



Salim was collecting firewood along with two other boys in central Tajikistan when they found a cluster munition. Another boy hit it with an axe and it exploded. During data collection, Salim points out which device they had found.

Chapter 5

Child-focused Victim Assistance

Section 5.1

Data collection and analysis

Explanatory Note

THIS document is one of **eight** PDF documents that comprise the Guidance on Child-focused Victim Assistance. All are available in PDF at <http://www.unicef.org/publications/>. The full document is also available.

The first PDF contains the Acknowledgements, Foreword, Acronyms and Chapters 1 through 4:

Chapter 1. Introduction: The Need for Child-focused Victim Assistance Guidance

Chapter 2. Mine Action, UNICEF and Guidance on Child Victim Assistance

Chapter 3. Victim Assistance: Stakeholders and International Standards

Chapter 4. Principles, Coordination and Cross-cutting Aspects of Victim Assistance

This stand-alone PDF document on **Data collection and analysis** is one of the six technical components of Child-focused Victim Assistance Guidance. Together, they comprise Chapter 5 – Child-focused Victim Assistance. The other five parts of Chapter 5 are:

Section 5.2 Emergency and continuing medical care

Section 5.3 Rehabilitation

Section 5.4 Psychological and psychosocial support

Section 5.5 Social and economic inclusion

Section 5.6 Laws and policies

The eighth and final PDF document, Chapter 6, contains resources and references that users may find helpful.

BETWEEN 1999 and 2012, 88,331 people living in some 60 countries are known to have been killed or injured by landmines or explosive remnants of war (ERW). Of these, at least 15,868 were under the age of 18 at the time of the accident. Although progress has been made in reducing the threat of unexploded ordnance worldwide, some 1,000 children – 90 per cent of them boys or young male adolescents¹ – are still killed or injured annually.

Cluster munition remnants and improvised explosive devices (IEDs) are particularly deadly for children. Blast and fragmentation injuries often cause long-lasting impairments including limb amputations, loss of eyesight and hearing, severe injuries to genitals, internal organs, face and chest, brain damage and spinal cord damage.

These physical injuries are aggravated by the psychosocial, socio-economic and protection consequences of the traumatic event of a blast accident as the survivors confront lifelong difficulties accessing education, livelihood opportunities and, like many vulnerable children with disabilities, are subject to violence, abuse and exploitation.

This Guidance was developed in response to requests for support in developing child-focused victim assistance programming. It provides support for:

- Developing new policies and programmes (or adapting existing ones) that assist child mine/ERW victims that are age- and gender-appropriate and promote the rights of children and young people² with disabilities.
- Promoting access for children directly and indirectly affected by landmines and ERW to comprehensive support in emergency situations, directly or through their families, communities and service providers.
- Designing programming for mine/ERW injured children that is mainstreamed into wider disability, economic and social development, and poverty reduction efforts.
- Supporting stakeholders to meet the needs and enhance the quality of life of children and their families affected by landmines and ERW by advocating for and facilitating access to affordable health care, rehabilitation, psychosocial support, social and economic inclusion (education, livelihood support and social assistance, etc.).
- Encouraging stakeholders to facilitate the empowerment and participation of children affected by armed conflict and of children with disabilities.

This Guidance will be useful to Governmental and non-governmental entities and civil society organizations that provide services or influence policy and budgeting related to survivors and victims of landmines/ERW and persons with disabilities; UNICEF and other UN programme and policy staff at all levels; children and people with disabilities and their families and other care givers; Mine Action actors; Governmental and non-governmental entities and international organizations, including UN actors, providing services for survivors and victims of landmines/ERW and persons with disabilities; and researchers and academics.

Acronyms

AIDS	acquired immune deficiency syndrome	PDR	People's Democratic Republic (as in Lao PDR)
APMBC	Anti-Personnel Mine Ban Convention	PFA	psychological first aid
C4D	communication for development	P&O	prosthetics and orthotics
CBR	community-based rehabilitation	UN	United Nations
CCM	Convention on Cluster Munitions	UNDG	United Nations Development Group
CCW	Convention on Certain Conventional Weapons	UNDP	United Nations Development Programme
CDC	Centers for Disease Control and Prevention (United States)	UNICEF	United Nations Children's Fund
CMC	Cluster Munition Coalition	UNMAS	United Nations Mine Action Service
CRC	Convention on the Rights of the Child	UXO	unexploded ordnance
CRPD	Convention on the Rights of Persons with Disabilities	VA	victim assistance
DFID	Department for International Development, Government of the United Kingdom of Great Britain and Northern Ireland	WASH	water and sanitation and hygiene
DPO	disabled people's organization	WHO	World Health Organization
ERW	explosive remnants of war		
GA	General Assembly (of the UN)		
GICHD	Geneva International Centre for Humanitarian Demining		
GMAP	Gender Mine Action Programme (A Swiss NGO)		
HI	Handicap International		
HIV	human immunodeficiency virus		
ICBL	International Campaign to Ban Landmines		
IDP	internally displaced persons		
IED	improvised explosive device		
IMAS	International Mine Action Standards		
IMSMA	Information Management System for Mine Action		
ISPO	International Society for Prosthetics and Orthotics		
ISU	Implementation Support Unit (of the APMBC)		
MA	mine action		
MRE	mine risk education		
NGO	non-governmental organization		
NSA	non-state actor		

Boxes

- Box 7:** Cambodia Mine/ERW Victim Information System (CMVIS)
- Box 8:** Nine Steps of Nepal's Surveillance System
- Box 9:** "I am happy I am alive!" – Village-focused Needs Assessment Paired with Advocacy by Landmine Survivors in Cambodia

5.1 Data Collection and Analysis

Introduction

If we do not know the dimension of a problem, and understand the many complexities, we cannot respond effectively.

