetings on the development, monitoring & evaluation of development policies & programs, including those on VA.

PROJECT EXAMPLE: BAN ADVOCATES [9]



© Mary Wareham

Ban advocates and campaigners at a Conference on Cluster Munitions, Dublin, 2008

"Ban advocates" (BA) is an advocacy group of cluster munitions victims from 12 countries. It started in 2007 with the support of HI.

Identified problem: Lack of systematic & informed involvement of victims (survivors, family members of people injured & killed, persons living in affected communities) in the process to ban cluster munitions.

Objectives: To empower victims – also referred to as BA themselves - to know & advocate for their own rights; to support international efforts to rid the world of cluster munitions; to raise awareness on the human impact of cluster munitions and advocate for a total ban, nationally & internationally.

Activities: 1. **Identification & awareness-raising** of victims in affected countries. 2. **Peer support & training** of the BA to increase their psychological well-being and improve their capacities to engage in effective advocacy. 3. Support to BA to **network** with other victims, DPOs & civil society networks & organizations. 4. **Technical, logistical & financial support** to facilitate the BA's advocacy initiatives at national & international level.

Sustainability: The BA are engaged in peer support and participated in several trainings on the CCM, the MBT & the CRPD, and on advocacy & management. They increased their network with other civil society organizations & are recognized as representative members of their communities by government officials. BA actively participate in policy dialogues at local, national & international level. Their commitment towards the universalization and implementation of the CCM & the MBT perseveres, particularly regarding VA, and more largely, advocating for the rights of PwD.

Key indicators: * There are 32 BA in 12 countries, of which 11 are women. * Active participation & expert contribution of the BA in over 25 conferences related to the CCM & the MBT, as well as in 4 regional workshops on VA. Advocacy efforts continue in their respective countries. * Participation of BA in 7 formal trainings & specific briefings prior to each conference.

Duration and donors: 6 years, ongoing as of March 2013. Norwegian Ministry of Foreign Affairs and Belgian Ministry of Foreign Affairs, Foreign Trade and Development Cooperation. Past contributors: The Diana Princess of Wales Memorial Fund, the Netherlands, Australia, Ireland and Austria.

References [1][4] HI Policy Paper. *Support the Organizations Representative of Persons with Disabilities.* 2011 | [2] Department for International Development (DFID, UK). *Disability, Poverty and Development.* 2000 | [3] HI. *Personalized social support: thoughts, methods and tools for proximity services.* 2010 | [5][6][7] WHO, UNESCO, ILO, IDDC. *CBR Empowerment Guidelines.* 2010 | [8] Uganda Landmine Survivor Association website and emails. *www.uganda-survivors.org* | [9] HI. *Ban Advocates Project Evaluation.* 2009; HI. *Advocacy with victims: Good practices and lessons learned in influencing policy.* 2013

HANDICAP INTERNATIONAL

9

Victim assistance cross-cutting issues: **ACCESSIBILITY**

Development sector: **ACCESSIBILITY, ACCESS TO SERVICES**

WHAT IS ACCESSIBILITY?

Accessibility means all persons have freedom of movement and can use a service in safety, regardless of age, gender, disability. [1] It is linked to the concept of **universal design** - products & services should be **usable by all people, to the greatest extent possible**, without the need for adaptation or specialized design [2] (e.g. a well-built slope is accessible to all, no need to add stairs for persons without disabilities) Its goal is to ensure that the physical environment & information can be accessed by everyone, with **no physical, communication or attitudinal barriers**, with dignity and the highest possible level of independence. It helps improve quality of life through increased **participation, mobility & communication** of PwD - but also benefits **society as a whole**, including older persons, persons with temporary impairments, children & pregnant women. **Therefore, accessibility is not a constraint but an added value.**

Because of its important contribution to improving quality of life, a great emphasis has been put specifically on **access to services**. Six criteria underlie the concept of access, namely: **availability, accessibility, affordability, acceptability, accountability & good technical quality**.[3] All services, including those in mine/ERW affected areas should meet these six criteria of accessibility.

Quick Facts

- **Setbacks in the accessibility** of services for survivors occurred in at least 12 countries in 2011, mostly as a result of declining international assistance & new or intensified conflicts. [4]
- When a person is poor & has a disability, she faces significant **barriers to access services**. This in turn limits opportunities for reducing her level of poverty. [5]
- The effect of **disability-based discrimination** has been particularly severe in education, employment, housing & transport. [6]

The following methodologies contribute to making services accessible and thus inclusive of PwD:

- **Assessment:** improve **understanding** of the challenges faced by, and priorities of, service providers in terms of accessibility.
- **Information:** improve service providers' **knowledge** on the rights & needs of PwD.
- **Awareness:** change negative **attitudes** on the part of service providers towards PwD.
- **Training:** improve the **practical skills** of a service provider to increase accessibility of services for PwD. This includes training on how to make the physical environment accessible for the majority of persons (including those with physical and other impairments); and on how to facilitate & improve communication with persons who are hearing, sight or intellectually impaired.
- **Advocacy:** change the **policies** of service providers or relevant authorities towards the inclusion of PwD.
- **Coaching:** Ongoing support to service providers to improve **knowledge, attitudes, practical skills & policies at all levels**, among **all staff**, in a **sustainable manner**.

LEGAL & POLICY FRAMEWORKS

CCM: Art. 5 para 1, 2.A. Art. 7 para 1.K. | **Vientiane Action Plan:** Actions #22, #25. | **Cartagena Action Plan:** Section IV, Action #25. | **CRPD:** Art. 3, 9.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD. | **Service providers** in all VA sectors. | **Ministries: Infrastructure**, all other Ministries. | **International organization:** International Organization for Standardization and other relevant UN organizations.

WHAT ARE COMMON CHALLENGES IN LOW-INCOME COUNTRIES?

