SIR BOBBY CHARLTON FOUNDATION

An Analysis of Victim Assistance in Mine Action

Lessons from the Frontline in Afghanistan, Cambodia, and Ukraine

Summary

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Contributors and Acknowledgements

The Sir Bobby Charlton Foundation thanks the survivors, their families, and all those affected by landmine/ERW harm that gave up their valuable to time to answer questions, sometimes on personal, complex, and/or sensitive subjects. One would be hard pressed to encounter more driven, courageous, and capable people. This report aims to serve the participants as a tool that can be used to help drive forward the implementation of effective and sustainable policies and programmes built by and for persons with disabilities and all those affected by victim-activated explosive ordnance.

We would also like to thank the agencies and organisations that continue to work tirelessly and selflessly to assist survivors and indirect victims of victim-activated explosive ordnance. This report would not be possible without their efforts.

Introduction and Methodology

This report is the result of a 15-month review of victim assistance (VA) – one of the five pillars of humanitarian mine action (HMA) – conducted by The Sir Bobby Charlton Foundation (SBCF). The overarching goal of the project is to ensure that those who have been impacted by victim-activated explosive ordnance (VAEO), including people with disabilities and indirect victims living in contaminated areas, are supported by victim assistance mechanisms and are properly considered in sustainable, suitable, and effective policies, laws, and programmes on both a national and international level.

A core objective of this research is to understand the progress made in relation to VA and provide an insight into the role of humanitarian mine action victim assistance (HMAVA). This has been made even more necessary by the emergence of COVID-19, the humanitarian crisis in Afghanistan, and the ongoing conflict in Ukraine.

The study aims to understand whether persons directly and indirectly impacted by VAEO are being sufficiently supported by assistance mechanisms across three countries: Afghanistan, Cambodia, and Ukraine. These regional case studies were selected because they each offer a different context, while all being among the most-affected countries by explosive ordnance (EO) contamination and casualties[1] in the world. Their differences include types of contamination, the magnitude and timeframe of conflict, geography, when their mine action programme was established, the strength of their mine action structures, resources and level of international support. By observing these different contexts, the research observed the short-, medium- and long-term results from (humanitarian and development) victim assistance in varying contexts.

[1] Cambodia and Afghanistan are two of the 34 countries that have declared to have a significant number – hundreds or thousands - of survivors (AP Mine Ban Convention, 2022), and Ukraine, despite not making this declaration is thought to also have a significant number of survivors (Landmine & Cluster Munition Monitor, 2018). According to Landmine & Cluster Munition Monitor data, all three countries have consistently had some of the highest levels of contamination, although Ukraine is yet to be surveyed.

Certain findings exist across the three cases and should be considered by VA actors universally. In other instances, findings are specific to each case (or in two of the three cases), highlighting the need to contextualise policy and strategy for victim assistance. Based on these findings, the study presents recommendations for national and international stakeholders of VA-related programmes.

Survivors and victims are the principal subjects of this paper but there is also a focus on persons with disabilities living in VAEO-affected areas more generally, since the challenges faced by survivors and other persons with disabilities are often shared, and the mechanisms to support them intertwined. For the same reason, attention is also given to the families of survivors and other indirect victims.

The study aims to demonstrate that survivors, victims, and people with disabilities are the experts on their own realities and that their insights are instrumental to the design and implementation of effective policies, laws, and programmes in place to support them.

The focus areas of the investigation, considered by the SBCF to encompass a holistic system of care for direct and indirect victims of conflict and covered, were:

1. First response/emergency response (primary medical aid and security);
2. Continuing healthcare and physical rehabilitation;
3. Mental health and psychosocial support;
4. Education;
5. Economic inclusion;
6. Food security and financial support;
7. Housing and domestic infrastructure;
8. Social and political inclusion;
9. Protecting and promoting rights; and
10. Identification, data collection, information management.

In order to study these focus areas fully, an inductive investigation was conducted throughout 2021 in Afghanistan, Cambodia, and Ukraine. The primary research method was field visits to communities, schools, hospitals, physical rehabilitation centres, vocational training centres, and other relevant sites. These visits were carried out between 02nd July and 1st December 2021 and covered rural, suburban, and urban areas.

A total of 481 people across Afghanistan, Cambodia, and Ukraine participated in interviews, including 278 possible programme recipients (149 survivors and 129 indirect victims) and 182 administrators and service providers.

The research was carried out prior to the regime change in Afghanistan, and the Russian invasion of Ukraine. It, therefore, provides insight into the challenges already faced by people with disabilities in the two counties prior to the tumultuous events of the last 12 months (which are only likely to have seen the situation deteriorate further) and provides lessons learnt and a blueprint for addressing the problems as and when the opportunity arises.

The Sir Bobby Charlton Foundation

The Sir Bobby Charlton Foundation is a UK international charity that specialises in help for the victims of conflict.

The charity was founded in 2011 by football legend Sir Bobby Charlton following a visit to Cambodia where he witnessed first-hand the devastating impact that landmines and the explosive legacy of war was still having on innocent civilian communities more than 20 years after the conflict had ended. On returning to the UK Sir Bobby established the SBCF as a not-for-profit conflict recovery NGO. Today, the SBCF is a well-respected member of the international humanitarian & development sectors and is making a crucial contribution to the safety and well-being of conflict affected people. We do this in three ways:

1. **Humanitarian & Development Assistance -** including physical therapy & prosthetics for those injured as a result of conflict, trauma counselling, art therapy and safe play areas for children;
2. **Education and Training –** including vocational/ business start-up training and mine risk education; and
3. **Research and Innovation –** including technological led medical & landmine clearance solutions.

