VICTIM ASSISTANCE

During the Mine Ban Treaty's first decade, victim assistance (VA) has made the least progress of all the major sectors of mine action, with both funding and the provision of assistance falling far short of what was needed. This is despite the treaty's promise in Article 6.3 that, "each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims…"

At the First Review Conference in Nairobi in November–December 2004, States Parties reaffirmed their promise to do "their utmost" to assist survivors by agreeing to undertake a set of actions to improve services, strengthen coordination, and ensure participation of survivors in decisions that affect them from 2005–2009.[1] Yet, by May 2009, the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration indicated that this promise had not been fulfilled. According to the co-chairs, "The challenges faced in 2009 are to a large extent identical to those faced in 2004 and likely will be the same as those to be faced in 2014."[2]

Certainly, VA coordination has improved and there is greater awareness of survivors' needs, but service provision has not improved significantly, particularly in the last five years. While many survivors have received some form of assistance through the years, services have had too many gaps, and been too unsystematic and unsustainable to improve the living conditions of most in any lasting way. Most efforts remained focused on medical care and physical rehabilitation, often supported by international organizations and funding, rather than on promoting economic self-reliance for survivors, their families, and communities.

At the First Review Conference, States Parties agreed that 23 States Parties with significant numbers of survivors should make special efforts to meet their needs. Throughout 2005–2009, progress among these now 26 States Parties has been variable, with some countries actively engaging and others hardly at all. Progress was mostly visible in coordination aspects, rather than in implementation of actual services, even by those who made significant advances, as many of the so-called VA26's objectives related to data collection, strategies, awareness-raising, and coordination. Progress on activities was often unrelated to the plans the 26 countries set for themselves.

At the Second Review Conference in November 2009, States Parties are expected to renew, if not reinforce, their political commitment to "ensure the full and effective participation and inclusion" of the "victims."[3] Yet these individuals—hundreds of thousands of men, women, and children across more than 120 countries—need more and better assistance, not more unfulfilled promises, and they need it now.

[1] "Ending the Suffering Caused by Anti-Personnel Mines: Revised Draft Nairobi Action Plan 2005–2009," APLC/CONF/2004/L.4/Rev.1, 5 November 2004, Actions 29–39. The 11 concrete actions include pledges to increase and improve medical, rehabilitation, psychosocial and economic reintegration services, as well as casualty data collection capacities and legal frameworks. Additionally, States Parties were called upon to allocate sufficient resources, include survivors and experts in relevant discussions, and report regularly on progress.

[2] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Victim Assistance in the Context of the AP Mine Ban Convention—Priorities and challenges during the period 2010–2014," Geneva, 29 May 2009, p. 8.

[3] "A Shared Commitment, Draft Cartagena Action Plan 2010–2014: Ending the Suffering Caused by Anti-Personnel Mines," Geneva, 17 July 2009, p. 4. Victim in this context means the directly-affected individuals, their families, and their communities.

Survivor Inclusion

According to the Nairobi Action Plan, States Parties need to "ensure effective integration of mine victims in the work of the Convention."[4] The draft Cartagena Progress Review notes that, "States Parties have come to recognise the importance of the inclusion and active participation of mine victims and other persons with disabilities" in VA.[5]

Drawing on lessons from the Mine Ban Treaty, the negotiation of the Convention on Cluster Munitions involved survivors more extensively, contributing to stronger VA obligations. Many States Parties to the Mine Ban Treaty have joined the UN Convention on the Rights of Persons with Disabilities, in which participation of persons with disabilities was underscored by the call "nothing about us without us." In practice, however, only a few Mine Ban Treaty States Parties (for example, **Afghanistan**, **Albania**, **Tajikistan**, and **Uganda**) have fulfilled their commitment to involve survivors in planning, implementation, and monitoring of VA activities at local, national, regional, or international levels.

From 2000–2001, "raising the voices of landmine survivors" was one of the key themes at intersessional Standing Committee Meetings. In 2003–2004, Croatia, as co-chair of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, encouraged the participation of survivors in State Party delegations to improve coordination with civil society and was one of very few delegations to Meetings of States Parties to regularly include a survivor from 2005–2009.

Most survivors participating in international meetings were sponsored by civil society, such as the Raising the Voices program run by Landmine Survivors Network and its successors, or the ICBL VA focal point network.[6] Civil society-organized survivor participation culminated in the Survivor Summit in November 2004 bringing together survivors from 30 countries and government representatives to discuss survivors' needs. They submitted a declaration to the First Review Conference reiterating that governments should do more to ensure the rights and needs of survivors are met, and that survivors should be included in decision-making.[7]

At the national level, assessing survivors' needs by consulting them directly is key to increasing both effectiveness and efficiency of services. Yet a survey of more than 1,500 survivors published by Handicap International (HI) in September 2009 found that just one in five respondents thought that survivors were included in VA/disability coordination and only one in four thought that VA plans were based on the needs of survivors. The study noted that 38% of respondents believed that survivors were involved in implementation of activities, but added that, "this percentage is likely too high as many respondents were NGO, DPO [disabled people's organizations] or survivor organization members."[8]

At international meetings, States Parties reported regularly on VA, although this was often not accompanied by the provision of regular information domestically, resulting in a lack of information on services and on VA achievements among survivors. The HI study noted that just 17% of survivors thought that they received regular information on VA/disability achievements:[9] "When asked if they had a final comment, survivors most often said that this survey was an opportunity to get people to finally 'Listen to Us'."[10]

[4] "Final Report, First Review Conference of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction," Nairobi, 29 November–3 December 2004, APLC/CONF/2004/5, 9 February 2005, p. 101.