- Survivors & PwD often report the following **barriers** to accessing services: insufficient financial means to afford the services, geographical distance, perceived negative image of PwD by service providers, physical inaccessibility of the service, communication difficulties, overly complicated administrative procedures & lack of information on existing services.
- Some organizations may facilitate awareness raising sessions to improve service providers' accessibility without considering that **regular support & practical technical advice** is required to ensure services become and remain accessible & inclusive at all levels.
- Services providers may have the **misconception** that PwD only **need « specialized » services**, and do not know about their rights & needs, or see accessibility as a « luxury » or second step, when accessibility is a right & easy adaptations can be made to ensure services are accessible to everyone from the start of their existence. [7]
- In some cases, **service delivery is not based on equality**, and may favor only certain groups of the population. The incentives to deliver services for vulnerable populations may be impaired by a lack of government knowledge, capacity & willingness, or as a result of conflict. [8]
- **Accessibility standards** may not exist in legislation & policy. Where these do exist, they may not take into consideration existing standards & good practices, or may not be adapted to the context (such as rural or remote areas); they may not be widely known & disseminated.
- Improving accessibility of services is not enough: **social work or personalized social support** may not be available to empower victims & PwD to reach out and access the services they need.

SUCCESSFUL PROJECTS THAT PROMOTE ACCESSIBILITY & ACCESS TO SERVICES

In the Burmese Refugee camps in Thailand there is high percentage of PwD including survivors. They face more difficulties in mobility, communication & access to services than the rest of the population – which already faces severe challenges. *HI* improved the accessibility of the camps by **simple adaptations to slippery dirt slopes** and in the **huts of PwD**. It trains other organizations to become accessible, such as those working on healthcare, water & sanitation. *ZOA*, a partner NGO, has supported survivors to **adapt their tools** so they can engage in gardening & farming activities.

In Uganda, the organization *Uganda National Action on Physical Disability*, along with the *Ministry of Gender, Labor & Social Development*, developed and disseminated **Accessibility Standards** to facilitate the implementation of the National Policy on Disability. These provide practical guidance for architects, service providers & policy-makers during the design & implementation of construction projects.

WHAT CAN STATES DO?

To improve quality of life:

- Carry out **accessibility diagnosis & provide solutions in the homes** of survivors & other PwD, including water & sanitation facilities.
- Provide tailored/personalized support to ensure survivors & PwD **know about & are empowered to** access all services they need.

To improve access to services:

- Ensure survivors & **PwD can provide input into efforts to improve accessibility**, and that persons with **different types of impairments** (visual, hearing, speech, physical, mental, intellectual & multiple impairments) are represented.
- Assess **service providers' knowledge, attitudes & practices** in the area of accessibility and jointly design a tailored strategy to improve accessibility of their services.
- Carry out **awareness raising activities on accessibility** with specific, verifiable objectives & indicators. Make sure awareness raising activities are targeted & relevant to the specific audience: architects, authorities, service providers, etc.
- Train services providers on what **accessible & inclusive** services mean in **practical terms** & in their specific sectors, services & geographical areas of intervention.
- Prepare & disseminate **practical guidelines on accessibility** that are adapted to the context & also specific guidelines per sector (health, education, employment…). These should include accessibility in terms of physical, attitudinal & communication perspectives.
- Identify **innovative practices** & ensure their dissemination.
- To ensure sustainable impact of efforts to improve accessibility, target **select service providers for coaching** including awareness raising, training & advocacy to improve infrastructure, communication & attitudes of the whole organization & staff and ensure follow-up on outcomes of these efforts over the following 6 months.

To improve legislation and policies:

- Ensure that **legislation & policies in all sectors** include **accessibility standards** that are based on good practice.
- Support the development & implementation of **local accessibility plans** at community provincial level both technically & financially.

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

Quality of life:

* # of survivors reporting increased mobility in their homes after accessibility modifications.
* # of victims reporting access to a given service for the first time *# of victims reporting improvement in quality life as result of being able to access services.

Access to services:

* Increased percentage of PwD amongst overall users of a given service * Improved knowledge, attitudes & practices in regards to accessibility by service providers * # of actions to improve accessibility that are carried out by participants following training on the subject.
* # of service providers receiving ongoing coaching to make their services accessible for PwD. * Accessibility is included in existing training curriculums on architecture, urban planning & civil engineering.

Legislation and policies:

Availability and # of government audits on accessibility undertaken with the participation of PwD * Existence of mandatory technical standards for barrier-free access to all buildings.

PROJECT EXAMPLE: ACCESSIBILITY OF THE SMALL BUSINESS EMPLOYER ELIBY IN SENEGAL

© J-J. Bernard / Handicap International

Employees with and without disabilities working together. Senegal, 2010.

Identified problems: Lack of employment opportunities (up to 60% of overall unemployment); lack of knowledge on the part of employers on how to make their services **accessible to, & inclusive of**, PwD (in particular, disabled poor women) in the mine-affected region of Casamance.
Objectives of the project: 1. To improve the accessibility of a local small cashew nut producer; 2. To support survivors & PWD to access waged employment in conditions of decent work, on an equal basis with others.
Activities: 1. Improved **knowledge & attitudes** of small business staff & at community level on the rights & capacities of PwD through awareness raising sessions. 2. Improvement of **practices** of small business owners through training on how to enable employment of PwD following the **ILO standards for decent work**. 3. Provided technical support to improve the **physical accessibility** of the cashew nut factory (entrance to the premises, circulation in the small factory, adaptations to the job stations, toilets and to equipment & tools for wheelchair users…) 4. Support to the small business owners to liaise with a **fair trade** network. 5. Provided **personal support** for PwD to access waged employment (personalized social support, referral to rehabilitation services & assistive devices, as well as to vocational training).
Sustainability: The project was implemented jointly with a small local business; contacts were facilitated with a fair trade network to facilitate linkages with national & international markets; an awareness raising video was prepared to disseminate good practices.
Key indicators: Over 40 PwD were employed by both the small business & by its partners, representing at least 10% of their work force.
Duration of the project: 3 years.
Donors: Embassy of the Netherlands.
Implemented by: HI, EnterpriseWorks, Eliby.