The SBCF's response, track record and programming in relation to conflict affected communities is driving new ways of working in international development & aid. In the last three years alone The SBCF has worked with 10 different partners to reach more than 52,500 vulnerable conflict affected people from seven different countries. Results achieved include traumatised children returning to school, people with a disability gaining qualifications & employment, the development of ground breaking landmine detection technology and pioneering research into human bone regeneration and trauma prevention.

Victim Assistance in Mine Action

Antipersonnel landmines, unexploded ordnance (UXOs), and other victim-activated explosive ordnance continue to have major humanitarian, socioeconomic, and environmental impacts in over 50 countries, contaminating thousands of kilometres of land and causing thousands of casualties each year[2]. The physical, psychological, and socioeconomic consequences for those injured and/or disabled by explosive ordnance (i.e., survivors) can be intense and life-changing, but the reverberating effect of harm extends far beyond survivors. Mine[3] contamination and harm can disrupt the provision of food, medical aid, and other critical services. Explosive harm can also

[2] In 2020, the Landmine & Cluster Munition Monitor (2021) reported that over 7,073 casualties (2,492 killed and 4,561 injured across 53 countries, up by 21% from 5,853 in 2019 (Landmine & Cluster Munition Monitor, 2021). In the same year, nine countries reported to have massive levels of contamination (over 100km^2) (ibid, 2021).

[3] The terms 'mine', 'landmine', and 'VAEO' will be used as reference to interchangeably to refer to all anti-personnel victim-activated explosive ordnance. See Appendix I for full details on the selected definitions that this report uses.

damage infrastructure, absorb government resources, disrupt economic and social activity, and push people into poverty.

To counter the direct humanitarian impacts of anti-personnel mines, victim assistance (VA) was officially inaugurated in the Convention on the Prohibition of Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction in 1997. Since then, VA has been one of the five pillars of mine action[4]. The role of victim assistance in mine action has also been extended to address the direct and indirect impacts of landmine harm on affected societies and to recognise the additional strain on countries' welfare and humanitarian systems caused by the presence of landmines.

In 2019, the States Parties agreed that VA should be integrated into "broader national policies, plans, and legal frameworks on the rights of persons with disabilities and support the realization of the Sustainable Development Goals (SDGs)"[5] (Landmine & Cluster Munition Monitor, 2021, p. 77). As such, one of the primary groups that are targeted by victim assistance are survivors disabled by VAEO. The Convention on the Rights of Persons with Disabilities, a legally binding international convention, references victims of indiscriminate weapons and is used as the foundation for international and national laws and policies related to VA.

Responsibility for VA, as with all HMA activities, primarily falls on the government of the affected country, but, as outlined in the APMBC, assistance from the international community in supporting victims of VAEO harm is crucial, especially in countries with limited resources. As such, international stakeholders are expected to provide training and resources to national and local actors (where suitable), ensuring that support is only withdrawn once the national authorities have attained the skills and resources to take ownership of relevant services. Despite the emphasised responsibility of international actors to support victim assistance in affected countries with limited capacity, VA still receives only a fraction of the funding it requires, which is only approximately 6% of total HMA funding.

Victim assistance faces many barriers to the provision of effective, sustainable, and suitable programmes and policies to address victims' needs. This study aims to exemplify some of those challenges, both from the perspective of the service recipients as well as the providers.

[4] The other four being: clearance, explosive ordnance risk education, stockpile destruction, and advocacy.
[5] The SDGs are closely linked to the role of HMA and VA. See the GICHD report exemplifying the link here: https://www.gichd.org/fileadmin/GICHD-resources/rec-documents/The_Sustainable_Development_Outcomes_of_Mine_Action_in_Jordan.pdf

Key Findings & Lessons Learnt

In this section, we explore the research findings across all the three case study countries. The findings and recommendations should be considered by actors operating globally in mine action, as the challenges identified transcend national borders and are likely to exist in other VAEO-affected countries.

General Lessons

Despite specific examples of effective cooperation, there is a general lack of synergy between governmental and non-governmental sectors in relation to victim assistance. In each country, there was imperfect coordination between ministries and actors that hindered the implementation of VA services. In Ukraine and Afghanistan, there was also the need to gain the support of all parties to the conflict in order to access victims and provide aid.

Furthermore, the lack of a national mine action authority and suitable legislation related to disabilities, mine action, and victim assistance in Ukraine heightened the barriers to cooperation. In Afghanistan and Cambodia, where National Mine Action Authorities (NMAA) were established, activities such as data collection, collaboration between actors, referral systems, and monitoring were more effective and streamlined (relative to Ukraine).

When designing or developing mine action strategies, relevant governmental and non-governmental humanitarian mine actors must work in close coordination with one another to provide care and protection to those living in VAEO-affected areas. To achieve this, international bodies (such as the United Nations) that are experienced in forming humanitarian structures should work closely with the government to advise on this process. In turn, a NMAA should work closely with the relevant ministries (such as ministries responsible for healthcare, social care, and finance). Funding should be directed towards NMAAs to ensure that they are able to fulfil their role as a coordinator, and guidance should be offered by international experts on the development of suitable legislation and policies.

Due to recent funding decisions by international and national investors, the capacity of organisations to provide effective and critical victim assistance (e.g., rehabilitation and healthcare services) has diminished. International donors, private investors, and the ministries in charge of national budgets must carefully reconsider their investment policies and review the sustainability of existing projects. Direct provision of services by international organisations should be designed to cultivate a national and local capacity through the provision of training, resources, and facilities, with the end goal of handing over responsibility to the government at an appropriate time.

In the construction and management of any victim assistance policy or programme, there needs to be extensive consultation and fair representation of survivors, indirect victims, ethnic groups, indigenous groups, local communities, local and national authorities, and other stakeholders. Each

group, and each individual, has unique needs and will have insight that should be considered if policy or programmes are to be suitable and effective.

