VICTIM ASSISTANCE
ASIA

STATES PARTIES WITH SIGNIFICANT NUMBERS OF SURVIVORS AND NEEDS

Victim assistance process indicators

State Party	Mine Ban Treaty	All known Survivors	Coordination	Plan	Needs assessment
Afghanistan	1 March 2003	Estimated 52,000–60,000	The Disability Stakeholder Coordination Group; the Disability and Physical Rehabilitation Taskforce and several other groups	Redrafting Nation Disability Action plan including victim assistance	2005-Pilot only
Cambodia	1 January 2000	More than 44,000	National Disability Coordination Committee (NDCC)	National Plan of Action for Persons with Disabilities, including Landmine/ERW Survivors 2009–2013	2012-Ongoing (regularly updated)
Tajikistan	1 April 2000	478	National Disability Coordination Committee Victim Assistance Coordination Group/ Disability Support Unit	Annual victim assistance work plan, linked to the five-year Mine Action Strategy 2010–2015	2012–2013
Thailand	1 May 1999	At least 1,364	National Sub-Committee on Victim Assistance (under National Committee for Humanitarian Mine Action)	Master Plan for Mine Victim Assistance 2012–2016	2012–2013 (regularly updated)

Notes: "State Party" refers to those states that have ratified or acceded to the Mine Ban Treaty. "Mine Ban Treaty" is the date the Mine Ban Treaty entered into force for that state. "All known survivors" is the total number of survivors recorded in Monitor country profiles from when survivors began to be reported in a given country through the end of 2012. "Coordination" is the government coordination mechanism that includes efforts to address the needs of survivors. "Plan" is a national plan that aims to address the needs of survivors, sometimes along with the needs of other vulnerable groups. "Needs assessment" is a process by which states or other actors have determined what assistance survivors and/or a broader group of victims require.

Victim assistance in Asia since 1999[1]

Member states of the Mine Ban Treaty with significant numbers of survivors in the Asia region have taken active steps to advance the accessibility and availability of victim assistance since entry into force of the Mine Ban Treaty for each state. Most states ratified the treaty early on, with the one last being Afghanistan in 2002. However, in all of these states significant challenges remain, and many survivors remain far from having even their basic needs addressed.

The scale of the numbers of survivors in Afghanistan and Cambodia is much higher than compared to Tajikistan and Thailand. However, Afghanistan and Tajikistan have close regional cooperation and knowledge sharing on victim assistance, particularly psychological support.

Where progress has been made it has been influenced by improved coordination and more substantive linkages between victim assistance and the disability sectors. More recently, Afghanistan, Cambodia, Tajikistan, and Thailand have also all committed to the 2012 regional Incheon Strategy on disability and equality, the provisions of which underscore the connection by including the principle that the diverse disability groups empowered should include "victims of landmines."

In Afghanistan, special advisors, supported by the mine action program and placed in key ministries, advanced the implementation of disability measures that have also benefited survivors. The Tajikistan victim assistance program worked closely with disability stakeholders and in 2013 was renamed as the Disability Support Unit (DSU) to reinforce the understanding that efforts to assist mine/explosive remnants of war (ERW) survivors are part of broader disability and development frameworks.

In Cambodia, the steering Committee for Landmine Victim Assistance began a transformation into the National Disability Coordination Committee (NDCC) in 2009, giving it a broader coordination role for the disability sector. By 2010, Thailand had completely integrated victim assistance with its implementation of the Convention on the Rights of Persons with Disabilities (CRPD). Linkages between disability rights, victim assistance, and community-based rehabilitation (CBR) in Thailand strengthened since 2009 through improved interagency cooperation and identification of focal points in relevant ministries.

Gender and age

More female health workers are needed to treat women in Afghanistan, which has worked to address this issue by mobilizing and training female health staff to work in health teams, especially in the regions of the country where there is a clear need. The Afghan Landmine Survivors Organization, a national NGO, supported the development of a semi-independent advocacy network of women with disabilities, including mine and ERW survivors. In Cambodia a large and extensive economic training project for persons with disabilities, including mine/ERW survivors and family members, ensured that about half of participants were women. In Tajikistan, children and youth participated in psychological support activities through annual summer camps for children and adults.