References [1][2] HI. *Accessibility Policy Paper.* 2009 | [3][7] HI. *Access to services for persons with disabilities in challenging environments.* 2010 | [4] ICBL, CMC. *Landmine and Cluster Munition Monitor.* 2012 | [5] IDDC. *Make Development Inclusive website.* Accessed March 2013 | [6] HI. *How to build an accessible environment in developing countries.* 2008 | [8] OECD. *Service delivery in fragile situations.* 2008

HANDICAP INTERNATIONAL

10

Victim assistance cross-cutting issue: **DATA COLLECTION**
Development sector: **STATISTICS AND DATA COLLECTION**

WHAT IS DATA COLLECTION?

Data collection refers to gathering, analyzing & sharing of information in a given domain. In the context of VA, this means the collection of data on the number, situation & quality of life of victims. Its **goal** is: 1) To understand, report on & disseminate information on the **number, sex, age, situation, needs & capacities** of victims; 2) To enable Ministries & other stakeholders to **formulate, implement, monitor & evaluate policies, plans & programs** to respond to the rights & needs of victims. **Without relevant & precise data**, it is impossible to propose effective policy options, to have a baseline to measure progress, to mobilize resources, and more generally, to plan & implement VA effectively & strategically.

There are many methodologies to carry out data collection. Usually, a few of them are used at the same time – ideally, in a coordinated manner – to respond properly to different data collection objectives.

Main methodologies include the following:

- **Casualty data collection**: Gathering & analyzing data on casualties with the main purpose of planning risk education, clearance & land release. The *Information Management System for Mine Action* (IMSMA) is one tool often used for this purpose by Mine Action Centers & Authorities. (1)
- **Needs & capacities assessment & mapping of services**: These methodologies gather relevant data to understand the situation in a given territory, and to plan & prioritize programs including allocation of resources in a participatory manner. Data is collected on A) *the target population*: needs, demands, capacities & resources; and B) *the environment*: service providers, social & cultural norms and infrastructure that can act as either facilitators or barriers to the quality of life of victims. (2)
- **Diagnosis for personalized support**: It collects information about, and with, the most vulnerable of victims & PwD with the specific aim of supporting them to improve their quality of life. It includes the needs & priorities of the person and feedback from her family & professionals such as health & social workers; it also identifies barriers & facilitators in her environment. (3)

Quick Facts

- **4,286** identified mine/ERW **casualties worldwide** in 2011. (4)
- **Casualty data** is more systematic in countries using IMSMA; but other methodologies are more comprehensive to plan & monitor VA.
- Most affected countries **lack baseline information on the quality of life** of victims – thus it is difficult to measure progress.
- Only **10 countries** have carried out fairly comprehensive VA needs assessments. (5)

LEGAL & POLICY FRAMEWORKS

CCM: Art.5, para 1, 2.A. Art.7 para 1.K.
Vientiane Action Plan: Actions #22 & #25.
Cartagena Action Plan: Section IV, Action #25.
CRPD: Art.31.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD | **Service providers** in all sectors of VA | **Ministries:** Social Affairs, Focal Point on Disability, all other Ministries | **Mine Action Centers (MAC) and Authorities (MAA)** | **International organizations:** The UN Statistics Division, the Geneva International Centre for Humanitarian Demining.

WHAT ARE COMMON CHALLENGES IN MINE/ERW AFFECTED COUNTRIES?

- Most countries have not yet established **statistics, data collection & census mechanisms** in accordance with **CRPD standards**.
- **Health information systems** in most developing countries are weak.(6)
- There are **limited resources & trained staff** on data collection methodologies, and on how to interview victims & PwD. Authorities, service providers & DPO may gather data with little coordination among them and often lack a mechanism to compile data in a systematic manner. Such data is rarely comparable and thus difficult to use to understand the global situation.
- In some cases, the **data collected is not used** to design programs to improve the quality of life of victims, with the negative consequence of only raising expectations.
- Not enough coordination **between the MAC, the MAA & Ministries** regarding data collection methods, their purpose & use.
- Lack of knowledge on **how to design appropriate questions on disability**: traditional questions asking household members if they are "deaf, blind, crippled or mentally retarded" use dated terminology & are based on a medical approach that is outdated and has shown to be limited & biased. The number of PwD identified using such an approach has been low and has allowed governments to largely ignore them, or to relegate the policies & programs regarding PwD to medical care & rehabilitation services only. (7)

SUCCESSFUL PROJECTS ON DATA COLLECTION

In Albania, **extensive data collection used for program design & information sharing** contributed to the success of the VA program in 2005-2009. In 2011, the DPO ALB-AID maintained data on all the survivors among its members. The Albanian Red Cross Society collects data on casualties in 12 provinces. Data is disaggregated by age, sex & recorded in the IMSMA database. (8)

In Afghanistan, the 2005 **National Disability Survey** resulted in a better understanding of the number of PwD, including survivors, and their needs & priorities in the areas of health, rehabilitation, education & livelihoods. (9)

In Cambodia, a project by HI, the local NGO OEC and the Cambodian DPO collects data on the basic needs, capacities & participation in community, social & political life of victims before & after project completion, which allows to measure and to report on **improvements in quality of life**. (10)

In Nicaragua, information on survivors has been collected as part of **disability community surveys** across the country. (11)

WHAT CAN STATES DO?