Systematic data collection is fundamental to Victim Assistance (VA) to ensure that decision makers and service providers are informed by a sound evidence base on the demographic profiles of affected persons. Practitioners need to know what, where, how and why injuries occurred and to be assured that they are reaching victims/survivors of accidents, while not fostering preferential access to services specifically for survivors of landmines and explosive remnants of war (ERW). Data should enable States Parties to monitor and report regularly on the progress of their legal obligations to address the needs of mine/ERW victims and survivors. Despite broad acceptance that it is critical to have comprehensive data, most of the 60 plus countries affected by landmines and ERW do not have complete and updated data or information on landmine/ERW casualties (the term casualty includes those killed as well as those injured) or on the services they or their family members have received.

The availability of data and information on mines/ERW may start with a media report about an accident. Because they are prepared for a different purpose, media reports are often incomplete and insufficient to inform programming. Few, for example, mention the age or sex of the victims. To ensure effective child-focused victim assistance, it is critical to systematically collect, verify, manage, and analyse sex and age-disaggregated landmine and ERW casualty data.

Most mine-affected countries that collect and manage this information use the Information Management System for Mine Action (IMSMA) or other injury surveillance systems. Even seemingly complete casualty data, however, often provides only a snap shot. Available data is usually limited to information on what happened from the time of the accident until the admission to hospital. Data collection usually stops once a survivor is released from emergency medical care. VA actors rarely know whether he or she benefited from services, what kinds of assistance and support have been provided (e.g. continuing medical care, prosthesis or hearing aid, school reintegration, job placement or livelihood support), and their life situations post-accident (e.g. whether they have been able to return to school or, for adults to found a family and have children, whether they are employed and so forth).³ Generally, information is not collected on the family members of survivors or those who have been killed, including on how the death or injury of an adult affected their children and family.

Cartagena Action Plan 2009-2014 Action #25:

Collect all necessary data, disaggregated by sex and age, in order to develop, implement, monitor and evaluate adequate national policies, plans and legal frameworks including by assessing the needs and priorities of mine victims and the availability and quality of relevant services, make such data available to all relevant stakeholders and to meet obligations under the Convention, and identify these activities as a priority in relevant development goals and strategies.

Anti-Personnel Mine Ban Convention, Final Report of the Second Review Conference, Part III, 2010, pp. 145-146

Gathering accurate information on the specific impact of landmines and ERW is challenging. Data from hospitals or from rehabilitation centres often do not specify the cause of the amputation, spinal cord injury, loss of eye sight or other injury. National censuses and other data collection methods for conflict victims or persons with disabilities may not specifically identify the cause of the injury. Collecting data on war-related injury, particularly on children, during conflict or in a volatile post-conflict situation can be perceived by the government as very sensitive and caution may be required.

Goal

Stakeholders have access to reliable age and gender disaggregated data on landmine/ERW victims (including survivors, families and the mine/ERW affected communities) to plan, implement, monitor and report on victim assistance.

The role of data and information in child-focused victim assistance

The role of data and information in child-focused victim assistance is to ensure that:

- Sex and age disaggregated data is collected on mine/ERW casualties and their families;
- Sex and age disaggregated data is collected on type of impairment of mine/ERW survivors;
- Data is collected on existing services;
- Sex and age disaggregated data is collected on specific needs and services received by survivors and victims;
- Sex and age disaggregated data is collected on self-



Box 7: Cambodia Mine/ERW Victim Information System (CMVIS)

The Cambodia Mine/ERW Victim Information System (CMVIS) was established in 1994 by the Cambodian Red Cross (CRC) with technical and financial support from Handicap International Belgium and UNICEF to provide systematic collection, analysis, interpretation and dissemination of information about civilian and military casualties of landmines and explosive remnants of war. By 2013, more than 64,400 casualties had been recorded.

In 2009, CRC handed over management of the CMVIS to the Cambodian Mine Action and Victim Assistance Authority (CMAA). All CMVIS staff became government staff. In 2013, CMVIS deployed 15 full-time data gatherers at district and provincial levels who cover 24 municipalities with the support of volunteers.

Main tasks include:

Mine/ERW casualty and accident data collection: On a daily basis, CMVIS data gatherers look actively for mine/ERW casualties and incidents by visiting communities and collecting information from different institutions.

Data Follow-up: Ensure the accuracy of data collected by CMVIS data gatherers by regularly checking with casualties, their families, local authorities, and other relevant people. Data follow-up also includes spot-checking, verifying information sources and cross-checking with other data sources.

Mine/ERW Casualty Database: The database has been regularly updated and developed to reflect the evolution of mine action and expectations of end-users. It was integrated into IMSMA New Generation software.

Information Analysis and Reporting: The mine/ERW casualty situation is analysed and reports are prepared monthly, annually and customized or ad-hoc and disseminated to all concerned mine action stakeholders and other agencies nationally and internationally to assist their planning and monitoring.

