ENHANCE VICTIM ASSISTANCE IN ASEAN MEMBER STATES

REGIONAL VICTIM ASSISTANCE GUIDELINE IN MINE ACTION

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ACRONYMS AND ABBREVIATIONS

AMS	ASEAN Member States
AKCF	ASEAN-Korea Cooperation Fund
ARMAC	ASEAN Regional Mine Action Center
ASEAN	Association of Southeast Asian Nations
CCW APII	Convention on Certain Conventional Weapons Amended Protocol II
EO	Explosive Ordnance
IMAS	International Mine Action Standard
NMAAs	National Mine Action Authorities
NMACs	National Mine Action Centres
NGOs	Non-Governmental Organizations
PWDs	Persons With Disabilities
VA	Victim Assistance
VAN	Victim Assistance Network

KEY DEFINITIONS

Assessment : The process of working with a victim/survivor and their family to evaluate the individual's situation – including risks, challenges, needs, and available support – in order to plan appropriate assistance.

Case Closure : The conclusion of a support case after successfully meeting the victim's/survivor's identified needs and goals (i.e. a successful outcome).

Case Plan : A structured plan of activities and services developed to address a victim's/survivor's needs, based on the assessment.

Case Termination : The ending of a support case without meeting the planned outcomes (e.g. if a survivor withdraws or circumstances prevent further progress). This indicates the case was unsuccessful or could not continue to a positive resolution.

Direct Victim : An individual who has directly suffered the consequences of an EO accident, whether or not they survived the incident (IMAS 13.10, 2023, amendment 1). This term encompasses people injured by the explosion as well as those who were killed (casualties).

Explosive Ordnance (EO) : All munitions that pose explosive risks, including landmines, cluster munitions, unexploded ordnance (UXO), explosive remnants of war (ERW), abandoned ordnance, booby traps, and other such devices (as defined in CCW Amended Protocol II). This also includes improvised explosive devices (IEDs).

Ethics : A set of moral principles and standards of behavior that guide service providers in delivering support to victims/survivors. In victim assistance, ethics inform providers of the do's and don'ts – ensuring respect, integrity, and professionalism in all actions.

Indirect Victim : A person who was not physically harmed by the explosive incident but is adversely affected because of their relationship to a direct victim or their proximity to the event. Indirect victims include family members of those injured or killed, as well as members of communities impacted by explosive ordnance.

Intake	:	The initial step of admitting or enrolling a victim/survivor into an assistance program or service after referral. Intake involves welcoming the individual, collecting necessary information, and officially beginning to provide support under the project or institution.
May	:	Indicates an option or a possible course of action, without implying obligation or preference (IMAS 13.10, 2023, amendment 1).
Referral	:	The act of directing or sending a victim/survivor to an appropriate service or organization for additional support. For example, a survivor might be referred to a specialized medical facility or a vocational training program
Shall	:	Indicates a requirement or mandatory action that must be followed to conform to the standard (IMAS 13.10, 2023, amendment 1).
Should	:	Indicates a recommended or preferred action. It signifies the best practice or most appropriate approach under the standard, though not strictly mandatory (IMAS 13.10, 2023, amendment 1).
Survivor (EO Survivor)	:	A person who has survived an accident caused by explosive ordnance. This term usually refers to an individual who was injured by the EO incident but lived. Survivor is often used in place of "victim" for those who are alive, as it emphasizes the person's resilience and ongoing life rather than defining them by the trauma
Values	:	Fundamental principles or ideals that guide victim assistance efforts and the conduct of service providers. In this context, values (such as quality service, social justice, respect for dignity, etc.) set the ethical foundation for how support is delivered to EO victims/survivors
Victim	:	Any person who has suffered harm as a result of an EO accident. This includes individuals directly impacted by the explosion (those injured or killed) as well as others affected such as their family members and community. In other words, "victim" encompasses both direct victims and indirect victims. (International practice often uses "victim" in legal and policy contexts to cover everyone harmed, while encouraging the term "survivor" for those who lived through the incident.)
Victim Assistance (VA)	:	In mine action, the range of holistic activities and services designed to meet the immediate and long-term needs of EO victims and to uphold their rights. Victim assistance includes emergency and ongoing medical care, physical rehabilitation, psychosocial support, economic inclusion, education opportunities, and other efforts that facilitate the full recovery and reintegration of survivors. It is recognized as a pillar of mine action and requires a multi-sector approach.
Victim Assistance Service Provider	:	Any person, organization, or institution that delivers victim assistance services. This term encompasses all actors engaged in supporting EO victims/survivors – for example, government agencies, non-governmental organizations (NGOs), healthcare providers, rehabilitation centers, and community-based groups working in victim assistance

Note: *Several definitions above (for example, Explosive Ordnance, Direct Victim, and the use of shall/should/may) are drawn from or aligned with the International Mine Action Standards 13.10 "Victim Assistance in Mine Action" (Amendment 1, 2023) and IMAS 04.10 "Glossary of Mine Action Terms." The definition of Victim is consistent with language used in international conventions such as the Convention on Cluster Munitions, which includes those injured, killed, and their families and communities in the term "victim." This guideline uses survivor-centered terminology: "survivor" is used to highlight the dignity and agency of individuals who have survived EO accidents, while the term "victim" is retained where needed in line with legal definitions and broader victim assistance frameworks.*

INTRODUCTION

Significant progress has been achieved in the global mine action sector across all five pillars of mine action – clearance, risk education, victim assistance, advocacy, and stockpile destruction. Despite these strides, explosive ordnance (EO) contamination remains a serious concern and poses grave risks to people worldwide, including in ASEAN Member States (AMS). Southeast Asia in particular has endured decades of conflicts that left behind landmines and explosive remnants of war, resulting in ongoing incidents causing death, injury, disability, and psychological trauma. These hazards have created long-term challenges for EO victims and survivors, as well as their families and communities, who often require extensive support to recover from their adverse situations.