National-level:

- Casualty data collection via IMSMA is more adequate for setting priorities in terms of risk education, clearance & land release than for establishing priorities in inclusive development & VA.
- When a **MAC takes the lead** on VA, it should be on a **temporary basis** and with a focus on raising awareness, mobilizing & supporting relevant Ministries to take this responsibility - particularly if one Ministry is already in charge of Disability.
- Identify a **Ministry, Authority or Committee** in charge of guiding & coordinating data collection efforts for the specific purpose of improving VA & access to services for PwD.
- Data that will be used to define policies, plans & programs related to VA should remain under the **primary responsibility of relevant Ministries** (Health, Social Affairs, Employment…).

Field-level:

- Define the different data collection needs & goals in a **participatory** manner in order to decide on the most **appropriate methodologies**. A single methodology (e.g. injury surveillance, survivor needs and capacities assessment…) cannot respond equally well to the needs of Mine Action programs, of VA policy planning, or to measuring and reporting on improvements in the quality of life of victims.
- Ensure that all efforts related to improving data collection regarding survivors are linked to larger efforts to collect data on **all PwD**.
- **Train data collectors** on effective data collection methodologies, on the rights of victims & PwD, and on communication methods with persons with different types of impairments.
- Ensure that those victims interviewed **understand** the purpose of data collection.
- Establish safeguards to **ensure confidentiality & respect for the privacy** of the data on victims & PwD.
- Ensure that the questionnaires use **appropriate terminology regarding disability**, i.e. avoid using discriminatory terms such as « crippled ». Questions & terminology should be based on UN Statistics Division recommendations, which follow the International Classification of Functioning. Examples exist on how this has been incorporated in a number of censuses in Asia.[12]

HOW TO MEASURE PROGRESS

The factsheets show some areas in which States should be able to demonstrate change. Advances in access to services and in legislation & policies should ultimately contribute to making a positive impact in quality of life.

- National census includes disability using relevant questions & interview approaches, following the guidelines of the UN Statistics Division.
- The national injury surveillance system differentiates between different causes & types of injuries, including those resulting from mine/ERW accidents.
- IMSMA data on casualties is used as a first step to identify victims and disseminated to relevant Ministries in a systematic manner.
- A data collection mechanism on PwD exists, is in accordance with the CRPD & includes data on survivors.
- A focal point or Committee exists to guide & coordinate all data collection efforts related to VA, including different mechanisms & methodologies (injury surveillance, IMSMA, survivor needs & capacities assessments…).
- Data collectors are trained in methodologies & on meaningful & respectful communication with victims & PwD.
- A participatory baseline is established to measure and report on progress on VA with a focus on quality of life & participation.
- Pertinent data is disseminated & available to relevant stakeholders, while ensuring the confidentiality of victims.

EXAMPLE OF A DATA COLLECTION MECHANISM: THE CAMBODIA MINE/ERW VICTIM INFORMATION SYSTEM [13] [14]

© Nicolas Axelrod / Handicap International

Thoeun Leang, grocer and beneficiary of TIGA project, Battambang Province, Cambodia; 2013

Identified problem: Lack of systematic, comparable, precise & up-to-date information on mine/ERW casualties in Cambodia.
Objective: To provide **systematic collection, analysis, interpretation & dissemination of information** about casualties of landmines, unexploded ordnance & other ERW in Cambodia.
Activities: The Cambodia Mine/ERW Victim Information System (CMVIS) chain of operations is formed by data gathers who are selected for their knowledge of a specific geographic area, and trained on how to fill the CMVIS forms. They report to a provincial coordinator who feeds the data to capital. CMVIS also relies on a network of volunteers in areas less contaminated by mine/ERW.
Sustainability: CMVIS was established in 1994 by the Cambodian Red Cross with technical and financial support of HI & UNICEF. The process of transfer to the Cambodian Mine Action & Victim Assistance Authority (CMAA) was completed in 2009.
Key indicators: The information system is completely managed by the CMAA. CMVIS has enabled the Cambodia government to establish that from 1979 to January 2013 there have been a total of 64,214 mine/ERW casualties. As of January 2013, 30% of casualties were engaged in livelihood activities at the time of their accident, 78% of all casualties were injured and 22% died, and 31% were children. This information allows for planning & prioritizing mine action activities and, along with other data, informs the planning of VA.
Managed by: The Cambodian Mine Action and Victim Assistance Authority.

References [1] [9] [11] GICHD. *Assisting Landmine/ERW survivors in the context of disarmament, disability and development.* 2011 | [2] HI. *Inclusive local developement policy paper.* 2009 | [3] HI. *Personalized social support : methods, approaches, tools.* 2009 | [4] [5] [8] ICBL-CMC. *Landmine and Cluster Munition Monitor.* 2012 | [6] World Health Assembly. *Strengthening of health information systems.* 2007 | [7] UNESCAP. *Results of the Testing of the ESCAP Extended Question Set on Disability.* 2011 | [10] HI. *Good practices from the project Towards Income Generating Activities in Cambodia.* 2010 | [12] WHO, UNESCAP. *Training Manual on Disability Statistics.* 2008 | [13] Cambodia Mine Action and Victim Assistance Authority Website. | [14] GICHD. *CMVIS External Evaluation Report.* 2006; James Madison University Mine Action Information Center. *Landmine Casualty Data: Best Practices Guide.* 2008; WHO. *Guidelines for conducting community surveys on injuries and violence.* 2004

HANDICAP INTERNATIONAL

11

Victim assistance cross-cutting issues: **NATIONAL ACTION PLANS, COORDINATION**

Development sector: **NATIONAL ACTION PLANS, COORDINATION**

WHAT ARE NATIONAL ACTION PLANS?

