Lessons Learned Workshop

A Review of Assistance Programs for War Wounded and other Persons with Disabilities Living in Mine-Affected Countries

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EXECUTIVE SUMMARY

Background

This workshop brought together an experienced group of rehabilitation professionals with considerable field experience from Asia, Africa, Eastern Europe and Central America to review assistance programs for war wounded and other persons with disabilities living in mine-affected countries. The review was undertaken in anticipation of the upcoming fifth year anniversary of the Convention to Ban Landmines, which mandates a review of progress made since ratification and the articulation of new policies and the strategies to achieve them over the next five years.

Methodology

The participants reviewed the programmatic elements outlined in the International Campaign to Ban Landmines' Guidelines for the Care and Rehabilitation of Survivors, published in 1999. Those programmatic elements include:

- Emergency Medical Care/Continuing Medical Care
- Legislation, Advocacy and Public Awareness
- Physical Rehabilitation
- Psycho-Social Support
- Economic Integration
- Capacity Building and Sustainability
- Access to Services
- Data for Decision-Making

Participants conducted a series of SWOT analyses (Strengths, Weaknesses, Opportunities, and Threats) that focused on the role of three of the primary stakeholders working in victim assistance: international NGOs, national institutions and donors. This methodology let the participants review the current state of rehabilitation programming in a rapid but focused manner that produced recommendations without getting bogged down in the interesting but complicated minutia of program implementation. At the conclusion of each SWOT, time was spent reflecting on the effects of the Treaty on each of the elements reviewed.

Effects of the Treaty

In the past five years of Treaty implementation, impressive and measurable progress has been made in gathering signatories, in surveying, marking and clearing land, in mine risk education and in destroying mine stocks. Measuring the effects of the Treaty on victim assistance, however, is far more difficult. Baseline data on the number of mine victims worldwide is not reliably available and quantifying access to services would thus be meaningless. Treatment for landmine survivors is by its very nature embedded in larger programs of assistance for all disabled in a particular country and any improvement in services cannot be disaggregated from overall improvements in the health and social services in the countries concerned. Nonetheless, the Treaty has helped improve the services available to war wounded and other persons with disabilities living in mine-affected countries even if that improvement is not quantifiable. International awareness of the plight of landmine survivors has deepened appreciation and understanding of the needs of persons with disabilities living in low income countries in general and has strengthened funding and other support for programs that address their needs. Finally, the Treaty implementation process has helped encourage States Parties to think harder and more strategically about capacity building and sustainability.

Participants in the workshop found they agreed more often than they disagreed on the strengths and weaknesses characteristic of NGOs, national institutions and donors working on assistance programs for war wounded and other persons with disabilities. Rehabilitation NGOs, local partners and donors have been working together in countries like Cambodia and Afghanistan for more than a decade. Sharp disagreements over technologies and standards have been largely resolved and a broad consensus is emerging on a number of key issues. In a very real sense, all serious practitioners know that good outcomes for patients are not only possible but profoundly liberating when done right. But the road to good practice is hard and everyone who has started down it over the past twenty years has been to some extent humbled – no one thinks they can make the journey alone.

Lessons Learned

Although the discussions were often very detailed, five reoccurring themes emerged from the SWOT analyses.

- Medical help, especially surgery, remains surprisingly weak in a significant number of countries and should be addressed again, this time from a long term development perspective.
- Strategic Planning matters. Without coherent long term strategic planning at the local, national and international levels and among all the players, there will be no long term sustainability for rehabilitation programs.
- Linkages matter. No single NGO, national institution or donor can make significant contributions to strong and sustainable programs in isolation. The growth of health delivery systems, economic integration and access to all services for persons with disabilities will stem from intelligent, collaborative and cost efficient linkages among a wide number of actors.
- Collaboration and coordination are key building blocks for program sustainability.
- Livelihoods are paramount. Economic integration is the primary unmet need identified by beneficiaries in every mine-affected country in the world.

Recommendations

Participants recommended that donors concentrate funding over the next five years on:

- Economic integration activities;
- Expand access to and build sustainability for physical rehabilitation programs;
- Long term training for technical experts, management and capacity building; and
- Capacity building in national planning for local counterparts.

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LIST OF ACRONYMS

ADB	Asia Development Bank
CBR	Community-based Rehabilitation
CDC	Center for Disease Control
CPO	Certified Prosthetist Orthotist
DAC	Disability Action Council
DFID	British government's Department for International Development
DPO	Disabled Persons Organization
EU	European Union
GICHD	Geneva International Centre for Humanitarian Demining
HI	Handicap International
HRW	Human Rights Watch
ICBL	International Campaign to Ban Landmines
ICRC	International Committee of the Red Cross
ILO	International Labor Organization
IMSMA	Information Management System for Mine Action
ISC	Intersessional Standing Committee
ISPO	International Society of Prosthetists Orthotists
ITF	International Trust Fund
LIS	Landmine Impact Survey
LM	Landmine Monitor
LSN	Landmine Survivors Network
MASG	Mine Action Support Group
MoH	Ministry of Health
MRE	Mine Risk Education
NGO	Non-governmental Organization
OAS	Organization of American States
OCAT	Organization Capacity Assessment Tool
OT	Orthotist
POC	Prosthetics and Orthotics Center
P&O	Prosthetics and Orthotics
PSR	Physicians for Social Responsibility
PT	Physiotherapist
PWDs	Persons with Disabilities
SWOT	Strength, Weakness, Opportunity, Threat grid analysis
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	UN International Children's Emergency Fund
UNMAS	UN Mine Action Service
UNOPS	UN Office for Projects Services
USAID	United States Agency for International Development
VA	Victim Assistance
VVAF	Vietnam Veterans of America Foundation
WB	World Bank
WHO	World Health Organization
WRF	World Rehabilitation Fund

I. Introduction

A. Background

The preamble of The Convention to Ban Landmines aims to "put an end to the suffering and casualties caused by anti-personnel mines that kill or maim hundreds of people every week, mostly innocent and defenseless civilians and especially children, obstruct economic development and reconstruction, inhibit the reparation of refugees and internally displaced people, and have other severe consequences for years after placement." The Convention also recognizes States-Parties' desire "to do their utmost in providing assistance" and requires in Article 6, section 3, that "each State in a position to do so shall provide assistance for the care and the rehabilitation, and social and economic reintegration, of mine victims…."

The fifth year anniversary of the ratification of that Convention takes place in 2004. The anniversary obligates the international community committed to the aims of the treaty to review what the signatories have done to achieve the four core objectives of the Convention: clear mined areas, assist victims, destroy stockpiles, and universalize the Convention. More importantly, the States must also articulate policies and strategies for the implementation of the Convention for the next five years.

Although representatives of the international community committed to the Convention's aims have been meeting twice a year in Geneva at the Intersessional Standing Committee (ISC), people directly involved in developing and implementing victim assistance programs have rarely attended. In the five years since ratification, however, people involved in victim assistance programming have developed an impressive range of knowledge about what works and what has not – and why. That experience and the lessons learned provides an essential expertise that should help shape the vision and direction for the future.

Acknowledging the need to articulate a field perspective on lessons learned in implementing rehabilitation programs, Handicap International brought together a small group of practitioners with considerable hands on experience in implementing assistance projects for persons with disabilities living in mine affected areas to meet in Paris from May 25th – 28th, 2004. The primary criteria for participation was that each participant be currently based in the field and have at least five years field experience. The 20 participants who came have years of practical experience designing and implementing program, usually in more than one geographic region. All have practical experience in one or more of the crucial aspects of rehabilitation programming: hospital care, physical rehabilitation, psycho-social support, socio-economic integration, and national legislation/protection of rights. Geographic breadth was a consideration as well and those invited came from Asia, Africa, Eastern Europe, and Central America.

The group that came together at this workshop has no formal authority and does not claim to be in any way wholly representative of the hundreds of dedicated individuals and organizations working on mine action issues around the globe. They were asked to think and speak as individuals rather than as representatives of their respective organizations. Consequently, no progress reports about individual country programs were requested and the views captured in this report reflect the thoughts of individual participants, not their institutions. Instead, the participants were asked to pool their collective experience to reflect on the impact of the Treaty on victim assistance work and to provide some clarity, realism and focus to the international communities' planning for the sector over the next five years.

B. Methodology

To ensure that the participants and their intended audience shared commonly understood definitions of what makes up victim assistance activities, the programmatic elements reviewed were taken from the *Guidelines for the Care and Rehabilitation of Survivors*, published by the International Campaign to Ban Landmines (ICBL) Working Group on Victim Assistance in 1999. Those program elements include:

- Emergency Medical Care/Continuing Medical Care
- Physical Rehabilitation
- Psycho-Social Support
- Economic Integration
- Legislation, Advocacy and Public Awareness
- Capacity Building and Sustainability
- Access to Services
- Data for Decision-Making

Although not a part of the original guidelines, coordination was included in the assessments because of its increasing importance as programs mature.

Of equal concern was identifying a methodology that would let the participants review the current state of rehabilitation work for war victims and other persons with disabilities living in mine affected countries in a rapid but focused manner that could produce recommendations without getting bogged down in the interesting but complicated minutia of program implementation.

These requirements were met by using a series of SWOT analyses (Strengths, Weaknesses, Opportunities, Threats) that focused on the role of three of the primary stakeholders working in victim assistance: International NGOs, national institutions and donors. Each program element taken from the Guidelines was thus reviewed three times, once from the perspective of the NGOs, then from the perspective of national institutions, and finally from the viewpoint of donors. National institution was defined very broadly to mean any local entity including government, its ministries, local NGOs and other civil society organizations. At the conclusion of each SWOT, the group was asked to consider the effects of the Treaty on that particular element.

Once the SWOTs [1] were completed, the group reviewed the factors contributing to failure (taken from the weaknesses and threats column of the SWOT) and to successes (taken from the strengths and opportunities columns). Each participant also filled out a questionnaire that asked which of a number of core documents that have been produced on victim assistance over the last five years had been read and, if read, shared, and if shared, with whom. Participants were also asked to describe one additional activity each would tackle over the next 18 months if time and funding permitted. Finally, the group drew up recommendations to be presented at the June 2004 Intersessional Standing Committee meeting on Victims Assistance (ISC) in Geneva.

[1] *The SWOTs from which lessons learned summaries and recommendations are taken can be found beginning on page 21.*

II. Lessons Learned

A. Emergency Medical Care and Continuing Medical Care

The Guidelines Aim: Emergency medical care standards assume that "Healthcare and community workers in mine-affected areas should be trained in emergency first aid to respond effectively to landmine and other traumatic injuries." Continuing medical care standards assume that "medical facilities should have medical care and supplies that meet basic standards." Those basic standards include clean water and clean instruments in surgeries and the presence of a cadre of skilled surgeons and other health personnel capable of proper amputation procedures and reconstructive surgery.[2]

Summary of Lessons Learned: Progress made in providing ongoing effective emergency and medical care has been disappointingly limited. Overall, participants have seen no lasting improvement in medical care, particularly in surgical standards. Even when successful training programs had been offered with noted improvements in surgical techniques, the improvement has rarely been institutionalized. The reasons for this are manifold: medical systems in landmine affected countries are often failing or weak in general. Countries emerging from long years of civil strife rarely if ever have effective emergency response systems in place and first aid delivery at the time of injury is often poor, accounting for the high fatality levels among landmine victims. The injured often come from rural areas but services are concentrated in urban centers and rural dwellers' access is limited by poverty. And rehabilitation ranks low on the agenda of most national ministries tasked with health care. If war injured, for example, account for less than 0.1% of the population, their needs are unlikely to garner much budgetary support.

