

Explosive Ordnance Child Casualties: Prevention and Response



Webinar
11 June 2020

PART 1

INTRODUCTION AND BACKGROUND



Collective outcomes

1. PREVENTION

Reduce the number of children who have an accident with an explosive ordnance;

2. REDUCE MORTALITY

Increase the survival rate of child casualties through increased access to first aid, access to safe blood cold chains, trauma surgery, and ongoing medical care;

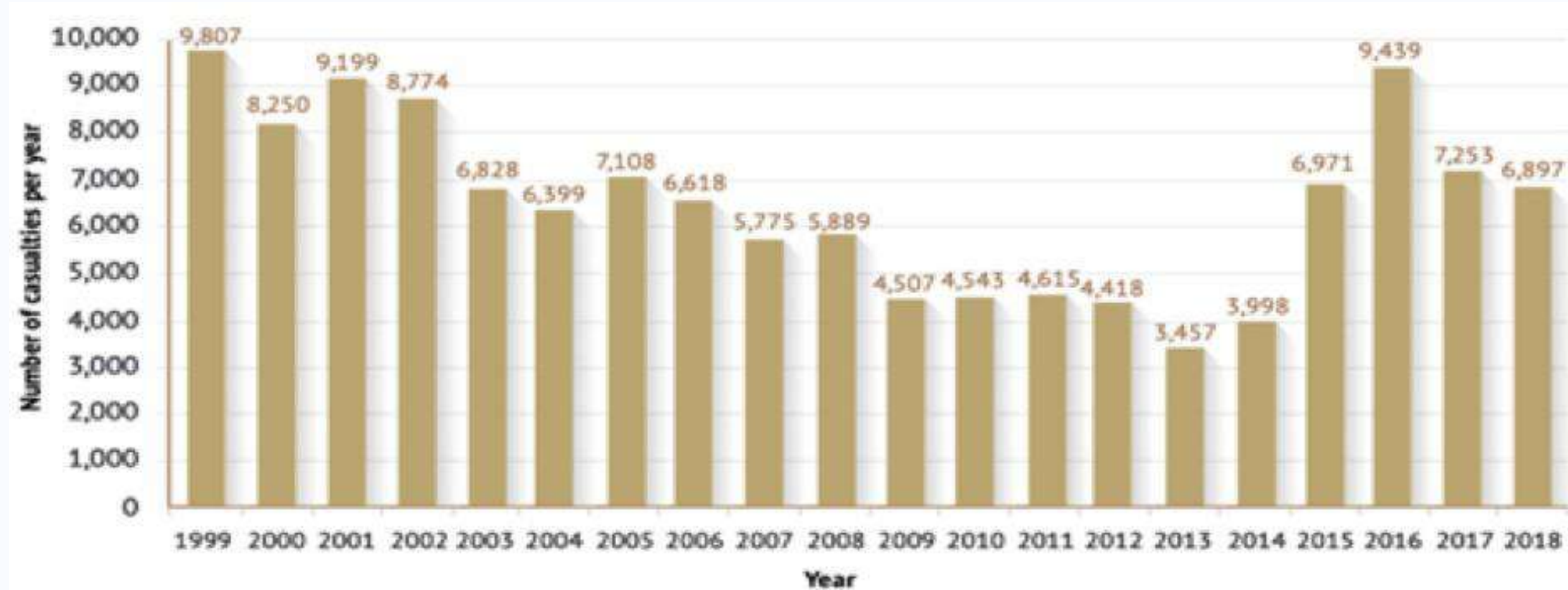
3. INCREASE PERSONAL CAPACITY

Of child survivors through rehabilitation, as well as mental health & psychosocial support (MPHSS) of both child survivors and their caregivers;