States Parties, in particular those accountable to, and responsible for, the well-being of significant numbers of victims, have committed to elaborating a **National Action Plan to assist victims**. Their goal is to establish a **strategic & coordinated framework** through which: a) All ministries and other stakeholders increase their **awareness** on the rights & needs of victims & PwD; b) A **focal point/committee** on VA and/or disability is established; c) **Clear & specific responsibilities are identified** to ensure VA is adequately addressed; d) There is **improved coordination** among stakeholders working on VA, disability, development efforts; e) Victims & PwD are **empowered** and participate in decision-making; f) **Baseline data** exists which allows for monitoring and reporting on progress in VA nationally; g) There is **common basis on which to mobilize national**, and if necessary, **international resources**.

National Action Plans to assist victims should: a) be linked to or **included in larger plans on disability/ inclusive development** when existent; b) be drafted with the **informed participation** of victims & PwD; c) be based on data collected in the process of a survivor needs assessment & a mapping of services; d) be in accordance with the **standards & guidelines** set by the CRPD, the CCM, and the Vientiane & Cartagena Action Plans; e) be built on **good practices from different sectors**, i.e. health, rehabilitation, mental health including psycho-social support, education, social & economic inclusion; f) **incorporate a gender & age-sensitive approach.**

The development of a National Action Plan to assist victims can launch a national disability dynamic, particularly in those countries not yet party to the CRPD, contribute to improving national ownership, facilitate the sustainability & impact of VA, and that of broader disability & development efforts, and allow each State Party to identify its own priorities & objectives in a participatory manner.

National Action Plans should include, at the minimum:

- An analysis of existing **legislation & policies** relevant to VA, disability & development.
- An analysis of r**elevant stakeholders.**
- An analysis of the current situation in **each sector** relevant to assisting the victims.
- A description of what **data** still needs to be collected/updated.
- A list of **SMART objectives** per sector with actions to reach them & indicators to measure progress.
- A **summary of resources** needed to implement, monitor & evaluate the plan including national & international resources already secured, and resources yet to be secured.
- A summary of the **monitoring mechanism** of the Plan.

Quick Facts [1]

- At least 19 States Parties to the MBT had **national coordination mechanisms** addressing VA in 2011.
- At least 17 States Parties to the MBT had **VA or broader disability plans** that explicitly included survivors.
- For the first time in recent years, in 2011 several States Parties reported **declines in quantity & quality in all VA sectors.**

LEGAL & POLICY FRAMEWORKS

CCM: Art.5, para. 2.C. | **Vientiane Action Plan:** Actions #21, 24, 33, 56. | **Cartagena Action Plan:** Section IV Action #27, Section V Action #34.
CRPD: Art.33.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD; community-based & civil society organizations, including those of women & women with disabilities | **Service providers** in all VA sectors | **Ministries:** Health, Labor, Social Affairs, and others relevant to VA, disability & development | **Mine Action Centers and Authorities** | **International organizations:** ICRC, UN agencies & others relevant to VA.

WHAT ARE COMMON CHALLENGES IN MINE/ERW AFFECTED COUNTRIES?

- **No or little knowledge, involvement & commitment of relevant Ministries** (Health, Labor, Social Affairs, etc.) in a given VA topic. It may still be considered as the primary responsibility of Mine Action stakeholders, instead of the responsibility of each relevant Ministry.
- Not enough links or coordination **between VA efforts & frameworks to advance the rights of PwD.**
- **Lack of sufficient, updated, relevant & comparable data** on survivor needs and available services, and data analysis to build a relevant & feasible National Action Plan on VA.
- **Not enough human & technical resources** to lead the design, implementation, monitoring & evaluation of National Action Plans.
- Not enough commitment or capacities to regularly **update, monitor & evaluate** the Action Plan once it has been adopted.

EXAMPLES OF NATIONAL ACTION PLANS ON VICTIM ASSISTANCE & DISABILITY

Albania has a **National VA Plan** that is aligned with the recommendations of the Cartagena Action Plan. The Albanian Mine and Munitions Coordination Office monitors its implementation, which allows Albania to report in detail on its VA efforts. Survivors are represented at all levels of planning & implementation of the Plan. [2]

In Jordan, VA is included in the **National Disability Strategy**. The Higher Council for the Affairs of Persons with Disabilities is the national focal point on VA. VA is coordinated through the Steering Committee on Survivors & VA, and includes governmental & non-governmental representatives as well as survivors. VA is also included in the National Mine Action Plan 2010–2015. [3]

In Chad, a **National Action Plan on VA** was adopted in 2012. It is in accordance with the Cartagena Action Plan, and recognizes the principle of non-discrimination between victims & PwD. The coordination effort was led by the Mine Action Center with the active participation of relevant Ministries (in particular of Social Affairs), the ICRC, NGOs & DPOs that include survivors. Technical support for the process was provided by the United Nations in partnership with HI.

HOW CAN STATES PREPARE A NATIONAL PLAN OF ACTION?

This section is based on "The thirteen-step strategic approach to assistance VA" developed by the AP Mine Ban Convention Implementation Support Unit [4]. It includes some modifications built on HI's recent experience in supporting the development of National Action Plans, and Inclusive Local Development Plans, in various countries. It also builds on policy papers & publications on Inclusive Local Development by HI [5][6] and the International Disability and Development Consortium [7]. This section is an overview of the process - each country should certainly adapt it to its own context and make sure that there is no duplication between efforts to advance VA & the rights of all PwD.