Explosive Ordnance Reporting: Information on the location of explosive ordnance is collected on a daily basis from community members. The information is passed on to mine action agencies for removal and destruction.

Victim assistance and risk education: VA referrals are provided for new mine/ERW casualties to guide them towards appropriate resources. Disability awareness messages are shared with mine/ERW casualties in communities in order to encourage them and to improve their living conditions. Mine Risk Education (MRE) began in 2006 in order to reduce the number of accidents occurring in vulnerable communities. CMVIS field staff provides MRE briefings when traveling through affected communities.

Source: CMAA, CMVIS, see <<http://www.cmaa.gov.kh>>

- perception of psychosocial well-being of survivors;
- Information that is relevant to families and communities should be included in the collection and analysis system, in addition to data for national database and reporting;
- The voices of boy and girl survivors and indirect victims (i.e. family members of people injured and killed) are heard and reported in needs assessments and in monitoring and evaluation exercises;
- Collected data is consolidated and safety and confidentially managed;
- Collected data is systematically verified, analysed and shared;
- Evidence based data is used for informed action in planning, implementing, monitoring and evaluating delivery of services, and for reporting and advocacy.

Key concepts

Data collection and analysis

Data collection and analysis, and corresponding information management systems, are a core component of victim assistance. Good data leads to effective assessment and situation analysis, incident reporting and surveillance, the establishment of referral mechanisms, case management, and monitoring and evaluation of programmes.

Data collection is the process of gathering and measuring information on identified variables of interest. This should be done in an established systematic fashion that enables specific questions (e.g. whether the needs of a particular group are being adequately met) to be answered and hypotheses to be tested (e.g. assumptions based on media coverage that one group or area is more severely impacted than another). It also allows for quality monitoring and evaluation of outcomes. While methods vary by discipline, an emphasis on ensuring accurate and honest data collection is common to all data collection efforts.

Data analysis is the process of systematically applying statistical and/or logical techniques to interpret, describe and illustrate, condense and recap, and evaluate data. *Information management* is the process of consolidating, analysing, summarizing, sharing and using information and data to inform programmatic decisions. Databases are used as the primary tools to support this process.

To ensure VA-related services are responsive to the specific needs of boys and girls of different ages, data must be disaggregated by age and gender. A simple disaggregation between children (those under 18) and adults (those 18 and above) is insufficient to ensure that assistance is responsive to specific stages of the life cycle (see Box 3 in Chapter 4 for suggested age categories). If the exact age is not known, it is better to put an estimated age category rather than 'unknown'. At a minimum, it is important to indicate that the victim was a child and not an adult, thus capturing at least a minimal age disaggregation.

Key considerations for data collection also include *how, by and from whom, where and when* data is collected. Several questions should be answered to ensure the most complete methodology or methodologies for collecting data. *Who* is conducting the data collection or discussions? Have they been adequately trained? *How* do we ensure that persons with different types of impairments (physical, sensory, mental, intellectual, multiple) are equally represented in the data collection? Is it adequate to use a questionnaire for interviews or focus group discussions? Is it appropriate to audio-record interviews? Are other people around when data is being collected and is their presence appropriate? Is a mechanism in place to ensure informed consent and the privacy of those providing information? Are there risks to collecting data? How do we ensure those already marginalized in society will be given a voice? *When* is the best time to reach women, girls, boys and men, male or female adolescents? Should meetings be held separately according to age and gender? *Where* are we going to obtain the information, as part of house-to-house visits or in 'neutral' communal spaces? Are we able to access and reach those who are marginalized in society and those living in remote affected areas?

Many quantitative and qualitative methodologies exist for collecting data; ensuring the collection of qualitative information is equally important in a victim assistance

strategy. Likewise, cell phones and other technologies can be used to collect data even in remote areas.

The make-up of teams collecting data is an important consideration – for example, forming and training a survey team with gender balance, or which includes representation of marginalized groups, to obtain optimal data from the spectrum of those affected. Data collection teams should strive to include survivors, victims and other persons with disabilities. It is essential to build trust with the community members prior to collecting detailed information, particularly in situations where this information is deemed sensitive.

Data is not useful in and of itself. Once collected it must be consolidated, analysed, interpreted and disseminated in order to inform a response. Analysis can be facilitated through tables and charts that demonstrate what the data 'shows us'. Interpretation should be undertaken by those who are familiar with the context and issue and are able to 'tell the story' of what the data shows. Interpretation should avoid over-generalization, and assumptions and the limitations of the data should be clearly spelled out.

The data, analysis and interpretation should then be translated and disseminated through reports, presentations and other manners for specific groups based on their role in VA. For example, information required by donors is different from that required by actors implementing VA programmes and providing services. Communities, including boys and girls, should also be given the opportunity to review the data and analysis so they contribute to refining actions that will help fulfil their rights.

Needs assessments and situation analyses

A needs assessment aims to document the impact of a particular crisis and to identify the needs of an affected population. Needs assessments are undertaken prior to the development of a programme or an action plan. *Situation analyses* which contextualize needs assessments are undertaken periodically, usually as a mechanism to update initial needs assessments and to measure changes over time. (In UNICEF's programme planning process, a comprehensive national-level Situation Analysis is undertaken with the Government at the beginning of the programme planning cycle. Smaller ones may be undertaken more frequently.) In the VA context, both processes systematically collect and analyse data and information in order to identify *who* is in need of services, *where, why, and what* is being done to respond. They should be undertaken in close collaboration and shared with all relevant stakeholders, including with affected individuals, families and communities.