[1] Unless otherwise indicated all information is based on country profiles in the Monitor, www.the-monitor.org.

Availability and access to services

Afghanistan

Significant progress has been made in developing services available to mine/ERW survivors and other persons with disabilities in Afghanistan. However, in many areas of the country access to victim assistance remains hampered by a lack of services, poor to non-existent infrastructure, and the impact of ongoing conflict.

Since 1999, geographic coverage of healthcare expanded and became more service-oriented, with basic healthcare made available throughout the country. Physical rehabilitation services have been almost entirely operated by international NGOs and the ICRC under the coordination of the government and coverage remains insufficient despite improvements.

Economic inclusion projects have been limited and conducted mostly by NGOs under the coordination of relevant ministries. The government, through relevant ministries, paid some disability pensions, mostly to war veterans and family members, and ran some vocational training. However, to date, this has not been sufficient to reach all survivors in need. Inclusive education has increased significantly since 2008 due to a dedicated program of training and awareness-raising by the Ministry of Education.

Throughout the period, CBR networks have grown and become better coordinated with the support of the Ministry of Labor, Social Affairs, Martyrs and Disabled (MoLSAMD) and numerous NGOs active in the area, thereby creating greater accessibility of assistance in remote areas.

Psychosocial support services have increased from almost non-existent, as has peer-to-peer support, although they are still insufficient to meet needs and are run by local organizations, often survivors' networks, which are extremly vulnerable to funding changes as donors reprioritize their concerns in Afghanistan.

Highlighted challenges and recommendations:

- Access to physical rehabilitation needs to be expanded geographically as it remains out of reach for some survivors in need. **New rehabilitation facilities or safe and affordable transport to existing centers should be put in place in provinces lacking services or where traveling to receive rehabilitation is difficult for survivors.**
- Funding, capacity, and sustainability are significant challenges that are harder to address due to a lack of coordination between service providers and donors that support services for persons with disabilities. **A response could include a donor coordination body or donor liaison mechanism for disability and inclusive development including government and NGO representatives.**

Cambodia

Since 1999 the basic needs of many mine/ERW survivors and persons with disabilities have not been adequately addressed.

In 1999, assistance was almost exclusively provided by NGOs that were facing decreasing donor interest. Reaching survivors in remote and rural areas remained a challenge for service providers and generally these populations did not have adequate assistance. Many survivors lacked education and literacy skills and had no employment or land from which to make a living. Overall, they received little or no support and did not have full access to social services and healthcare. In 2012 and 2013, cooperation between the government and civil society, including the Cambodia Campaign to Ban Landmines, resulted in improved village-level referral and rights-based interventions that are starting to connect many survivors to needed services.

Since 1999, access to free healthcare programs for survivors has increased as services and geographical coverage has expanded with an emphasis on CBR in remote and rural areas. Inclusive education programs provided by the government as well as other relevant organizations have also grown.

Physical rehabilitation, still primarily supported by NGOs and the ICRC, has improved in both quality and in the number of services available during this period. In 2009, a gradual handover of the physical rehabilitation sector to full state management began. The pace has been slower and the handover more difficult than planned and this has resulted in a lack of available services in some areas.

Gradual improvements in the availability of employment opportunities that had been achieved since 1999 eroded rapidly, starting in 2009. There were more vocational services for survivors in 1999 than by 2011–2012, when programs were phased out due to a lack of available resources. As a result, opportunities for economic inclusion through training have decreased.