Surgical trainers pointed out that amputation is often seen as a medical failure and even if a doctor does an excellent job, the patient is unlikely to thank him or her for it. In general, people avoid learning thankless tasks. Many programs began in response to emergencies and failed to recognize or plan for the fact that medical training must be repeated as each new generation of students enter school. Training young surgeons or doctors is particularly important because amputations are often handled by apprentice surgeons as older and more experienced physicians tend to avoid this kind of work for the reasons mentioned above. Finally, all too often doctors/surgeons are trained in isolation without an experiential understanding of what good surgery does for successful rehabilitation outcomes. In countries where medical personnel have met with landmine survivors who are successfully completing physical rehabilitation, they have expressed amazement and a renewed commitment to contribute. Where these relatively simple interchanges have been tried, the effect has often been substantial in relation to the costs.

In conclusion, as victim assistance programs were initially designed and implemented, the people running them moved forward with what they had – and it was not enough if the general goal of effective medical response to injury and the creation of a cadre of skilled surgeons and other health personnel capable of proper amputations is to be met. International NGOs often approached the problem as emergency response specialists (e.g., ICRC) or from the perspective of physical rehabilitation with an emphasis on device production and fitting (e.g., HI and VVAF). All of the participants could remember lost or wasted training opportunities – all of the organizations that work in rehabilitation failed to understand the degree to which this is a systemic problem and our responses were consequently not proportionate to the problem. National governments usually put Ministries of Social Welfare or Veterans Affairs in the lead, but medical care is an issue for the Ministry of Health, so international NGOs often interacted with counterparts who were in no position to tackle the problem effectively. And Treaty donors often were wary of entanglement in a complex sector – health – that would involve them in long term development issues.

The consequences, however, of poor medical services for landmine victims are profound: fatality rates at the time of injury are high and, if the injured person survives, a poorly done amputation seriously impedes the successful fitting of a prosthetic device. If the device does not fit comfortably because of the condition of the stump, the wearer is much less likely to use it effectively. Good surgery in adequate clinical settings is also essential for children, who face multiple stump revision operations as they grow. Such surgery is life-threatening if performed in poorly equipped and unhygienic hospitals. Thus poor medical interventions undercut the rehabilitation potential of each patient.

More positively, much work has already been done, by ICRC and others, in preparing guidelines, training manuals and other materials that can be used to improve medical care given to war wounded. The key question is how to institutionalize such training into whatever systems currently exist.

Effect of Treaty on Medical Care/Continuing Medical Care: Participants generally felt that the Treaty has had a very limited effect on emergency and continuing medical care. There is at present no way to ascertain whether or not survival rates have changed over the last five years and if they have, whether or not the changes are a result of the treaty.

[2] *All definitions of service included under "The Guidelines Aim" sub-title are taken from "Guidelines for the Care and Rehabilitation of Survivors", International Campaign to Ban Landmines (ICBL) Working Group on Victim Assistance, 1999.*

Recommendations:

- Commit resources to improve the quality of amputations and surgery for war-related injuries.
- Motivate surgeons to improve their work by showing them the connection between what they do and how their patients recover and reintegrate in the long term.
- Work to institutionalize good surgical training for amputations by incorporating this aspect of surgery into medical schools' required curriculum.
- Concentrate on educating young doctors and medical students as they are most often responsible for handling amputations.
- Educate other health professionals and institutions about the role of medical care in rehabilitation.
- Improve linkages among ministries and other health delivery systems in each country where victim assistance programs are being implemented.
- Encourage international NGOs, national institutional-stakeholders and donors to make better use of existing resources/systems to bring in a broader range of institutional players including international professional associations and the medical NGOs.
- Consider having one agency take the lead in setting standards, disseminating curriculum and providing assistance in training.

B. Physical Rehabilitation

The Guidelines Aim: Rehabilitative services should produce devices that are safe, durable, and can be maintained and repaired locally. The Guidelines also states that "the availability of long-term services must be ensured for necessary adjustments or replacement. There is also strong consensus that all rehabilitation programs should support locally manufactured, fitted and serviceable prostheses; that pre and post-prosthetic care should include physiotherapy to prepare for and ensure proper use of assistive devices and prevent secondary problems or injury; and that attention must be given to resources and training for physiotherapists and other rehabilitation personnel, and for the treatment of injuries other than limb loss.[3]

Summary of Lessons Learned [4]: Participants at the workshop agreed that a general consensus is emerging among rehabilitation professionals that rehabilitation works best when it is comprehensive (medical plus physical rehabilitation plus psycho-social assistance plus economic integration); holistic (considers body, mind, spirit, environment); and multi-layered (individual, family, community, society). Program impact should be measured by improvements in quality of life rather than a more limited "fix the broken limb." Rehabilitation programs should be accountable: How do you know what you did had a positive impact? It is essential to follow up at least a percentage of people treated if we are to understand whether or not our programs are having a cost effective impact on the lives of the people we are trying to help. Device production and fitting is not the goal. It is a means to an end. The end goal is that each person with a disability has an improved quality of life. All of the above should be reflected in planning from the beginning whether by NGOs, national institutions or donors.

Growing physical rehabilitation programs takes a long time. Even when started during an emergency, international NGOs, backed by their donors and in cooperation with local partners, should plan for their eventual departure even if it takes many years. Clear goals with time tables should be built into program design early on. Otherwise international NGO staff will tend to underestimate the capabilities of local staff and government and fail to develop well-thought out training programs, which, because they require years to complete, must begin early in a program's history. It is all too easy to just keep on doing the work oneself rather than tackle the more complicated requirements of assisting in the design and implementation of new local systems – work that demands coordination, linkages with other institutions and NGOs and a whole complex web of growing relationships with multiple actors.

Cooperation among NGOs, relevant ministries and donors has improved in a number of key countries where programs have matured: Cambodia and Afghanistan in particular provide interesting examples. Finally, there is a growing acknowledgment that few physical rehabilitation programs are financially sustainable as currently constituted. That reality is opening the way for a much broader look at a whole range of possibilities for addressing the issue: cost analysis (each program must be able to say what each service component costs), cost recovery and direct fee for service are all being examined. Program planners and some government counterparts no longer assume that all disabled persons must have access to free services forever. Conversations about mixed revenue streams – taxes, insurance, lotteries, and local charity – are now taking place. Questions about quality and what is appropriate for each country are being reopened.

Effect of Treaty on Physical Rehabilitation: The effects of the Treaty on physical rehabilitation have been both positive and negative. A number of victim assistance projects were inspired and funded because of the attention drawn to the issue by the ICBL campaigns leading to the Treaty's creation. Funding, particularly from private sources (individuals and foundations) has increased significantly over the past five years.[5] The Treaty process has encouraged a number of involved governments to include some form of planning for services for the disabled in their national plans. Better trained local counterparts are to be found in a number of countries. Ministries of Health are increasingly involved alongside the more traditional Ministries of Social Welfare or Veterans Affairs. On the negative side, the Treaty has helped create a new class of disabled – landmine victims – and thus sometimes undercuts integrated planning for the needs of the disabled as a whole.

Recommendations:

- Fund holistic programs designed on the premise that the goal of rehabilitation is successful reintegration into family and community and that increased mobility should help achieve the patient's top priority, which for many is access to income-generating activities and/or education.
- Fund training for Certified Prosthetists Orthotists (CPOs) and physiotherapists (PTs) keeping in mind that every program should have a trained PT for every trained CPO.
- Fund training for managers, who are as important as technical experts in designing, implementing and sustaining strong programs.
- Continue to provide core international support to ensure that what is the beginning of a new profession in many

[3] Op Cit. Guidelines for the Care and Rehabilitation of Survivors.

[4] In the interest of avoiding duplication of effort, a draft copy of "Implementing Prosthetics & Orthotics Projects in Low-Income Countries: A framework for a common approach among international organizations" was sent to each participant before the workshop and discussed briefly during the workshop. This paper, authored by Anders Eklund with support from the Landmine Survivors Network (LSN) and input from over 25 NGOs involved in prosthetics and orthotics projects in low income countries, will be reviewed in depth at a meeting in Geneva in June 2004. It seeks to provide a common approach for international NGOs working on P&O issues. The Lessons Learned group thus critiqued the paper as a starting point to its own discussion of Physical Rehabilitation. A summary of that critique can be found on page 26.

[5] The Landmine Monitor researcher on victim assistance, Sheree Bailey, is preparing a study that will be finished before the Treaty Review Conference in late 2004 on the breakdown of donor funding to victim assistance which may help elucidate trends.

low income countries continues to grow and expand.
- Insist on coordination of resources, planning, and training among all stakeholders, including people with disabilities themselves, a commitment that should come from donors, national institutions and NGOs.
- Link physical rehabilitation to economic integration.

C. Psycho-Social Support

The Guidelines Aim: Community-based peer support groups offer cost-effective psychological, social and other health benefits, and a means to educate local populations about the needs of persons with disabilities and the resources available to help. Psychosocial support should be community-based, and involve social service providers from both the non-formal and formal health and social service sectors in order to provide culturally appropriate support. The families of mine victims play a crucial role in recovery, and should receive education and support to care for injured family members. Survivors who have progressed in their rehabilitation and reintegration into society are well-suited to provide peer support. Research on trauma and recovery suggests that empathy and attentiveness expressed through peer support has positive therapeutic effects. Ideally this support should be started at the wake-up after the amputation surgery. In post-conflict countries where there are virtually no psychological support services, investment should be made in training and employing competent and locally based social service providers and development workers.[6]

Summary of Lessons Learned: There is wide spread agreement that psycho-social work plays a critical role in successful rehabilitation. Device use increases when other kinds of follow up support are included: peer counseling, peer support, follow up with patients once they return home. Ideally this support should begin from the moment a survivor wakes up from his or her surgical amputation. Psycho-social support helps patients overcome depression and improves pain management. Effectively done, it can prevent many types of secondary problems from arising such as domestic abuse and violence, chronic depression, substance abuse, and family disintegration

Practitioners recognize that much clearer definitions of what we mean by such activities are needed if we are to convince donors and national players of its importance. Most rehabilitation centers already include various aspects of psycho-social support even if the activities are not specifically labeled as such. Too often, however, when staff try to describe this aspect of their work, it tends to sound peripheral or "too soft". Organizations working in this sector need to be able to explain/justify the impact of psycho-social components already incorporated into what we do. How can that be done: The Cambodia Trust has done a study of such activities in Cambodia which provide some good explanation and defense of this work. Peer counseling and support can be a very cost effective approach to helping those newly injured have enough hope to make the effort it takes to make medical and rehabilitation services work. Linkages with others who are knowledgeable in this field, such as trauma recovery specialists, psycho-social specialists, and those who work with other vulnerable groups in low income countries need to be more aggressively explored.

Many of us recognize that sports and recreation can have a profound effect on disabled persons' recovery and reintegration into their communities but we have a hard time convincing donors of this fact. We may be looking in the wrong places for funding. Program designers also need to get better at recognizing what's culturally, socially and spiritually available in each of the communities in which we work and utilize all three more effectively.