Emergency Care

In all three contexts, emergency transport was unreliable, especially for those living in rural and remote areas. For those living in areas of ongoing conflict in Ukraine and Afghanistan, the difficulty of accessing emergency services was further exacerbated. Similarly, in areas that were (or suspected to be) contaminated with VAEOs in Ukraine and Afghanistan, emergency services were unable to access those areas. All these factors increased prehospital time, increasing the risk of morbidity and mortality for victims. There was also a shortage of emergency healthcare staff in both the state and non-government spheres.

To reduce prehospital time, the government ministry responsible for healthcare should prioritise and direct funding towards emergency evacuation/transportation and international donors should direct resources towards the improvement of emergency care for trauma victims. For NGOs and government healthcare providers operating in high-intensity conflict zones, there should be a focus on smaller first aid points with suitable and properly equipped transportation to reduce delays in treatment for those injured in rural and remote areas. Where there are high levels of conflict and contamination, negotiations should focus on establishing safe corridors for the emergency transportation of casualties. Clearing contaminated access routes to hospitals and healthcare facilities should also be a priority.

Continuing Healthcare and Physical Rehabilitation

It was observed that those living in rural areas had severely limited access to rehabilitation, prostheses, and continuing healthcare services. Because of this, many had to travel to major cities (sometimes hundreds of miles from their homes) to receive treatment, taking costly time out from work and often incurring additional costs related to travel and treatment. There was also a lack of effectively implemented standards across hospitals and healthcare centres in all three countries, which resulted in survivors and persons with disabilities paying for services that should be free. Moreover, survivors and persons with disabilities repeatedly faced barriers to accessing free healthcare and rehabilitative services due to difficulties in securing the necessary legal statuses.

Both the national and local authorities responsible for healthcare policy and standards must make every effort to ensure that continuing healthcare and rehabilitation services are provided for free to persons with disabilities and, if it is required, formulate a swift and easy process for persons to gain the necessary status. The international community should direct resources towards these services until local and national structures are equipped to take ownership. It is also imperative that hospitals and healthcare centres have the necessary equipment, resources, and staff. In the design of any short- or long-term policy, persons with disabilities, survivors, and local communities should be consulted and represented in the design, implementation, and management.

Mental Health and Psychosocial Support

Mental health and psychosocial rehabilitation are important processes for those disabled by violent trauma such as VAEO harm. In all three countries, there were first and second-hand accounts of

survivors facing short- and long-term mental health difficulties (e.g., sleep disruption, anxiety, stress, depression, suicidal thoughts) due to the VAEO incident and subsequent injuries. In most cases, those who had received mental health and psychosocial support (MHPSS) said that it was helpful to their recovery and wellbeing. However, misinformation and stigma relating to MHPSS can add an additional barrier to the provision of such services.

Health ministries, NMAAs, and international health and victim assistance actors should consider MHPSS services as a priority for survivors of VAEO harm. This may include integrating such services into rehabilitation and continuing healthcare, where the physical and psychological recovery processes can work in close cooperation. Mental health services should be accessible and free for survivors and indirect victims, including those living in rural areas. At the local level, peer-to-peer support networks should also be established.

Education

In all three contexts, there was acutely limited inclusive and specialist education. This was due to the lack of equipment, suitably trained staff, specialist curricula, and accessibility in schools. There was also a lack of effectively implemented education standards, laws, and policies that considered the special education requirements of persons with physical, sensory, and cognitive disabilities. Education was found to be most limited in rural areas. Child survivors and children with disabilities also often faced discrimination in schools, which led to increased absenteeism.

Child-focused humanitarian organisations need to share expertise with the national education ministries to support the creation and implementation of suitable inclusive and specialist education. This might also mean the creation of specialist syllabi and curricula. The design of any policy should be based on international standards. Both inclusive schools and specialist schools should be established to cater for the varying types of disabilities.

Economic Inclusion and Vocational Training

In all three countries, persons with disabilities faced extraordinary barriers to employment, and many survivors referenced economic inclusion and monetary incomes as one of their primary concerns. It was repeatedly stated that employment provided independence and transformed how the survivor and their community viewed their position in society. It was also said to have an influence on mental health. Conversely, a lack of employment was linked to an increased willingness of people to take risks by collecting scrap metal and entering or travelling through VAEO-contaminated areas. This, in turn, led to an increase in casualties. The vocational training that was in place was, in some cases, successful but in others programmes fell short of facilitating sufficient and sustainable incomes for survivors.

When designing programmes, victim assistance NGOs should ensure that they consider the local economy, the skills and ambitions of the recipients, and what were the viable paths to income generation. This may include supporting start-up costs for businesses. The most successful economic support programmes observed across the case studies were those that preserved the agency of survivors as groups or individuals.

Food Security and Financial Support

The short- and long-term financial impact of VAEO harm on survivors and their families was evident in all three countries. As well as healthcare-related costs, many survivors forewent income for days, weeks, and sometimes months as a result of the initial harm. Many survivors referenced income and food security as their primary concerns and granting financial support to survivors was seen as a way to empower them and grant them agency and independence. Despite this, the provision of cash assistance to survivors and indirect victims by the respective governments was extremely limited and difficult to access due to the process of obtaining the necessary legal status.

Based on effective identification and proper assessment, VA stakeholders should ensure that quick and suitable resources are accessible to vulnerable groups living in conflict-affected areas. Support can take the form of direct provision of food, clean water, hygiene products, and other resources, or through cash assistance. Cash assistance in particular localises the decision-making to survivors, granting them flexibility and independence.