1. **Raise awareness** on the VA framework and on the rights & needs of victims & PwD among key Ministries & other relevant stakeholders. Develop information materials in accessible formats. Involve victims themselves as partners in awareness raising activities & in the development of the National Action Plan from the beginning of the process.
2. **Assign responsibility for the process of drafting the National Action Plan**. This responsibility should be that of the same entity that is responsible, or focal point, for the rights of PwD- e.g. the Ministry of Social Affairs or of Gender and Youth. If no such focal point exists, other possibilities to spearhead the process on a temporary basis should be explored – including the Mine Action Center or Authority. Ultimately, the responsibility should fall under the most relevant Ministry.
3. **Designate an inter-ministerial/inter-sectoral committee** to coordinate the whole process. This group should be representative of all the different sectors of VA (e.g. health, economic inclusion) and include representatives of Ministries, services providers & organizations of survivors & PwD. The Committee should have an official mandate with adequate resources and terms of reference.
4. **Carry out a preliminary situation analysis**. In order to develop a relevant plan, it is necessary to understand a) the existing legal & policy context; b) the current situation of victims (needs, demands, capacities, resources & priorities); c) conduct a stakeholder analysis: who is doing what and where, in terms of service provision, in all sectors of VA. If necessary, conduct of an in-depth study can be included in the Action Plan itself.
5. **Organize a first national workshop & consultations to introduce the topic of VA as fitting in broader disability, development & human rights frameworks; review & complete the preliminary situation analysis & start discussing possible ways forward.** All relevant stakeholders should participate in this workshop.
6. **Organize working groups per sector** (rehabilitation, education, etc.) **& develop SMART objectives, indicators & actions to reach them**. Each working group should identify an organization/focal point to lead discussions & report on the work of each group throughout the process. Note that, when actions or projects are already taking place and contribute to the Action Plans' objectives, these should also be included in the Plan. This ensures that the efforts implemented are fully taken into consideration, and that future actions build on existing initiatives. The Plan should include a budget that mentions and clearly differentiates national & international resources, as well as secured & non-secured funding.
7. **Organize a second national workshop to integrate work of each group, prioritize & finalize a draft of the National Action Plan**
   Compile and present work of all groups and prioritize objectives & related actions on the basis of existing resources.
8. **Disseminate the draft plan to all relevant stakeholders for final comments & approval, and follow any necessary adoption procedures**.
9. **Coordinate, monitor, evaluate & report** on the advances & challenges faced in implementing the Action Plan, at local, national & international level, and on regular basis. Victims & PwD should be actively involved in the monitoring & evaluation of the Plan, as well as in all other stages.
10. **Update and review the Plan at least once a year** to ensure it remains relevant and that any challenges are addressed as soon as possible.

PROCESS TO PREPARE A NATIONAL ACTION PLAN IN AFGHANISTAN [8]

© Chris Horwood / Handicap International

Family victim of mine / ERW, Afghanistan, 2003.

Identified problem: Afghanistan is one of the countries with the most mine/ERW victims in the world. Lack of coordination & absence of a systematic approach to VA were seen as an obstacle to responding to the rights & needs of victims and more generally of PwD.

Objectives: The main goal of the Plan was to *"address the rights & needs of all PwD, including mine survivors, within the framework of the Afghanistan National Development Strategy & the MBT"*.

Methodology: The Afghanistan's National Disability Action Plan 2008-2011 was drafted in a **consultative process under the auspices of the Ministry of Labor, Social Affairs, Martyrs & Disabled, in link with the MDGs and the National Development Strategy**. It was drafted through a series of awareness sessions & workshops and includes a review of the status/current situation, objectives in 2006 & revised objectives in 2008, and actions to achieve the revised objectives. Through consultations and on the basis of the MBT & on national priorities, the following sectors were identified as pertinent for inclusion in the Plan: *1. Data collection; 2. Emergency & continuing medical care; 3. Physical rehabilitation; 4. Psychological support & social reintegration; 5. Economic reintegration; 6. Community based rehabilitation; 7. Inclusive education; 8. Laws and public policies.* It is currently being reviewed & updated.

Sustainability: The National Action Plan was led and drafted by relevant Ministries with international stakeholders providing technical support. From the outset, it was linked with national disability & development frameworks. It was established through a consultative process involving all national & international stakeholders and, in particular, survivors & PwD.

Led by: The Afghanistan Ministry of Labor, Social Affairs, Martyrs and Disabled.

References [1][2][3] ICBL-CMC. *Landmine and Cluster Munition Monitor.* 2012 | [4] GICHD. *Assisting Landmine and other ERW Survivors in the Context of Disability, Development and Disarmament.* 2011 | [5] HI. *Recommendations for National Action Plans on Victim Assistance .* 2011-2015. 2010 | [6] HI. *Inclusive Local Development Policy Paper.* 2009 | [7] IDDC. *A Guidance Paper on Inclusive Local Development Policy.* 2009 | [8] Ministry of Labor, Social Affairs, Martyrs and Disabled/Afghanistan. *Afghanistan National Disability Action Plan 2008-2011 to address the rights and needs of persons with disabilities, including mine survivors.* 2008

HANDICAP INTERNATIONAL

12

Victim assistance cross-cutting issues: **INTERNATIONAL COOPERATION AND ASSISTANCE**

Development sector: **INTERNATIONAL COOPERATION AND ASSISTANCE**

WHAT IS INTERNATIONAL COOPERATION AND ASSISTANCE?

International Cooperation & Assistance refers to **all support** provided to affected States & stakeholders by countries, regional or international organizations, **to implement VA in an effective, efficient & sustainable manner. It can be channeled through** bilateral, regional & multi-lateral mechanisms, amongst others: UN Agencies, as well as through South-South cooperation to the ICRC, NGOs, service providers, organizations of survivors & PwD.

Affected countries face multiple challenges that impede the swift & effective implementation of VA, such as ongoing conflict, widespread poverty & lack of sufficient human, technical & financial resources. As such, the **goal of international cooperation & assistance** is to **support States** that lack sufficient resources to **comply with their VA** obligations, thus ensuring the rights of victims & PwD are enforced and their quality of life is improved. International cooperation & assistance have more impact if it responds to the priorities set by affected States Parties in their National Action Plans. This is why International Cooperation is one of the pillars of the MBT & CCM, and is included in the Cartagena & the Vientiane Action Plans.