Psychological and psychosocial needs are often expressed less well by the victims, especially children. This may be due to feelings of shame, because such needs are not always conscious or because the level of trust between the survivor and the counsellor is not yet high enough. In many instances,

time for trust-building may be required until the full story emerges. Use of painting or drawing or other art therapy methods can be applied but this requires prior training. Too often, no or little data is collected on the strengths and capacities of the people, although this should be an integral part of any needs assessment.

After the initial assessment and situation analysis are finished, it is important to update and reassess them continually in order to ensure that programmes remain responsive to changes and shifts in the situation of children over time. While this can be done by undertaking situation assessment periodically, a better approach is to support the establishment, make use of and analyse data and information available through other institutionalized victim assistance, disability- or mine action related information management processes. For example, existing incident reporting, injury surveillance or case management systems that collect information on an ongoing basis should be utilized. Such systems enable programmes that are responsive to shifts in situations as and when they occur are more sustainable and represent a more cost-effective use of limited resources.

Incident reporting and injury surveillance

Surveillance in epidemiology refers to a systematic monitoring mechanism that provides data on the scope and distribution of a health problem. As blast injuries are a form of violence that are addressed by the health sector, epidemiological approaches can be used to monitor incidents

and ensure more responsive and up-to-date information on the situation.

In epidemiology, the terms *active* and *passive surveillance* are used. Health care facilities typically undertake *passive surveillance*. That is, they routinely report on the cases of diseases/injury that reach their facilities, but cases that are not treated are missed. A passive system therefore misses those who are killed prior to reaching hospitals, or those who are unable to access medical facilities due to transportation challenges or other causes. Injury surveillance is also usually set up at a central level hospital that is equipped to deal with severe injuries, and is based on a few selected 'sentinel' sites. As a result, many persons with minor injuries are also likely to be missed.

Active surveillance involves an effort to pro-actively identify and document all incidents regardless of their severity and whether or not the casualties reach a health facility. Usually undertaken by community members or networks, mine action centres, mine risk education teams, Red Cross or Red Crescent volunteers, or human rights activists, cases of blast incidents are reported and then followed-up on to determine whether the accident was related to a landmine or ERW. If so, detailed information is collected on the incident and person(s) impacted. If the situation permits, active surveillance can greatly benefit from civilian data collectors establishing close collaboration and case reporting and referral pathways with law enforcement agents and security forces.



Box 8: Nine Steps of Nepal's Surveillance System

Step 1: Explosive device detonates and injures or kills one or more individuals.

Step 2: A partner organization of the national human rights non-governmental organization (NGO) Informal Sector Service Centre (INSEC) or other entity notifies INSEC. Injured individuals, family or community members, police and INSEC's partner organizations inform INSEC officials. INSEC officials may also become aware of an incident through the media. If INSEC central office personnel receive such a report, they contact the appropriate INSEC district representative (DR) and INSEC regional offices follow up with DRs to ensure prompt data collection.

Step 3: INSEC DR investigates the incident and collects data. DRs gather information from injured individuals, relatives, incident witnesses, police, hospital personnel, teachers, and members of community-based organizations. DR goes to the incident site if possible. He/she records the data in a standardized form and when possible also includes case studies with photographs of the injured individual(s). The DR then sends the information to regional and central offices, mostly via Google Forms. If required, the DR also refers injured individuals and their families for victim assistance services.

Step 4: INSEC regional office reviews data. Each office has a documentation officer (DO). DO reviews forms sent by DR before forwarding them to the central office. Regional office personnel can assist DR with victim assistance referral as required.