[5] "Draft Review of the Operation and Status of the Convention on the Prohibition of the Use, Production and Transfer of Antipersonnel Mines and on their Destruction: 2005–2009," Geneva, 17 July 2009, p. 24.

[6] Between 2000 and 2004, 62 survivors from 37 countries/areas participated in the Raising the Voices program, which later became Widening the Voices, and Expanding the Voices.

[7] "The Survivor Summit Declaration," www.icbl.org.

[8] HI, "Voices from the Ground: Landmine and Explosive Remnants of War Survivors Speak out on Victim Assistance," Brussels, 2 September 2009, p. 232 (hereinafter HI, "Voices From the Ground").

[9] Ibid, p. 232.

[10] Ibid, p. 2.

Landmine Monitor has found that while some countries made efforts to include survivors in activities, this was not systematic and was hampered by the limited means and capacities of survivor organizations or DPOs.

Afghanistan made concerted efforts to include survivors in workshops, though DPOs and survivors noted that coordination with the government remained difficult and that more activist organizations were often excluded. In **Colombia**, most survivors were not aware of their rights or services available to them, and occasional "survivor meetings" of the mine action program reached only a few of them. After initially excluding survivor organizations, **El Salvador** included them in VA work as of mid-2007, though most survivors still felt excluded as improved planning had done little to improve their daily lives. In **Uganda**, stakeholders said the main achievement since 1999 had been the increased autonomy of survivor associations. However, the government was unable to assist the national umbrella organization; blocked international funding hindered associations' activities; and logistical challenges made it difficult for associations, particularly from the west, to participate in meetings.

Victim Assistance Implementation

2008–2009: A status quo?

From 2008–2009, there was a continued lack of psychosocial support and economic reintegration even where there were improvements to national healthcare, physical rehabilitation, or disability laws/policies. The global economic crisis was cited for setbacks in placing survivors in jobs, for example by government representatives in **Serbia** and by survivors themselves in **Thailand**. Some countries, such as **Pakistan** and **Sri Lanka**, saw deterioration of services nationwide or in certain areas because of conflict and natural disasters.

Other trends included: the continuing handover of physical rehabilitation programs to national management and a continued increase of survivor associations and/or their capacities. On the downside, this period also saw the closure of several national NGOs/DPOs, continued capacity problems for others, and persistent funding challenges.

Understanding the needs

Accurate data about the number of survivors and their needs is critical to VA. Mostly, even countries with relatively complete casualty data continued to lack usable information about survivors' needs or services received. As in previous years, certain states aimed to improve this type of information through surveys or data consolidation, such as **Chile** or **Lao PDR**. A number of states (e.g. **India**) conducted disability surveys which could indirectly improve services relevant to mine/ERW survivors. **Azerbaijan** initiated a needs assessment of persons with disabilities and started offering skills development services as a result. **Thailand** completed a comprehensive casualty survey and needs assessment establishing the baseline for future planning and implementation of services.

Elsewhere, delays in setting up disability or injury surveillance mechanisms were cited as a reason for not collecting information on survivors' needs. At the same time, a few states made progress in VA entirely dependent on better data, notably in **Angola**, **Croatia,** and **Serbia**. As of 2009, Bosnia and Herzegovina (**BiH)** had not completed the casualty data revision project planned since 2006, and data on VA services, which had previously been available, had not been collected. In **Cambodia**, a survivor survey was shelved because it was deemed discriminatory towards other persons with disabilities by external technical advisors. This survey was one of Cambodia's main 2005–2009 objectives to mitigate the negative impact of the continued lack of disability information on VA.

Emergency and continuing medical care

Improvements in medical care received by survivors were nearly always the result of efforts to improve healthcare for all, thus also benefiting survivors. As in earlier years, these gains were unrelated to VA planning, and were part of large-scale international development assistance or post-conflict reconstruction programs (**Ethiopia**, **Iraq,** and **Lao PDR**), improved economic situations (**Armenia**, **Azerbaijan,** and **Chechnya**), or more socially-oriented government programs (**Nicaragua**).

Notable exceptions in 2008–2009 were in **Albania**, where improvements to emergency medical care were based on the needs of survivors in its mine-affected northeast region and resulted from strategic VA planning; and **Thailand,** where general emergency medical services were expanded to reach adequate coverage, which was at the same time coherent with VA needs and plans.

Sometimes, infrastructure improvements happened but states lacked the capacity to utilize these improvements to enhance service provision, as in **Angola**. Conflict damaged or prevented the maintenance of medical systems in several countries (**Pakistan**, **Somalia,** and **Sri Lanka**). Conflict also prevented survivors from accessing existing facilities, such as in the Casamance region (**Senegal**) and the Kivu region (**Democratic Republic of the Congo**, **DRC**).