EO victims, survivors, and affected family members typically need a range of services to rebuild their lives and livelihoods. Key needs and assistance services include:

- **Emergency and continuing medical care, including life-saving first aid and ongoing healthcare for injuries and rehabilitation;**
- **Physical rehabilitation, encompassing physiotherapy and provision of assistive devices such as prosthetics and orthotics to restore mobility;**
- **Psychosocial support and mental health care to help survivors cope with trauma, grief, and psychosocial adjustment;**
- **Socio-economic inclusion support, such as access to education, vocational training, employment opportunities, and livelihood assistance to regain economic independence; a**
- **Other forms of social support, including basic needs assistance, peer support networks, and community-based inclusion initiatives that ensure survivors and persons with disabilities can fully participate in society.**

Victim Assistance (VA) is not only a humanitarian imperative but also a legal and moral obligation recognized internationally. Assisting the victims of landmines and other explosive ordnance was first established as a formal commitment in the 1997 Anti-Personnel Mine Ban Convention, and later reinforced through instruments like the Convention on Certain Conventional Weapons (CCW) and the Convention on Cluster Munitions (CCM). Additionally, the 2006 UN Convention on the Rights of Persons with Disabilities (CRPD) provides an overarching framework for upholding the rights of survivors. Together, these treaties oblige States Parties to ensure adequate assistance to those affected by explosive ordnance, and victim assistance has thus come to be regarded as one of the five pillars of mine action.

For ASEAN Member States – several of whom are States Parties to these conventions – fulfilling victim assistance commitments is an important part of honoring international and regional obligations and ensuring no one is left behind in the ASEAN Community. Equally important, victim assistance is fundamentally a national responsibility of an EO-affected state's government. According to the International Mine Action Standard IMAS 13.10 Victim Assistance in Mine Action (Amendment 1, 2023), the primary responsibility for coordinating and providing VA rests with the government of the affected state. National Mine Action Authorities (NMAAs) and National Mine Action Centres (NMACs) are charged with working in support of relevant government entities to meet the needs and uphold the rights of EO victims and survivors. This requires a long-term commitment on the part of national institutions and stakeholders to plan, resource, and deliver services for the short, medium, and long-term needs of women, men, girls, and boys who have been injured or otherwise affected by EO. Victim assistance is a crucial pillar of mine action, equal in importance to other pillars such as clearance and risk education, because it addresses the enduring impact of EO on people's lives and livelihoods.

Providing effective victim assistance necessitates a holistic and integrated multi-sector approach, especially in the ASEAN context where developmental and humanitarian challenges intersect. Meeting the diverse needs of survivors — medical, physical, psychological, social and economic — cannot be accomplished by the mine action sector alone. The vast majority of assistance services are delivered through broader sectors like healthcare, rehabilitation, education, social services, and employment, with the mine action sector playing a key role in identifying survivors, coordinating referrals, and advocating for their needs. A multi-sector approach ensures that victim assistance is provided in a coordinated manner across ministries and agencies (health, social welfare, labor, education, etc.), and is aligned with broader disability inclusion and social protection efforts. Importantly, mine action-related victim assistance should be viewed as a specific yet integrated component within the broader national disability, social protection, and welfare frameworks. EO victims are a subset of the wider population of persons with disabilities (PWDs), and as such, national systems should address their needs without discrimination, in line with their broader responsibilities to uphold the rights and dignity of all persons with disabilities.

Within ASEAN, there is a strong recognition of the importance of regional cooperation and shared standards to support victim assistance. The ASEAN Regional Mine Action Center (ARMAC), in collaboration with all ten AMS, has established a Regional Victim Assistance Network (VAN) to enhance coordination and share best practices on victim assistance across the region. Through this network, ASEAN states and stakeholders have engaged in dialogues and joint actions to address the needs of EO victims, survivors, persons with disabilities, their families, and affected communities. This initiative is part of a three-year project titled "*Enhance Victim Assistance Program in the ASEAN Member States,"* commonly known as the ASEAN VA Project, which is funded by the Government of the Republic of Korea through the ASEAN-Korea Cooperation Fund (AKCF). The Regional VAN serves as a platform or "hub" for AMS and partners to connect, exchange information (e.g. policies, guidelines, research findings), and mobilize resources in order to expedite much-needed support to EO victims and other persons with disabilities. By fostering such regional collaboration, ASEAN aims to strengthen the capacities of its Member States and ensure more efficient, sustainable, and harmonized victim assistance efforts region-wide, in line with ASEAN's people-centered and inclusive vision.