Effect of the Treaty on Psycho-Social Support: Stakeholders involved in mine action have been introduced to the term and there is some growing understanding of its role in rehabilitation.

Recommendations:

- Develop better definitions and evaluations of the role psycho-social work plays in good rehabilitation programming.
- Incorporate peer counseling and support into all aspects of rehabilitation.
- Find and forge linkages with other groups who specialize in this work both internationally and locally.

D. Economic Integration

The Guidelines Aim: Assistance programs must work to improve the economic status of persons with disabilities in mine-affected communities through education, economic development of community infrastructure and creation of income generation and employment opportunities.

The economic status of survivors depends upon the political stability and economic situation of the communities in which they live and on attitudes of the society in which they live towards persons with disabilities and landmine survivors in particular. Employment opportunities, income-generating and micro-enterprise projects, literacy and vocational training, apprenticeship and job referrals contribute to the self-reliance of survivors and community development. Economic rehabilitation programs for survivors should be designed using the same principles of good development work and an awareness of the attitudinal and institutional blocks that persons with disabilities face. Post-conflict economic reconstruction in mine-affected communities should include rehabilitation of the health and social service systems.[7]

Summary of Lessons Learned: For years now landmine victims and other persons with disabilities and the professionals working to help them have been reporting that their top priority is to be able to earn a living and take care of their families. That concern is usually far more powerful than concerns about medical care or mobility per se. Accounts from rehabilitation programs all over the world report similar findings. In 2002, The World Rehabilitation Fund conducted focus groups with survivors and rehabilitation staff in Lebanon, Uganda and Guatemala and found that "Feedback from survivors revealed that the most acute needs identified by landmine survivors were not the medical rehabilitation services, but assistance in helping them to resume their roles as productive community members and contributors to their families' well being.[8]

The social stigma found in many cultures against war wounded and other persons with disabilities can be profoundly isolating and debilitating. It is most successfully countered, however, when

[6] *Op Cit. Guidelines for the Care and Rehabilitation of Survivors.*
[7] *Ibid. Guidelines for the Care and Rehabilitation of Survivors.*
[8] *Guidelines for the Socio-economic Reintegration of Landmine Survivors, Jack Victor, Steven Estey and Heather Burns Knierim, World Rehabilitation Fund & United Nations Development Programme, August 2003. pp 1.*

persons with disabilities are acknowledged as fully capable of supporting themselves and their families. This holds true regardless of gender, age, or type of disability. In the late 1990s, women landmine victims living in northern Cambodia were destitute after being abandoned by their families. They believed they would never marry or have a family. Not only was this emotionally devastating, it meant living without the fundamentally important safety net provided by extended family networks. But when these women were trained as silk weavers and began to earn a very good living, a significant number wed and had children. Economic independence trumped very strong social stigmas against persons with disabilities, who are perceived as cursed and feared as bringers of bad luck.

Few international NGOs specializing in rehabilitation, however, have serious expertise in economic integration work. The difficulties of economic integration are also compounded by the fact that persons with disabilities in war-torn countries are often very poor and have had little or no education. Many programs targeting economic reintegration suffer from what one participant labeled "well meaning dabbling." Traditional vocational training programs are too often implemented in war ravaged states where unemployment is very high. Too little market research is done to ensure that the training given is rationally connected to job possibilities in the society at large. Many well-intentioned handicraft projects are unsustainable once the international NGO supporting the project pulls out. And some vocational training programs still engage in a form of job typecasting, assuming that persons with disabilities are most appropriately trained for relatively low level and unimportant positions, like handicraft workers or shoe makers. For some, being a shoe maker will fulfill a lifetime dream – but others want to work as teachers, health workers, lawyers and so forth. What is important is that persons with disabilities have the same choices as their non-disabled peers in the economy in which all happen to live. Vocational training efforts must be able to show measurable impact on quality of life rather than just counting the number of people who go through training programs.

No matter how difficult social and economic integration programming is, however, this issue should be given primary focus over the next five years in recognition of its paramount importance to the people the Treaty is meant to help. World Rehabilitation Fund's Guidelines for the Socio-economic Reintegration of Landmine Survivors identifies five crucial factors in designing such programs: psychosocial support, vocational rehabilitation, economic development, education and community integration and support. The participants at the workshop pointed out that vocational rehabilitation should first and foremost link physical rehabilitation with return to earning an income. Injured farmers may often most desire to return to farming if physically possible and the program of rehabilitation for that individual should focus on that outcome if desired. If other opportunities exist, however, then the physical rehabilitation program must consider the patient's occupational hopes and make sure that the device(s) given are appropriate and that referral is made to whatever opportunities for training, education, or financial assistance exist.

Landmine survivors everywhere often want to start a business but all too often are unable to get loans or grants because they are disabled. There is growing recognition that organizing for access to existing programs now off limits to PWDs is worth considerable effort. A number of rehabilitation programs are experimenting with small loans and/or grants to enable PWDs with good ideas for earning a living to get the funds needed to start. Interesting examples of growing economic integration programs are taking place in Lebanon, Nicaragua, Senegal and Angola. In Vietnam, some NGOs and newly forming self-help groups are pushing for inclusion of people with disabilities in micro-finance networks. NGOs involved with disability programming have a role to play in linking up those in need with existing resources, whether education, vocational training, or micro finance networks.

This is also an area where headquarters staff of rehabilitation NGOs have a coordinating and educational role to play by advocating for PWDs with bi-lateral and multi-lateral development agencies that fund many of the programs that would be of great assistance to the disabled if they could get access.

Effect of the Treaty on Economic Integration: As in physical rehabilitation programming, the Treaty process has tended to create a sub-category of PWDs that get special attention denied to many other persons with disabilities. Programs that pre-date the Treaty were inclusive of all PWDs. It must be noted, however, that such programs were never numerous and programs designed for amputees have benefited other persons with disabilities as many programs no longer discriminate. The Treaty has also had a positive effect in that it has introduced the issue of economic integration to a much broader group of actors.

Recommendations:

- Fund economic integration programs because they are of the utmost importance to landmine survivors and other persons with disabilities.
- The primary goal for the next five years should be inclusion and mainstreaming of PWDs into whatever systems for education, vocational training, and financial programs that exist for the general population or for vulnerable groups in general within their communities.
- Targeted linkages with key players like World Bank, ADB, and major finance institutions should be explored and advocated for vigorously.
- Include more PWDs in our own organizations.
- Explore links with the business community and advocate for jobs.

E. Capacity-Building and Sustainability

The Guidelines Aim: From the beginning, survivor assistance programs should emphasize the training and employment of local workers to take responsibility for all aspects of project design, implementation and management.

To help survivors in a sustainable way requires building local capacities of community service providers, health professionals and trainers. Capacity-building measures could include training and employment in office administration, financial management, fitting and production of prostheses as well as literacy and language training and education for social service providers and survivors. Private and public donors should invest in existing local infrastructure of all social sectors (rather than creating new

or parallel systems) to strengthen education and care for mine victims, their families, communities and those organizations offering support to persons with disabilities.[9]

Summary of Lessons Learned: The participants felt that there is growing agreement about the skills required to design and implement good rehabilitation programs but that coherent and well coordinated training programs, and the funding to pay for them are still in their infancy. Good programs now include training for management staff and for local counterparts as well as technical staff. When addressing capacity needs and its relationship to sustainability, most experts now agree that competent managers are as important as well trained technicians.

There is also widespread agreement that training good managers and technicians, although important, does not lead to financial sustainability, although good staff are necessary to the process. Rehabilitation programs are usually non-commercial endeavors requiring public support but governments in mine-affected countries rarely have sufficient revenue sources to assume the costs. Even as NGOs and their governmental counterparts design ever better training programs, most project design still does not confront the problem of where the money to pay for these new professionals is going to come from. There are no easy answers to this dilemma but at least program designers are confronting the issue of financial sustainability more honestly. Rehabilitation activities will need to court a wide variety of funding sources including private and public monies that will change over time. Ultimately, government may contribute through the tax systems, lotteries, and health insurance schemes while also accepting help from local charitable institutions that may be willing to help the indigent disabled with transportation costs, for example. Local authorities need to be involved in planning as early as possible so that there is agreement about what is being developed and how it is to be financed over the long run.

NGOs still tend to write funding proposals to meet donor timeframes rather than program needs. Long term planning is crucial in rehabilitation programming because good program with the necessary staff to run them take a long time to develop and are expensive. If planning timeframes are too short, then the true costs of developing the program will be understood too late and thus undercut any hope of long term sustainability. All rehabilitation programs should incorporate capacity building and training for both technical and management staff into project design from its inception. NGOs and their counterparts need to identify training needs and develop long term strategies to meet them. This planning is best done sectorally rather than by each NGO and its country counterparts. Because training is expensive and time consuming, country and regional coordination among all stakeholders is increasingly important so that resources and costs can be shared.

NGOs must incorporate thinking about exit/achievement strategies early on, which can be difficult when staff are developing systems and implementing them simultaneously. Program goals need to be linked to national plans, when they exist, or at least linked within the sector to the work of other organizations to avoid overlap and duplication of efforts. Even during emergency periods, thinking about capacity building can begin with donors and NGOs and should include national authorities as soon as possible.
Recognition of national roles in setting standards needs to improve. Who decides? What is the right balance between internationally recognized standards and local conditions, which may not support such standards for years? Taking local conditions into account from the beginning of project development makes long term sustainability more likely. Capacity building is not just a requirement of individual programs; it is equally important for government staff and other local counterparts. Good data also is needed for realistic long term planning of training needs. Finally, rehabilitation NGOs and their local partners often lack expertise in health system development and management expertise. Nor do donors of victim assistance programs often have much experience dealing with long term capacity building in the health sector. All three stakeholders need to link up with centers of expertise that might include more mainline health development agencies.

Effect of the Treaty on Capacity Building and Sustainability: Landmine Monitor teams around the world have helped build local capacity in monitoring and advocacy. The Treaty has also provided a forum in which NGO expertise in disability issues has been increasingly recognized by both UN agencies and bi-lateral donors. The Treaty implementation process has helped encourage States Parties to think harder and more strategically about capacity building and sustainability.

Recommendations:

- Never invest in new programs where a good one already exists.
- Recognize and plan for the fact that exit/achievement strategies may take many years to achieve, well past the typical funding cycle of most donors.
- Work to develop greater clarity on what must be sustained and at what levels both within countries and within the sector.
- Link capacity building requests to national plans, and to clear objectives.
- Develop medium-term expenditures and planning forecasts for the whole sector.
- Coordinate and share information and resources across the sector within countries and within regions.
- Take advantage of top quality global resources for training.

F. Legislation, Advocacy and Public Awareness

The Guidelines Aim: National legislation should promote effective treatment, care and protection for all disabled citizens, including landmine survivors.

The disabled population must have legal protection against discrimination and assurance of an acceptable level of care and access to services. Survivors should have access for a formal statutory complaint mechanism to address their concerns and protect their interests. Each government has a responsibility to raise public awareness of the rights and needs of its disabled citizenry and to counter the stigmatization of persons with disabilities. Community education should include a campaign to publicize the rights and abilities of persons with disabilities and the availability of rehabilitative and social services.[10] The United Nations is now working to create a human rights treaty for persons with disabilities, which should contribute significantly to governmental awareness around the world that people with disabilities have the

[9] *Ibid. Guidelines for the Care and Rehabilitation of Survivors.*
[10] *Ibid. Guidelines for the Care and Rehabilitation of Survivors.*

same rights as all other human beings. Once the Treaty is enacted, PWDs' claims to those rights will be backed by the force of law.