Housing and Infrastructure

In all three countries, utilities (e.g., clean water, electricity, internet) were limited in rural areas, especially those that had been heavily impacted by conflict. Public transport, as well as the safety and quality of roads in many areas, were also compromised. Additionally, many houses had been damaged in conflict zones and many survivors had been displaced due to war, leaving them without sufficient accommodation. Many people had also been displaced due to VAEO contamination, causing them to relocate to major cities to access healthcare.

Humanitarian organisations should support relevant government ministries and actors to provide suitable housing for those who have been displaced by conflict and contamination. There should also be additional support to repair housing damaged by conflict and the prioritisation of clearance in domestic areas to allow the return of their residents as soon as possible. Government departments responsible for infrastructure, urban planning, and rural development should collaborate with the private sector to establish a long-term national strategy to improve access to infrastructure, buildings, and transportation. Utilities are also critical to the survival of those living in VAEO-affected communities, especially those with mobility difficulties. Their needs must be taken into consideration in the planning process. As with other areas of support, the design and implementation of housing and/or infrastructure policies and programmes must consult and represent persons with disabilities.

Social and Political Inclusion

Discrimination and stigma were repeatedly experienced by survivors in all three countries. The effect of stigma and discrimination impacted survivors' well-being, as well as their desire to participate in social, economic, and educational activities. There was also underrepresentation of persons with disabilities in government institutions and NGOs (with a few notable exceptions).

Creating opportunities for survivors and persons with disabilities to take active roles in society (social, economic, and political) improves the perception they have of themselves and that of their communities. Sports programmes were also considered to be of benefit in the recovery and

rehabilitation of VAEO survivors. Any actor focused on victim assistance should have a suitable ratio of persons with disabilities and survivors in their workforce at all levels.

Protecting and Promoting Rights

In Ukraine, the rights of those impacted by VAEO harm were still being established in national law. In Cambodia and Afghanistan, inclusive legislation had been put in place but there were failings with the implementation of these laws (such as free healthcare for survivors, financial support, etc.). The bureaucratic process of applying for various legal statuses of persons with disabilities in all three contexts created barriers to accessing government-run services and financial support for many survivors. There was a lack of understanding of disabilities and the rights of persons with disabilities. This led to stigmatisation and discrimination of persons with disabilities in schools, places of employment and local communities.

Victim assistance actors and ministries responsible for social policy and welfare should work to ensure that appropriate legal statuses can easily and quickly acquired, especially where they are necessary to access critical services and financial benefits. This may include developing a remote application process, streamlining validation, or providing advice hotlines. Governments should commit to international conventions and establish national laws relating to the rights of persons with disabilities and victims of VAEO harm. In addition, governments should consider national initiatives to promote the rights of persons with disabilities through media, cultural, and sporting campaigns, as well as the implementation of employment rates for persons with disabilities across the public, private, and NGO sectors.

Identification, Data Collection, and Information Management

Service providers in all three countries complained of insufficiently available data regarding victim assistance. For example, many survivors and persons with disabilities were not registered and, as such, did not have the appropriate legal status. As a result, the data held on them was limited or non-existent. Additionally, none of the healthcare systems had a centralised patient database. In Cambodia, however, the Cambodian Mine Action and Victim Assistance Authority (CMAA) was piloting a quality-of-life survey to collect more comprehensive information on survivors and persons with disabilities.

Victim assistance authorities should therefore establish an information management system to identify victims and their needs by both level and type. This information system should collect data based on international definitions of disabilities, survivors and victims. The Information Management System for Mine Action (IMSMA) should be adapted to measure and map the needs of both direct and indirect victims throughout affected areas. International actors that have experience in building information systems in mine-affected countries should advise in the process of designing and implementing an information system, and international bodies such as the Geneva International Centre for Humanitarian Demining (GICHD) should facilitate information sharing in each country. The ministries and departments responsible for healthcare should consider establishing centralised databases for patients that can allow for secure information transfer between hospitals.

Case Studies - Highlights

Afghanistan

Key Findings

The government of Afghanistan was facing significant challenges in providing emergency responses due to a lack of resources and trained healthcare staff. At a national level, their capacity to treat VAEO victims was hampered by an intensification of the conflict with the Taliban, increased VEAO contamination, and the destruction of key infrastructure (including utilities such as electricity and healthcare facilities). The challenge of providing emergency and continuing care was further compounded by the spread of COVID-19 and a reduction in international funding. Due to a lack of staff, many surgeries and specialist treatments related to trauma could only be provided in the large cities (predominantly Kabul) and, in some cases, abroad. However, there were multiple claims that state hospitals even in Kabul did not have the resources to meet the mid- to long-term needs of trauma patients with spinal injuries or who are paraplegics. Because of this, patients were discharged too early. When it came to emergency evacuations after a VAEO incident delays were exacerbated in rural and remote areas. At one surgical centre for conflict-caused trauma victims, only 54% of patients arrived at the centre within six hours, and, in 2021, they lost 15 patients in transit to the hospital.

Rehabilitation is a critical service for those with disabilities in Afghanistan but they were only available in 22 of 34 provinces and were particularly difficult to access for those living in rural and remote areas. NGO workers believed it was unethical and inefficient to only provide rehabilitation services for those directly harmed by conflict as contamination and conflict impacted a much larger group of people. The provision of services in government-run rehabilitation centres was limited and the amount of funding being directed towards them from the national budget was being reduced. Staff in government-run centres complained of short contracts and reduced wages, leading to a falling retention rate.

Service providers in Afghanistan universally agreed that while physical recovery was the same for trauma victims no matter what the cause, psychological recovery was different for violent trauma survivors. It was also important for their families. Despite this there was a severe lack of psychosocial and mental health programmes and professionals in the country. None of the survivors interviewed had seen a psychologist or psychiatrist, however, informal peer-to-peer support was conducted in multiple rehabilitation centres and considered effective. Most survivors said having active economic and social roles in society was the most important factor in terms of their mental health.