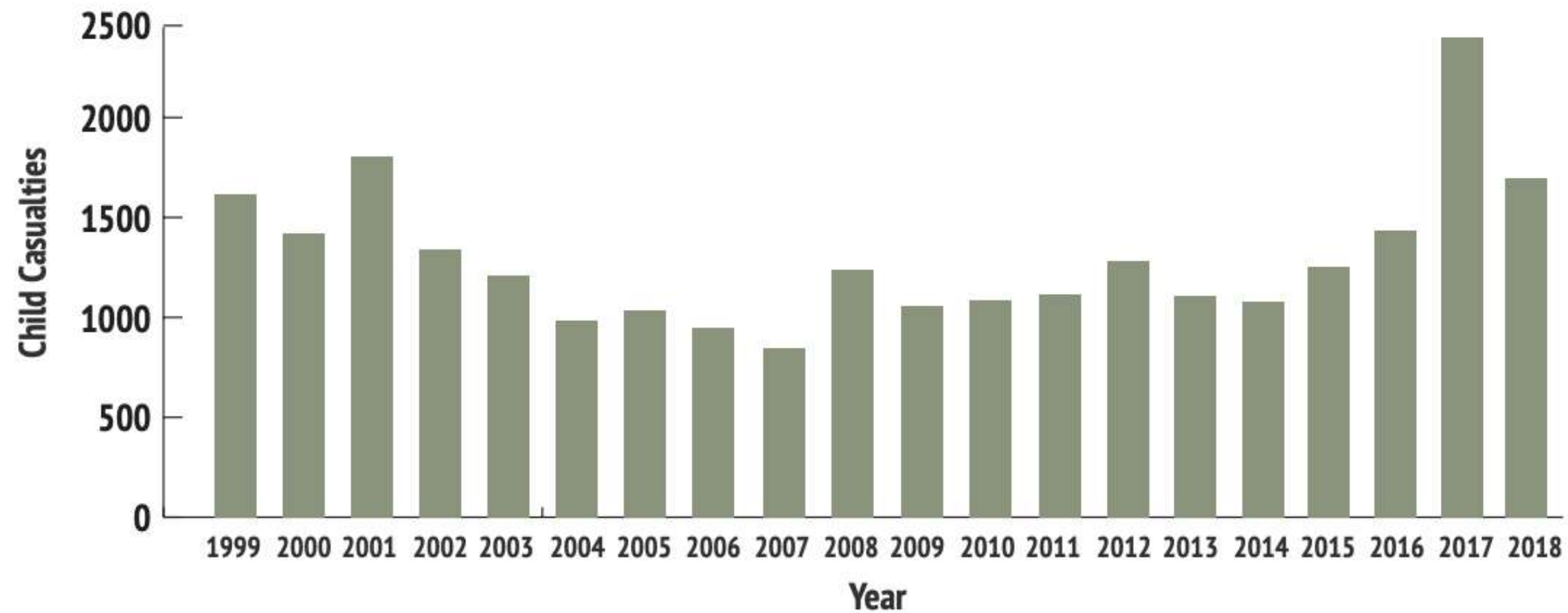
4. SOCIAL INCLUSION

Social Inclusion: Increase inclusion of child survivors in family, community and school life.

Mine/ERW casualties annually (1999-2018)



Child casualties recorded annually in 1999-2018



➔ Increasing since 2007 even while overall global figures were on the decrease.

The Impact of Mines/ERW on Children

Child mine/ERW casualties globally in 2018

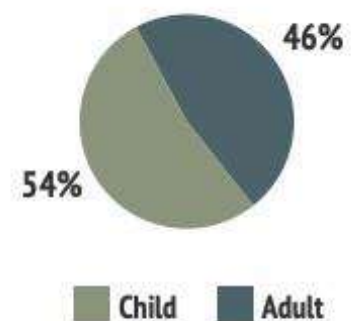


Countries with the most child casualties in 2018

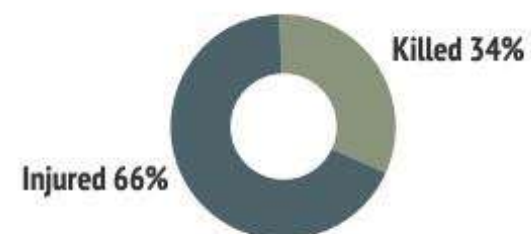
State	Child Casualties	Percentage of total global child casualties in 2018
Afghanistan	851	50%
Syria	347	20%

Bold: State Party to the Mine Ban Treaty

Child casualties among all civilian casualties



Survival of child casualties in 2018



Child casualties by gender in 2018



Devices causing child casualties in 2018



LANDMINE & CLUSTER MUNITION
MONITOR



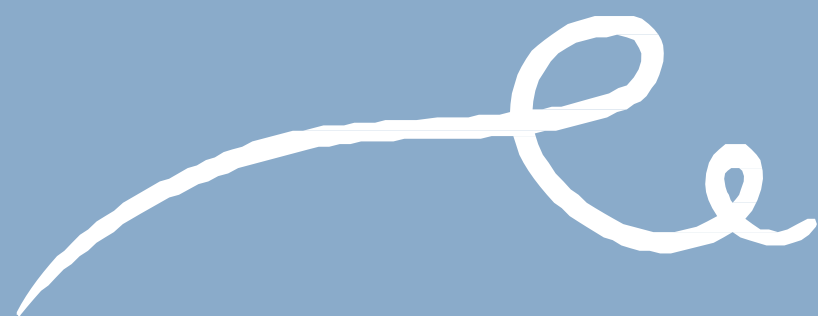


PART 2

SURVEY RESULTS



Survey Design



ACKNOWLEDGEMENTS

Child Protection and Mine Action AoRs, Education Cluster and a reference group of colleagues from UNMAS, UNICEF, Save the Children, WHO, GICHD, Landmine Monitor, OCHA, MAG, IASC MHPSS Reference Group, and the IFRC/ICRC provide inputs

- A sequence of integrated questions aligned with collective outcomes and core aspects of victim assistance in humanitarian response planning
- The survey builds, integrates or harmonizes with work done during the Bangkok Conference 2018, protection/health framework, inter-agency workshop on data sharing (Amman) and other key frameworks such as the Oslo Action Plan



Survey Purpose



1

To increase understanding of the current level of collaboration between Clusters, AoRs and other relevant entities at global and field level towards four collective outcomes, and help establish a baseline.