Physical rehabilitation

From 2008–2009, as in all previous years of the last decade, steady advances were made to physical rehabilitation. Services improved because of increased availability (new facilities or increased production), as in **BiH**, **Jordan,** and **Western Sahara**. In other cases, more efficient management and planning, sustained training and on-the-job capacity-building, or the establishment of minimum standards and curricula led to advances (**Afghanistan** and **El Salvador**). In **Nicaragua**, the government restructured the management of physical rehabilitation, began developing a national plan specifically for physical rehabilitation, and increased national funding.

Transition to national structures continued (**Azerbaijan**, **Ethiopia,** and **Tajikistan**), and a number of handovers prior to 2008–2009 were evaluated positively (for instance, the Juba Teaching Hospital in **Sudan**). Elsewhere, a deterioration of services in 2008–2009 was directly linked to the reduction of international support and the failure of national players to increase their role accordingly, such as **Algeria**. Despite a handover process started in 2001, none of the **Angolan** rehabilitation centers were fully functional—and services had deteriorated to levels worse than 2005—after the last international operator departed in August 2008. Some said the handover to national ownership was insufficiently prepared; many experts thought the main reason was a lack of Ministry of Health interest.

Some countries were able to operate solely on national capacity (**Armenia**, **Chile**, **Croatia,** and **Thailand**). In many more countries improvements to services remained heavily dependent on international support. While a three-year handover of rehabilitation services in **Cambodia** was initiated in mid-2008, the government achieved less than 50% of its targets for 2008 and international operators guaranteed all services. International operators expected that the government would not be capable of managing the sector by the end of 2010 as foreseen, although international funding for NGOs was decreasing. In **Guinea-Bissau**, the only operating physical rehabilitation center, which was NGO-run, lacked personnel for most of 2008 and its production decreased by 50% compared to 2007, despite increased international support.

Most services remained centralized although a few countries sought to increase the number of mobile workshops and outreach services, such as **El Salvador** and northern **Sudan** (albeit planned since 2005). The HI survivor study revealed that, in **Albania**, few survivors thought they could access services closer to home, even though a new center opened by early 2008 and a repair unit had been upgraded.[11] In **Iraq**, although rehabilitation centers were made operational nationwide so that patients would not have to travel great distances, fewer people came to the centers due to transport costs, insecurity, and a lack of information about the availability of services.

Psychological support and social reintegration

Despite a chronic lack of psychosocial support services for survivors, government institutions often failed to address the issue, leaving this type of assistance to family or friends, local NGOs, and DPOs or survivor organizations. The latter gradually gained more attention and some managed to expand activities, but for the vast majority of organizations, sustainability remained precarious due to a lack of financial support or capacity-building. Moreover, 2008–2009 saw the closure of several well-established survivor organizations citing financial and sustainability issues (**Serbia**), and reduced capacity due to management changes (**Peru**).

[11] Ibid, p. 25.

In **BiH**, **El Salvador,** and **Ethiopia,** existing survivor networks previously depending on the NGO Survivor Corps were transitioning to national organizations and in doing so expanded the scope of their work. In **Cambodia**, self-help groups continued to multiply, although coordination or exchanges of lessons learned between groups or the NGOs supporting them did not happen. Also, the groups' primary function was financial rather than psychosocial, and some were contribution-based, thereby excluding many survivors.[12] The only remaining survivor NGO in **Croatia** closed in 2008, following the closure of the largest one, the Croatian Mine Victim Association, in 2007.

In countries such as **Burundi** and **Senegal**, international NGOs provided psychosocial services but usually targeted all war-traumatized people, or increasingly focused on other groups of war victims rather than mine/ERW survivors, for example rape victims in the **DRC**.

Economic reintegration

The HI survey noted that 85% of survivors thought that they were the last to get jobs.[13] Indeed, few advances were made to increase survivors' access to education and vocational training, to help secure employment, or to receive sufficient pensions. Many countries recognized economic reintegration as an absolute priority, but also acknowledged making the least progress in this area (**Afghanistan**, **El Salvador,** and **Serbia**). Others reported that economic reintegration projects were postponed or ended due to lack of funds (**Guinea-Bissau**).

Elsewhere, VA programs remained more focused on medical interventions and failed to recognize the importance of economic reintegration, for example in **Yemen**. Two long-term international funding commitments (to 2011) enabled national NGOs to boost economic reintegration activities in **Sudan**. However, most were small-scale pilot projects, not all were reselected for second-phase contributions, and insufficient attention was given to following training programs with work opportunities.

Some countries reported advances in economic reintegration opportunities through the disability sector or, at least, adhered to the theory of integrating survivors in broader disability and development projects, for example in **India** and **Nicaragua**. Even when measures to this effect were taken, they did not necessarily lead to increased opportunities for mine/ERW survivors, since they were only one among many vulnerable groups seeking to receive assistance. The general economic slowdown in 2008–2009 further reduced economic prospects.

In some countries pensions increased, such as **El Salvador** and **UK**. **Croatia** established a department for persons with disabilities within the national employment agency and gave financial incentives to those employing persons with disabilities. In 2009, however, a government representative reported that employment rates remained low and that persons with disabilities were often fired as soon as companies' financial benefits ended.