Mainstream schools lacked equipment and adaptations to allow physical access to persons with disabilities. They also lacked properly trained specialist staff. These failings severely limited schools' abilities to provide education for children with disabilities. The provision of specialist and

inclusive education for children with disabilities was inadequate both in terms of reach and suitability. Girls' schools were repeatedly targeted in attacks by extremist groups and girls were more likely to be taken out of school to support a family than boys. The provision of transport, food, and cash were considered fundamental to supporting children with disabilities and allowing them to access education.

Integrating socioeconomic support into rehabilitation centres has proved to be widely successful and helped survivors reintegrate into society but its reach was limited. The reach of vocational training programmes was also restricted, could not accommodate all those that wanted to take part, were narrow in focus and suffered from a lack of employment opportunities to go into. One of the most successful schemes was a microcredit programme which was praised for not taking agency away from persons with disabilities.

Most survivors and indirect victims said that their families had suffered financially due to the harm caused by VAEO. This vulnerability led to people taking increased risks for economic gain, sometimes resulting in injury by VAEOs. The Ministry which provides financial benefits to survivors, admitted that these benefits were not enough to sufficiently support them and their families and due to the worsening humanitarian crisis, providing cash and food assistance was becoming more costly and difficult. Persons with disabilities not directly caused by conflict did not receive any financial benefits.

All interviewed survivors believed that they lived in suitable housing but residential centres for those who are homeless or require care do not have the capacity to meet the demand or care needs of residents. There was also insufficient infrastructure and domestic amenities for persons with disabilities.

None of the survivors believed that the government was supporting people with disabilities. Most interviewees referenced selfishness and corruption as the reason for this belief. Multiple survivors and administrators said active roles in society and communities were the key to overcoming internal and external stigma but none of the survivors had received any information on their rights.

The information management system that was in place in August 2021 in Afghanistan did not include sufficient information on the needs of survivors and the services they could access. Many survivors were not registered by the government as persons with disabilities and did not have an identity cards resulting in the chronic underreporting of victim numbers.

Recommendations

- establish a network of first aid points and smaller healthcare posts with suitable transportation to emergency facilities
- clearance operators should prioritise creating corridors for emergency transportation by surveying and clearing access roads
- increase the training of specialist healthcare staff to ensure that surgical services are available within suitable proximity of those who need them

- international organisations should connect experts to local healthcare staff, to support the training of specialist personnel
- international experts should increase efforts to negotiate with conflicting groups to allow safe passage for emergency vehicles across the country and dissuade attacks on healthcare infrastructure and facilities
- in the short-term, focus funding on existing resources and infrastructure managed by the NGO sector in order to utilise money most efficiently and quickly to respond to the humanitarian crisis
- when establishing new services, national and international stakeholders must focus on utilising local human and material resources to ensure that they are building the capacity of Afghanistan's civil sector
- partnerships and pooled funding should be established by smaller donors and organisations to ensure that facilities and services are sustainable
- develop healthcare clusters managed by an international organisation with extensive experience in the country (such as the ICRC)
- design of the national healthcare structure should include persons with disabilities and conflict victims at all levels and stages
- ensure that there is a sufficient number of suitably trained female healthcare workers so that Afghan women have equal access to care
- establish rehabilitation centres in the remaining 12 provinces that have none
- put in place financial and logistical support for those who must travel to access services
- consider the use of mobile centres to provide alternative access to services
- direct resources towards life-saving and critical healthcare support
- prioritise existing PRCs and organisations for funding, to address the increasing demand for rehabilitative services most quickly
- improve the availability of MHPSS services across Afghanistan through the training of mental health professionals
- establish peer-to-peer support networks to operate in local communities and at existing healthcare and rehabilitation institutions
- ensure survivors and indirect victims have family/community-based support networks. Inform local support networks about the importance of MHPSS care
- provide more opportunities for social and economic roles for persons with disabilities
- target education funding to improve physical access, increase specialist resources and equipment, and train staff to facilitate inclusive education
- establish adapted curricula and resources so that all children with varying cognitive, sensory, and/or physical disabilities can receive suitable education
- put in place community and remote education services until schools and educational facilities can be re-established
- in the short to medium term, direct financial assistance funding to provide essential and immediate humanitarian support such as emergency cash assistance, food packages
- reintroduce and expand microcredit and employment programmes when suitable
- socioeconomic programmes should be integrated into all rehabilitation centres

- improve the financial sustainability of vocational programmes and consider longer courses, business and accounting options, networking opportunities with employers and start-up funding for enterprises
- establish clear referral mechanisms between hospitals, healthcare centres and other key sites for accessing benefits
- make financial support available to all vulnerable families rather than only those that have been injured by conflict
- improve the availability of accessible public transport for people with disabilities
- bolster mechanisms of transparency and accountability to counter real or perceived corruption
- ensure that persons with disabilities are granted the opportunity to play active social, economic and political roles in society to help fight stigma
- improve education on rights in public workshops, employment facilities, healthcare centres and schools
- pressure government and local structures to protect and promote women's rights, with special consideration for vulnerable groups such as women with disability
- update the information management system so that it serves as a more effective tool for identifying victims, their needs, and referrals to appropriate services

Cambodia

Key Findings

The standards of roads in Cambodia and the availability of appropriate emergency response vehicles, especially in rural areas, are major factors that determine how quickly VAEO victims can reach health facilities for emergency treatment. Almost no survivors had access to state-provided emergency transport at the time of their incident. Those living in rural areas also have to travel long distances for continuing healthcare treatment and services, sometimes hundreds of miles. Survivors and people with disabilities living in rural areas often did not receive much-needed prostheses or rehabilitation because of the distance to their closest physical rehabilitation centre.