Summary of Lessons Learned: Many countries view disability as a charity issue, not an issue of rights. Some countries still need basic level training about the rights of PWDs and the responsibilities of government in helping ensure such rights are legislated and enforced. Most countries have some sort of constitutional, legislative and/or statutory provisions regarding human rights, which in theory apply to persons with disabilities even if they are not specifically mentioned. Rarely do such legal provisions signal out landmine survivors nor should they:[11] Landmine survivors are eligible for whatever is legislated for all persons with disabilities, and persons with disabilities are eligible for whatever is legislated for all citizens.

Most countries now also have some sort of regulations specifically addressing the rights of persons with disabilities. Such laws or statutory provisions prohibit discrimination and often mandate some sort of access to care and education. Some peace agreements specifically identify war wounded as a class of people who deserve special benefits as compensation for having served their country, and incorporate assistance to them into the terms of the agreement.

Currently, however, there is widespread recognition that legal provisions for persons with disabilities are rarely implemented. Handicap Internationals' *Landmine Victim Assistance: World Report 2002* found that even when there are laws for people with disabilities regarding specific issues like accessibility to buildings or transport, they are rarely enforced.

The exceptions are provisions that target military personnel disabled while on duty and, in general, there is "a blatant difference in the treatment of civilian and military mine victims, notably in Africa and Asia, as the status of civilian victims is rarely recognized as such."[12] Respect for the rights of people with disabilities depends on the capacity and willingness of States to implement the provisions that exist. Much of that struggle will depend on the ability of survivors and other persons with disabilities to advocate on their own behalf. The international community, including those dedicated to implementation of the Ban Landmine Treaty, has a role to play in helping those advocates find their voice. Raising the Voices is an example of a program that aims to build the capacity of landmine survivors to become advocates and activists for themselves and other people with disabilities.

Public awareness campaigns can play a two-fold role of raising the voices of persons with disabilities and of informing those who need help that services exist (if they do.) There are increasingly interesting models available for consideration. Ethiopia's primary radio stations broadcasts a show on disability issues two days a week. Senegal has organized associations for disability advocacy. LSN's survivor networks include advocacy training and practice into the health and economic integration work they do in mine-affected countries. Newly emerging self-help groups in Vietnam are slowly linking up provincially and nationally. Cambodian activists are beginning to look beyond their borders to other countries in the region like Singapore for inspiration regarding model legislation. Rehabilitation Centers can assist in the development of civil society work around disability issues simply by providing a place for persons with disabilities to meet similarly minded individuals, to hold training sessions in the skills needed for advocacy and, as always, to serve as a referral center for those interested in advocacy.

Effect of the Treaty on Legislation, Advocacy and Public Awareness: The Treaty has had an important role in highlighting the plight of civilian landmine survivors in mine affected countries as a counterbalance to many countries' preferential treatment of military victims. Advocacy by landmine survivors for landmine survivors has begun to be strengthened as well through the funding of efforts like Raising the Voices and the creation of networks like those sponsored by LSN. The Treaty indirectly obliged signatory governments to look at delivery systems for PWDs and in so doing to consider legislation or, if it already exists, enforcement of that legislation if it helps them meet Treaty obligations.

The Treaty implementation process has also led to the writing of national plans for mine action that should include coordination of victim assistance activities. The profile of National Plans has been raised along with a heightened sense of expectation that they will be funded and implemented. Linkages can be forged between those aspects of national plans involving victim assistance and larger legislative initiatives targeting persons with disabilities. The implementation of national plans can help strengthen services for all persons with disabilities.

Finally, the Mine Ban Treaty has served as a model inspiring many in civil society to work to change the world through international law, and many landmine survivors have been active in the process to create a new human rights convention for the rights of persons with disabilities.

Recommendations:

- Fund implementation and enforcement of national laws relating to disability.
- Fund local advocacy groups capable and willing to lobby governments to provide services and to participate in international processes aimed at achieving global changes.
- Support with training and funding the creation of self-help groups that want to work on key issues affecting persons with disabilities.
- When available, fund local lawyers or projects that have a clear plan for utilizing local legal systems to help PWDs push for the design, implementation and/or enforcement of legislation.
- Fund pilot programs in a few countries to explore effective implementation mechanisms and expand the most effective.

G. Access to Services

The Guidelines Aim: Persons with disabilities, like all people, should have full and open access to a variety of services and assistance.

Full and open access to the physical environment, rehabilitation and social and economic programs is a means of equalizing opportunities in all spheres of society. Access includes: the elimination of physical obstacles to mobility, ensuring access to build-

[11] *For a succinct discussion of landmine victim assistance and the law, see Handicap International's Landmine Victim Assistance: World Report 2002, pages 20 & 21.*
[12] *Ibid., pp 21.*

ings and public places; availability of first aid, emergency and continuing medical care; physical rehabilitation; employment opportunities, education and training; religious practice; sports and recreation; safe land and tenure of land; and information and communication about available services.[13]

Summary of Lessons Learned: Access remains crucially important to all aspects of successful rehabilitation. Participants report that services available to landmine survivors and other persons with disabilities living in mine - affected countries still vary greatly and generalizations are suspect. Access encompasses a range of problems from lack of information about existing services to no services at all. In some regions, centers are overwhelmed with patients and the fundamental problem is how to sustain growth; in other countries centers stand half empty because potential beneficiaries do not know about them or cannot reach them or the quality of help offered is so poor people do not want to come. In many countries, services like education and vocational training may exist but social stigma around disability denies access to PWDs.

Access to services requires information first and foremost as potential beneficiaries can't use what they don't know about. In some countries referral between hospitals and rehabilitation centers now work well. In Afghanistan, for example, most patients come to the rehabilitation centers the same day they are discharged from the hospital. But this is often not the case. Much more can be done to use local communication, whether radio, TV, local churches and other civil society organizations to let potentials users know what help is available.

Lack of transport or the means to pay for it can keep potential beneficiaries from getting help. In some countries like Angola, demining roads is a first crucial step. In countries with inexpensive public transport, much can be done with subsidies. In Mozambique, the government pays public transport to deliver PWDs to rehabilitation centers. Decentralization and increase in crutch distribution should be considered a cost efficient and fast way to get people moving again before they are fitted for a limb or orthotic device. Crutches should be distributed to survivors and PWDs at all hospitals, which is not yet the case in many countries.

If cost effective small grant mechanisms existed, more could be done to explore local solutions to access. Long running programs that address access issues should be evaluated and replicated if useful. ICRC's Special Fund for the Disabled may provide useful lessons as may Landmine Survivors Network's advocacy networks, which will be evaluated in mid-2004.

Access also means the elimination of physical barriers to mobility. HI has worked on guidelines with national federations of architects. International players like the UN agencies, ESCAP in Asia, the Asia Development Bank (ADB), the World Bank, and so forth could help governments include physical accessibility in all new infrastructure development. Donors can have a powerful effect on accessibility by insisting that it be taken into account when they fund reconstruction work. In Afghanistan USAID and UNICEF are working with the Ministries of Education and Social Welfare to construct over 700 schools with access for the disabled.

Access depends first and foremost on developing effective networks of referral and assistance. Rehabilitation Centers can serve as hubs, taking people in and sending them on to other organizations, both international and locally run, that can help meet their needs. Many services do not need to be centralized – some device repair can be done at the village level; government staff in the provinces can be trained to be outreach workers (as is happening in Cambodia.) Rather than reinventing the wheel, NGOs, national institutions and donors need to take a hard look at what has been tried and replicate what has worked.

Effect of the Treaty on Access to Services: Treaty networking has led to a greater understanding of access issues among donors. Focus on physical accessibility has been helped by the treaty. There is increased understanding that physical access issues can and should be addressed during the emergency phase in post conflict situations because accessibility can be incorporated into reconstruction work. Although better understood, it is not yet often implemented. The Treaty focus on landmine victims can sometimes help create discrimination – fee structures in Bosnia favor landmine victims, for example.

Recommendations:

- Involve the multilateral organizations in promulgating best practices and standards for access to buildings and involve national architects and construction companies in implementation.
- When the international community provides assistance to post-war reconstruction, use donor influence to help ensure that PWDs have access to all assistance programs.
- Small grant mechanisms should be funded to liberate local entrepreneurialism in addressing access issues across the spectrum of needed services.
- Fund national media capacity to inform people about services available.
- Support PWDs access to whatever services already exist rather than the creation of new services.
- Place much greater emphasis on access to economic opportunity over the next five years.

H. Data Collection for Decision Making

The Guidelines Aim: Survey implementers must be trained and sensitized to issues of trauma and recovery experienced by mine victims and their families before engaging landmine survivors in interviews.

Data collection that involves interviews with survivors must be handled sensitively so as not to heighten trauma, raise expectations or exhaust communities repeatedly interviewed by any number of organizations. The collection of information must translate quickly into humanitarian action and serve the purpose of improving services for mine victims to integrate socially and economically into their communities.[14]

Summary of Lessons Learned: The discussion on data collection was long and heated with a general consensus that this issue needs a more rigorous examination than was possible at this workshop. The discussion ranged well beyond the Guidelines admonitions on survey protocol. Participants agree that this is the one issue about which we still argue and with considerable passion because data collection for decision making is hard to get right.

[13] *Op Cit.Guidelines for the Care and Rehabilitation of Survivors.*
[14] *Ibid. Guidelines for the Care and Rehabilitation of Survivors.*

Data collection covers a lot of territory from the most basic questions regarding what tracking systems are needed in a workshop/clinic to admit patients, track care, follow up and monitor individual progress toward rehabilitation to aggregate data needed by national planners. Even at the clinic level, too many systems don't match; information can't be shared; there is too little agreement on what crucial data must be kept and how to house it in such a way that it is useful to multiple users. What is needed to plan at the local, national and regional level? Who does this work and how can the community of practitioners find the most cost efficient manner to collect and disseminate the most useful information? This is an arena fraught with difficulty!

Data is a tool for better decision making and planning and all agree that is why it is important. Good impact indicators depend on good data. Most amateurs collect too much and then cannot use what they have effectively. All rehabilitation organizations should look first at what is available already and build off it. ICRC's patient management system software will be available by mid-summer 2004 and should be examined for universal applicability in physical rehabilitation programs.

NGOs need to coordinate much more closely on data standards and the tools necessary to collect it. Consideration should be given to funding an intranet site organized by key topics where tools in use by NGOs could be posted for review and use by other programs. Information available could range from patient intake forms, job descriptions for technical staff and managers, impact indicators for physical rehabilitation, tools for organizing self-help groups to cost analysis software and budgets for standard program activities. Some programs are now seeing increasingly complicated cases and thus require access to more sophisticated medical and rehabilitation sources, often available through universities. The sector could make better use of CDs, DVDs, etc. NGOs should hold themselves to high standards of collaboration and make sure that uniform systems of collection and dissemination are established within the sector.

Effect of the Treaty on Data for Decision Making: There is concern that the Treaty has skewed data collection within countries away from tracking disabilities in favor of tracking one class of disabled – war victims. And data collection on landmine victims alone can unintentionally limit funding for disability programming in general.