Laws and public policy

New disability laws, policies, and/or coordination structures were developed in many countries, such as **Afghanistan**, **Montenegro**, **BiH**, **China**, **Namibia,** and **South Korea**.[14] Elsewhere, legislation had been pending for so long that it was in need of adjustment by the time of approval (for example, in **Cambodia**). In other countries, legislative changes intended to benefit survivors remained pending for most of the last decade, for example in **Eritrea** and **Guinea-Bissau**. In other cases, the development of new legislation had an adverse effect, making the legal framework too complex, laws mutually exclusive, or reducing the number of sources for assistance. **Colombia**, for example, aimed to mainstream complex compensation mechanisms because survivors could not navigate the bureaucracy. While bureaucracy remained complex, a new decree actually limited access to services because the time to apply was reduced, documentation requirements were made stricter, and funding channels reduced.

[12] This means that a survivor needs to be able to make monthly (or other) payments into the group's fund in order to be able to make use of the group's support.

[13] HI, "Voices from the Ground," Brussels, 2 September 2009, p. 235.

[14] Of the 75 countries with casualties in 2008, 62 had specific or general legislation prohibiting discrimination against persons with disabilities. Legislative efforts were pending in two more (Eritrea and Guinea-Bissau).

Much of this legislative activity was the result of countries starting to align their disability legislation with the UN Convention on the Rights of Persons with Disabilities (UNCRPD); this effort should benefit survivors as well as other persons with disabilities.[15] Sometimes survivors have been mentioned as a specific target group, for example in **Sudan**. It is still too early to determine if these laws will be enforced and positively impact survivors.

1999–2009: Decade of known and unresolved challenges

Information and understanding about survivors have improved significantly since 1999. Since then, however, Landmine Monitor reported the same unmet challenges to VA service provision, i.e. that in the vast majority of countries "one or more aspects of [VA] were inadequate to meet the needs of mine survivors."[16]

The conclusion in 2009 can only be that, although there is better knowledge and more services, this has failed to impact survivors in a systematic way. In the 2009 HI survey, survivors reached similar conclusions: just over 25% found they received more services in 2009 than in 2005 and 28% thought that services were better in 2009 compared to 2005.[17]

Survivor challenges

Survivors did not receive the assistance they needed when they needed it due to access, cost, availability, bureaucratic, and discrimination challenges.

Already in 2001, it was noted that most resources were dedicated to medical and physical rehabilitation;[18] in 2009 economic reintegration and psychosocial support remained neglected. HI's survey found that from 2005–2009, survivors saw most progress in medical care (36%). Apart from being virtually non-existent, psychosocial services remained under-valued and stigmatized.[19]

Since 1999, better national legislation and an increasingly strong international framework (with the UNCRPD), has resulted in increased disability awareness among the general public and legislators. In practice, disability legislation remained poorly implemented, budgets not allocated to disability strategies, and activities virtually not monitored. Recourse to action if rights were not respected was often unavailable, bureaucratic procedures complicated, and compensation payments not worth their while. The lack of legislative enforcement was most felt in the areas of economic opportunities and physical accessibility.

Economic reintegration was the area where nearly a quarter of survivors in the HI study saw deterioration.[20] Programs remained limited in number of beneficiaries, geographic coverage, and timeframe, and were mainly operated by NGOs with fluctuating funding. Programs did not meet market demands or survivors' needs and training was not followed by job placement or business opportunities. Vocational training required educational levels many survivors did not have, did not cater to the aging survivor population, and was not inclusive of family members. Survivors were often not granted loans because they were considered high-risk groups and employment quotas were not enforced.

Almost everywhere, basic (mostly medical) services in 2009 were available at the community level. In contrast, specialized services remained, as noted in 2002,[21] centralized in urban areas far away from the mine-affected rural areas where most survivors live. Community-based

[15] As of 15 September 2009, there were 142 signatories to the UNCRPD, and 66 ratifications. In addition, 85 states signed the Optional Protocol and 44 ratified it. Of the so-called VA26, 17 signed the UNCRPD (16 on 1 September 2008) and 10 ratified it (six on 1 September 2008); 13 signed the Optional Protocol (10 on 1 September 2008) and seven ratified it (three on 1 September 2008). See *Landmine Monitor Report 2008*, p. 43.

[16] See for example *Landmine Monitor Report 2003*, p. 1, 43. *Landmine Monitor 2003* states there was inadequate services in 48 of 61 countries in 2002; *Landmine Monitor Report 2004*, p. 47. *Landmine Monitor 2004* states there was inadequate services in 53 of 66 countries with casualties in 2003–2004; *Landmine Monitor Report 2005*, p. 52. *Landmine Monitor 2005* states there was inadequate services in 51 of 58 countries with casualties in 2004–2005; and *Landmine Monitor Report 2007*, p. 59. *Landmine Monitor 2007* states that only around one-quarter of services in countries with casualties were adequate.

[17] HI, "Voices from the Ground," Brussels, 2 September 2009, p. 230.

[18] See *Landmine Monitor Report 2001*, p. 41.

[19] HI, "Voices from the Ground," Brussels, 2 September 2009, pp. 230–231.

[20] Ibid, p. 231.