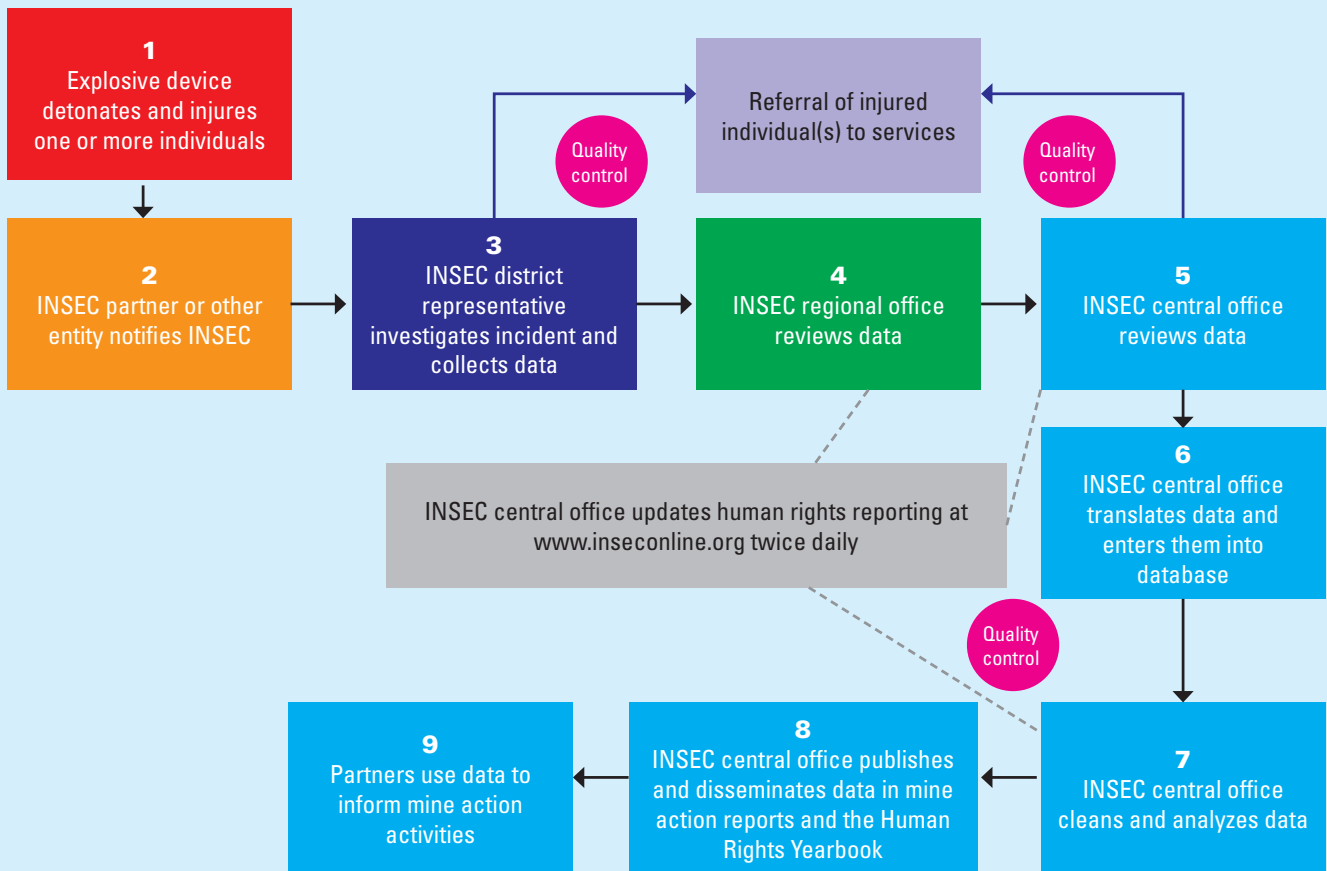
Step 5: INSEC central office reviews data. The focal person reviews forms sent by regional offices.

Step 6: INSEC central office translates data and enters them into database. The focal person for mine action checks data for consistency and enters them into a database. All data are translated from Nepali to English upon entry into the database, so that international use may also be made of this important information.

Step 7: INSEC central office cleans and analyses data. The project coordinator cleans and analyses data in Microsoft Excel on a monthly basis and prepares a flash report.

Step 8: INSEC central office publishes and disseminates data in mine action reports and the Human Rights Yearbook.

Step 9: Partners use data for mine action interventions.



Advantages: The surveillance system is operational in all 75 districts of Nepal.

INSEC district representatives from all 75 districts have been trained in data collection on incidents, identification of explosive devices, interview techniques, safe behaviour and referral of survivors. The system continuously generates quality data which has been used to plan mine action activities (including emergency response) such as selection and prioritization of communities for MRE; referral of injured individuals to victim assistance-related services; marking and fencing of areas in which incidents occur; prioritization of clearance activities; advocacy for the acknowledgement of the explosive device problem in Nepal and raising funds for the mine action programme.

Limitation: There is a risk of under-reporting especially if an incident occurs in a remote area, unnoticed by media or INSEC’s extended network of partner organizations. Because it is not state-funded, the system depends on the financial and managerial viability of the NGO INSEC.

Source: UNICEF Nepal, <www.inseconline.org>

Case and other information management systems

In a number of mine-affected countries, information management systems have been established to collect information on survivors and to support case management. With regard to child-centred victim assistance, case management for children may be undertaken through VA programmes or through child protection/social welfare case management systems that support the provision of social supports for vulnerable children. The utility of these systems is sometimes perceived to be limited to their use as a tool purely to facilitate the provision of assistance to individuals who have been affected. It is important to bear in mind that these systems, if the information is amalgamated, analysed and interpreted, can also provide a wealth of information to provide a more complete 'picture' and enable more general situational monitoring of the impacts of landmines/ERW on affected populations and on children specifically.

Whether from needs assessments or situation analysis undertaken by different actors, from passive or active surveillance systems, or from case management systems, collected information should be consolidated into a single centralized database or mechanism to enable systematic management of the information. Once analysed, interpreted and disseminated, this should be used to inform improved targeting and quality of programming, by enabling:

- Evidence-based identification of programme priorities;
- Improved targeting and adaptation of programmes to the needs and profiles of those most affected (e.g. children versus adults; girls versus boys; types of injuries; etc.);
- Improved targeting and evidence-based resource allocation for geographic areas most affected (e.g. where survivors and victims may be concentrated);
- The development of evidence-based policies and strategies to respond to risks and impacts;
- Evidence-based advocacy.

Finally, consideration should be given to what institution(s) and organizations may contribute to the database and where the database will ultimately reside. Cost considerations are important, as the software used must be accessible and affordable for end users and for the entity that will be responsible for updating and sharing the information over time. Resources are wasted if the database set up is too expensive or complex for the sometimes under-resourced government entity that may ultimately "own" it. Make sure that data collection and analysis systems, an invaluable resource when done correctly, will endure because the information can be regularly updated by partners.