Quick Facts

- **Setbacks in the accessibility** of services for survivors occurred in at least 12 countries in 2011, most as a result of **declining international assistance**. (1)
- Addressing the rights & needs of PwD is a **long-term commitment** at political, financial & material levels. (2)
- Funding for Mine Action was the largest ever at almost EUR 578 million in 2011, but VA funding accounted for **only 6%** of total mine action support.

Modalities include:

- **Technical support:** On-site support for the implementation of a specific project, such as developing a National Action Plan or carrying out a needs assessment & mapping of resources.
- **Capacity development:** Training & coaching of relevant authorities or service providers on a regular basis over a period of time, with the goal of improving their knowledge, attitudes, practices & overall skills on a given topic. It may be specific to one sector (e.g. training of rehabilitation professionals), or on aspects such as Monitoring & Evaluation of policies & programs.
- **Financial support:** Budget support through bilateral, regional or multilateral cooperation mechanisms to States, UN & international organizations, international & local NGO, organizations of survivors & PwD and service providers.

LEGAL & POLICY FRAMEWORKS

CCM: Art.6, para 7. | **Vientiane Action Plan:** Actions # 33 – 38, 41, 42, 47, 56 and 59. | **Cartagena Action Plan:** Section IV, Action # 32. Section V, Actions # 35, 36, 37, 39, 41, 47, 48, 50, 51 and 52. | **CRPD:** Art.32.

WHO ARE THE MAIN STAKEHOLDERS?

Organizations of survivors & PwD | **Service providers** in all sectors of VA | **Ministries:** All relevant Ministries in affected countries | **International organizations:** UN agencies, GICHD, ICRC, international NGO | **Regional & multilateral forums** | **International Development & Cooperation agencies** such as: ADA, AusAid, AFD, BMZ, CIDA, DFID, DGDC, JICA, NORAD, SIDA, USAID, WRA … **Ministries of Foreign Affairs** of countries committed to international cooperation & assistance.

WHAT ARE COMMON CHALLENGES FOR INTERNATIONAL COOPERATION?

- Prioritizing international cooperation is difficult when there are **few evidence-based studies** analyzing needs & capacities of victims, existing services and resources, & national efforts to respond to the gaps.
- There are still many barriers that prevent PwD from **being included in all aspects of development & development cooperation**; and difficulties remain in ensuring efforts on VA are based on, or at least linked to, **efforts on the inclusion of PwD**.
- Countries committed to international cooperation & those affected may **have different priorities.**
- **Good practice on international cooperation on VA** from different countries has not yet been well-documented, making it difficult to maximize.

SUCCESSFUL PROJECTS IN INTERNATIONAL COOPERATION

In Afghanistan, the *Afghanistan Landmine Survivor Organization* (ALSO) implements projects on peer support, awareness raising, accessibility, inclusion, advocacy & empowerment. These activities are **supported by** WRA through Clear Path International (CPI) and OSI, CIDA, Norway, Finland and Australia's Embassies, as well as by small grants from ICBL, CMC & HI. CPI made a big difference for ALSO's early activities through 1. Provision of funding for the first peer support project; 2. Covering in part of ALSO's capacity building & running costs; 3. Ongoing support throughout the years; 4. Development of ALSO's human resources through training on accounting, management & monitoring. Through its projects, ALSO has empowered hundreds of women with disabilities including female survivors; nearly 100 schools & other public places became accessible; introduced peer support as a new concept in Afghanistan; supported numerous persons to enroll in school & find jobs. ALSO has contributed to ratification of the CRPD & CCM. (3)

In the Democratic Republic of Congo, the *UN Mine Action Coordination Center* (UNMACC) provides support to national authorities & mine action organizations to coordinate & implement VA. *UNMACC* mobilizes resources, advocates for the ratification of the CRPD & maintains the victims' database. Donors include *Japan, AusAid & MONUSCO*. In 2011-2013, UNMACC provided sub-grants to national NGO for VA projects, in particular on economic inclusion; it carried out a VA survey; updated the victims' database & led the effort to draft the National Strategic Mine Action Plan 2012-2016 and led, facilitated, supported and worked together with partner organizations on the development of the National Strategic Plan for Assistance for Mine/ERW Victims and other PwD 2010-2012. As a result, 1,243 survivors were identified & 228 are engaged in income generating activities & have improved their household income; 135 persons have accessed physical rehabilitation services; there is harmonized information on VA; an updated database is functioning. The UNMACC promotes projects that use a comprehensive approach including physical rehabilitation, psychosocial support & economic inclusion, which ensures a more lasting & significant improvement in the quality of life of survivors. (4)

WHAT CAN STATES DO?

This section includes recommendations for affected States to mobilize international resources available for VA, disability, development & human rights more effectively and recommendations for countries committed to international cooperation & assistance to facilitate fulfilling the VA provisions of the CCM & MBT in line with the CRPD. For specific recommendations on each sector that VA is part of, or on cross-cutting issues, please refer to factsheets 1-11.

Recommendations for affected States:

- Collect, analyze & disseminate evidence-based information on the needs & capacities of victims & PwD, on existing resources & service providers, and on national efforts to comply with VA provisions of the CCM & MBT in line with the CRPD.
- Develop a National Action Plan to assist victims and/or Disability, complete with a situation & gap analysis, SMART objectives and related activities & budget.
- When requesting international cooperation or assistance, demonstrate how it could contribute to achieving one or more SMART objectives of the National Action Plan to assist victims and/or Disability. Mention all national & international efforts already committed towards the same objective.
- Request international cooperation & assistance jointly with relevant stakeholders such as NGO, organizations of PwD & survivors, service providers.
- Accede to or ratify relevant frameworks such as the MBT, CCM & CRPD, as this will increase funding opportunities that will benefit both survivors & PwD.