[21] See *Landmine Monitor Report 2002*, p. 45.

rehabilitation increased though it remained limited. Rural facilities had difficulties coping with emergency and trauma situations and emergency transport or fast response times were inadequate, despite road and infrastructure improvements in many countries. This led the ICRC in 2009 to call for more investment in emergency services in affected areas because too many casualties "never become survivors."[22]

Whereas basic services are often free, specialized or follow-up care usually are not, especially for the uninsured, nor are costs of transportation, accommodation, or accompaniment by a caregiver. NGOs have increased their efforts in providing transport and accommodation, sometimes with local authorities, although these efforts only cover the identified beneficiaries and are often by reimbursement, which does not solve survivors' initial financial problems. Many survivors' economic situation does not allow them to be away from home or work for a long time, causing them to postpone or forego essential treatment. Long waiting lists further complicate the situation.

Despite calls for a holistic approach to VA, many actors focus on one aspect, do not refer systematically to other types of services, and teams in centers are not multi-disciplinary. Referral systems were often non-existent or deficient. A lack of awareness about available services, as well as bureaucratic obstacles to survivors receiving them, further exacerbated already significant difficulties for survivors. Overall, services for military survivors remained better than those for civilians.

Operator challenges

Most operators have had to face significant challenges in delivering assistance to mine/ERW survivors. First, while steady progress has been made in training physical rehabilitation staff, nurses, and first-aid responders since 1999, professionals trained in trauma care or formal psychological support, and teachers educated in disability issues, remained uncommon. Increased technical and management training was still needed for many staff, DPOs, and government stakeholders. Qualified staff, particularly specialized professionals, are usually concentrated in urban centers. Retaining well-trained staff has also proved to be a problem, particularly when programs were handed over to national management, or when competing with neighboring countries, the private sector, or NGO salaries.

Infrastructure, equipment, and supply shortages remained more common in rural areas, even though they were also a challenge in urban facilities. Cost issues were a particular problem for continuing medical care and physical rehabilitation (often requiring purchase of equipment and goods from abroad).

Increasingly, minimum standards and guidelines have been developed for the physical treatment and care of survivors, and also for mental health, though their systematic implementation as well as the sharing of lessons learned remains a challenge. VA continued to be carried out without sufficient casualty and service data. When data exists, it is not always used for planning, shared, or stored centrally, as evidenced by the difficulties of the VA26 countries in compiling statistical information for the Cartagena Progress Review.

International cooperation

The draft Cartagena Progress Review noted that, "a lack of financial resources and/or technical support continues to limit the potential for progress in some States Parties to develop and/or implement plans…States Parties in a position to do so are obliged to provide assistance..."[23]

Throughout 1999–2009, VA remained the smallest component of mine action funding, despite calls for increased and sustainable funding to match the long-term nature of VA/disability assistance. Increasingly, handovers and NGO pullouts were hurried by donor fatigue, even

[22] "Proposals for the Cartagena Action Plan: compilation of key issues highlighted by the ICRC during the Standing Committee Meetings and the First Preparatory Meeting," provided by email from Camilla Waszink, Policy Adviser, Arms Unit, Legal Division, ICRC, 9 June 2009.

[23] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of implementation of the Convention in relation to victim assistance," Geneva, 26 May 2009, p. 3.

when national entities were only slowly increasing their contributions and lacked the financial resources to continue programs after international organizations had withdrawn.

Of the 20 countries with significant numbers of survivors which responded to an open question on their expectations for VA from 2005–2009, 18 had expected to receive increased financial and technical assistance, and 14 felt they had not received such support. Just one in seven donors deemed international contributions to VA sufficient, most often citing the continuing high levels of need and competing public health priorities in many recipient countries. Nevertheless, they added that unless affected countries could cover their own VA needs in 10 years or less, they would never be fully able to.[24]

Victim Assistance Strategic Framework

2008–2009: cementing slow-paced progress

In 2008, Landmine Monitor stated that, with one year left, the VA26 States Parties [25] would have to increase their efforts if they truly wanted to make a difference in the lives of survivors in 2005–2009.[26] In 2008–2009, most progress was made in the following countries:

- **Albania**, the most consistent performer on VA from 2005 to 2009, completed or made significant progress towards all its objectives.
- **Afghanistan** and **Sudan** both started implementing their action plans and could demonstrate significant advances even though a good number of objectives remained unachieved.
- **Tajikistan** for the first time received funding sufficient to further its needs-based plan, although it had been able to maintain some small-scale activities and consistent coordination throughout 2005–2009.
- **Thailand's** improvements were based on finding a more appropriate VA coordination body and increased prioritization.
- **Jordan** made a promising start by identifying a focal point with a significant mandate, starting stakeholder consultations on how to effectively integrate VA into the disability sector while still ensuring that the special needs of survivors are met.
- **Cambodia** finalized its VA/disability action plan in February 2009, though operators have indicated the plan is too broad and may be unrealistic given current government capacity.
- In **Nicaragua**, the more socially-oriented government made progress in the health and disability sectors. This benefited survivors but was unrelated to VA planning.
- The **Peruvian** mine action center focused more on VA in 2009 by expanding the VA committee and holding regular meetings, though the benefits had yet to be felt by survivors.

