LANDMINE & CLUSTER MUNITION MONITOR
FACT SHEET
November 2011

Victim Assistance and the Cartagena Action Plan

The total number of survivors of landmines and explosive remnants of war (ERW) worldwide is not known, but is estimated to be in the hundreds of thousands.[1] The overall number of survivors is growing each year. In 2010, there were at least 3,000 more people injured from mines, victim-activated improvised explosive devices (IEDs), and ERW.

One of the aims of the Mine Ban Treaty's Cartagena Action Plan 2010–2014 (CAP) is to increase accessibility and availability of victim assistance services. Accessibility of services was recognized as the most neglected aspect of mine action up to the adoption of the CAP. This is the area with the greatest potential to have a positive impact in the daily lives of the growing number of survivors worldwide.

Monitor reporting indicates that since the adoption of the CAP, some progress, albeit slow, has been made by states in turning the CAP's vital promise into reality on the ground. For the most part, States Parties have maintained existing coordination mechanisms and national victim assistance plans. The vast majority of survivors have yet to experience increased assistance, but in some cases groundwork has been laid for future progress. Only a limited number of countries have started to address gaps in services in remote and rural areas where assistance is most needed by survivors. Those services reaching survivors in their own communities generally have been provided by NGOs.

To determine progress in implementing the victim assistance actions included within the CAP, the Monitor profiled changes and developments in victim assistance in 25 States Parties to the Mine Ban Treaty with significant numbers of survivors.[2] In total, 41 countries and areas with victim assistance activities, including 14 states not party and two disputed areas, were profiled using the same criteria. Changes were monitored in: victim assistance needs assessments; victim assistance coordination; survivor inclusion; accessibility, availability, and quality of services; and age and gender sensitive victim assistance.

Victim assistance needs assessments

States Parties have committed to collect all necessary data, disaggregated by sex and age, and to ensure that the data includes information on both the needs of survivors and the availability of relevant services.

Although data collection was not consistent, many States Parties made progress in conducting or using needs assessments. Information was disaggregated by sex and age in nearly every country with an official system for data collection. Angola, Chad, the Democratic Republic of the Congo (DRC), El Salvador, and Peru conducted assessments of mine/ERW survivors needs in 2010.[3] Bosnia and Herzegovina (BiH), Senegal, Sudan, and

[1] Based on the total number of recorded survivors and estimates for some states without data collection mechanisms, there were between 300,000 and 500,000 survivors worldwide by the end of 2010.

[2] The 25 states parties to the Mine Ban Treaty profiled were (States in bold had also signed or ratified the Convention on Cluster Munitions as of 15 September 2011): **Afghanistan**, **Albania**, Algeria, **Angola**, **BiH**, **Burundi**, Cambodia, **Chad, Colombia, DRC, Croatia, El Salvador**, Eritrea, Ethiopia, **Iraq, Mozambique, Peru, Senegal,** Serbia, Sudan, Tajikistan, Thailand, Turkey, **Uganda,** and Yemen.

[3] In addition, in Colombia, registering those victim assistance services provided to survivors within the national Epidemiological Monitoring System became obligatory throughout Antioquia, one of the departments with the great number of mine survivors, though this had not been replicated on a national scale. Similarly, Uganda conducted a second pilot of the national casualty surveillance system following an initial pilot in 2008.

Tajikistan used the information from past surveys while Albania and Thailand continued to update earlier data in the most affected areas. Iraq began to implement a needs assessment through its health care sector in 2011.

However, half of the States Parties profiled have not carried out, or used information from, victim assistance needs assessments: Afghanistan, Algeria, Burundi, Cambodia, Croatia, Eritrea, Ethiopia, Mozambique, Serbia, Turkey, and Yemen, as well as Colombia and Uganda which implemented only partial surveys.

Victim assistance coordination

The CAP underscores the importance of coordination and planning of victim assistance. All but one of the 25 States Parties profiled had victim assistance focal points. Turkey had no focal point, but in 2011 its national disability administration under the president was identified as the key body for victim assistance.

Burundi, Cambodia, Colombia, Croatia, and the DRC initiated or revised national victim assistance coordination mechanisms since the adoption of the CAP. At least 13 States Parties already had functional national victim assistance coordination mechanisms from the beginning of the CAP.[4] Algeria, Ethiopia, Iraq, Mozambique, Serbia, Turkey, and Yemen lacked a functioning coordination mechanism.