Highlighted challenges and recommendations:

- Many survivors lack education and literacy and have no work or land from which to make a living. **Survivors require more direct support, improved access to social protection services and education and training opportunities that are appropriate for survivors and other persons with disabilities.**
- Survivors in remote and rural areas continue to face obstacles to access adequate assistance. **More resources are needed to reach these survivors where they are.**

Tajikistan

From the beginning of Monitor reporting in 1999 until 2004, there were no dedicated programs assisting mine/ERW survivors in Tajikistan. The availability and accessibility of services for survivors began to improve after 2004, particularly with the recruitment of a victim assistance officer in 2006 and the development and implementation of a specific national victim assistance program.

Improvements in the availability of medical care have been reported since 2004, when medication and supply shortages were chronic and most facilities were said to be in poor condition. Between 2005 and 2009, the government gradually assumed more responsibility for the only rehabilitation center; it was handed over to full government management by the beginning of 2009. Since 2011, the quality of prosthetics services has decreased due to the departure of trained staff.

In response to inadequate or unavailable psychological support for survivors, the government's Victim Assistance Program held regular camps to begin to address those needs. Increasingly, economic inclusion projects are carried out through the national mine action center and United Nations Development Programme (UNDP), based on the needs identified in the survivor assessment survey first undertaken in 2008. Physical accessibility to public buildings also increased as a result of these efforts. However, many activities in victim assistance plans, including economic reintegration projects, were not implemented to the extent planned since 2008 due to funding constraints.

Highlighted challenges and recommendations:

- The quality of physical rehabilitation services has worsened since 2011. **This should be addressed through training and with sufficient resources dedicated to sustain these services.**
- Physical accessibility needs to be improved. **Building on the progress made to date, buildings both new and existing should be made physically accessible and accessibility guidelines finalized and there application monitored.**
- Survivors and other persons with disabilities need economic inclusion opportunities. **In line with broader disability planning, survivors should be included in mainstream livelihood and economic development programs as well as provided opportunities based on individual needs.**

Thailand

NGOs and local survivors' group advocacy, combined with tangible government responses, have led to improvements in the quality and coverage of services for mine/ERW survivors since 1999. The number of services provided to survivors from both government agencies and civil society organizations/NGOs has gradually increased.

Emergency transportation is now more widely available and rescue response time has improved with training. The CBR program expanded significantly since the early efforts of 1999, and its outreach worker network covered 99% of the country by 2007. Access to free healthcare programs has increased through universal health coverage that applies to mine/ERW survivors and other vulnerable persons who are Thai nationals or registered refugees.

There have been gradual improvements in the availability of employment opportunities, social inclusion activities, and in the accessibility of existing services. Inclusive education programs provided by the government and relevant organizations have increased.

The availability of rehabilitation services has increased with resources contributed through universal healthcare coverage as well as the development of new centers in mine-affected areas. The CBR network continues to improve services in rural areas. As a result of changes to policy, all survivors, including stateless survivors living in Thailand without identification, can have better access to health services.

Highlighted challenges and recommendations:

- Since most survivors live in rural areas and work in the agricultural sector, existing employment and training programs generally do not meet their specific needs for economic inclusion. **Programs should be adapted or new programs developed, including through credit and micro-finance.**
- The most vulnerable survivors, including the elderly, remain exposed to some gaps between CBR coverage and universal healthcare coverage. **Additional resources should be provided to survivor networks, while communication between local administrations, survivor networks, and the CBR program should be improved.**

Survivor inclusion and participation

Afghanistan

National NGOs, disabled person's organizations (DPOs), and survivors' organizations became increasingly active and participated regularly in disability coordination. Survivors' organizations have had a leading role in promoting accessibility regulations and in filling gaps in existing services by implementing innovative services and programs that reach survivors and other persons with disabilities, particularly in economic inclusion and psychosocial support.

Afghanistan regularly included persons with disabilities who were also directly involved in victim assistance coordination on its delegations to meetings of the Mine Ban Treaty.

Cambodia

Representative organizations of survivors and persons with disabilities were included in coordination and planning activities through the National Disability Coordination Committee (NDCC). Survivors were engaged in the implementation of many services provided by NGOs and extensively involved in the village-level disability survey in 2012–2013.