2

Inform recommendations on progressing towards collective outcomes.





Overview

71 Respondents with a range of profiles including Cluster Coordinators / Co-Leads and Programme Coordinators for Education, Mine Action, Child Protection and Health, organizational directors, Heads/Chiefs of Office, IM, child protection and protection specialists, Security officers etc.

Over 21 Organizations including UN agencies, INGOs, Local NGOs.

15 Countries covering EO contaminated contexts.



Key findings – Information Management and Analysis

Plenty of Data, many tools, but not being brought together or necessarily being put to use or acted on

- High number of contexts (>70%) with multiple relevant data collection tools (over 15 - many listed in Table 2) and even higher rates (>70% (although Bangkok reported higher rates) of data sharing and disaggregation
- However rates of shared analysis are lower (~60%) with negligible practice in terms of cross-border / regional dimensions of IM
- 7 countries indicate existing good practices in this area

Despite positive indications in data collection and sharing – this is not being reflected in HRPs (see HRP indicator review) – Why is it not making it?

Reducing Mortality



Key measures to save lives not systematically in place in high risk areas

- Respondents indicate that presence of first aid service providers in contaminated areas is 50-50
- However, even if present, indication is that the majority are NOT equipped or trained
- <50% of respondents indicate that any training is provided through health cluster, MA/CP AoRs or members
- <40% indicate that first aid / emergency response is integrated with Health Cluster strategies in contaminated contexts

No specific related indicator in any HRP although 7 countries indicate existing good practices



Increasing Personal Capacity

Lack of dedicated resources impedes progress

- >50% respondents indicate inter-cluster collaboration on Physical Rehab services and >50% saying inclusive MHPSS services are available to child survivors
- However, >90% say there is lack of resources to address rehabilitation needs of child survivors
- >90% of respondents indicate that during beneficiary registration at rehabilitation facilities data related to cause, type of injury is not recorded
- 8 countries indicate good practices

Issue of dedicated resources in general, but also reporting constraints as there is no common practice to specifically register EO victims in physical rehab facilities (related to issue of non ear-marked funding). Even when/if EO child survivors receive services there are no related indicators in any of the HRPs which also may explain why it is not reported on.

Social Inclusion



- ~ 95% indicate that Education sections in HRPs do not specifically address needs of EO child victims although
- ~40% reported some inter-cluster efforts on awareness-raising
- ~80% indicated that they are no or not aware of inter-sectoral approaches in this domain

Case Management and Referrals

Case Management and Referral key child protection service needing to be leveraged for child victims - dedicated resources required

- No specific indicators for EO child victims on case management / referrals in HRP, but 6 countries indicate good practices
- Review of existing CPCM SOPs at global level and specific countries (where SOPs exist) confirm the above in terms



- Service Mapping good but not necessarily reaching (disseminated to) target groups
- SOPs on case management procedures are either not in place or not well-known among service providers, in particular among health service providers
- The majority of responses indicate that referral systems are not in place in EO affected regions
- Where SOPs do exist, most of the time specific provisions to register and manage cases of child survivors and indirect victims are not included

Integration of VA & FieldSupport



- ~40% report that there are inter-cluster efforts on VA, designated focal points and that good practices are in place;
- >60% reported HRP's address the issues.
- Low rate of requests for field support, even lower rate of support reported