Recommendations:

- Evaluate existing data collection tools and fund the expanded use of the good ones.
- Fund an organization to house and manage an intranet site for rehabilitation professionals working in low income countries that would make available a wide range of both existing and yet to be developed data collection tools from patient intake forms to cost analysis software[15].
- Provide expertise to national planners involved in long term planning for persons with disabilities.

I. Coordination

This final category was added in by the workshop organizers as it is not a category included in the Guidelines for the Care and Rehabilitation of Survivors. It was included, however, because this workshop offered an interesting opportunity to consider coordination mechanisms among all three stakeholders whose work was being reviewed: NGOs, national institutions and donors.

The Aim: Effective coordination promotes the development of efficient and cost effective programs to assist war wounded and other persons with disabilities living in mine-affected countries. Collaboration needs to take place within NGOs, national institutions and donors and among all three stakeholders at the international, regional and country level.

Summary of Lessons Learned: The workshop considered coordination in the broadest possible sense whether within a single organization, within the sector, a country, a region, or internationally. Debates continue over who is coordinating whom? What is to be coordinated? How does good coordination work in practice? Participants agreed that coordination works when there is a common need, interest or vision. The strongest and best financed entities tend to take the lead in coordination at the field level, which means that NGOs are all too often found in this role. This is both a curse and a blessing – dangerous because unilateral decision making can disenfranchise other stakeholders with serious consequences for long term sustainability. NGOs sometimes need to play a lead coordination role regardless of the dangers because counterparts among national institutions are poorly organized, poorly trained and lack resources.

Overall, coordination is strong in several key countries, i.e., Cambodia and Afghanistan and is improving in Angola. In Cambodia the Disability Awareness Council (DAC) was funded by an international donor and provided an important structure to help set and maintain standards among organizations. The DAC brought together all organizations working in rehabilitation and led to sharing of information, bulk purchase of raw materials, sector wide impact analyses and shared training. DAC members have been working on a sector wide strategic plan that covers the next ten years. Above all, the DAC helped organizations find a common voice, which gave them leverage and coherence in negotiations with the Cambodian government for increased support. NGO collaboration also has made it easier for the government to obtain accurate and useful information to use in planning.

In Afghanistan, privatization has begun to have a serious impact; it is pushed by the donors and NGOs now compete with the private sector for funds. UN institutions play a large role in coordination through the distribution of funds and through monitoring and evaluation of expenditures. Local bodies increasingly coordinate among themselves to good effect.

Confusion exists as to the role of major multilateral institutions in coordination, especially for the long term. What is the role of WHO, for example? What should it be? Coordination and communication is lacking at the inter-governmental level, but no one is sure who might be best for this role. The sector as a whole still needs mechanisms to share information and experience and to efficiently refer patients to the available services.

There is a growing appreciation for mainstreaming of disability in all areas of World Bank planning, an effort spearheaded by Judy Heumann, and many believe that the UN system should consider doing the same. University connections and networking need exploring as programs grow more sophisticated and need access to better research and design. The Omega Initiative

[15] Implementing prosthetics & orthotics Projects in Low-Income Countries includes a very useful list of information sheets, forms and other essential documents needed for to implement a P&O program. The documents listed, for example, could be housed on such an intranet site so as to be available for program staff globally.

www.omegainitiative.org is a new source of information and networking for sub-Saharan Africa rehabilitation programs, as is the Asia-Pacific Development Center on Disability (APCD Project) www.apcdproject.org for Asia Pacific.

Effect of the Treaty on Coordination: The Treaty has created a number of new mechanisms and institutions that have led to improved coordination, particularly at the international level. UNMAS, MASG and the ISCs serve as coordinating bodies and as a forum for the exchange of information and standard setting at the multinational level. Regionally, the Organization of American States has begun to implement the Treaty in Central and Latin America. Standard setting documents like "Implementing P&O Projects in Low-Income Countries" reviewed in this report grew out of the initiative of NGOs attending the ISCs on Victim Assistance. In general, the various stakeholders are talking to each other more at the international (diplomatic) level. Some of this interchange trickles down to the countries in which program is being implemented through NGOs' head quarters.

Recommendations:

- The UN should consider mainstreaming disability, and consider the current initiatives at the World Bank.
- NGOs and donors should investigate ESCAP as a source for regional coordination in Southeast Asia.
- Fund the development of links between NGOs and other institutional training programs and universities to help meet long term training needs.
- Fund small grant making mechanisms, which reach out to indigenous organizations that are often otherwise beyond the reach of international funders.
- Donors, NGOs and national institutions should all insist on country-wide coordination within the sector to develop standards and strategic planning and to address training needs.

III. Conclusions

Participants in the workshop found they agreed more often than they disagreed on the strengths and weaknesses characteristic of NGOs, national institutions and donors working on assistance programs for war wounded and other persons with disabilities living in mine-affected countries. Rehabilitation NGOs, local partners and donors have been working together in countries like Cambodia and Afghanistan for more than a decade. Sharp disagreements over technologies and standards have been largely resolved and a broad consensus is emerging on a number of key issues. In a very real sense, all serious practitioners know that good outcomes for patients are not only possible but astoundingly liberating when done right. But the road to good practice is hard and everyone who has started down it over the past twenty years has been to some extent humbled – no one thinks they can make the journey alone.

Lessons Learned

Although the discussions were often very detailed, five reoccurring themes emerged from the SWOT analyses.

- Medical help, especially surgery, remains surprisingly weak in a significant number of countries and should be addressed again, this time from a long term development perspective.
- Strategic Planning matters. Without coherent long term strategic planning at the local, national and international levels and among all the players, there will be no long term sustainability for rehabilitation programs.
- Linkages matter No single NGO, national institution or donor can make significant contributions to strong and sustainable programs in isolation. The growth of health delivery systems, economic integration and access to all services for persons with disabilities will stem from intelligent, collaborative and cost efficient linkages among a wide number of actors.
- Collaboration and Coordination are key building blocks for program sustainability.
- Livelihoods are paramount. Economic integration is the primary unmet need identified by beneficiaries in every mine-affected country in the world.

Primary Issues to be addressed

To determine how each participant would approach the major issues confronting the development of rehabilitation programs in difficult circumstances, each was asked what one new issue he or she would invest serious time and effort in solving over the next 18 months if time and funding permitted. Their answers overlapped to a significant degree and were concentrated around training, capacity building and expanding services through collaboration and linkages.

Strategic planning:

- Help all players shift from a victim assistance approach to a disability approach in all funding and planning.
- Contribute to effective national planning.
- Improve the planning process for economic integration and training.
- Expand coverage of service delivery through improved planning and collaboration.

Coordination/Collaboration/Linkages:

- Improve rehabilitation interventions at each level in country: center, community, and government.
- Improve collaboration at the national level among all three stakeholders.
- Work to include PWDs in all poverty reduction planning undertaken by development agencies.

- Work on broadening P&O programs to incorporate all other aspects of rehabilitation work.

Training & Tools Development:

- Improve the quality of physiotherapy and P&O through training.
- Develop better financial management systems for P&O workshops.
- Develop standards for measuring impact and follow up.
- Improve training for managers.

Advocacy:

- Organize self-help groups among PWDs to advocate on their own behalf.

When asked which three components of rehabilitation work each participant would recommend that donors fund over the next five years the top four choices were:

- Economic integration activities;
- Expand access to and build sustainability for physical rehabilitation programs;
- Long term training for technical experts, management and capacity building; and
- Capacity building for national planning for local counterparts.

Suggestions for Stakeholders

Finally, participants offered up the following observations for each of the stakeholders to keep in mind while planning and implementing program over the next five years.

NGOs should work to

- Use a participative and multi-disciplinary approach when planning for program and involve local counterparts from the inception in both planning and implementation;
- Do better long term planning and coordination while listening to local partners;
- Build in benchmarks and timetables for the removal of expatriates and the assumption of program control by local staff from day one of program planning;
- Develop achievement strategies at the national level;
- Improve coordination of activities among all NGOs to save resources and make better use of funds and staff; and
- Work to extend service delivery coverage.

National Institutions should work to

- Increase governmental budgets for rehabilitation programs;
- Develop and enforce national planning that incorporates the work of NGOs and includes measurable implementation mechanisms;
- Coordinate donor flow of funds through national planning;
- Develop fee for services programs and be innovative in developing other ways to finance health delivery;
- Work with NGOs without expecting per diem payments;
- Demonstrate increased commitment to develop internal capacity;
- Select the right people for the right jobs and increase transparency; and
- Treat PWDs as equals.

Donors should

- Worry about quality, not quantity;
- Treat victim assistance as a development issue;
- Develop mechanisms to give small grants to local players;
- Fund realistic long term programs including training and capacity building;
- Put more emphasis on capacity building;
- Monitor implementation and keep funding;
- Broaden victim assistance support to include all disabilities;
- Fund measurable capacity building in national planning and implementation;
- Develop trust in and with government; and
- Know that the creation of rehabilitation assistance systems needs committed funding and follow up for long periods of time.

Funding Recommendations

Finally, when asked which three components of rehabilitation work each participant would recommend that donors fund over the next five years the top four choices were:

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- Expand access to and build sustainability for physical rehabilitation programs;
- Long term training for technical experts, management and capacity building; and
- Capacity building for national planning for local counterparts.

Annexes.

SWOT Analyses: strength, weakness, opportunity, threat

MEDICAL CARE: SWOTS 1 - 3 & Effect of the Treaty

NGOs & Medical Care: SWOT 1

Internal	External
Strengths • *Have organizational links to mine risk education* • *Can forge linkages to other medical institutions* • *Speed* • *Technical expertise* • *Have staff and material resources to address issue* • *Beneficial side effects: strengthens other services, systems and beneficiaries* • *Easy to fund raise for victims*	**Opportunities** • *Strengthen linkages to mine risk education* • *Can tap into additional funding to address problem* • *Strengthen linkages to other medical organizations* • *Can develop Standardization* • *The Treaty* • *Can introduce importance of surgical intervention in successful rehabilitation*
Weaknesses • *Sometimes have poor links to mine risk education* • *Emergency, not development, oriented* • *Lack of continuing care* • *Charity orientation* • *Lack of local capacity building* • *Lack of understanding of local context* • *Lack of coverage* • *Institutional focus – too centralized* • *Poor linkages with other organizations with expertise* • *Weak partners* • *Don't tap all resources available within any given country* • *Poor training – bad attitudes toward trainees and/or counterparts* • *Inappropriate interventions* • *Too late – don't train each new generation of doctors*	**Threats** • *Continuity of mine risk education not supported thus leaving new populations at risk* • *Funding (running out, too short term)* • *Lost capacity* • *Sustainability* • *Transition from emergency care* • *Emergency care focus (save lives), but no long term focus on disability* • *Limitations of MoH budgets* • *No linkage with public policy* • *No public policy* • *NGO inputs can distort health systems* • *Too specialized (not integrated or coordinated with existing systems)*