Ethics and data collection

The collection of information from affected populations, especially children, is unethical in the absence of concrete

and specific plans for how this information will be used to benefit affected populations. Such plans should be shared and feedback invited in order to ensure realistic management of the expectations of those providing information. Many individuals and communities in mine/ERW affected communities feel 'over-surveyed', which can lead to 'survey' or 'assessment fatigue', especially when people do not see a tangible benefit to their participation in such processes. The dignity and best interests of those interviewed must be a primary consideration, and potential risks to those providing information must be identified and mitigated.

These considerations are of particular concern when interviewing and collecting information from children due to their more limited maturity and heightened vulnerability to violence, abuse and exploitation. Specific considerations for children that must be addressed include:

- Before information is collected, there must be informed consent of children and/or their care givers, including clear and understandable information on the purpose of data collection and to ensure realistic expectation of how data collection will benefit the child. Asking questions on a child's situation and the assistance he or she requires often raises expectations;
- Children's privacy and anonymity has to be guaranteed and the confidentiality of the interview as well as the management of the information collected has to be ensured. Personal or other information on specific cases of children should not be shared with any other actors except on a strict need-to-know basis and only if the child's guardian has provided specific consent to do so;
- The safety and security of children must be a primary consideration. If providing information can put the child or their family at risk, the information should not be collected or safeguard measures applied that are trusted by all;
- Leading questions should be avoided, i.e. those 'suggesting' an answer. Questions should be adapted to ensure that they are appropriate to the maturity level and situation of the child. Children should not be pushed to discuss issues that cause them distress;
- Feedback should be provided, and findings shared if possible;
- Duplication of survey/assessment/surveillance efforts should be avoided at all costs — victims/survivors should not be subjected to multiple interviews conducted by various organizations collecting the same data;
- All persons interviewing and collecting information from children must be trained on how to do this in a safe, ethical and age- and gender-appropriate manner.⁴

Victim Assistance Officer from Tajikistan Mine Action Centre, Reykhan Muminova, collects casualty data during a field visit. Saygufron signs the IMSMA form to confirm that the data are correct. At the age of 10, he lost both hands from a cluster munition incident during the Civil War in 1996.



Desirable outcomes⁵

- All actors have a sound evidence base on the profiles of landmine/ERW survivors and victims, how they are affected, and where they live in order to inform VA-related programmes and services;
- Affected individuals and communities have sufficient information on availability and access to the spectrum of services, including hospitals, rehabilitation centres, psychosocial support, inclusive education facilities, vocational training opportunities, and so forth;
- Data is available to identify and address gaps in the delivery of services, including for people of different ages, impact of services on the quality of life, geographic coverage, and so forth;
- Advocacy is informed by and resources are mobilized based on sound evidence.

Suggested activities

1. Identify landmine/ERW casualties

In most countries with existing injury or incident surveillance systems, the 'case definition' of who is a mine/ERW victim has not been universally defined. Are we collecting information only on survivors, or also on those killed? Are we collecting information and data on those indirectly affected? Without a specific case definition that is disseminated and understood by all those collecting data and a standardized data collection form to ensure that those in different areas are collecting the same information, the systematic consolidation, analysis and interpretation of data is not possible.

- ✓ Agree on a definition of a "landmine/ERW victim". Definitions may differ from country to country. Sri Lanka, for example, includes persons injured/killed by a "trap gun", an improvised explosive device that is victim-activated and therefore indiscriminate in nature. Even in countries where surveillance on landmines/ERW is undertaken within systems for more general

injury surveillance or where information collection on landmines/ERW survivors and victims may be integrated within data and information systems for persons with disabilities more generally, or child protection more specifically, it is important to specifically define what we mean by a 'victim', with inclusive and exclusive criteria.

- ✓ Agree on whether and how to include family members of those killed and injured. Given the specific vulnerabilities and needs of children, the collection of information on children indirectly affected is particularly relevant for child-centred VA.
- ✓ Collect casualty data on victims from landmine and ERW including on cluster munition accidents. Ensure they are age- and sex-disaggregated.
- ✓ Identify all stakeholders who already collect data to ensure coordination and to avoid overlap.
- ✓ Specify mines/ERW as a specific cause under Killing and Maiming of Children within Child Protection monitoring systems, including Security Council Resolution 1612 Monitoring and Reporting Mechanism.

2. Train stakeholders in data collection and management and establish information security protocols

Working level stakeholders involved in data collection and information management for VA must be technically trained. They should have a sound understanding of such processes, both in terms of the establishment of data and information management systems and also in appropriate collection of data from children. In order to ensure the safety and confidentiality of informants, as well as the security of information, specific data storage and data-sharing protocols should also be developed and put in place. See also Box 23 in Section 5.6 "Laws and Policies" for principles to observe when dealing with children.

- ✓ Develop or enhance injury surveillance systems that include landmine/ERW injury. UNICEF and the US-based Centers for Disease Control and Prevention (CDC) have trained dozens of mine action staff in Field Epidemiology for Mine Action Courses (FEMAC).