The Ministry of Health has established comprehensive standards but at the hospital and healthcare levels, there was evidence that administrators did not always adhere to these standards. In particular, the system of free healthcare and financial support for people with disabilities was undermined by inadequate identification of those who are eligible for support. Some survivors were charged for state-provided healthcare, despite it being free for people with disabilities and those with ID Poor.

There is a general issue with staff availability and staff retention in the governmental and NGO health sectors, which has a negative impact on the accessibility of emergency and continuing healthcare services. Many workers move into the private sector, seek out alternative careers, or work abroad. Although retention was better in the state-run healthcare system, availability of staff – especially specialist staff – was poor.

There is a decline of external/international funding for services provided to survivors which has consequently led to a loss of capacity in both sectors. It is the opinion of many working in the rehabilitation sector that capacity will continue to decline over the coming years. It was clear that many issues in the healthcare and rehabilitation sectors stem from funding but shifting the cost onto the user would likely push many survivors further into poverty.

A lack of local specialist treatment/testing services means that accessing necessary care can be costly and time-consuming. This can also have a reverberating impact on the families of survivors. The loss of earnings while accessing healthcare services has, in some cases, prevent survivors from accessing treatments. Availability and accessibility of services in rural areas is particularly poor. Many survivors said that they would be pushed into poverty if they were to spend more than a week in the hospital.

Physical access was also an issue for survivors. Even in hospitals, healthcare centres and schools, where improvements had been made, there was still limited access for those with mobility difficulties.

Many survivors experience depression, sadness, difficulty with sleep, anxiety, and other social, emotional, and mental health problems but most had not received mental health support. Mental health problems in the form of depression can also extend to family members but they rarely have access to support. It was a commonly held view that psychological support resulted in improved outcomes.

Cambodia has some of the lowest education completion and attendance rates in Southeast Asia and children with disabilities, especially those living in rural areas and from low-income families, are less likely to complete primary and secondary education. Special or integrated education services for persons with disabilities were particularly poor. There is also an apparent lack of additional support for children with disabilities in mainstream schools in the form of specialist staff and equipment. The disability-related poverty cycle also means children of survivors are often needed to work and support the family or help their disabled parents rather than going to school.

The Cambodian National Disability Strategic Plan gives special consideration to the economic status of landmine/ explosive remnants of war (ERW) survivors, which is bolstered by Cambodia's additional SDG 18 aimed at extra economic support for landmine victims.

Many survivors are often engaged in low-income, unsuitable employment in the informal, primary, and secondary sectors (such as farming or labouring). Because of this, many survivors rely on family to financially support them, limiting their independence. The training and employment opportunities offered to people with disabilities are often poorly matched with their abilities, skills, or interests. Many survivors believe the public sector is not fulfilling its obligation to achieve 2% minimum density of disabled employees.

Food security and disposable incomes impact the entire family when the survivor is the head of the household. The governmental and NGO support systems alleviate some of the economic pressure on low-income families but it is often not enough to lift survivors out of poverty. The

income of some survivors is far below their cost of living but the quality of life for those who received military pensions was far higher than those who did not.

Nearly all the survivors had experienced discrimination, but the majority now felt supported by their community. Many reported that they faced less discrimination thanks to new laws, media campaigns, and general awareness-raising. Survivors also agreed that being economically active helped to reduce discrimination.

The Cambodian authorities have enacted several laws to protect the rights of persons with disabilities, including a mechanism to report rights violations and get legal advice. Awareness of these mechanisms was limited, as was general awareness of the rights of persons with disabilities. A quality-of-life survey of persons with disabilities is being carried out in Cambodia, which, in part, will help to identify how well rights are being respected.

Most survivors felt their interests were being represented by the government, but some did not feel as though they had been included in the process of policy design and implementation. In some specific economic programmes being carried out by NGOs and local authorities, limited consultation with survivors led to poor and unsustainable support.

Survivors and people with disabilities living in rural and remote areas almost never had access to water and/or electricity mains, relying instead on filters, bottled water, and solar panels. Land ownership is also a significant issue for families in Cambodia and a lack of certainty over land issues leaves them feeling vulnerable.

The widely used data Information Management System for Mine Action (IMSMA)in Cambodia has been criticised for its limited functionality regarding victim assistance. Less than 40% of the survivors interviewed have been formally registered as having a disability and lacked an ID card that proved their disability. There is no centrally managed database for patients within Cambodia's healthcare system.

The lack of a clear, universally used definition of disability has led to confusion and unreliability of data relating to the numbers of people with disabilities in Cambodia.

Recommendations

- improve roads that serve as corridors to emergency and healthcare facilities
- in the long term, increase the number of local healthcare centres that can provide specialised emergency and continuing care for trauma victims
- reintroduce mobile rehabilitation facilities
- monitor the adherence of hospitals and healthcare centres to government standards
- display information clearly in hospitals and healthcare facilities so that patients are aware of the services they should receive and their cost
- a national programme to incentivise people to enter the national healthcare and rehabilitation sectors should be implemented, including improvements to terms and conditions of employment, especially for those working in the rehabilitation sector