Deterioration was seen in **Yemen** during the reporting period because the mine action program's VA department was forced to scale back its operations due to reduced national funding. The funds given were earmarked for clearance. As the program did not link with the disability sector, it was unable to identify funding and assistance alternatives, creating a dire situation for survivors solely dependent on the VA department. **Iraq** expected to have a VA focal point by the Second Review Conference but remained largely unengaged despite indicating in July 2008 that it was responsible for a significant number of survivors.

For the remainder of the VA26 countries, activities continued, though the status quo appears largely to have prevailed.

- **Burundi**, **Chad,** and **Guinea-Bissau** were unable to make progress due to incessant capacity and funding gaps.

[24] HI, "Voices from the Ground," Brussels, 2 September 2009, pp. 227–228.

[25] Afghanistan, Albania, Angola, BiH, Burundi, Cambodia, Chad, Colombia, Croatia, DRC, El Salvador, Eritrea, Ethiopia, Guinea-Bissau, Iraq, Jordan, Mozambique, Nicaragua, Peru, Senegal, Serbia, Sudan, Tajikistan, Thailand, Uganda, and Yemen.

[26] See *Landmine Monitor Report 2008*, p. 39.

- In **Senegal**, the mine action center was unable to raise funding for VA and did not know which ministry it had to turn to for disability issues.
- Despite elaborate plans and well-established disability structures, progress in **Uganda** remained hindered by funding blockages and the lack of a technical advisor in 2008.
- In **Angola**, **BiH**, **El Salvador,** and **Mozambique** the main obstacle was a lack of authority by the coordinating body (often combined with funding/capacity constraints).
- Progress in the **DRC** and **Ethiopia** was hampered by continued ambiguity about who was in charge of coordination and a lack of government backing, among other reasons.
- In **Colombia** the VA coordinating body focused on planning rather than implementation, while in **Serbia** the focus was purely on physical rehabilitation.
- In several cases a lack of political will or involvement was noted, as in **Croatia** or **Eritrea**.

1999–2009: coordination successful while implementation failed?

The co-chairs noted in May 2009 that "Of course the most identifiable gains have been process-related…"[27] This is confirmed in the draft Cartagena Progress Review which lists developing objectives/plans, establishing coordination mechanisms, and VA/disability expert participation at international meetings among the main successes for 2005–2009. In 2004, Landmine Monitor similarly concluded that the main progress since 1999 had been awareness-raising.[28]

Increased state participation

Whereas in 1999 international NGOs and the ICBL dominated the VA discourse, in more recent years the co-chairs gradually succeeded in engaging affected and donor states on VA, although interventions were usually "one-off" or just listed international NGO activities. More importantly since 2005, States Parties started to send appropriate people from health or social affairs ministries or from the disability sector to discuss VA at Mine Ban Treaty-related meetings. Whereas in 2004 just two of 19 statements were given by VA/disability experts, by 2009 this increased to 15 of 22.[29] Some government experts have continuously participated from 2005–2009, although for most states the expert changed frequently and/or was present irregularly.

Already in 1999, the establishment of national coordination bodies was seen as necessary to bring together stakeholders and improve services.[30] A 2002 UN Mine Action Service consultation concluded that national coordination and planning was a key priority to ensure adequate assistance.[31] Affected countries were encouraged to report more often and to use the so-called 4P's format (plans, priorities, progress, and problems). By 2004, at least 22 States Parties had started developing VA action plans, including at least 13 of the future VA26, some of whom still did not have complete plans as of 2009.[32]

Narrowing the focus to 26 states

Although all States Parties have a commitment towards survivors, the primary responsibility for the period 2005–2009 was placed on affected states. Because of significantly different development, contamination, and political contexts, affected countries should be directly in charge of determining the goals they wanted to achieve by the next milestone Review Conference

[27] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of implementation of the Convention in relation to victim assistance," Geneva, 26 May 2009, p. 2.

[28] See *Landmine Monitor Report 2004*, p. 47.

[29] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Status of implementation of the Convention in relation to victim assistance," Geneva, 26 May 2009.

[30] See *Landmine Monitor Report 2000*, p. 32.

[31] See *Landmine Monitor Report 2003*, p. 65.

[32] Albania, Angola, *BiH*, Cambodia, *Chad*, *Colombia*, *Eritrea*, *Guinea-Bissau*, *Mozambique*, *Nicaragua*, Sudan, Thailand, and Yemen. See *Landmine Monitor Report 2004*, pp. 62–63 (those without plans in italics).

of the Mine Ban Treaty in 2009. Since 2004, "this responsibility is most pertinent"[33] for 23 (now 26) States Parties declaring responsibility for significant numbers of survivors, but also with the "greatest needs and expectations for assistance."[34]

During 2005–2009, these 26 countries participated in an informal process to ensure more measurable action[35] by committing to:

- assess their VA situation;
- develop SMART (specific, measurable, achievable, relevant, and time-bound) objectives to be achieved by 2009;
- create plans to achieve the objectives; and
- identify resources to realize the plans.[36]

These states were also encouraged to set up inter-ministerial coordination mechanisms. Their main tool was a questionnaire provided by the co-chairs in 2005. No other States Parties and just one state not party to the Mine Ban Treaty (Lebanon) have used the questionnaire to guide their activities.