To complement the work of the VAN and translate these regional commitments into concrete guidance, this Regional Victim Assistance Guideline in Mine Action has been developed as a practical framework for all AMS. The guideline is intended to ensure that EO victims, survivors, and persons with disabilities receive prompt, adequate, and holistic support, regardless of which ASEAN country they reside in. It serves as a common reference that AMS can use to develop or strengthen their national policies, action plans, and services related to victim assistance, thereby promoting consistency with both international standards and regional expectations. Notably, the guideline draws on the latest International Mine Action Standards – in particular IMAS 13.10: "Victim Assistance in Mine Action" (2023, Amendment 1) – as a key normative reference. Aligning with IMAS 13.10 ensures that the definitions, principles, and recommended practices in this document reflect globally recognized best practices in mine action. At the same time, the guideline has been carefully tailored to the ASEAN context, taking into account the inputs from national consultations and stakeholder discussions across the Member States. In line with a human-rights based approach, AMS should ensure that survivors and other persons with disabilities are actively involved in these processes and that assistance is delivered in accordance with humanitarian principles of humanity, neutrality, impartiality, and independence.

Ultimately, a comprehensive approach to victim assistance – spanning immediate medical care to long-term socio-economic reintegration – is essential to restore the dignity and uphold the rights of those affected, enabling them to become productive and included members of their communities.

The drafting process involved extensive feedback from AMS representatives and victim assistance experts, helping to shape a guideline that is both technically sound and sensitive to the varied cultural, social, and institutional contexts in Southeast Asia. Consistent with ASEAN's standard language and protocols, the text emphasizes shared values and uses terminology agreed upon by Member States (for example, the use of "victims/survivors" and referencing persons with disabilities in line with the ASEAN Enabling Masterplan 2025 on disability rights). This inclusive and consultative approach to developing the guideline has built regional ownership and consensus, which will support its acceptance and effective implementation.

This guideline is designed as a practical reference for ASEAN Member States, including government ministries, NMAAs, national social welfare agencies, and relevant national service providers. It aims to support the development, strengthening, and harmonization of national policies and actions on victim assistance, within the broader context of disability inclusion and social protection frameworks. It is also relevant for UN agencies, civil society organizations, mine action operators, and organizations of persons with disabilities (OPDs) who contribute to victim assistance or related sectors. By promoting a common understanding and shared standards, this document helps align national efforts with both international frameworks and ASEAN regional commitments

In summary, this Introduction underlines that victim assistance is a critical pillar of mine action in ASEAN, one that addresses the enduring human impact of explosive ordnance and aligns with international humanitarian and human rights commitments. The regional guideline presented here is a milestone in ASEAN's collective efforts to enhance victim assistance: it provides a clear, comprehensive, and structured framework for action that ASEAN Member States can adopt and adapt nationally. By applying this guideline, AMS reaffirm their commitment to a people-centered ASEAN Community that leaves no one behind. Strengthening victim assistance not only improves the lives of EO survivors and other persons with disabilities, but also contributes to national resilience, social cohesion, and sustainable development across the ASEAN region – ensuring that the promise of a safe and inclusive society extends to all individuals affected by mines and explosive remnants of war.

PURPOSE

This Regional Victim Assistance Guideline in Mine Action is developed to ensure that explosive ordnance (EO) victims, survivors, and persons with disabilities (PWDs) across ASEAN receive prompt, adequate, and holistic support. It provides a common framework to guide ASEAN Member States (AMS), institutions, and partners in implementing inclusive, coordinated, and sustainable victim assistance interventions in line with international standards and regional commitments.

Specifically, the Guideline aims to:

1. **Serve as a technical reference and operational framework for members of the ASEAN Regional Victim Assistance Network (VAN) to enhance coordination, quality, and consistency of victim assistance (VA) in mine action across the region.**

2. **Inform the development and alignment of national legislative frameworks, policies, strategies, and capacity-building initiatives among ASEAN Member States and stakeholders—including government institutions, non-governmental organizations (NGOs), and the private sector—to strengthen support systems for EO victims, survivors, and persons with disabilities.**

VALUES AND ETHICS

All victim assistance (VA) service providers and relevant actors in ASEAN Member States should have the capacity to assess and analyze the situation of explosive ordnance (EO) victims, survivors, and persons with disabilities (PWDs). They must recognize each individual's needs and challenges and ensure prompt responses, including referral to appropriate service providers. VA service providers are expected to uphold the highest professional values, ethical principles, and standards in their work. The National Association of Social Workers (NASW) Code of Ethics identifies six core values—service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence—that provide a foundation for ethical practice. These core values and their related ethical principles should guide all victim assistance efforts.

CORE VALUES AND ASSOCIATED ETHICAL PRINCIPLES

VALUE # 1. QUALITY SERVICE

Ethical Principle: VA service providers prioritize delivering quality service to those in need. Their primary goal is to help EO victims/survivors and PWDs address the challenges they face, drawing on professional knowledge, experience, and skills. This commitment to service is carried out selflessly, with no expectation of personal gain or financial reward.

VALUE # 2. SOCIAL JUSTICE

Ethical Principle: VA service providers challenge social injustice and work for positive change on behalf of EO victims/survivors and PWDs. They focus on issues such as poverty, unemployment, discrimination, and other forms of inequality that affect survivors. Providers promote awareness of oppression and respect for cultural and ethnic diversity, striving to ensure that all individuals have equal access to information, services, resources, and opportunities to participate in decisions affecting their lives.