More recently, based on the FEMAC, a course focused on the technical aspects of establishing or strengthening surveillance of weapons-related injury, and more broadly, on injury related to violence against children, has been developed and is being implemented.⁶

- ✓ Ensure that those who are collecting information from children and their families or who have a role in managing such information are trained on ethical and safe child interviewing, data collection and management procedures.
- ✓ Train information management personnel on data management, analysis, interpretation, reporting and dissemination.
- ✓ Train staff in health, social protection or other ministries to monitor child injury and to develop comprehensive prevention programmes.
- ✓ Include child survivors/victims and/or their parents in the design and implementation of data collection

This involves costs, but survivor involvement in data collection has been shown to have additional benefits, such as opportunities to provide informal peer support, while also making people more comfortable in responding to questions.
- ✓ Establish specific protocols and standard operating procedures to ensure data security and the privacy, confidentiality and safety of those providing information, including specific measures for the informed consent and protection of children.

3. Identify both needs and potentials

In collecting data, the survivors/victims should not be disempowered; while they may have specific needs, they also have potentials and capacities like everybody else.

- ✓ Make use of existing data before collecting additional data. Include situation assessments of children in general, not just of children with disabilities or child survivors of victims of landmines/ERW. What sources of data on landmine victims, survivors and persons with disabilities are already available? What information do they provide? How can different sources of data be integrated? Once such questions are answered, then the need for additional information can be determined.
- ✓ Identify needs and potentials of child survivors and of children of injured or killed victims. Pursue child-informed research including on children and

adolescents with disabilities. Ensure the family and community context is also assessed.

- ✓ Focus on mine-ERW affected areas including those already cleared where victims remain but be aware that some victims and their families may have moved to the provincial or national capital or even abroad in search of services.

Not everyone who is a mine/ERW victim will necessarily need support, but their situation should be documented and their views should be heard.

4. Collect data on VA-related service provision

- ✓ Collect data on the services that landmine/ERW victims receive. Ensure data is age- and sex-disaggregated.
- ✓ Map referral mechanisms including through case and social work information management systems.

A referral pathway and standard operating procedures can only be created with a full and regularly updated picture. Mapping also helps identify gaps in the provision of child-centred services (e.g. lack of prosthetic workshops that serve children), in reaching certain groups of children, and in response capacities (e.g. lack of same-sex staff in prosthetic workshops). For referral systems to work, referral handbooks and mappings must be updated regularly.
- ✓ Analyse the capacity of existing organizations to ascertain whether they address the needs of child survivors and victims of mines/ERW.

5. Mainstream the databases

Data including those on children with disabilities are often collected by various sources and kept in different formats at local, district, provincial and national levels. A centralized database is an ideal to be sought for.

- ✓ Analyse what data collection mechanisms already exist and agree on one that can be adapted to meet the needs of those providing services to survivors, other persons with disabilities and the broader group of indirect victims.
- ✓ Governments should coordinate among relevant institutions to collect data and use coherent categories and definitions; coordinate with initiatives for child protection, social work and case management, and children with disabilities including parents' initiatives.
- ✓ Stakeholders should assist each other in data verification and ideally agree on one central data base focal point.
- ✓ When an unambiguous definition of mine/ERW victim has been agreed upon, all stakeholders should use this category when collecting data.

- ✓ Existing databases such as those for registration of children, on family reunification, and other protection issues should include the category “landmine/ERW victim” to support mainstreaming.
- ✓ Include mine action actors involved in incident surveillance in Child Protection information management-related training to ensure that they are able to take the protection of children into consideration in their work.

Box 9: “I am happy I am alive!” – Village-focused Needs Assessment Paired with Advocacy by Landmine Survivors in Cambodia

‘I am happy I am alive!’, a Cambodia Survivor Network Project report, presents findings of a low-cost needs assessment undertaken by Cambodia’s Campaign to Ban Landmines & Cluster Bombs (CCBL) and the Jesuit Refugee Service (JRS) in 393 villages in 21 provinces from June 2012 to May 2013.

This research showed that many people with disabilities are happy and well-adjusted, helping their communities ensure their rights are upheld. But it also had some sobering news:

- 1) 41 per cent of people with disabilities have identity cards
- 2) 39 per cent have land titles
- 3) 56 per cent can read and write, though for women, the figure is 39 per cent
- 4) 51 per cent have enough food to eat
- 5) Few say they have enough income to live in dignity.

The study did not compare people living with disabilities to those with no disabilities.

This village-focused approach was undertaken by landmine/ERW survivors. Not only did they come up with a wealth of data, they also connected local authorities with persons with disabilities from their own community and advocated for fulfilling their rights, discussed the Convention on the Rights of Persons with Disabilities and the local law on persons with disabilities. The report aims to improve the quality of life of people with disabilities at the village level through emergency response (by taking people to the hospital) and through rehabilitation (by providing crutches and wheelchairs or by linking people to income generating activities).

Among the 3,448 participants in the assessment, 276 (8%) were 15 years old or younger and 168 (5%) between 16 and 20. This is a notable exception to other studies that rarely reach out to children/young people. It is noteworthy that 1,523 (44%) respondents had children going to school. Of the 276 children under 16, 103 were girls and 173 were boys. The majority of this group answered ‘bad’ to the statement ‘I feel healthy’.

The needs assessment was not representative of all persons with disabilities but it did reach out to other persons with disabilities. Nearly 50% of those who provided information on the cause of the disability were mine/ERW survivors (1,215 mines and 417 ERW).