Tajikistan

Survivors were involved in regular victim assistance coordination meetings as well as the provision of victim assistance-related services, including rehabilitation. Survivors and their representative organizations contributed to the preparation of government transparency reports and/or statements to be presented at international meetings and shared input for data collection and presentations.

A landmine survivor working in the national mine action center participated in meetings of the Mine Ban Treaty as a member of the delegation and in other international victim assistance meetings.

Thailand

The role of local landmine survivor networks was strengthened during the period since 1999. In particular, since 2012 these networks have received more support from government victim assistance experts. Inclusion of survivors and other persons with disabilities increased through their participation in the development of the victim assistance master plan and surveys. Survivor participation continued to improve at the community and provincial levels; several survivors remained active in leadership roles in their communities. In 2013, Thailand's government team of victim assistance experts organized the first formal meeting of landmine survivor leaders.

Survivor participation challenges and recommendations in the region:

- In Thailand and Cambodia, an increased role for survivors in monitoring and reporting to coordination bodies should be incorporated into disability and victim assistance coordination planning.
- Afghanistan and Tajikistan can better ensure survivors and persons with disabilities are included in all decision-making positions, as well as the current few advisory positions in ministries.

International cooperation and national support

Afghanistan's victim assistance providers have faced a funding decline since 2009 due to changing donor focus. A lack of coordination among donors which have been funding services for persons with disabilities alongside other competing priorities for assistance was identified as a particular challenge. Funding to NGOs in Cambodia sustained the physical rehabilitation system. Funding for activities designed specifically for mine/ERW survivors was expanded to include broader disability issues in the period since the Second Review Conference of the Mine Ban Treaty (2009-2014).

Tajikistan has faced continuous challenges mobilizing the international resources needed to accomplish its victim assistance plans, with the UNDP playing an important role in mobilizing donor resources. Thailand benefited from only small amounts of donor funding mostly through relief organizations and assistance structures for refugees. The bulk of Thailand's resources for victim assistance have been dedicated through national funding and have been allocated through universal health and social welfare coverage and the growth of the national community-based rehabilitation system.

Awareness of victim assistance in states not party to the Mine Ban Treaty

The proportion of mine/ERW survivors living in states not party to the Mine Ban Treaty is larger in Asia than in any other region. Significant work needs to be done to ensure that survivors' needs are met, but in several countries with significant numbers of survivors awareness has been raised already and this has resulted in government action in some cases.

There is a relatively high level of awareness of survivors' needs in Azerbaijan, where the government focal point for victim assistance is the national mine action center that coordinates based on a specific strategy. In India, awareness of the needs of mine survivors in Jammu and Kashmir is frequently raised in the media, particularly related to challenges in accessing rehabilitation and financial compensation. However, in the absence of any government coordination system, the lack of consistent compensation has remained the most prominent issue.

In Iran, there has been publically available research into the needs of mine survivors; however, there is no single government body responsible for coordinating assistance to all survivors. Awareness of the need for victim assistance in Myanmar has increased since 2012 as a result of initial activities by NGOs. Demonstrating an increasing awareness on the part of the government, in 2013 MP Aung San Suu Kyi stated publically that she would work to ensure mine/ERW survivors receive prostheses and vocational training. Victim assistance was included in the mine action strategy and Millennium Development Goals in Lao PDR, a countries with victim assistance obligations as a States Party to the Convention on Cluster Munitions and where mine/ERW survivors represent a significant proportion of persons with disabilities.

There was no specific coordination of victim assistance activities in Nepal, however national and international NGOs, including members of a survivor network, increased public awareness of the lack of adequate assistance for survivors. Pakistan asserted that there were no mine/ERW victims, but also reported that it has a victim assistance coordination mechanism. A national NGO continued to raise awareness of the existence of survivors and their needs in the media, and also produced an extensive and detailed report in 2012.