VALUE # 3. RESPECT THE DIGNITY AND WORTH OF THE PERSON

Ethical Principle: VA service providers respect the inherent dignity and worth of every individual. They treat each EO victim/survivor and PWD with compassion, being mindful of individual differences and cultural backgrounds. Providers support each person's right to make their own decisions (self-determination) and work to enhance their capacity to meet their needs. They also recognize a responsibility both to the individual and to the broader community. If a survivor's personal interests conflict with the broader interests of society, providers strive to resolve the conflict in a socially responsible manner consistent with these values and ethical principles.

VALUE # 4. IMPORTANCE OF HUMAN RELATIONSHIPS

Ethical Principle: VA service providers shall recognize the central importance of human relationships. They shall understand that relationships between and among people are an important vehicle for change. They shall engage people as equal partners in the helping process. They shall seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

VALUE # 5. INTEGRITY

Ethical Principle: VA service providers act in a trustworthy and honest manner at all times. They align their work with the profession's mission, values, and ethical standards, and they promote ethical practices within their organizations. Providers take responsibility for their actions and also take care of their own personal and professional well-being, recognizing that maintaining their integrity includes practicing self-care to prevent burnout and uphold high standards.

VALUE # 6. COMPETENCE

Ethical Principle: VA service providers practice within their areas of competence and continually seek to improve their professional expertise. They strive to expand their knowledge and skills through ongoing learning and apply this expertise in their work. Providers also contribute to advancing the victim assistance field whenever possible, for example by sharing best practices or participating in professional development, to strengthen the overall knowledge base of the profession.

ETHICAL STANDARDS

Building on the core values above, the following ethical standards outline the key professional responsibilities of VA service providers:

ETHIC # 1. RESPONSIBILITIES TO EO VICTIMS/ SURVIVORS AND PWDS:

- Prioritize the well-being, safety, and best interests of the individuals being assisted.
- Respect and promote their rights, including the right to make informed decisions about their own care and to set personal goals. Support survivors in understanding their options and in making their own choices (informed consent).
- Safeguard privacy and confidentiality. Only share a survivor's personal information with proper consent or when it is necessary to prevent serious harm.
- Never exploit or abuse the individuals you serve. Under no circumstances engage in any form of sexual exploitation or harassment of EO victims/survivors or PWDs.
- Refer individuals to other qualified professionals or services when additional, specialized support is needed to fully address their needs.

ETHIC # 2. RESPONSIBILITIES TO COLLEAGUES:

- Treat colleagues with respect and foster a collaborative, supportive working environment.
- Support and assist each other, especially when coordination is required to meet the specific needs of EO victims/survivors and PWDs. A strong team approach ensures more comprehensive care for those affected.

ETHIC # 3. RESPONSIBILITIES IN PRACTICE SETTINGS

- Seek appropriate supervision and consultation to improve practice and decision-making.
- Pursue ongoing education and training opportunities to continually strengthen professional knowledge and skills. Service providers should stay up to date with best practices in victim assistance and related fields.

ETHIC # 4. VA SERVICE PROVIDERS' ETHICAL RESPONSIBILITIES AS PROFESSIONALS:

Do not engage in or condone any form of discrimination in professional practice. Providers must ensure that no one is treated differently or denied services on the basis of personal characteristics such as age, gender (including gender identity or expression), sexual orientation, marital status, race, ethnicity, national origin, religion, political belief, immigration status, or physical/sensorial/mental impairments. All individuals should be treated with fairness and respect.

ETHIC # 5. VA SERVICE PROVIDERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION:

- Uphold and advance the values, ethics, knowledge, and mission of the victim assistance profession. Work diligently to maintain high standards of practice and ensure the credibility of victim assistance services.
- Contribute to the continued improvement of the profession's knowledge base and integrity. This includes engaging in research, sharing experiences and lessons learned, participating in professional dialogue, and offering constructive feedback on policies and practices. Such activities help strengthen the overall effectiveness and credibility of victim assistance.
- Act to prevent the unauthorized or unqualified practice of victim assistance. This means discouraging untrained individuals or organizations from providing services that require professional expertise. Additionally, monitor and evaluate victim assistance programs, policies, and interventions to ensure they are implemented effectively and ethically, and advocate for improvements when necessary.

ETHIC # 6. VA SERVICE PROVIDERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY:

- Promote the general welfare of society at the local, national, and regional levels. Advocate for living conditions and social systems that allow all people, including EO victims/survivors and PWDs, to fulfill their basic needs and live with dignity. This includes supporting efforts that improve health, education, employment, and social inclusion for affected communities.
- Engage in social and policy actions that advance social justice and inclusive communities. VA service providers should work with others to ensure that all people have equal access to resources, services, and opportunities. By addressing broader social issues (such as inaccessibility, poor economic empowerment, and discrimination), providers contribute to an environment where the rights and well-being of EO victims/survivors and PWDs are recognized and upheld.