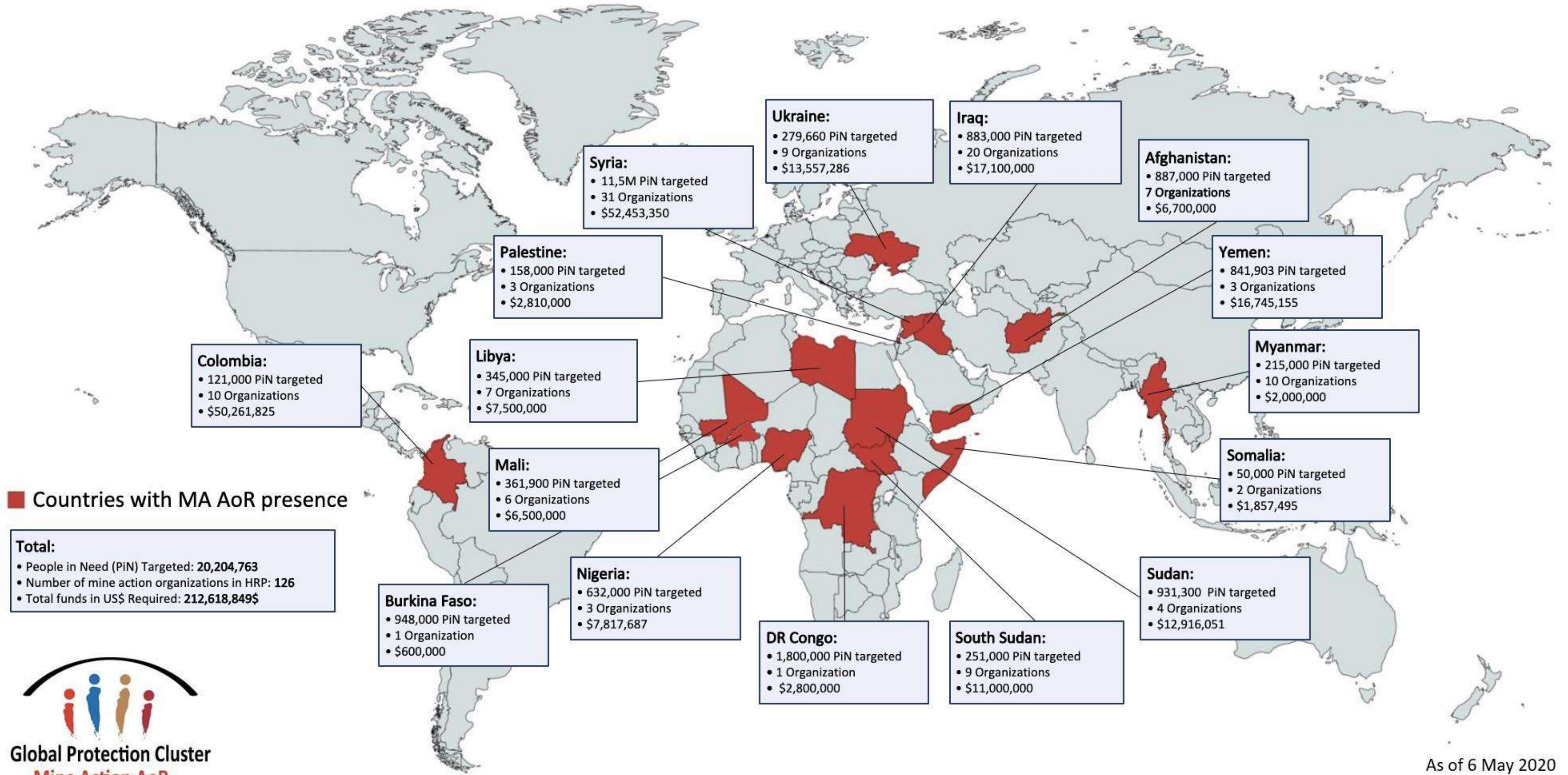
Prevention



- EORE related indicators are the most frequent of MA related indicators in HRPs (indicating a lot of activity in this domain);
- However, <40% of respondents indicate EORE programs / strategies are developed jointly among clusters.
- ~80% of respondents indicate that Clearance Prioritisation processes do not include contributions from clusters and respective members

Nearly All countries indicate that there are existing good practices in EORE, and 6 indicate so for social inclusion

Mine action in 2020 Humanitarian Response Plans





HRP Review

- Out of 16 Mine Action contexts with published HRPs
- ~81% have MA indicators
- In total 28 MA related indicators counted



1

2

3

4

Clearance related: 32% in 6/16 (38%) countries

EORE related: 43% in 8/16 (50%) countries

Victim Assistance related: 11% in 3/16 (19%) countries

Other: 14% in 4/16 (25%) countries

➔ Priority Contexts: Afghanistan (1,2,4) Iraq (4), Syria (1,2,4), Ukraine (1,2,3)

Broad Conclusions (where we are and want to go)

- Where comparable data exists from 2018 survey, no significant changes are seen (although good practices do exist in the field)
- Key data requirements not integrated under overarching protection analysis framework, or systematically included in HNOs
- Need for specific efforts to move towards a situation where all EO contaminated contexts have balanced HRP indicators (reflecting inclusive response plan) corresponding to needs articulated in HNO (even when needs are reflected in HNO, it is often not included in HRP, Protection Strategies etc.)
- Clear and dedicated budgeting and costing required
- Level of inter-cluster collaboration, joint frameworks and practices at global level is often reflected in the field (SOPs, Operational Frameworks (Prot/Health), Resource Mobilization and Advocacy)
- Broad range of targeted recommendations addressing these findings under development in consultation with clusters, lead agencies