Vietnam, which has active national NGOs and a strong survivor network, publically announced its "Victim Assistance Project for the Period 2012–2015," which includes actions to be taken, designated responsible or cooperating agencies, and annual budgets. Extensive UN agency support to victim assistance coordination and implementation in Sri Lanka, together with the activities of implementing NGOs, has resulted in increased awareness of the needs of survivors in relevant ministries.

Development and disability indicators

Development indicators have been presented in victim assistance reporting since 2006, when it was found from Landmine Monitor reporting on 24 States Parties, that:

> *There appears to be a relationship between a country's Human Development Index (HDI) ranking and the provision of emergency and continuing medical care. States Parties with higher HDI rankings tend to have better emergency and continuing medical care, while countries that are underdeveloped continue to struggle to meet the basic needs of the population as a whole, including people with disabilities and, among them, landmine survivors.*

ICBL, *Landmine Victim Assistance in 2006: Overview of the Situation in 24 States Parties*, published by Standing Tall on behalf of the ICBL Working Group on Victim Assistance, 3rd Edition, April 2007, p. 12, victimassistance.files.wordpress.com/2014/06/landminevic2006.pdf.

Relevant development indicators for the period of the Mine Ban Treaty Nairobi Action Plan (2005-2009) can be found in country chapters examining progress in victim assistance in 26 States Parties in *Voices from the Ground: Landmine and Explosive Remnants of War Survivors Speak Out on Victim Assistance*, Handicap International (Brussels -September 2009), reliefweb.int/sites/reliefweb.int/files/resources/778DB759408546044925764500124 86A-Full_Report.pdf.

State Party	Disability rights			Health expenditure Total % of GDP					Physicians per 1,000 people 2007–2012
	CRPD	Regional strategies		1999 Baseline	2009	2010	2011	2012	
Afghanistan	18 September 2012	ESCAP, Incheon Strategy; Asian and Pacific Decade of Persons with Disabilities, 2013–2022	-	N/A	8.7	8.7	8.4	8.6	0.2
Cambodia	20 December 2012		ASEAN, Bali Declaration, 2011	6.2	6.3	5.8	5.6	5.4	0.2
Tajikistan	No		-	3.9	5.9	6	5.8	5.8	1.9
Thailand	29 July 2008		ASEAN, Bali Declaration, 2011	3.5	4.1	3.8	4.1	3.9	0.4

State Party	ILO 159	Human Development Index Rank	IDHI Value 2012	Health expenditure Per capita (US Dollars) 1999, 2009—2012					Out-of-pocket payments as a % of health spending
Afghanistan	7 April 2010	**175**/187	N/A	N/A	$35	$43	$48	$51	74.4
Cambodia	No	**138**/187	0.402	$18	$46	$46	$49	$51	61.7
Tajikistan	26 November 1993	**125**/187	0.507	$7	$40	$44	$48	$55	60.0
Thailand	11 October 2007	**103**/187	0.543	$70	$164	$183	$214	$215	13.1

Notes: "State Party" refers to those states that have ratified or acceded to the Mine Ban Treaty. "CRPD" is the Convention on the Rights of Persons with Disabilities. Statistics on health expenditure as a total percent of the gross domestic product are compiled by the World Bank and are available at: http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS. Physicians per 1,000 people: http://wdi.worldbank.org/table/2.15. "ILO 159" is the International Labor Organization's Convention on Vocational Rehabilitation and Employment of Persons with Disabilities (1983) http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:11300:0::NO::P11300_INSTRUMENT_ID:312304. The "IHDI" Inequality-adjusted Human Development Index is a measure of the level of human development of people in a society that accounts for inequality. Lower index numbers and rankings (out of 187) indicate a lower level of human development. It is published by the United Nations Development Programme at: data.undp.org/dataset/Table-3-Inequality-adjusted-Human-Development-Inde/9jnv-7hyp. Health Expenditure per capita in current US$: http://data.worldbank.org/indicator/SH.XPD.PCAP/countries. Out-of-pocket payments as a percentage of health spending: http://wdi.worldbank.org/table/2.15.