KEY PRINCIPLE OF VICTIM ASSISTANCE

Victim assistance activities should also be guided by overarching humanitarian principles and regional commitments. In accordance with International Mine Action Standard (IMAS) 13.10 (2023), victim assistance should be carried out in line with the core humanitarian principles of humanity, neutrality, impartiality, and independence. Reflecting these ideals, ASEAN Member States should ensure that their victim assistance efforts are directed by the following key principles:

NON-DISCRIMINATION:

Provide assistance without discrimination to all those affected by explosive ordnance. Differences in treatment should only reflect differing needs for medical care, rehabilitation, psychosocial support, or socio-economic inclusion – never the cause of injury or any personal attribute. No one should be given preferential or lesser treatment because of disability, gender, age, ethnicity, race, religion, language, socio-economic status, or any other aspect of identity.

VULNERABILITY

Recognize and address factors that increase the vulnerability of certain individuals or groups. Broader environmental and social conditions can worsen the negative impacts of EO incidents on victims/survivors and PWDs. For example, living in poverty or remote areas, or facing social stigma, can put survivors at greater risk of continued financial hardship, social isolation, or physical insecurity. Such factors should be taken into account in laws, policies, and programs. Victim assistance efforts must strive to reduce these risks and protect those who are most vulnerable, ensuring they are not left behind.

AGE, GENDER, DISABILITY, AND OTHER DIVERSITY CONSIDERATIONS:

Tailor victim assistance to account for the diverse needs of different groups. Age, gender, disability status, and other aspects of identity (such as ethnicity or language) influence how people experience harm and recovery. These factors should be considered in the design, planning, and delivery of all assistance activities. Programs should be culturally sensitive and adapted to meet the specific needs of women, men, boys, girls, and others with distinct experiences. To support effective planning and to avoid overlooking any group, data on casualties and beneficiaries should be disaggregated by relevant factors (for example, by gender, age, and disability). This ensures that assistance strategies are informed by accurate information about who is being reached and who may need additional support.

PARTICIPATION AND INCLUSION:

Ensure that EO victims/survivors and their representative organizations are actively consulted and included in decision-making processes that affect them. They should have a voice in the development of laws, policies, and programs related to victim assistance, and be involved in the implementation of these initiatives. By participating in these processes, survivors can help shape assistance efforts to better address their real needs and circumstances.

ACCESSIBILITY:

Make certain that EO victims/survivors and PWDs can access the services and support they need. Identify and remove any barriers that might hinder access to assistance – whether those barriers are physical/monetary (e.g. distance or transportation, lack of wheelchair access), financial (e.g. service fees), informational or communication-related (e.g. language or digital access), or social (e.g. stigma or cultural norms). All services should be designed and delivered in a way that is accessible and user-friendly. Where needed, provide reasonable accommodations (such as assistive devices, interpreters, or adjusted procedures like outreach and/or digital solutions) to ensure that everyone, regardless of their abilities or circumstances, can benefit equally from victim assistance programs.

SUSTAINABILITY AND NATIONAL OWNERSHIP:

Commit to a long-term, sustainable approach for victim assistance. Establishing and maintaining services for EO victims/survivors and PWDs is a long-term effort that requires continuous support. ASEAN Member States should take ownership of these efforts by developing national policies and action plans, dedicating budget resources, and building local capacities to deliver services. Victim assistance initiatives should be nationally driven and integrated into public systems where possible, so that support for survivors is not dependent on short-term projects. The goal is to ensure that needed services (such as medical care, rehabilitation, psychological support, education, and economic inclusion programs) are available and accessible for many years to come, under the leadership of each country.

RIGHTS-BASED APPROACH:

Ensure that all victim assistance efforts are grounded in a rights-based approach. This means aligning assistance with international humanitarian law and human rights law, and upholding the rights of survivors and PWDs at every stage. In practice, a rights-based approach includes guaranteeing access to health care (emergency medical care, ongoing medical treatment, physical rehabilitation, and psychosocial support), education and economic opportunities (such as vocational training, employment, sports and social activities), an adequate standard of living (including housing and nutrition), and social protection schemes. Victim assistance is not charity, but rather a fulfillment of survivors' rights and states' obligations. By framing assistance in terms of rights, ASEAN Member States and their partners ensure that services are delivered with dignity and that survivors are empowered to claim their entitlements as equal members of society.

LAWS AND POLICIES

Victim Assistance (VA) programme development and implementation in ASEAN Member States (AMS) should be carried out in accordance with relevant international conventions, national laws, policies, and institutional mandates. Adhering to these frameworks ensures that EO victims/survivors and persons with disabilities (PWDs) receive prompt, rights-based, and holistic services.

International Conventions:

Key international instruments provide the foundation for victim assistance obligations and standards. AMS should align their efforts with conventions and agreements such as:

Anti-Personnel Mine Ban Convention (APMBC or Mine Ban Treaty):

Requires States Parties to assist landmine victims within their jurisdiction, ensuring their rights and needs are addressed

Convention on the Rights of Persons with Disabilities (CRPD):

Upholds the rights of PWDs (including EO survivors with disabilities) to access rehabilitation, healthcare, education, employment, and full inclusion in society on an equal basis with others.

Convention on Cluster Munitions (CCM):

Includes provisions for victim assistance similar to the Mine Ban Treaty, obligating States Parties to provide age- and gender-sensitive assistance, including medical care, rehabilitation, psychological support, and social and economic inclusion for cluster munition victims.