BREAK

EXPLOSIVE ORDNANCE
CHILD CASUALTIES:
PREVENTION AND RESPONSE

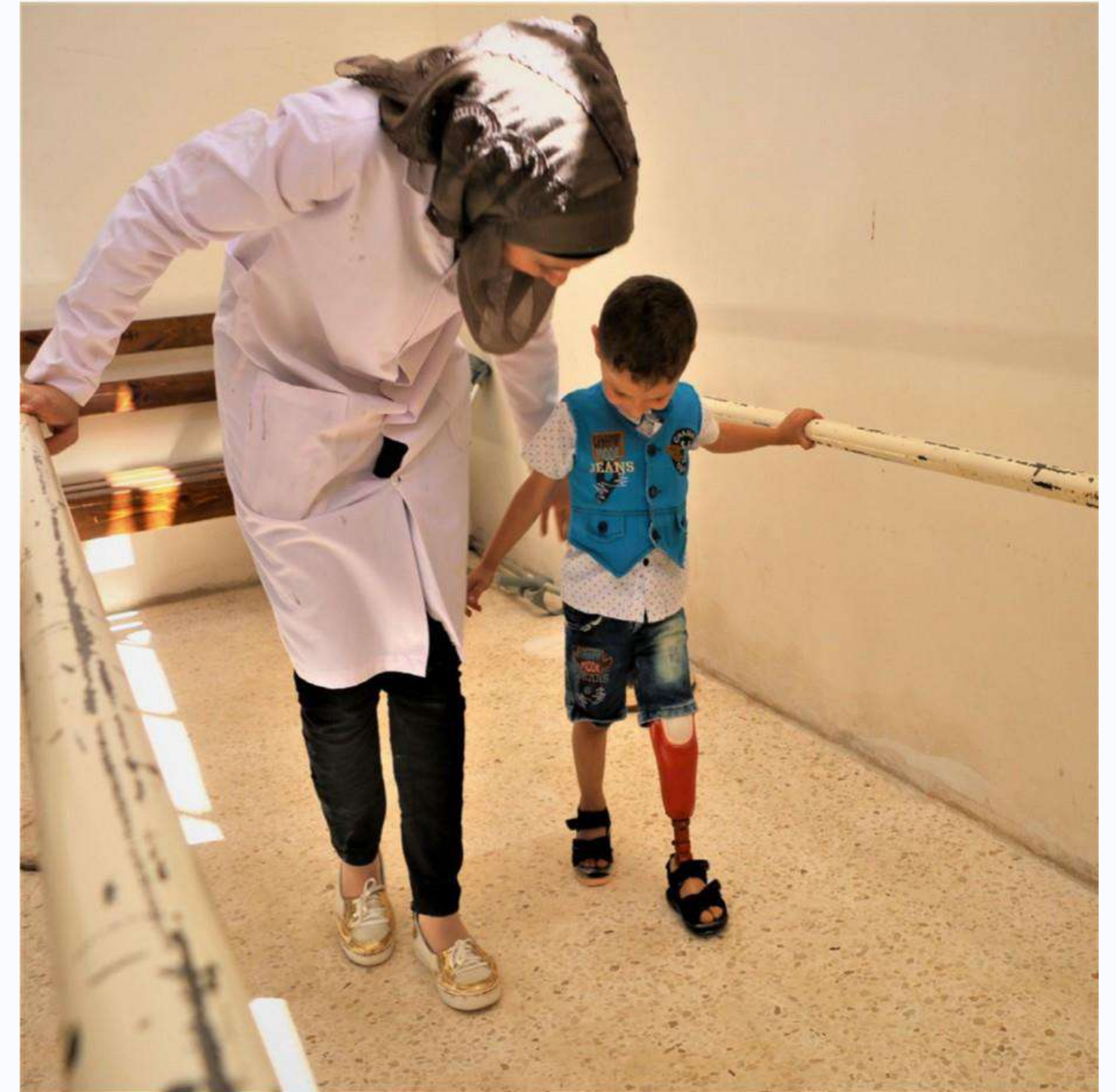
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PART 3

GUIDANCE



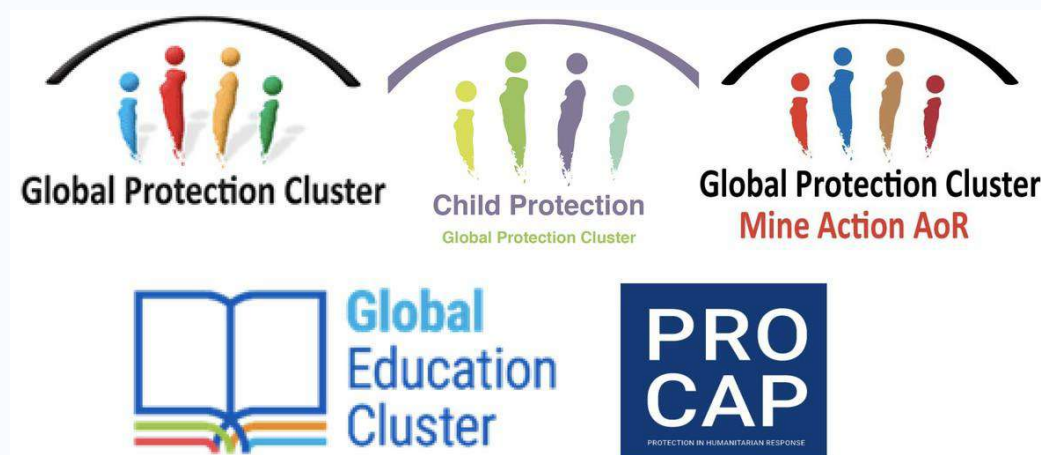
Mitigating the impact of Explosive Ordnance on Children through Collaborative Humanitarian Action



Step by Step guidance for inclusion in HPC

HNO (STEPS 1-3)

- Inter-sectoral information/data requirements (only possible to fulfil if data is pooled and jointly analysed)
- Informs geographical prioritisation, priority groups and priority issues
- Identifying and addressing the IM gaps: What info/data is readily available? What is missing?
- Making use of existing data and bringing together under an overarching and joint analysis framework
- Approval of Results – Standard processes at different levels (Cluster / AoR, Inter- Cluster, HCT etc)



Only information that is needed to promote quality and accountability in programming, and only that which will be acted upon should be collected (reduce assessment fatigue in communities).