- international investors and stakeholders in rehabilitation should revisit the value of VA and carefully reconsider the withdrawal of funding for the sector
- in addition to the supplementing the cost of services, which in most cases are free for survivors and other vulnerable groups, auxiliary costs and loss of income should be considered as part of Cambodia's VA strategy
- roll out a nationally recognised form of ID for survivors and people with disabilities. The CMAA should utilise the established data from the quality-of-life survey to identify those who require identification cards
- improve the physical accessibility of buildings and infrastructure through the introduction and implementation of national regulations
- establish survivor networks in their communities, supported by local authorities
- mental health services and support should be extended to the families of survivors
- properly equip and staff schools to provide specialist and inclusive education
- increase formal training/employment opportunities, options, and outcomes for survivors, people with disabilities, and their families
- enforce the rate of persons with disabilities in private and public sector workforces
- consider tax exemption incentives for employers to increase the number of survivors and persons with disabilities they employ
- take steps to increase disability awareness and rights training for employers and staff
- ensure that survivors/ persons with disabilities are not automatically directed into low-skill work
- consult with survivors on income generation and employment initiatives
- prioritise increased levels of welfare support (such as the provision of cash assistance or essential supplies) for financially vulnerable survivors, people with disabilities, and their families
- continue campaigns to reduce discrimination through information-sharing in schools, workplaces, other community facilities and the media
- increase the number of senior political positions reserved for persons with disabilities
- use the quality-of-life survey to identify how well rights are being respected
- both governmental and non-governmental actors should align with the 'nothing about us without us' vision and implement international standards accordingly
- vulnerable persons (including survivors) should be identified and, where necessary and possible, offered subsidised utilities
- continue providing administrative assistance to turn "soft deeds" into formal and recognised proof of land ownership for vulnerable people
- CMAA should consider adapting its information management system to be more suited to the analysis of victims' needs and the provision of victim assistance services
- design and build a digitised and centrally managed database for people with disabilities that can be accessed by all medical facilities
- make any database on victims and survivors available to all stakeholders

Ukraine

Key Findings

Almost all VAEO casualties occur in the grey zone (the line between Government (GCA) and non-Government (NGCA) controlled areas) which are the most inaccessible areas for emergency services. For those who were injured in the grey zone and other high-risk areas, accessing emergency transportation was not possible. Some had to wait hours or days to reach operating theatres or facilities where they could be treated.

NGOs provide equipment and support to the emergency services where they do not have enough resources. This includes both emergency healthcare centres and hospitals, as well as transportation but service providers said that civilians injured or disabled in the NGCA could not access healthcare services in the GCA due to discriminatory policies of the government.

The lack of specialists meant that some survivors had to travel to major cities and, in severe cases, the capital Kyiv following their incident. This increased prehospital time and the risk of increased long-term damage or death from injuries. Ukrainian hospitals and healthcare centres were mostly considered by stakeholders to be outdated and inefficient.

Most survivors claimed to have suffered some form of financial loss and/or debt related to their injury. These costs were, in most cases, largely related to healthcare, absence from work, and accommodation for them and their family during care. The majority said they had paid for medication and other auxiliary costs. Some even said that they had paid out the equivalent of thousands of US dollars over the years since their incident.

No physical rehabilitation centres existed on the GCA side of Donetsk and Luhansk. This meant that some survivors had to travel hundreds of miles for rehabilitation services, spending critical time away from work and family. In some cases, survivors forewent rehabilitation due to the difficulties and time involved, even when it was free.

The referral system between organisations and agencies (governmental and non-governmental) struggled to identify people that needed their support.

None of the survivors believed that they required MHPSS despite going through traumatic incidents. Most of the survivors who had been offered MHPSS rejected it. Children who experience trauma are rarely enrolled in MHPSS services by their families due to the related stigma. However, one MHPSS programme had been successful in gaining the support of the local community through its partnership with a local charity which was already established and trusted. There was a lack of MHPSS services available to survivors and indirect victims in Donetsk and Luhansk. There was also a scarcity of psychologists and trauma specialists.

Mainstream, specialist and boarding schools are often ill-equipped to provide effective education to children with disabilities. Specifically, they often lack resources, suitable buildings, and trained staff. In addition, children were not granted additional support if they were absent from school due to their injury or disability.

There were multiple accounts of discrimination by communities, peers, teachers, and families. Some parents even chose not to send their children to school due to perceived stigma related to their disability.

Due to a lack of job opportunities and a failing economy, people living along the contact line between the GCA and NGCA were taking increased risks to make money or find food. Where they had found work some survivors suffer physical pain from manual labour and many felt that there was a lack of alternative opportunities. Where survivors had been offered alternative employment it was linked to an improvement in their quality of life. The minimum rate (4%) of persons with disabilities in employers' workforces was not being implemented.

For survivors and persons with disabilities, the principal barrier to accessing suitable assistance was the process of applying for and being granted the appropriate legal status of a person with disabilities or a person disabled by conflict. For some, this process took years. Some had their application rejected despite meeting the requirements. Without these statuses, many could not afford the healthcare they required and had to seek financial support from NGOs, family, and their local community. Even when their status was confirmed the government assistance available was limited. Only 50% of the interviewed survivors had official disability status and only two had the status of someone injured by conflict. In addition, the difficulties involved in crossing the line of contact were a tremendous barrier for those living in the NGCA when collecting pensions and benefits.

Reparation for housing damaged in the conflict was not suitable and many were left without appropriate and safe housing. Contamination also resulted in individuals being injured metres from their homes. Tripwires, boobytraps, and other explosive devices were common in areas that were once the frontline of conflict. A lack of electricity, internet, transport, water, and other infrastructure also caused physical and economic hardship for survivors.

None of the survivors had been made aware of any social inclusion programmes and they did not see social inclusion as an important activity.

All service providers complained of the lack of a reliable and comprehensive information system in Ukraine, including a lack of understanding of the scale and needs of victims. Many service providers complained of severe difficulties in using it to identify survivors. A prospective information management system was being worked on at the end of 2021.

According to humanitarian and development NGOs, the lack of an NMAA (and a comprehensive mine action law that outlines the roles, responsibilities, and accountability of government bodies) has hindered the progress of national mine action policy in Ukraine.

Many survivors did not feel represented or supported by local or national governments. In many cases, this was a result of their experience within the system of support (such as healthcare and social care).