Siem Reap–Angkor Action Plan (2024)- Victim Assistance Commitments (Actions 27–36):

Reaffirms and strengthens States Parties' commitment to integrate mine victim assistance into national frameworks (policies, plans, laws and budgets related to disability, health, education, employment, etc.), to strengthen multi-sectoral coordination in addressing survivors' needs, and to monitor progress through specific action plans and indicators. Under this plan, States must assign a national focal point and develop a survivor-inclusive action plan to ensure that the rights and needs of mine survivors are effectively met and reported on, in line with broader disability and development objectives.

ASEAN Enabling Masterplan 2025 and Beyond: Mainstreaming the Rights of Persons with Disabilities –

Mainstreaming the Rights of Persons with Disabilities- A regional policy framework that guides AMS in integrating the rights of PWDs across all pillars of ASEAN. It underscores principles of accessibility, inclusiveness, and equal opportunity which are directly relevant to victim assistance services.

National Law and Legal Standards:

Each AMS should have in place (and continually develop) national legislation and standards that protect the rights of EO victims/survivors and PWDs. These laws should guarantee fundamental rights – right to life, emergency and ongoing healthcare (including physical rehabilitation and psychosocial support), education, employment and economic empowerment, accessibility and participation in social life, and an adequate standard of living. National legal standards provide a basis for governments, NGOs, and the private sector to ensure survivors' rights are respected and their needs met. Such laws may include disability rights acts, healthcare and social protection laws, or specific decrees on mine/ERW survivor assistance. They create a binding framework so that all service providers operate with a clear mandate to support victims in line with international norms.

National Policies:

Beyond formal laws, each AMS should develop national policies or action plans to guide victim assistance implementation. These policies serve as practical frameworks for government ministries, civil society, and other stakeholders in planning and decision-making. A comprehensive VA policy will outline objectives, roles and responsibilities, coordination mechanisms, and resources for services such as medical care, rehabilitation, psychological support, socio-economic inclusion, and accessibility. By institutionalizing guidance on victim assistance, national policies help ensure consistent and effective services across different regions and providers in the country. They also demonstrate political commitment and align with broader strategies (e.g. public health, disability inclusion, or sustainable development plans).

Institutional Mandates:

Relevant institutions in each country – whether governmental agencies (e.g. ministries of health, social affairs, education, defense), National Mine Action Authorities (NMAAs)/Centers, local authorities, non-governmental organizations (NGOs), or private sector service providers – should establish clear mandates and internal guidelines for victim assistance. An institutional mandate defines an organization's scope of responsibility and authority in providing support to EO victims/survivors and PWDs. For example, a health ministry might mandate all provincial hospitals to treat EO injuries as an emergency priority, or an NGO might have a mandate to provide prosthetic services to people with amputations. Ensuring each actor has a well-defined role avoids overlaps, fills service gaps, and facilitates coordination. Institutional mandates should be in line with national laws/policies and encourage collaboration so that the combined efforts of all stakeholders result in comprehensive coverage of survivor needs.

THE IMPLEMENTATION OF VICTIM ASSISTANCE SERVICES IN ASEAN MEMBER STATES

The following sections outline the key components and best practices for implementing victim assistance (VA) services across AMS. These components should be integrated into national programs to ensure that assistance to EO victims/survivors and PWDs is comprehensive, coordinated, and responsive to individual needs.

1. Referral and Intake Mechanism

A **clear referral and intake mechanism** is the first step to ensure that EO victims/survivors and PWDs are connected to the right services without delay. VA service providers and all relevant actors in each AMS should develop a coordinated process for identifying survivors, assessing initial needs, and referring them to appropriate service providers. This mechanism should be formalized as a national tool or protocol agreed upon by government agencies, NGOs, and private sector service providers involved in VA. **Key considerations include:**

Referral Pathways:

Establish straightforward pathways to guide survivors from the point of injury or identification to service providers. Typically, this involves first responders or community authorities notifying a central coordinating body (often the NMAA or a designated focal point) who then connects the survivor with healthcare facilities or support services based on their needs. Clear guidelines should detail how referrals are initiated, documented, and followed up.

Role of NMAA:

The National Mine Action Authority (or equivalent national coordination body) in each AMS should act as the focal point for case referrals and intakes. NMAAs are authorized to coordinate among different sectors (health, social services, rehabilitation centers, etc.) to facilitate a survivor's access to services. To support this, each NMAA should maintain an updated mapping of services available nationally – including emergency medical units, rehabilitation centers, psychological support services, educational and economic inclusion programs – along with the eligibility criteria and contact information for each service provider. This service directory enables efficient matching of survivors' needs with available resources.

Prompt Contact and Accessibility:

It is critical to establish hotline numbers, emergency contact points, or dedicated email addresses for referrals in every relevant institution. All hospitals, clinics, rehabilitation providers, social service agencies, and NGOs that assist EO victims should designate a point of contact for referrals. This ensures that when a survivor is identified, help can be mobilized quickly through a direct line of communication. Communities should be informed of these referral contacts (for example, via public awareness campaigns or local authorities) so that survivors and their families know how to reach out for help.