National Institutions & Medical Care: SWOT 2

Internal	External
Strengths • *Strengthened capacity* • *Know local context* • *Don't segregate between mine injuries & other injuries* • *Availability of staff & infrastructure to take advantage of what NGOs bring* • *Sustainability and continuity* • *National coverage* • *Training levels increased/strengthened capacity*	**Opportunities** • *Strengthened capacity* • *Can provide national coverage* • *Can mandate increased training* • *Privatization* • *Can be institutional memory* • *Real interest in other heath care delivery*
Weaknesses • *Incompetent staff/government counterparts* • *Don't know local context (urban based government planners unfamiliar with rural realities)* • *Uneven geographical coverage (e.g. urban/rural distribution of services)* • *Uneven resource allotment between civilian/military* • *Internal discrimination* • *Insufficient staff/inadequate staff salaries* • *Lack of ongoing running funds* • *Lack interest in improvements (institutional & individuals)* • *Lack institutional memory* • *Sustainability of quality* • *Weak surgical techniques, training and poor aftercare* • *Ministerial limitations*	**Threats** • *Incompetent staff/government counterparts* • *Uncontrolled privatization* • *Weak policy and/or implementation* • *Local institutions lack access to donors* • *Lack of multi-disciplinary approach* • *Lack of management skills* • *NGOs can distort national priorities* • *Over-run by NGOs* • *Lack of autonomy/control* • *No long term impact*

Donors & Medical Care: SWOT 3

Internal	External
Strengths • *Resources: money & access* • *Can serve a coordination function* • *Can insist on clarity re measurement of impact* • *Can help expand services, both range and focus* • *Donor personality* • *Continuity of policy*	**Opportunities** • *If donors listen, could really help national institutions* • *Communication: attract other resources* • *World Bank* • *Conditional aid: demanding resource match* • *Disability convention process* • *Can link with national institution*
Weaknesses • *No priority – too much demand on limited funding* • *Don't listen to national authorities* • *No enough emphasis on medical care* • *Limited focus/short term focus* • *Distort application of standards by funding unqualified entities* • *Competition among donors* • *Politics versus need* • *National priority: for policy, local politics* • *Too emotional* • *Too political* • *Lack knowledge and information* • *Results focus sometimes too limited*	**Threats** • *Distort external priorities* • *Substitute for government* • *Who decides priorities* • *Distort power of local government* • *Force national policy* • *Short focus/time frame* • *Donor personality* • *Continuity of policy* • *Unwilling to tackle limitations of medical systems in poor countries*

Effect of the Treaty on Medical Care

- *Still on drawing table – Medical care generally weakest of all components*
- *Have survival rates changed? Do we know?*
- *Quietest Voice: Response not proportionate to the problem*
- *Do medical care standards from VA carry over to non-mine affected countries? Shouldn't we know?*
- *Must infiltrate system: hasn't been seen as system problem*
- *Everyone has seen examples of lost/wasted training opportunities*
- *Have seen NO improvement in medical care*
- *System lacks knowledge*
- *Prevention has improved/worked somewhat*
- *Treaty players don't understand medical care delivery*
- *Treaty money flowed through Foreign Ministries, not bi-lateral and multi-lateral institutions and Foreign Ministry staff rarely experienced in health sector development issues*
- *Examine partners in medical care: some players never or intermittently at the table*
- *Need a broader buy in (and better appeals to) donors*
- *Did we advocate broadly enough for medical care?*
- *We moved forward with what we had and it wasn't enough*

PHYSICAL REHABILITATION: SWOTS 4 - 6 & Effect of the Treaty

NGOs & Physical Rehabilitation: SWOT 4

Internal	External
Strengths • *Technical expertise* • *International logistical systems* • *Management expertise* • *Access to training* • *Curriculum development* • *Fund Raising/mobilization of resources & access to new funders* • *Can develop/use impact indicators* • *Hire/Fire* • *Communication with government, other NGOs, donors* • *New Blood* • *Mobilization of People* • *Can hook up to charity* • *Service direct to targets* • *Quality*	**Opportunities** • *Can introduce measurement tools to national entities* • *Can be replicated (management expertise)* • *Quality of life improved by rigorous use of impact indicators* • *Broaden service delivery (tied to communication skills)* • *Extend service reach (tied to mobilization of people)* • *Sustainability (can hook up to charity)* • *New donors (exploitation of funders* • *Can help expand services within country (service direct to target)*
Weaknesses • *Move too fast for partners* • *Limited NGO focus* • *Charity focus* • *Emergency focus* • *Use means that are unsustainable* • *Can't go small* • *Focus on war victims* • *Expectation of expertise not always delivered* • *Expats cost a lot* • *Curriculum unrecognized by government* • *Don't analyze service provision* • *Don't fund raise at local level* • *Staff turnover* • *No flexible curriculum: important for physical rehabilitation* • *Quality* • *Cannot integrate staff* • *Unsustainable programs* • *No government recognition for non-formal training* • *Prefer weak partners* • *Rehabilitation only with one ministry* • *Don't want to be unemployed* • *Too much emphasis on service delivery* • *Weak local partners*	**Threats** • *Miss the development boat* • *No certification* • *No integration into national systems* • *Not sustainable* • *Loss of history (staff turnover)* • *Sustainability affected by lack of local influence on NGO fund raising decisions*

National Institutions & Physical Rehabilitation: SWOT 5

Internal	External
Strengths • *Continuity* • *Vested in their countries* • *Charity* • *New donors* • *Training facilities exist* • *Can lobby local government* • *National institutions can become sustainable*	**Opportunities** • *Institutional history (linked to continuity)* • *Expansion of donors (new donors)* • *Training can be strengthened using locally available institutions both private and governmental* • *Expand services through lobbying of local government* • *Extension of services possible IF based on national institutions*
Weaknesses • *Inter ministerial competition for limited resources* • *Lack of collaboration/communication among ministries* • *No inclusion of users in planning* • *Charity – government mandated. Limits funding options* • *Narrow definition of beneficiaries* • *Lack the facts needed to argue contribution of rehabilitation to development. Need to prove macro argument* • *Little to no impact research* • *Unsustainable programs*	**Threats** • *Limited partners* • *Bad program (no inclusion of local users in planning)* • *Limited service (consequence of narrow definition)* • *Ultimate failure of services (unsustainable programs)*

Donors & Physical Rehabilitation: SWOT 6

Internal	External
Strengths • *Resources: money & access* • *Growing expertise among some funders* • *Could coordinate funding* • *Can help expand services, both range and focus* • *Donor personality* • *Continuity of policy*	**Opportunities** • *Growing expertise leads to better funding choices* • *Communication: attract other resources* • *World Bank* • *Conditional aid: demanding resource match* • *Disability convention process*
Weaknesses • *Charity approach* • *Don't coordinate funding* • *Lack expertise* • *No mechanisms to fund small local initiatives* • *Too narrow a definition of disability* • *Competition between donors inhibit NGO collaboration* • *Too emotional & too political* • *Lack knowledge and information* • *Results focus sometimes too limited*	**Threats** • *Lack of expertise can result in poor funding decisions* • *National interests can result in duplications of program* • *Lack of continuity of policy can leave good programs without funding and kill them before sustainable*

Effect of the Treaty on Physical Rehabilitation

- *New category or class of disabled has been created/emphasized*
- *National mine action plans created; many not yet implemented*
- *Skewed priority towards prosthetics (Question as to whether skewed funding)*
- *EU funding increased in 2000; Creation of ITF with funding for VA in Balkans*
- *Awareness/attention towards mine victims/amputees*
- *Attention for Angola*
- *Private funding has expanded*
- *National institutions expect(ed) funding from outside*
- *NGOs have to defend idea that services have to be open to all disabled*
- *Broadened definition in Geneva ISC, but narrowed focus in mine affected countries*
- *Very diversified attention to mine action*
- *WHO OMS put special attention on disability but some question if this due to treaty*
- *Do we need an economic integration treaty?*
- *Attracted attention from private funders*
- *Afghanistan plan includes VA*
- *Clashes between treaty-focused planning and other previously existing priorities*
- *No money for economic integration in Angola*
- *Pilot projects for economic integration*
- *Landmine victims associations lobbying government to pay attention to them*
- *VA projects sprang up from ICBL campaigns*
- *Connection between ICBL campaigns & national institutions*

Document Review of P&O Draft[16]

Internal	External
Strengths • *Lists one pager basic needs/requirements* • *Comparison tool* • *Standardize expectations* • *Reinforce factors of success* • *Evaluate internal* • *May identify weaknesses* • *Feedback to donors* • *Living document* • *Cross references excellent* • *Help/encourage institutional relationships*	**Opportunities** • *Use as tool to evaluate projects* • *Measurement tool among organizations* • *Base line data & interpretation (relates to comparison tool)* • *Lessons learned (may identify weaknesses)* • *Make it a living document: make a check list; make it easily available via internet as well as hard copy with removable forms & simplify*
Weaknesses • *Limited point of view as a tool* • *Doesn't reflect beneficiaries point of view* • *Doesn't address need for team approach, role of ministries, weaknesses in medical systems & the need to improve them* • *Not user friendly* • *Set up in other formats: short and intermediate versions* • *Over emphasis on P&O Cat I* • *Team follow up not persuasive* • *Need to emphasize inclusion all relevant disciplines* • *Institutional networking* • *Medical linkages* • *Sustainability??*	**Threats** • *Over focus on CPO/P&O undercuts holistic approaches to physical rehabilitation* • *CPOs will dominate (over emphasis on P&O, Cat I)*

[16] *Implementing prosthetics & orthotics Projects in Low-Income Countries: A Framework for a common approach among international organizations*

PSYCHO-SOCIAL SUPPORT: SWOTS 7 - 9 & Effect of the Treaty

NGOs & Psycho-Social Support: SWOT 7

Internal	External
Strengths • *Peer support/volunteers* • *P&O Workshop to REHABILITATION* • *Sports – when defined broadly* • *Can network & refer* • *Can help train* • *Provide goods/services (economic)* • *Can help create social work as new field* • *Can introduce other activities, e.g., sports* • *Inviting new field* • *Identify need and find new partners* • *Can educate institutional structures* • *Can employ workers in the centers dedicated to this function* • *Most show utility links to domestic violence/abuse* • *Crucial to combat depression* • *Help overcome isolation – injured often self-isolate if don't have family/community support* • *Attention to PWD can change attitudes* • *Economic role KEY: crucial to integration* • *Peer support – understanding importance* • *Enlist parental support*	**Opportunities** • *Creative approach* • *Rehabilitation Centers can provide inclusive range of services* • *Can be powerful psychological tools; must be inclusive* • *Intervene at moment of injury* • *Better use of UNDP quality-of-life tool*
Weaknesses • *Measuring impact: how is this done?* • *Unclear definitions of what is done* • *Poor follow up* • *No or weak evaluation* • *Lack of understanding of terms* • *Confusion with economic reintegration* • *Needs to start the moment from when the person wakes up after surgery but often doesn't* • *Is seen as fluff because we do a poor job of explaining it* • *Pain management* • *Limb use affected by psychological state* • *Poor communication skills among health workers* • *Peer support* • *Don't make case for sports well* • *CBR mistakes will be replicated in sports programming*	**Threats** • *Won't attract funding* • *Over professionalization (sports)* • *Danger of becoming elite and exclusive*

National Institutions & Psycho-Social Support: SWOT 8

Internal	External
Strengths • *Culture: if properly utilized* • *Sports & recreation already exist pretty much everywhere* • *Raising the Voices* • *Understanding the need. Field is there if utilized (nb in other fields, e.g., social work, child soldiers, torture victims, etc.)* • *Existence of Social Services* • *Can create jobs* • *Encourage other organizational involvement* • *KEEP! …SUPPORT*	**Opportunities** • *Culture can enhance social support* • *Can expand to include PWDs*
Weaknesses • *No social workers* • *Need innovative ways to approach* • *Weak link between hospitals & NGOs* • *Documentation weak* • *How do you institutionalize peer support* • *Distorted views of disability*	**Threats** • *Culture can hinder social support and "lock help out."*