Throughout 2005–2009, progress among the VA26 has been variable, with some countries actively engaging and others hardly at all. Progress was mostly visible in coordination aspects, rather than in implementation of services, even by those who made significant advances, as many of the VA26's objectives related to data collection, strategies, awareness raising and coordination. Progress on activities was often unrelated to the plans the 26 countries set for themselves. In many cases, achievements owed much to sustained UN support or to continuity in the VA focal point position. Gaps in capacity and financial means have been reported throughout the period.

Between 2005 and July 2009:

- **22 of the 26** States Parties presented the scope of their problem and objectives, although the latter were often not SMART and incomplete;[37]
- **13** countries convened workshops on VA and/or action plans, which did not always lead to the development of plans or better coordination;[38]
- **12** states refined their objectives to make them SMART-er, which sometimes meant making objectives less ambitious, extending timeframes, or removing specific beneficiary targets;[39]
- **12** countries developed inter-ministerial coordination mechanisms to implement action plans; in at least 50% of these countries, these mechanisms are not functioning;[40]
- **10** developed VA/disability plans. Because of the slow pace in developing them, most plans did not cover the first part of the 2005–2009 timeframe and extend past 2009;[41]

[33] "First Review Conference of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction – Final Report," APLC. CONF/2004/5, Nairobi, 29 November–3 December 2004, p. 33.

[34] Ethiopia became the 24th State Party shortly after the First Review Conference, Jordan the 25th in 2007, and Iraq the 26th in 2008.

[35] They received "process support" for this from the Geneva International Centre for Humanitarian Demining (GICHD) Implementation Support Unit Victim Assistance Specialist Support through in-country visits, requested by all of the 26 States Parties except Eritrea, distance support (for example via email), outreach to other relevant organizations, and assistance with workshop organization.

[36] Kerry Brinkert, "Making Sense out of the Anti-Personnel Mine Ban Convention's Obligations to Landmine Victims," GICHD, Geneva, 31 March 2006.

[37] Burundi, Chad, Iraq and Jordan did not present this, although the latter two joined the informal process more than half-way through.

[38] Afghanistan, Albania, Angola, BiH, Cambodia, El Salvador, Ethiopia, Nicaragua, Senegal, Sudan, Tajikistan, Thailand, and Uganda.

[39] Afghanistan, Albania, Angola, Cambodia, Croatia, DRC, El Salvador, Nicaragua, Serbia, Sudan, Tajikistan, and Uganda.

[40] Afghanistan, Albania, Angola, BiH, Cambodia, Chad, DRC, El Salvador, Sudan, Tajikistan, Thailand, and Uganda. The coordination body is not functioning in Angola, BiH, Cambodia, Chad, DRC, and El Salvador.

[41] Afghanistan, Albania, Angola, Cambodia, El Salvador, Sudan, Tajikistan, Thailand, Uganda, and Yemen.

- **seven** countries implemented plans, though several only started in 2008–2009 because of the time taken to develop and/or approve plans and a lack of financial means;[42]
- **six** "have reported progress in the achievement of specific objectives;"[43] and
- **three** states adequately monitored progress made against the plan (**Albania**, **Sudan**, and **Tajikistan**); and
- just **two** report on progress systematically (**Albania** and **Tajikistan**).

Reporting

It was recognized in the first years of Mine Ban Treaty implementation that better VA reporting was needed to assess progress. The development of Form J of the Article 7 reports started in 1999–2000 and the (ultimately blank) Form J was adopted in 2001. Since then, the need to further develop progress indicators has been a recurrent theme. As of 2009, the challenge of measuring progress, particularly in states' own reporting, has not been remedied even though the questionnaire of the co-chairs was to serve as a baseline for "an unambiguous assessment of success or failure" by the Second Review Conference.[44]

Very few states have adequate monitoring mechanisms. A review of VA statements and Article 7 reports in 2008–2009 by Landmine Monitor showed clearly that states' reports were usually unrelated to objectives or plans, did not clarify progress compared to previous years, or explain the impact of activities on survivors.

The focus on the VA26 also made statements from other affected states increasingly infrequent throughout 2005–2009, even though some, such as **Algeria** or **Turkey,** struggled with a significant VA challenge. In May 2009, the ICRC stated, "We urge States [P]arties at the Review Conference to call for the development of more standardized and rigorous reporting and monitoring of the implementation of victim assistance commitments," adding that this was "essential to maintaining a focus on victim assistance beyond the Review Conference and demonstrating that it is an area of implementation that merits increased investment."[45]

National Commitment and Capacity

In June 2008, the co-chairs noted that national ownership was "not a specific aim of the *Nairobi Action Plan*, perhaps because it should go without saying…"[46] More national ownership means improved VA coordination, ideally by the relevant ministries assessing needs and developing strategies adapted to local realities; placing organizations under national management; and increasing national budgets and abilities to mobilize external resources.

Since 2004, the co-chairs aimed to "work intensively, on a national basis with relevant States Parties in order to reinforce national ownership and ensure […] long-term sustainability."[47] VA became more effective when there was an ongoing, active involvement of national coordination bodies. Better coordination also helped to ensure participation of key stakeholders, more balanced priority-setting, better defined responsibilities, and increased accountability. Dialogue remained flawed when strategies were developed by one key player, often an expatriate, without consulting others, meaning that plans were not realistic nor had a broad base of support.