Intake Procedure:

Upon referral, a standardized intake process should be followed by the receiving service provider. This may involve registering the survivor in a database, collecting preliminary information about their injuries and circumstances, verifying their consent for services, and providing immediate guidance on available assistance. A formal referral letter or form – ideally issued or endorsed by the NMAA or local authority – can accompany the survivor to ensure all relevant information is passed to service providers and to legitimize the referral. (Remark: A referral letter for a case may be issued or certified by the NMAA as part of the official referral process.)

By establishing an effective referral and intake mechanism, AMS can make sure that no survivor "falls through the cracks" and that support is delivered in a timely and organized manner from the very start of the recovery process.

2. Health Care

Comprehensive healthcare services are crucial to saving lives after an EO incident and promoting the long-term recovery of survivors. Each AMS should ensure that health care for EO victims/survivors and PWDs covers three main areas: physical health support, physical rehabilitation, and psychological/social support. These services should be delivered by qualified health professionals at appropriate facilities, following a continuum of care from the moment of injury through rehabilitation and should be continued lifelong to ensure the highest possible quality of life. **Key stages and elements include:**

2.1.PHYSICAL HEALTH SUPPORT

This refers to the immediate and acute medical care provided to address survivors' physical injuries. It can be further broken down into:

a. Pre-Hospital or Emergency Care

The care administered as soon as possible after the explosive ordnance incident (often at the incident site or en route to a hospital). This immediate first aid and trauma care is a crucial step to stabilize the injured, stop life-threatening bleeding, manage pain, and prevent further harm. Each AMS, through its national and local authorities (NMAAs, emergency services, community health workers), should ensure that effective emergency response systems are in place. This includes training first responders and community volunteers in basic trauma care, equipping communities with first aid kits and evacuation transport (ambulance services or community vehicles), and establishing clear communication channels (e.g. village chiefs or rapid response teams alerting nearest clinics/hospitals). Rapid evacuation protocols should be developed so that survivors reach medical facilities as quickly as possible. NMAAs should also coordinate with health ministries to identify and address gaps in emergency medical response coverage (for instance, by expanding community-based first aid networks in remote affected areas). The professionalism and capacity of healthcare personnel at this stage is vital – ongoing training in trauma care, mass casualty management, and referral procedures should be provided to ensure the best possible immediate outcomes for EO victims.

b. Hospital and Medical Care

After initial stabilization, survivors require hospital-based care for thorough medical management of their injuries. This may involve surgery (e.g. to amputate severely damaged limbs or remove shrapnel), infection control, blood transfusions, and other intensive care measures. Each AMS should make sure that hospitals (especially those in or \near EO-affected areas) are prepared to treat blast and fragmentation injuries. This includes having surgeons trained in trauma and reconstructive surgery, stockpiling necessary medical supplies (blood, antibiotics, antiseptics, etc.), and ensuring referral systems from rural clinics to higher-level hospitals function efficiently. NMAAs, in collaboration with health authorities, should arrange for adequate transportation (ambulances or medevac services) and necessary medical equipment to be available to handle these injuries. Throughout hospitalization, medical teams should begin planning for longer-term needs, such as assessing the potential need for prosthetics if an amputation was performed or planning for psychological support. As with emergency care, capacity building is important: medical staff should receive updated training on treating blast injuries and postoperative care specific to mine/ERW survivors. Maintaining a high standard of care in hospitals maximizes the chances of physical recovery and minimizes preventable complications or disabilities.

2.2. PHYSICAL REHABILITATION

Many EO survivors will require ongoing rehabilitation services after the initial injury has been treated, to restore functional ability or adapt to the new impairments. Physical rehabilitation may include therapeutic intervention like physiotherapy and occupational therapy, provision of prosthetic limbs or orthotic devices and other assistive technology (wheelchairs, crutches, etc.) and surgery for long-term functional improvement. AMS should ensure that referrals to rehabilitation centers or services are made as early as possible – ideally, rehabilitation experts become involved while the survivor is still in hospital, to begin therapy (for example, early range-of-motion exercises or stump care training for people with amputation). NMAAs and relevant ministries (Health, Social Affairs) should map out rehabilitation providers in the country and facilitate survivors' access to these services, including transportation support if the facilities are far from the survivor's home. It's also important to coordinate with organizations that specialize in rehabilitation (such as the ICRC, HI, or national

institutes for disability rehabilitation) for technical support or to handle complex cases. Professionalism and capacity development in this field are just as crucial – physiotherapists, prosthetists/orthotists, and rehabilitation specialists should be trained and equipped to address war-related injuries and to fit devices correctly. Regular follow-ups must be arranged to repair or replace prosthetics and to adjust therapies as the survivor's condition evolves. Ultimately, robust physical rehabilitation services help survivors regain and maintain mobility, self-care abilities, and independence to the greatest extent possible.