Table 2 Data Requirements and Sources

Guiding Questions	Data Specification	Source
<p>How many child EO casualties are there and what are the types of injuries and impairments?</p>	<p>Number of new cases Sex, Age, Disability Disaggregated (SADD) EO casualty data SADD data on type of injury and impairment of EO survivors SADD Data on occupation of accompanying adults Whether the casualties had disabilities or not prior to the accident</p>	<p>Victim Data : IMSMA, injury surveillance, incident investigation, PHIS, MRM, Case Management IM, Child Protection IMS, Landmine monitor, REACH, ACAPS, iMMAP, MCNA</p>
<p>Was the child in or out of school at the time of the accident/incident?</p>	<p>School enrolment data</p>	<p>Casualty Data: Government Database; Education Management Information System (EMIS), Education Cluster IMS</p>
<p>What was the cause/circumstances of the accident/incident, including the place and the type of device that exploded?</p> <p>Any time patterns?</p>	<p>Cause/circumstances Type of place of the accident (e.g. school, forest, road, etc.) Type of devices Geographic locations of incidents Whether the area was marked or not Data on time patterns</p>	<p>Accident data</p>
<p>What is the proximity of accidents to education facilities?</p>	<p>Locations of schools</p>	<p>Mapping, MoE, EMIS</p>
<p>Was the victim a "by-stander"? If so, what triggered the explosion?</p> <p>What services have been received by child victims and what are their specific needs?</p> <p>What proportion of child victims overall had received EORE before the accident/incident</p>	<p>Activity at time of accident SADD on specific needs and services received by people critically injured, survivors Whether the casualties had received EORE or not</p>	<p>Victim Data : IMSMA, injury surveillance, incident investigation, PHIS, MRM, Case Management IM, Child Protection IMS, MCNA, JIPS, REACH, iMMAP</p>

<p>What are the existing services available for child victims?</p> <p>What barriers are faced by child victims to access such assistance?</p>	<p>Existing services: Emergency medical care; Continuous medical care; MHPSS; rehabilitation; social inclusion</p> <p>Physical, institutional, communication and social barriers (negative attitudes towards persons with disabilities)</p>	<p>Service mapping: MHPSS service mapping, REACH, ACAPS, PHIS/HeRAMS</p> <p>Accessibility Audits, post-distribution monitoring, feedback and complaints mechanisms</p>
<p>How do survivors and their families perceive their psycho-social well-being?</p>	<p>(IASC Common M&E Framework for MHPSS Programmes in Emergency Settings): SADD on self perception of psychosocial well-being; # child survivors with MHPSS problems who report receiving adequate support from family member; #child survivors receiving psychological care</p>	<p>Case management statistics, individual care & rehabilitation plans/ treatment plan.</p> <p>CP case management taskforce if existing or Rehabilitation agencies providing case management for survivors</p>
<p>Are EORE services available in schools?</p> <p>What are knowledge, attitudes and practices of children in high-risk areas regarding EO?</p>	<p>Data on availability of explosive ordnance risk education in schools</p> <p>Data on knowledge, attitudes and practices of children in high-risk areas regarding EO</p>	<p>EORE Data, Education Cluster IMS</p> <p>KAP survey or other behaviour change related surveys</p>
<p>What factors will contribute to clearance prioritisation as a means to reduce risks to children?</p>	<p>All of the above</p>	<p>All of the above</p>

Table 1 Types of Information Required (quantitative and qualitative)	
Level of Information	Contribution to quality programming
Individual/Household Level	<p>Identify individuals at risk to inform targeted interventions</p> <p>Understand self-perceptions of victims and their families/support persons</p> <p>Understand factors contributing to vulnerability of EO child victims in order to design an inclusive response</p> <p>As part of AAP mechanisms, understand concerns and priorities of EO child victims in terms of mortality, health conditions, protection issues</p> <p>Understand how EO child victims are accessing assistance, and any facilitators and barriers</p>
Infrastructure/program - level	<p>Identifying various types of barriers EO child victims face, including attitudes and perceptions, physical, institutional and communication barriers, enables the design of better programs that take into account diverse needs, and addressing gaps that may exist</p> <p>Determine the level of and constraints of existing health and education, WASH and other infrastructure to respond to related needs of victims</p> <p>Provide a basis for fundraising by informing the budget preparation process for actions that improve accessibility</p>
Population Level	<p>Data on number of EO child victims increases visibility for inclusion and decision-making level</p> <p>Baseline population data informs monitoring of access to services and participation by EO victims</p> <p>Disaggregated data of the affected population supports prioritization and targeting and development of appropriate programming</p> <p>Data on the circumstances of incidents and accidents help to corroborate risk analysis and inform prevention interventions</p>