The study noted that more research is needed on “quality of life”, especially for children. Future research should take into account children’s psycho-social health, family relations, and access to food.

Source: CCBL/CMAA/JRS (2013), *I am happy I am alive! A practical approach. Towards a dignified quality of life for people with disability in Cambodia*, From the Survivor Network Project. Siem Reap/Phnom Penh <<http://www.jrscambodia.org/publication/lamhappy.jpg>>

Technical Resources

Documents are listed in *inverse chronological order*, starting with the most recent ones.

Data collection and analysis

De Santis, Angela and Daniel Eriksson (GICHD) (2013), 'The New IMSMA and Victim Assistance', *The Journal of ERW and Mine Action*, V.17.3, Fall 2013, Harrisonburg, VA, [Only online: <<http://www.jmu.edu/cisr/journal/17.3/focus/desantis.shtml>>.]

Handicap International (HI) (2013), *Victim Assistance Factsheets*, Lyon; here Factsheet 10 'Data Collection', <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/Hi-FactSheets-HD.pdf>

ICRC (2013), *Professional Standards for Protection Work Professional carried out by humanitarian and human rights actors in armed conflict*, 2013 Edition, Geneva, <<http://www.icrc.org/eng/assets/files/other/icrc-002-0999.pdf>>

Child Protection Working Group (CPWG) (2012), *Minimum standards for child protection in humanitarian action*; here Standard 5 'Information Management', <<http://cpwg.net/minimum-standards/>>

Mine Action Information Center (2008), *Landmine Casualty Data: Best Practices Guidebook* [Author: Suzanne Fiederlein], James Madison University, Harrisonburg VA, <<http://www.jmu.edu/cisr/research/links/guidebook/download.htm>>

GICHD (2008), *IMSMA User Manual*, Geneva [The Information Management System for Mine Action is good for casualty data management; the latest version developed in 2013 allows to manage VA service delivery data. See article by De Santis and Eriksson 2013.] <<http://www.gichd.org/mine-action-resources/documents/detail/publication/imsma-user-manual/#.U-8OEmNW62o>>

UNICEF and GICHD (2005), *IMAS Best Practice Guidebook 1, An Introduction to Mine Risk Education. Best Practice Guidebook 2, Data Collection and Needs Assessment*, Geneva, <<http://www.gichd.org/fileadmin/GICHD-resources/rec-documents/IMAS-MRE-Guidebooks-2005-complete-en.pdf>>

Anderson, Mark and Michael L. Gerber (2004), 'Applying epidemiology to the field of mine action.' Centers for Disease Control and Prevention (CDC). *US Foreign Policy Agenda* V.9(1) 2004:11-13, See also <<http://www.cdc.gov/globalhealth/healthprotection/errb/publications/warrelatedinjuries.htm>>

WHO (2001), *Injury surveillance guidelines*, Holder Y, Peden M, Krug E et al. (eds.), Geneva, <http://www.who.int/violence_injury_prevention/publications/surveillance/surveillance_guidelines/en/>

Physicians for Human Rights (2000), *Measuring Landmine Incidents & Injuries and the Capacity to Provide Care: A Guide to Assist Governments and Non-governmental Organizations in Collecting Data about Landmine Victims, Hospitals and Orthopaedic Centers*. Boston, MA, <<http://physiciansforhumanrights.org/library/reports/measuring-landmine-incident-guide-2000.html>>

Endnotes

- 1 Landmine & Cluster Munition Monitor (2013), Fact Sheet Children & Landmines, full source see References. These are reported casualties; the actual figure may be higher. Landmines are explosive devices. However, as conventions and protocols address landmines and ERW separately, the two are listed separately henceforth. Protocol V of the Convention on Certain Conventional Weapons defines ERW as unexploded and abandoned explosive ordnance. The data include casualties from remnants of cluster munitions, a specific type of ERW.
- 2 A “child” is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. “Adolescents” are generally defined to be between 10 and 18 years old. Some definitions of “young people” go up to 24 years.
- 3 Often it is very difficult to locate victims and/or their families, for example, when attempting to survey victims. To address this, the government of Sri Lanka is suggesting that a specific code be introduced for people with disabilities so that they can be identified by this code in any data base. UNICEF is also working with the Non-Communicable Disease Unit of the Ministry of Health in establishing an injury surveillance system to strengthen the knowledge base.
- 4 For more information and guidance on safe and ethical data collection and management related to children and protection (including during armed conflict), see ‘Standard 5: Information Management’ and ‘Standard 6: Child Protection Monitoring’ of the Minimum standards for child protection in humanitarian action and ‘Chapter 5: Managing Sensitive Protection Information’ of the ICRC Professional Standards for Protection Work.
- 5 “Outcome The intended or achieved short-term and medium-term effects of an intervention’s outputs, responding to national priorities and local needs and UNDAF [UN Development Assistance Framework] outcomes. Outcomes represent changes in development conditions that occur between the completion of outputs and the achievement of impact.” United Nations Development Group (UNDG) 2010, Results-Based Management Handbook, Strengthening RBM harmonization for improved development results. Clean Draft Version. New York 2010. <<http://www.undg.org/docs/12316/UNDG-RBM%20Handbook-2012.pdf>>.
- 6 For more information on this work, see <<http://www.cdc.gov/globalhealth/healthprotection/errb/training/femac.htm>>.