Donors & Psycho-Social Support: SWOT 9

Internal	External
Strengths • *If prove utility* • *Sports are sexy*	**Opportunities** • *Donors would fund* • *Will attract new donors*
Weaknesses • *Perceived as fluff* • *May not fund if benefits not clearly defined* • *Donor fatigue in some of the older organizations*	**Threats** • *Won't fund*

Effect of the Treaty on Psycho-Social Support

• *Limited but have introduced the concept to new players*

ECONOMIC INTEGRATION: SWOTS 10 - 12 & Effect of the Treaty

NGOs & Economic Integration: SWOT 10

Internal	External
Strengths • *Wherewithal to provide incentives to include PWDs* • *Linkages to funds* • *Can target PWDs* • *Not too expensive* • *Follow evaluations* • *Training* • *Counseling* • *Bridge gaps* • *Integration of national entities* • *Can help address prejudices* • *Lots willing to do it* • *Can build on what's already out there, e.g., village economy* • *Bring knowledge of PWDs to other agencies* • *Identify financial partners* • *Grants/loans*	**Opportunities** • *Access to other systems* • *Advocates for access* • *Can promote more effective programming* • *Choice & ability to make better ones* • *Loans, not grants (linkage to funds)* • *Loans, return for service* • *Access (help address prejudices)* • *Can replicate* • *Networking (strength linkage to funds)* • *Can expand (Identify partners)*
Weaknesses • *Poor standards* • *Decentralized structures* • *Poor follow up* • *People dabble* • *Lack of skills in field* • *Lack of coordination among NGOs* • *False good ideas* • *Lack of creativity* • *Badly designed programs* • *Charity* • *Loans vs. grants -- confusion*	**Threats** • *Missed opportunities re linkages limits options for effective referrals for PWDs* • *Equal opportunities* • *No jobs (badly designed programs)* • *No sustainability (charity)* • *No market (charity)*

National Institutions & Economic Integration: SWOT 11

Internal	External
Strengths • *Informal economies – not too strict* • *Unregulated economies* • *Can be voice of PWDs* • *Labor marketing forecasts* • *Can identify partners* • *Good vocational training* • *Micro credit institutions* • *Educational systems* • *Role modals* • *Government incentives*	**Opportunities** • *Networking* • *Assistance to small business* • *Informal economies – opportunities* • *Establish placement strategies for PWDs (from labor marketing forecasts)* • *Loans/micro finance* • *Decentralization of approach* • *Hire disabled (role modals)* • *Community based*
Weaknesses • *Limited economic opportunities* • *Decentralized systems* • *No access to micro finance* • *PWDs cannot access good vocational training* • *PWDs cannot access micro credit* • *Lack of creativity in approach to issue* • *No access to education* • *Social attitudes & social stigmas*	**Threats** • *Less opportunities for PWDs* • *Wrecked economies* • *Weak economics*

Donors & Economic Integration: SWOT 12

Internal	External
Strengths • *Funds* • *Enforce access* • *Realistic assessments of opportunities* • *Institutions with expertise*	**Opportunities** • *ILO* • *FAO – mainstream* • *Advocates for access* • *Networking*
Weaknesses • *Denial of access to PWDs* • *Limited imagination*	**Threats** • *Failure*

Effect of the Treaty on Economic Integration

- *Similar to Physical Rehabilitation in that sub-category of PWDs get special attention*
- *For most economic integration activities that existed before targeted all PWDs*
- *For some, programs designed for amputees benefited other PWDs.*
- *Positive effect was bringing many actors in line – created discussion/dialogues*
- *Shifted caseloads—more PWDs from non landmine causes*
- *Donors say "We don't mind if you see other disabled as long as you also treat landmine victims"*

CAPACITY BUILDING & SUSTAINABILITY: SWOTS 13 - 15 & Effect of the Treaty

NGOs & Capacity Building/Sustainability: SWOT 13

Internal	External
Strengths • *Can provide tools for capacity building: training, OCAT (PACT)* • *ISPO scholarships for CPOs*	**Opportunities** • *Transfer to long term development from emergency* • *Plan your long term course honestly and proactively and let donors know your strategies* • *Persuade donors to de-link capacity building from programs* • *Train sufficient staff to allow for staff loss and movement into other sectors* • *Peace processes*
Weaknesses • *No similar program for PTs (ISPO/CPOs)* • *Planning processes often fail to involve local actors from the start* • *Who sets standards* • *Budgeting & management* • *Better definitions of needs so can establish clear and coordinated training plans* • *Budget transparency* • *Measuring impact of capacity have and what's needed* • *Limited understanding of key role of managers* • *Overemphasis on P&O, CPOs, CAT I* • *CPO promotion opportunities, but this group not always good managers* • *Management systems must be part of larger systems* • *Clear understanding of emergency to development framework* • *Linkages to other institutions* • *Don't do assessments* • *Loose definitions of capacity* • *Don't train ministerial capacity* • *Build in management from the start* • *Prepare exit strategy from beginning*	**Threats** • *Sending people abroad and they don't come back or they come back to a non-functioning system* • *Since don't train ministerial counterparts, don't create serious partners with capacity to oversee programs and/or set standards*

National Institutions & Capacity Building/Sustainability: SWOT 14

Internal	External
Strengths • *Some countries have capacity building departments within government, e.g., Ethiopia* • *Leadership capacity* • *Established budget for running costs from government* • *There is money for education* • *Setting clear salary scales* • *Cost recovery can be a means to increase salaries of technical staff*	**Opportunities** • *Greater ability to plan and oversee programs* • *Training CPOs/ management* • *Placement after training* • *Default on salary agreements carries a penalty* • *System of pledging to work in country that paid for training. Only give certificate to those who fulfill in country work requirements.* • *Set aside severance or bonus for workers which they receive after number of years of service* • *Stimulate government to include rehabilitation skills in government budget/ planning for education*
Weaknesses • *Lack of capacity in ministries* • *There is no planning for how to use those educated* • *No data on number of CPOs or the number needed* • *No status for CPOs, PTs, etc.* • *Educated cadre inserted into systems with no oversight leads to collapsed systems* • *On again/off again commitment* • *Unclear understanding of roles/training required* • *Do we know management training institutions relevant to our needs* • *Lack of leadership capacity* • *Lack of budget – ongoing costs, training, etc.* • *Loose terms – capacity building* • *Unclear standards* • *No budget for running costs & raw materials* • *Inability to retain trained people due to low salaries/prestige*	**Threats** • *Lack of capacity in ministries means no capacity to oversee or coordinate programs* • *People trained won't come back* • *Brain drain* • *Human resource market – trained people move easily to higher paid jobs* • *Capacity building for what? For positions with no status or budgetary commitment?*

Donors & Capacity Building/Sustainability: SWOT 15

Internal	External
Strengths	**Opportunities** • *Can have local NGOs apply for funds directly and thus build capacity as learn to access own needs* • *Can funds for capacity building of national institutions* • *Involve whole range of local partners at every stage of planning* • *Insist on joint management including bank accounts, joint decisions on spending* • *Capacity building plan/strategy has to be built in from beginning even during emergency* • *Policy development*
Weaknesses • *Very little materials/methods exist for capacity building in psycho social work* • *Little tolerance for capacity building in psycho-social work* • *Donors have a limited view of the capacities that are needed* • *Donors need to realize the importance of capacity building and its complexity* • *Definitions unclear* • *Contradictory demands on sustainability* • *Constrained by fact landmine monies often flow through Foreign Ministries, whose staff often have a limited understanding of capacity building issues*	**Threats** • *None identified*

Effect of the Treaty on Capacity Building/Sustainability

- *Support for Raising the Voices and other initiatives*
- *Feed back – engaged in the issue*
- *Landmine Monitor teams around the world can help build local capacity*
- *UNDP and other UN agencies now turn to NGOs with knowledge of sector*

LEGISLATION, ADVOCACY & PUBLIC AWARENESS: SWOTS 16 - 18 & Effect of the Treaty

NGOs & Legislation, Advocay & Public Awareness: SWOT 16

Internal	External
Strengths • *Pressure* • *International Day of the PwD* • *Can help organize local self-help groups* • *Teach the law* • *Coordinate government activities, for example, in schools & hospitals* • *Eastern Europe Sharsee projects use human rights approach* • *Access to legal threat* • *Training/communications; public awareness* • *Look for other advocates*	**Opportunities** • *Can lead to civil society strengthening* • *Sharing experiences among NGOs can lead to better results* • *Tapping into civil society; making links between what we do and Human Rights* • *Issue of compensation of LMVs deserves our attention* • *Possibility to unify the various DPOs* • *Link with other partners, e.g., human rights organizations* • *Capacity building*
Weaknesses • *Measuring impact* • *Division of DPOs according to the cause of disability* • *Cultural awareness – human rights not universal* • *Do not ensure that local NGOs take the lead* • *Need capacity building and opportunities*	**Threats** • *No follow-up/no funding*

National Institutions & Legislation, Advocacy & Public Awareness: SWOT 17

Internal	External
Strengths • *International Day of PWDs* • *Legislation* • *Eternal debate – disability included in all general laws or as a separate disability law?* • *Legislation is crucial as a starting point to get NGOs to do more and to provide a foundation for planning* • *Coordination: e.g., NGOs, schools, hospital*	**Opportunities** • *International Day to be used effectively* • *Enforcement of legislation by new actors* • *Pressure can be put on government to implement & make changes* • *Countries with legislation can provide "peer pressure" to those that don't* • *New Disability Convention may be huge boon to funding opportunities for all PWDs* • *Legislation can be an opportunity for DPOs and others* • *Compensation for laws*
Weaknesses • *Measuring impact* • *Inter-ministerial competition / confusion* • *Enforcement of legislation*	**Threats** • *No follow up / no funding* • *People may consider that new Disability Convention may lead to belief that VA has been solved* • *Legislation can be on paper but ineffective as force for change unless implemented* • *Could be bad legislation*

Donors & Legislation, Advocacy & Public Awareness: SWOT 18

Internal	External
Strengths • *Can be teeth in enforcement through funding power* • *Funds exist for civil society* • *Information sharing* • *Can fund cross-fertilization* • *Multilateral institutions and bilateral funders can insist on implementation* • *Can do block grants*	**Opportunities** • *Fund local groups* • *Help PWDs tap into self-advocacy* • *DPOs to hire lawyers to help legislation become implemented* • *Build organizational capacity and advocacy capacity of DPOs*
Weaknesses • *No mechanism for small-scale delivery*	**Threats** • *Want to avoid compensation liabilities*

Effect of the Treaty on Legislation, Advocacy & Public Awareness

- *Can be vehicle for unified voices on issue*
- *Raising the Voices*
- *Treaty has obliged governments to look at delivery systems for PWDs including legislation*
- *Also can be segregating voice: treaty can unify or can separate*
- *Has brought more visibility to disability issues and to the NGOs working in this field and may well lead to attitude changes*
- *Greatly increased public awareness in many countries*
- *No compensation for war victims yet but has raised issue*
- *National mine action planning can link to broader legislative initiatives and enforcement/implementation mechanisms*
- *Dream: massive class action suit on behalf of mine victims*