PART 3

Continued HRP

Steps 4-7

A dual and mutually reinforcing approach beyond a single agency programme



MAINSTREAMING:

- Facilitating access to services (overcoming barriers). Applicable for services such as WASH, Food Security and Livelihoods support as well as Protection, Health and Education
- An opportunity to keep track of beneficiaries across sectors regardless of whether they were directly targeted or not

DIRECT SERVICES:

- Specific, targeted services for children at risk of EO (Prevention)
- Live-saving emergency response (Reducing Mortality)
- Medium/long term services for survivors (Increasing Personal Capacity and Social Inclusion)

COSTING AND BUDGETING FOR ASSOCIATED SERVICES LINKED WITH RELATED INDICATORS:

- Dedicated indicators linked to dedicated/budgeted resources key

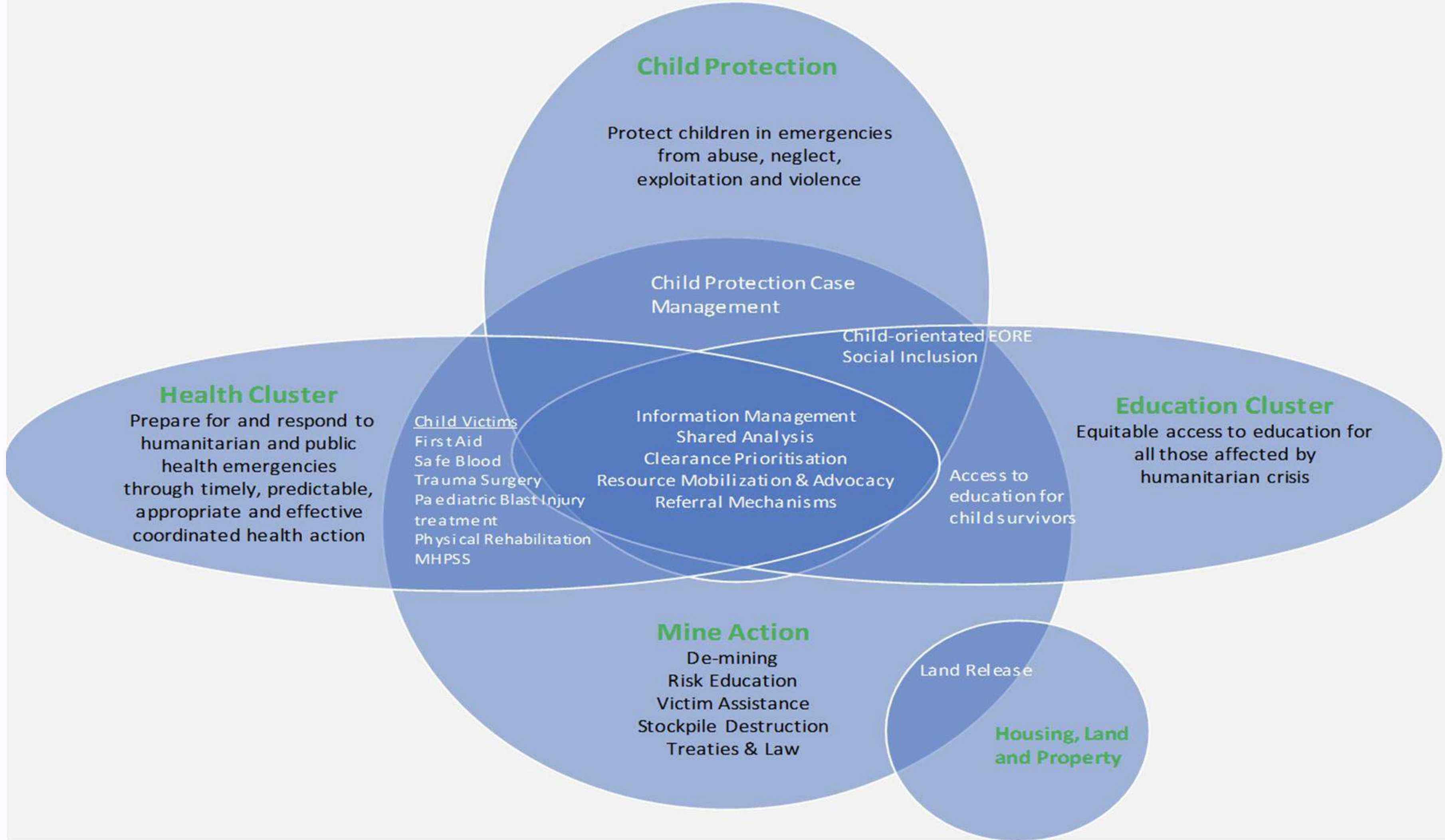


Table 3 Sample/Potential Indicators

Collective Outcome	Service/Activity	Indicators
Prevention	Dissemination of Risk Education Safety Messages	# of vulnerable people receiving EORE
	Face-Face presentations, theater pieces, cultural performances,	# of direct beneficiaries benefiting from EORE
	Mass Digital Media	# of indirect beneficiaries benefiting from EORE
	Safety/Risk Education Briefings	
	Other Trainings & services	
Reducing Mortality	First Aid	% of children having accidents that receive a first aid response
	Trauma Surgery	Survival rates
	Training and Equipment	% of affected communities receiving training and equipment for first aid response
	Access to Safe Blood Cold Chains	% affected population having access to safe blood
	Other	
Increasing Personal Capacity	Physical rehabilitation services	% of EO child survivors requiring physical rehabilitation that receive services
	MHPSS	# child survivors with MHPSS problems who report receiving adequate support from family members (SADD breakdown)
	Provision of prosthetics, orthotics	% of child survivors in need of prosthetics/orthotics who receive them
	Provision of other assistive devices	% of survivors in need of other assistive devices who receive them # child survivors receiving Rehab & MHPSS case management services (SADD breakdown) # child survivors receiving psychological care

Social Inclusion	Provision of mobility, audio, visual assistive devices;	# or % of school aged child survivors of EO who report EO impact as the main reason why they are not attending or enrolled in school (measures needs and response)
	Teacher training on referral procedures and resources for child survivors of EO;	% of child survivors of EO with physical barriers to accessing school (mobility, visual/audio impairments) who receive assistive devices
	Teacher training on inclusive education approaches, covering physical and non-physical special needs and adaptations;	# of education personnel that are trained on referral resources & procedures
	School based MHPSS services and referrals;	# of education personnel trained on inclusive education approaches, covering physical and non-physical special needs
	Establishing/ensuring functional school based referral mechanisms;	# of child survivors reporting non-physical barriers to accessing school (stigma/bullying, trauma, communication barriers)
	School-based anti-bullying/stigma activities	
Cross-Cutting	Child Protection Case Management	# child victims receiving case management services
	Referrals	Referral procedures established including referral documentation