[42] Afghanistan, Albania, Sudan, Thailand, Tajikistan, Uganda, and Yemen.

[43] Afghanistan, Albania, Serbia, Sudan, Tajikistan and Yemen; see "Draft Review of the Operation and Status of the Convention on the Prohibition of the Use, Production and Transfer of Antipersonnel Mines and on their Destruction: 2005–2009," Geneva, 17 July 2009, p. 24.

[44] "Mid-Term Review of the Status of Victim Assistance in the 24 Relevant States Parties," Eighth Meeting of States Parties, Dead Sea, 21 November 2007, p. 6.

[45] ICRC, "Notes for ICRC intervention under the agenda item 'Towards the Second Review Conference and beyond,'" Geneva, 29 May 2009.

[46] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Towards the Second Review Conference," Geneva, 6 June 2008.

[47] "Draft Review of the Operation and Status of the Convention on the Prohibition of the Use, Production and Transfer of Antipersonnel Mines and on their Destruction: 2005–2009," Geneva, 17 July 2009, p. 23.

Even when coordinating bodies existed this did not mean that they could coordinate without assistance, or could do so systematically. Their merit was often limited to awareness raising or liaison, without much effect on activity implementation. Giving the VA focal point or coordinating body more authority, as happened in **Afghanistan**, **Azerbaijan,** and **Thailand**, is a sign of increased ownership. The most common problems related to the lack of a mandate to direct other relevant government partners; competing claims of who is in charge; a lack of continuity in the coordination position; a lack of ministerial budgets; and a lack of political will. Responsibility for VA was often scattered among several bodies, just one of many competing priorities, or not integrated with the broader disability sector.

In 2001, Landmine Monitor noted that "it is essential that the international community focuses on local capacity-building…"[48] Increased government involvement has resulted in VA no longer being 'a mere NGO program' with national NGOs and DPOs increasingly participating and some sustainable handovers of programs to national authorities. Yet sustained international support remained indispensable in many more countries. In **Eritrea**, UNDP noted in 2004 that the "most comprehensive [VA] program in the world"[49] could be established, though activities seem to have halted as soon as Eritrea requested its UN technical advisors leave in mid-2005 and very little has been done since to assist mine/ERW survivors there.[50]

In 2008–2009, international operators noted in several countries that no handover could be foreseen in the near future because of a lack of government capacity and/or will. In other places, transitions were hastened by decreasing funding or long-planned handover processes were not successful due to a lack of government interest, funding or capacity, directly impacting availability and quality of services (see Physical rehabilitation section above).

Sometimes, international operators have been substituting for the government for so long that there is an overdependence on them and decreased ownership, interest, and room for action by those who are primarily responsible—the national authorities. Additionally, there is increasing awareness that international operators have not invested sufficiently in training local counterparts.

As a result, nearly all the VA challenges listed in the draft Cartagena Progress Review relate to a lack of national commitment and capacities, mainly:

- non-prioritization of, and weak capacity to address disability issues and a lack of national ownership or interest to tackle VA/disability issues when faced with other competing priorities;
- weak state structures lacking bureaucratic, human resource, technical, and financial capacity to develop, implement, and monitor objectives, national plans, and legislation;
- inadequate resources to build government capacity; and
- inadequate long-term international assistance to remedy the national challenges.[51]

Conclusion: Victim Assistance to 2014

It is hard to explain why assistance to mine and ERW survivors has been poorly supported in the past, particularly when donors have been generous to other mine action sectors. One factor is that VA has been the "least developed of the Convention's core aims."[52] Additionally, throughout the past decade VA has been seen as a complicated field dependent on broader development, poverty reduction, public health, social services, and legislative efforts, requiring a long-term commitment for which concrete results might not be directly or visibly measurable. Improving

[48] See *Landmine Monitor Report 2001*, pp. 43–44.

[49] See *Landmine Monitor Report 2004*, p. 431.

[50] See *Landmine Monitor Report 2006*, p. 413.

[51] "Draft Review of the Operation and Status of the Convention on the Prohibition of the Use, Production and Transfer of Antipersonnel Mines and on their Destruction: 2005–2009," Geneva, 17 July 2009, pp. 25–26.

[52] Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, "Priorities and challenges during the period 2010–2014," Geneva, 29 May 2009.

VA is of course a difficult task when public health systems are beset with problems, especially in war-torn or developing societies. In providing VA, however, states are also reinforcing broader human rights, public health, and promoting social inclusion of vulnerable groups.

While the Mine Ban Treaty was the first conventional weapons treaty to include victim assistance provisions, more advanced VA frameworks are now provided in the Convention on Cluster Munitions and the UNCRPD. Combined with the clear lack of implementation progress, the Mine Ban Treaty will need a strong and implementation-oriented action plan to ensure more success in 2010–2014.

Synergies should be sought with both the Convention on Cluster Munitions and UN the UNCRPD which aim to provide a more systematic, sustainable approach to VA, bringing it into the broader disability and development context. The stricter obligations of both new treaties pave the path for more measurable action. The States Parties to the Mine Ban Treaty can again lead the way by implementing a concrete 2010–2014 Cartagena Action Plan in which survivors can access comprehensive services, fully exercise their rights, and participate in decisions when and where needed.