Recommendations for countries and organizations committed to International Cooperation & Assistance: [5] [6] [7]

- Ensure that VA efforts are streamlined with other development activities such as health care, education, empowerment & humanitarian assistance. At the same time, ensure continuous VA funding as a part of mine action dedicated budgets to avoid funding gaps for as long as VA is not taken into consideration into broader development funds. VA specific budgets should be available even after a country has been declared mine and cluster munition free until the quality of life of victims is equal to that of the rest of the population.
- Ensure all funded development efforts are disability-inclusive. Train new & current staff responsible for assessing funding applications on VA & disability-inclusive development.
- Request recipients of international cooperation & assistance in all sectors to provide information on what measures will be taken to ensure their development efforts are inclusive so that victims & PwD may benefit on an equal basis with others.
- Be flexible & respond to the demonstrated needs & gaps in affected countries, including on less-funded aspects such as mental health, psychosocial support projects, medium & long-term capacity development of survivors organizations, DPO & national authorities.

Recommendations for countries and organizations committed to International Cooperation & Assistance and for affected States:

- Document & disseminate good practices & lessons learned on how international cooperation & assistance has supported national efforts on VA, including on strategies to link VA contributions to those undertaken as part of broader disability, development & human rights efforts.
- Consult with & employ PwD at all levels, including top-management. Appoint persons with specific responsibility for VA & disability. Such persons should have authority to influence decisions & budget allocation.
- All research, data collection, monitoring & evaluation of development programs should disaggregate data by sex, disability & age.
- Ensure the needs & capacities of victims are recognized and related efforts are being undertaken in forthcoming development & humanitarian agenda.
- Promote regional & bilateral exchanges on good practices as a key element in cooperation strategies.
- For States Parties to the MBT and/or CCM, report in article 7 how international cooperation & assistance to VA contributes to, and is being integrated into, broader disability, development & human rights strategies; contributes to the development of an inclusive system of available and accessible services and to improvement in quality of life of victims & PwD.

EXAMPLE OF INTERNATIONAL COOPERATION FOR VICTIM ASSISTANCE

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Signing conference of the Convention on Cluster Munitions, Oslo, 3rd December 2008.

The project: HI implemented a four-year project from 2009-2012 which **promoted South-South cooperation on VA** in Asia & South East Asia, the Middle East, Central & East Africa and Central Asia. Four regional VA workshops were organized to raise awareness on VA & disability more broadly, increase knowledge on how to develop a national action plan on VA/disability, and to provide a platform by which affected & donor states could exchange on best practices and capitalize on opportunities. These workshops were joined by all **relevant stakeholders** from a given region, namely representatives from Ministries and Mine Action Centers from mine/ERW affected countries; representatives from countries committed to international cooperation, regional organizations, DPO & survivor organizations, the ICRC, UN agencies, the ILO, ITF, the GICHD, the ICBL & the CMC. These regional workshops were organized in Bangkok, Amman, Nairobi, Dushanbe & Vientiane.

International cooperation: a. Funding: provided by France through a special fund to strengthen civil society organizations, and through the Agence Française de Développement (AFD); by Norway through its Ministry of Foreign Affairs; by the European Union through its fund for Education on Development.

Outcomes of the project: *Development of peer-to-peer support in Iraq, *Informed & powerful participation of DRC civil society in the subsequent development of the National Strategic Plan for Assistance for Mine/ERW Victims & other PwD: 2010-2012,*Subsequent exchanges between Lao, Vietnam & Cambodia on livelihoods.

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HANDICAP INTERNATIONAL

ABBREVIATIONS AND ACRONYMS

ADA: Austrian Development Agency

AFD: Agence Française de Développement

AusAid : Australian Agency for International Development

BMZ: Federal Ministry for Economic Cooperation and Development (Germany)

CBR: Community-Based Rehabilitation

CIDA: Canadian International Development Agency

CCM: Convention on Cluster Munitions

CMC: Cluster Munition Coalition

CMVIS: Cambodia Mine/ERW Victim Information System

CPI: Clear Path International

CRDP: Convention on the Rights of Persons with Disabilities

CwD: Child with Disability

DFID: Department For International Development (UK)

DGDC: Directorate General for Development Cooperation (Belgium)

DPO: Disabled People's Organization

ERW: Explosive Remnants of War

GDP: Gross Domestic Product

GICHD: Geneva International Centre for Humanitarian Demining

HI: Handicap International

ICBL: International Campaign to Ban Landmines

ICRC: International Committee of the Red Cross and Red Crescent

IDDC: International Disability and Development Consortium

ILO: International Labor Organization

ITF: International Trust Fund

IMSMA: Information Management System

ITF: International Trust Fund

IMSMA: Information Management System for Mine Action

JICA: Japan International Cooperation Agency

LDPA: Lao Disabled People's Association

MAA: Mine Action Authority

MAC: Mine Action Center

MBT: Mine Ban Treaty

MDGs: Millennium Development Goals

NGO: Non-Governmental Organization

NORAD: Norwegian Agency for Development Cooperation

OECD: Organization for Economic Co-operation and Development

OSI: Open Society Institute

PwD: Person with Disability

SIDA: Swedish International Development Cooperation Agency

UN ESCAP: UN Economic and Social Commission for Asia and the Pacific

UNDP: United Nations Development Program

UNESCO: United Nations Educational, Scientific and Cultural Organization

UNMACC: United Nations Mine Action Coordination Center

USAID: United States Agency for International Development

VA: Victim Assistance

WHO: World Health Organization

WRA: Office of Weapons Removal and Abatement

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Those factsheets have been produced with the financial assistance of the Norwegian Ministry of Foreign Affairs. The contents of this document are the sole responsibility of Handicap International and can under no circumstances be regarded as reflecting the position of the Norwegian Ministry of Foreign Affairs.

Conception & graphic design: L'Atelier Volant - ww.atelier-volant.fr