	Clearance Prioritisation	# of MHPSS staff and volunteers who are providing direct services that are aware of referral resources & procedures. Square M Cleared, Marked, Surveyed that are in X proximity to schools Square KM land released for use as playgrounds or education and cultural activity participated by children

Child Protection Case Management

- Case management (CM) is an approach for addressing the needs of an individual child who is at risk of harm or has been harmed. The child and their family are supported by a caseworker in a systematic and timely manner through direct support and referrals. CM provides individualised, coordinated, holistic, multisectoral support for complex and often connected child protection concerns.
- Child Protection Case Management steps include:
 - Identify vulnerable children & register according to eligibility criteria
 - Assess needs and strengths of the child and their family
 - In collaboration with the child & family (as appropriate), develop an individual case plan for the child addressing identified needs
 - Implement the case plan, including direct support and referrals
 - Follow-up and Review
 - Case closure



How are Mine Action
and Child Protection
Actors working together
in your context
to support explosive ord
nance child casualties ?



CHILD PROTECTION CASE MANAGEMENT RESOURCES:

- CPMS 2019 edition, Case Management Standard 18: https://handbook.spherestandards.org/en/cpms/#ch006_006
- Alliance Child Protection Case Management Resource Hub: <https://casemanagement.alliancecpha.org/en/alliance-special-sections/child-protection-case-management-resource-hub>
- CPMS 2012 edition, Case Management Standard Video: <https://resourcecentre.savethechildren.net/library/cpms-video-series-standard-15-case-management>
- CPIMS+ website and resources: <https://www.cpims.org/resources>

Ideas for Child Protection & Mine Action Coordination



- Review Child Protection Eligibility and Vulnerability Criteria in SOPs and CM forms together among the AoRs to ensure relevant child protection risks are reflected and definitions align
- Discuss process for determining primary case management and victim assistance focal points for EO cases per location
- Ensure CP referral pathways include multi-sector services for EO child casualties and their families and that CP actors understand these services
- Promote awareness of Child Protection referral pathways and mechanisms and understanding of CP Case Management services in particular
- Review Child Protection 5Ws to reflect relevant Child Protection risks
- Discuss data protection policies and information sharing protocols if plans to share data across sectors, ensuring adherence to confidentiality and privacy principles
- Work across sectors to ensure sufficient costing for EO child casualties (e.g., increasing MHPSS capacity among CP actors, ensuring health, disability, and education actors budget for EO child casualties, etc.)
-

Conclusion & Next Steps

- Summary of key issues
- Finalising the guidance
- Field support



© J.M. Vargas/HI - Jemerson, 12, lost his left hand in 2014 after a mine left after the conflict which hit Colombia. The accident was in Corinto municipality (Cauca department) in Colombia. Thanks to HI support, he received rehab sessions and psychosocial support. Today, he follows drawing class at the cultural centrum of his municipality