Recommendations

- establish a strategy for creating corridors to rural areas for emergency services (including ambulances)
- streamline emergency care and referrals to ensure that services are quickly and easily accessible
- identify the scale of healthcare needs and develop a strategy that ensures emergency services are properly equipped to respond to incidents in conflict-affected areas
- mine clearance organisations should make available resources such as vehicles and equipment to assist emergency evacuation and transport and utilise surveillance resources to quickly identify contamination (or lack thereof) to create safe corridors
- the authorities on both side of the contact line must allow humanitarian organisations to assist with emergency evacuation and care in all locations
- develop a national programme to increase the number of trauma specialists in state hospitals, especially specialist surgeons
- international NGOs working in the healthcare sector should prioritise the training of specialist staff and advise on hospital standards and procedures
- in conflict-affected areas, donors should prioritise the funding of emergency and continuing healthcare resources and facilities
- implement standards in hospitals that ensure that people with disabilities are granted free medication and subsidies for auxiliary costs
- local authorities should collect data to assess the demand for healthcare, social care, and other key services to identify funding needs
- ensure that those injured by conflict receive sufficient and sustainable financial support for primary and auxiliary costs related to healthcare and loss of income-related
- establish or bolster existing physical rehabilitation centres with comprehensive services, in areas where the needs are the highest, irrespective of the location
- make healthcare facilities in the larger cities financially accessible to survivors
- establish a national system of rehabilitation, prosthetics, and orthotics provision
- establish a publicly available platform that can make available all contact details and descriptions of activities of organisations and agencies working in victim assistance
- run a national awareness-raising campaign to improve the understanding of mental health and psychosocial support to encourage survivors to accept such services if required
- consider a national strategy to increase the number of MHPSS workers in Donetsk and Luhansk, especially psychologists
- establish peer-to-peer support networks in local communities to provide mental health support
- build, adapt, or rebuild schools that are accessible for children with disabilities
- put in place a national strategy to improve understanding and awareness of disabilities and the rights of persons with disabilities within communities
- investigate the suitability and safety of educational and residential institutions for persons with disabilities

- international education stakeholders should work with relevant local and national authorities to provide guidance on implementing suitable curricula and standards of education for children with varying disabilities, based on international standards
- NGOs (national and international) supporting victims and persons with disabilities should ensure that staff include an appropriate ratio of persons with disabilities
- streamline the application process to receive official status as a person with disabilities or a person disabled by the conflict
- NGOs should continue to provide cash assistance to survivors and assist with the administrative process of acquiring the relevant legal statuses
- on both sides of the contact line, the local authorities need to cooperate to ensure that people can easily access services and finances. For persons with disabilities, additional steps must be taken to ensure that crossing borders is simplified
- ensure that reparation services or costs for houses damaged by conflict are subsidised for survivors, persons with disabilities, and indirect victims
- prioritise demining of domestic areas (both urban and rural) and transport corridors to hospitals so that people living in contaminated areas can return to their homes safely
- prioritise the reconstruction and repair of utility supplies and infrastructure in areas where they have been disrupted or destroyed by conflict
- conduct awareness-raising of the benefit of social inclusion programmes
- create a national information management system available to governmental and non-governmental national and international actors working in victim assistance
- experienced organisations should provide guidance to national bodies and utilise both local and international knowledge to create an information system that comprehensively records the number of victims and level of need
- design and implement a strategy to improve the referral system within and between government services
- include NGOs and international organisations that work closely with government services in the design of a strategy to improve the referral system
- establish a national mine action authority, supported by legislation based on international standards
- outline the specific victim assistance responsibilities of the government, the policies that establish the budget and mechanisms by which they can implement that law
- survivors and other victims should be consulted and included in the process of policy making from the outset to ensure that their needs are considered

Conclusions

Survivors, victims, and persons with disabilities are not one-dimensional, and the complexities of their needs must be considered by VA actors if they hope to effectively implement assistance. As exemplified by this report, understanding the complexities of survivors' and victims' needs requires consultation with administrators, service providers, and, critically, the survivors themselves. Despite this obvious value, the representation of survivors, victims, and persons with disabilities was limited in each country observed as part of this research. This study found that the most

successful programmes were programmes in which survivors and persons with disabilities were well represented and had been consulted on.

An in-depth analysis of both the target group and the context in which they exist is needed to drive the design of programmes and the mechanisms for monitoring and improvement.

Effective assistance requires a multifaceted approach, with each sector working in coordination. This includes, but is not limited to, emergency and continuing care, physical rehabilitation, education, mental health support, and socioeconomic inclusion. To support this process national authorities should also collect, analyse, and disseminate comprehensive quantitative and qualitative data on the needs of survivors.

The international community – especially actors that are experienced in victim assistance, humanitarian, and/or development roles in multiple mine-affected countries – should use their experience and expertise to provide advice and technical support to bolster the work of national mine action authorities.

Beyond their advisory role, the international community has a responsibility to provide resources and funding to countries that do not have the capacity to provide suitable and comprehensive care to victims of landmine harm. In the funding strategy of any programme or policy – local, national, or international – sustainability should be a central consideration, with donors coordinating their efforts through strategies such as pooled funding to facilitate a consistent approach. Ensuring that any funding strategy maximises the longevity of projects is key to a sector that is heavily dependent on what has become inconsistent levels of funding. From the outset, victim assistance should consider ways in which it can improve local capacity, sustainability and utilise locally accessible and affordable resources wherever possible.

Despite its critical role, victim assistance stakeholders continue to struggle to secure funding and maintain their services. This suggests that current funding strategies are not working. This report recommends that donors consider new efforts to increase the sustainability, effectiveness, and suitability of victim assistance funding in affected countries.