Croatia and the DRC both developed new victim assistance plans and Mozambique and Uganda developed follow-up plans. Burundi and Chad began developing victim assistance plans for the first time. At least half of the States Parties profiled already had active victim assistance plans or broader disability plans that explicitly included mine/ERW survivors.[5]

Survivor inclusion

Survivors, their families, and representative organizations should be active participants in all aspects of treaty implementation. States Parties committed to ensure the continued involvement and effective contribution of victim assistance experts, including mine survivors, in their delegations.

Since the adoption of the CAP, just four States Parties—BiH, Peru, Tajikistan, and Thailand—included a mine/ERW survivor or other person with a disability in their delegations to international meetings. Mine/ERW survivors were included in victim assistance coordination in 21 of the States Parties with victim assistance profiles.[6] However, in eight of the 21 states, this participation was seen to be limited, often in terms of the ability of survivors to contribute to decision-making.[7]

In all but two of the States Parties profiled, survivors were involved in the implementation of victim assistance. In Turkey, survivors reported that they were not included in the implementation of services relevant to their needs. There was no information available for Eritrea. Most often this participation was through NGOs, survivors'

[4] States Parties with national coordinating mechanisms Afghanistan, Albania, Angola, BiH, Chad, El Salvador, Eritrea, Peru, Senegal, Sudan, Tajikistan, Thailand, and Uganda.

[5] State parties to the Mine Ban Treaty with active victim assistance plans in 2010 were: Afghanistan, Albania, Angola, BiH, Cambodia, Eritrea, Mozambique, Peru, Senegal, Sudan, Tajikistan, Thailand, and Uganda.

[6] This includes all States Parties with functioning victim assistance coordination mechanisms as well as other states in which survivors participated in *ad hoc* planning meetings or within broader disability coordination structures. States with survivor inclusion in coordination in 2010 were: Afghanistan, Albania, Algeria, Angola, BiH, Burundi, Cambodia, Chad, Colombia, DRC, Croatia, El Salvador, Ethiopia, Iraq, Mozambique, Peru, Senegal, Sudan, Tajikistan, Thailand, and Uganda.

[7] States with limited survivor participation in coordination were: Angola, Burundi, Cambodia, Chad, Colombia, Croatia, Iraq, and Uganda.

associations, or international organizations, such as the ICRC.[8] Survivors were most often active in peer support, social inclusion, and advocacy on survivors' rights, but in several states they were also active in the fields of physical rehabilitation and economic inclusion.

Accessibility, availability, and quality of services

Through the CAP, States Parties agreed to dedicate efforts to improving the availability, accessibility, and quality of services by removing "physical, social, cultural, economic, political, and other barriers, including by expanding quality services in rural and remote areas and paying particular attention to vulnerable groups."

General increases in the availability of victim assistance services were identified in just three States Parties: Mozambique, Senegal, and Thailand. Other States Parties reported increases in service availability in specific areas, such as emergency medical attention, physical rehabilitation, or economic inclusion activities.

Ethiopia, Tajikistan, and Uganda passed laws or guidelines on accessibility. In Afghanistan, the national survivors' association organized a multi-stakeholder conference to promote physical accessibility and peer support. Colombia, El Salvador, Ethiopia, Peru, and Thailand took steps to decentralize health and physical rehabilitation services outside of capital cities and to strengthen community-based rehabilitation in remote and rural areas where many survivors live.

Improvements in the quality of victim assistance were only identified in four States Parties profiled: BiH, El Salvador, Eritrea, and Tajikistan. However, some 15 States Parties reported having undertaken activities to develop and/or implement capacity-building and training plans for victim assistance during 2010.[9]

Age- and gender-sensitive victim assistance

Providing age-and-gender appropriate services is important to ensuring that victim assistance fulfills the needs of all survivors, family members and affected communities. However, states were not yet reporting on their efforts to address the specific needs of survivors according to their ages. Only slightly more information was available regarding gender-sensitive services.

The small amount of information available indicates that there is increasing awareness of differing gender needs in just a few countries, but that the principles of equality and non-discrimination are not being fulfilled in others. For example, in Afghanistan and Tajikistan, there was a persistent disparity in services based on age and gender, and in Yemen, the absence of female medical professionals prevented many women from seeking services.

[8] Most information on survivor inclusion in the implementation of services was provided by NGOs, not governments.

[9] UN, "Achieving the aims of the Cartagena action plan: The Geneva progress report 2009–2010," Geneva, 29 November–3 December 2010, APLC/MSP.10/2010/WP.8, 16 December 2010, p. 22.