ACCESS TO SERVICES: SWOTS 19, 20, 21 & Effect of the Treaty

NGOs & Access to Services: SWOT 19

Internal	External
Strengths • *Cross referrals/networking* • *Use of numbers BK vastly improved since '95 (Cambodia)* • *Can provide transport to beneficiaries* • *Accessibility needs underwritten* • *Different approaches to access to services* • *Institutional support across sectors/NGOs* • *Recognition of necessity of access widespread* • *Can train/involve government as outreach to expand access (Cambodia)* • *Can educate donors on range of services* • *Advocates for quality and access* • *Transport support not automatic* • *Sliding scale for transportation/access* • *Proactively searching for community support for transport* • *Providing transport increases rate of usage* • *Efficient/intelligent spending of donor dollars*	**Opportunities** • *Need to advertise to make centers visible* • *Information campaigns need to be repeated* • *Create community network before setting up programs* • *Peer counseling can contribute to those in need learning what is possible* • *Satellite workshops* • *Outreach workers* • *Recognize when to let go of parts of services to other entities* • *Stress crutches availability* • *NGOs can push during emergencies for including access design into reconstruction (example, HI in Turkey after earthquake)* • *Educate donors that production numbers are not the only goal*
Weaknesses • *Contradiction inherent in most countries where expect hospitals to pay for crutches but provide devices free in rehabilitation centers* • *Overemphasis on devices – should be willing to distribute crutches in as widespread manner as possible* • *Timing* • *Information doesn't move internationally or within capitals nationally down to field level* • *Inefficient/unintelligent spending of donor dollars* • *Tendency to do everything ourselves is wrong* • *Tendency to centralize maintenance is wrong – need to let go* • *Don't recognize that we are in intersectoral business* • *Support to beneficiaries for transport without question as what he/she or community can contribute* • *Some transport planning is just chasing numbers to justify workshops* • *People don't know centers exist* • *Design when limited to P&O only rather than broader rehabilitation center with involvement of community* • *Resistance to cooperate with hospital systems* • *Resistance to many approaches to mobility*	**Threats** • *Because information moves poorly, mistakes are repeated* • *Duplicate efforts* • *Create dependencies that last longer than necessary*

National Institutions & Access to Services: SWOT 20

Internal	External
Strengths • *Community assessment of needs when done well (Future Search – Nicaragua)* • *Some places local institutions support* • *Nicaragua: social security institutions refer to hospitals and clinics* • *Mozambique Model: mixture of support from two ministries (Health & Social Welfare). Use of transit centers.* • *Inclusion movements* • *Civil society and local institutions can play crucial role* • *CBR institutions (Balkans) very medical oriented; play strong outreach and peer counseling role* • *Bangladesh networks: training centers on disabilities* • *CBR/P&O link in Ethiopia provides interesting model* • *In Afghanistan, eye service hospital referral and NGO referral works well*	**Opportunities** • *Hospital-based information system* • *Cross referencing: to other institutions and within society* • *P&O Centers become HUBs rather than end points (Cambodia & Afghanistan)* • *ISPO interest in CBR* • *How to link with ISPO; how to understand role of ISPO and other professional associations* • *NGOs can utilize district/provincial government networks* • *Private – public referrals…patients come from hospital to clinic and back* • *Private practice linkages – as opportunities*
Weaknesses • *Relatively weak dollar commitment/ability to transport* • *Unwilling and/or unable to include across the board access for PWDs to whatever services exist for able bodied* • *Definition of CBR sometimes unclear. WHO uses definition of services owned by the community – rarely linked to specialist services* • *Access to research/development/training: where, when and how* • *Who's responsible: Industrialized societies have little to offer* • *Need P&O/PT etc. representative in ministry level planning* • *Poor institutional linkages among services (Laos) for example between hospital and clinics*	**Threats** • *Corruption & nepotism*

Donors & Access to Services: SWOT 21

Internal	External
Strengths • *Willingness to fund access* • *Widening of institutional support, e.g., Rotary, local churches, etc.*	**Opportunities** • *Donors should support mixed systems* • *Can help enforce standards* • *Can offer protection for civil society development* • *Donors can get the ear of other major donors and major multi-laterals regarding importance of access* • *Donors can influence access at International/national/ municipality*
Weaknesses • *Payment for transport/access unsustainable beyond emergency phase* • *By paying for everything we ignore the intersectoral nature of what we do* • *Transport can be provided to bring people in to meet production numbers* • *ISPO/WHO/Treaty connections lost* • *Can discourage private development*	**Threats** • *Emergency to development transition can be so poor as to undercut any possibility of sustainability*

Effect of the Treaty on Access to Services

- *Treaty networking have led to greater understanding of access issues among all donors.*
- *Focus on physical accessibility helped by treaty.*
- *Emergency phase is time to focus on access within society BEFORE rebuilding commences*
- *Treaty has not helped shift transition from emergency to development*
- *Livelihood not stressed any where near enough*
- *Access issues writ large – helped by treaty*
- *Has also created discrimination – fee structure in Bosnia, for example*

DATA COLLECTION: SWOTS 22, 23, 24 & Effect of the Treaty

NGOs & Data Collection: SWOT 22

Internal	External
Strengths • *Sometimes have clarity on what need to know and why* • *Can coordinate NGOs on data collection, standards and sharing within sector*	**Opportunities** • *Can discuss and help bring about consensus on data needs* • *Can agree on important questions that need answering* • *Can lead the way in sharing resources*
Weaknesses • *Not always clear why NGO(s) need to know* • *No uniform systems of collection* • *Consensus on data needs does not exist* • *Reliability of much data collected suspect* • *Too specific to landmine victims* • *Have not identified storage house*	**Threats** • *If can't show relationship between cost and delivery, gets very hard to work toward sustainability*

National Institutions & Data Collection: SWOT 23

Internal	External
Strengths • *Growing willingness to share data in many countries where we work* • *Templates are a starting point* • *Research done by various institutions – WHO/PSR often useful if circulated and used*	**Opportunities** • *Use variety of approaches including full coverage surveys or samples with extrapolations* • *Principles to apply to data collection can be developed and increasingly would be accepted* • *Center for Disease Control may be helpful new player here. See results of Afghanistan survey* • *Research/technical to update surveys – who has this expertise?*
Weaknesses • *Have people but no means* • *Planning and analysis for what? Need clear definitions and end use plan* • *Mixed data collections and mixed systems that can't communicate or aggregate data* • *Where to collect? Hospital? Center?* • *No centralization* • *No baseline data* • *Government underestimates need* • *Why hasn't disability issues been included in national censuses when done? Why don't governments want to know?*	**Threats** • *None identified* • *Will not be able to coordinate NGO/donor aid flow due to lack of strategic planning*

Donors & Data Collection: SWOT 24

Internal	External
Strengths • *Could/would fund data collection if users make clear what it is for*	**Opportunities** • *Donors support NGOs & national institutions to develop basic non-negotiable consensus principles on data collection.* • *Donors fund an organization to store and serve as gatekeeper of data for decision making in format and location that allows widespread access to data and data collection tools*
Weaknesses • *Lack indicators to measure victim assistance*	**Threats** • *Be careful of creating survey victims Be careful of having non-experts try to do this alone.*

Effect of the Treaty on Data Collection

- *Skewed data collection in mine-affection countries to landmine victims*
- *Can limit funding for overall disability funding*
- *Language in Landmine Monitor is problematic*
- *War-related injuries better term and at least more inclusive than landmine victims*
- *IMASMA does track recent victims but with two years limitation*

COORDINATION: SWOTS 25, 26, 27 & Effect of the Treaty

NGOs & Coordination: SWOT 25

Internal	External
Strengths • *Can standardize services* • *Professionalisation & growing maturity* • *NGO HQ network can provide direction for field staff* • *Free will/wish when needed* • *Good coordination comes from strong systems* • *DAC and individual characters and time* • *Dedicated staff can help it be effective* • *Can force coordination* • *Can free up resources (staff) to coordinate* • *Common standards – agreed to and coordinated* • *Cambodia – Angola* • *Listen to local authorities* • *Can challenge bad practice* • *Can provide protection to local authorities* • *Coordination strong when comes from free will when needed* • *Peer review*	**Opportunities** • *Strengthen standardization of services* • *Coordination* • *Direction for field staff* • *Diminishing returns leads to greater cooperation* • *Lessons learning – NGO in emergency* • *NGOs can assist in national coordination by insisting on it* • *NGO experience can help donors get it right* • *Can provide teeth to local authorities and donors* • *Results/information from mine ban treaty processes must trickle down to field*
Weaknesses • *Hard transition from emergency to development* • *Lack of continuity* • *No long term vision* • *Personality dependent* • *Force coordination* • *Lack of resources for coordination* • *One agency cannot do it alone* • *During emergency, have to coordinate* • *NGO HQs! Threats* • *Hobble growth of local players (easy to do during emergency phase)* • *Time consuming* • *Difficult* • *Corruption* • *Arrogance*	**Threats** • *Hobble growth of local players (easy to do during emergency phase)* • *Time consuming* • *Difficult* • *Corruption* • *Arrogance*

National Institutions & Coordination: SWOT 26

Internal	External
Strengths • *Better understanding of what we are doing – all partners* • *National Disability Commission – Afghanistan* • *Can have better ideal or selection of priorities and can speak to NGOs about direction* • *National Plans (where they exist)*	**Opportunities** • *Natural position to coordinate donor dollars and work in the country* • *Increase ownership* • *Multi-year planning process* • *Evaluate results – and correct the course of work if necessary* • *Can coordinate donors* • *Can negotiate with donors* • *Can call in help from NGO expertise*
Weaknesses • *Coordination external from NGOs and donors* • *Weak coordination among ministries* • *Chimney system / silos* • *Competition impedes coordination* • *No continuity* • *Weak capacity* • *No policy = no effective coordination* • *Lack resources for coordination*	**Threats** • *Vacuum* • *Corruption* • *Political instability* • *No State* • *Bureaucracy*

Donors & Coordination: SWOT 27

Internal	External
Strengths • *Can fund coordination mechanisms* • *Can insist on coordination among NGOs & counterparts* • *Can lead to stronger pressure on governments* • *Can be entry point or leaders of coordination mechanism* • *When donors call for coordination, it works* • *Over long term, efforts to coordinate will build capacity* • *Privatization* • *Ensure no duplications*	**Opportunities** • *Building capacity of coordinators is worth the price* • *CDAP/UNOPS/UNDP = tendering services* • *Use NGO experience* • *DFID Civil Society Tendering process for NGOs* • *Fitting into national plans*
Weaknesses • *Privatization* • *Having own priorities* • *Mechanism is a shell* • *Some don't care about it* • *No continuity* • *Donor-to-donor coordination is difficult/weak* • *Overlap*	**Threats** • *Privatization* • *Working outside National Plans (result own priorities)* • *Tendering* • *Donor driven projects* • *Duplication of program through lack of donor coordination or overriding national interests*

Effect of the Treaty on Coordination

- *UNMAS exists*
- *National plans for mine action can be starting place for broader coordinative mechanisms*
- *Mine action support groups*
- *ISC: provides guidelines and reports*
- *Treaty itself is a coordination body*
- *OAS: see implementation of treaty as responsibility*
- *P&O document and consensus it represents is example of increased collaboration and coordination through treaty relationships*
- *Coordination is at the upper levels*
- *Can and does educate stakeholders: diplomats*