2.3. PSYCHOSOCIAL HEALTH SUPPORT

Beyond physical injuries, EO victims/survivors and their families often endure significant psychological trauma, stress, or social challenges resulting from the incident (e.g. post-traumatic stress, anxiety, depression, stigma, or loss of livelihood). Psychosocial support should therefore be integrated from the early stages of assistance and continue throughout the recovery and reintegration process. This support can take many forms, including: psychological first aid at the time of the incident, counseling or therapy for the survivor and family members, peer support groups (often survivor-to-survivor discussions), and community-based mental health programs. Healthcare providers and VA service personnel should have basic skills in psychological first aid and empathetic communication, so they can provide emotional comfort and practical support to survivors starting from the hospital stay. As needed, cases that require more intensive care should be referred to professional counselors, psychologists, or psychiatrists. Each AMS is encouraged to build a network of mental health professionals and train them (or orient them) on the specific experiences of EO survivors (for example, trauma from an unexpected explosion, coping with disability, grief from loss of friends/family in the incident).

Psychosocial support should also extend to families and communities, who may struggle with caregiving stress or community stigma – involving them in therapy or support activities can promote healing in the survivor's social environment. Additionally, training workshops on psychosocial support for frontline workers (e.g. doctors, nurses, social workers, community volunteers, and survivor network members) should be conducted across AMS to strengthen the overall capacity to address mental health and psychosocial needs. All these efforts help survivors not only recover physically but also build resilience, confidence, and a sense of belonging as they return to daily life.

Remark: *Throughout all healthcare interventions, informed consent, privacy, and confidentiality must be respected. Survivors (or their guardians/family, when appropriate) should consent to the treatments and support offered. Personal medical information and case details should be kept confidential and shared only with relevant providers directly involved in the care, in line with medical ethics and data protection standards.*

3. Needs Assessment of EO Survivor and Family

A thorough needs assessment is a critical step in the case management of EO victims/survivors. VA service providers should conduct structured assessments with each survivor and their family to gain a holistic understanding of their situation – including the medical, physical, psychological, social, and economic impacts of the incident. The findings from this assessment will guide the development of an individualized case plan and determine what services or further referrals are required. Key points for effective needs assessment include:

Timing of Assessments:

It is often necessary to conduct assessments in stages. An initial assessment with the family can be done early – even while the survivor is still undergoing emergency or acute care – to gather background information and identify urgent needs (for example, if the survivor is hospitalized, the family might need immediate support such as travel assistance, accommodation, or basic subsistence). This early family assessment should only be done if the situation is manageable and the family is ready to engage; the priority at the emergency stage remains the survivor's stabilization. A more comprehensive assessment with the survivor should take place once they have medically stabilized and are in a suitable condition (often during rehabilitation or when they have returned home). At that point, the survivor can actively participate in discussing their needs, goals, and any challenges they foresee in recovery and reintegration.

Holistic Content:

The assessment should cover all relevant aspects of the survivor's life. This includes documenting the nature of injuries and impairments, needed medical follow-ups, rehabilitation and assistive device needs, psychological state and support needed, the family's socio-economic situation, housing and accessibility issues, educational or employment status, and the survivor's own aspirations. It should also identify available support structures (like extended family, community groups, or social services the survivor is already linked with) and any barriers (like discrimination or lack of transportation) that need to be addressed. Engaging both the survivor and family members is important to paint a full picture – family members can share their perspective on what support they might need as caregivers and how the survivor's injury affects the household.

Utilizing Assessment Results:

Based on the assessment findings, VA providers should develop a case plan in collaboration with the survivor and family. This plan will list the specific services to be provided (e.g. medical follow-up appointments, prosthetic fitting, school re-enrollment for a child survivor, livelihood training for a breadwinner who has lifelong impairment, trauma counseling sessions, home modifications for accessibility, etc.), along with a timeline and the responsible service providers for each item. If any needs are identified that the initial provider cannot meet, a referral to the appropriate agency or organization should be made (for instance, referring to a micro-finance NGO if income generation support is needed). Essentially, the needs assessment is the basis for ensuring the survivor receives targeted and relevant assistance rather than a one-size-fits-all package.

Provision for Basic Needs:

Often, the assessment will reveal immediate basic needs for the survivor or family, such as food assistance, temporary shelter, or emergency financial aid (especially if the incident has caused loss of income or added expenses). It is important that VA service providers plan and budget for meeting these urgent needs as part of assistance. Each government or organization involved in VA should allocate resources (or have partnerships in place) for basic needs support to stabilize the family's situation. This might include, for example, cash transfers, provision of assistive devices like wheelchairs or hearing aids, or linking with humanitarian agencies for relief support. Addressing basic needs quickly helps create a more stable foundation for the survivor's longer-term rehabilitation and inclusion.

Standardized Tools:

To ensure consistency and quality in how assessments are done, national standardized assessment forms or questionnaires should be developed. All VA actors (government ministries, NGOs, private service providers) in an AMS should collaborate to create or adopt a common set of assessment tools. These tools should be user-friendly for staff to administer and cover the key domains mentioned above. Standardization means that no matter which province or organization conducts the assessment, the core information collected is comparable – these aids in coordination and ensures survivors don't have widely different experiences of assistance due to varying assessment methods. Training should be provided on how to use the assessment forms effectively, and tools should be reviewed periodically to incorporate best practices or feedback from the field.

Remark: *During the assessment process, just as with healthcare services, informed consent, privacy, and confidentiality are paramount. The survivor and family should understand the purpose of the assessment and agree to share information. They should be reassured that the information will be used solely to organize support, and that personal data will be protected. Sensitive questions should be handled with tact and empathy, ensuring the dignity of the survivor and family is maintained at all times.*

4. Socio-Economic Inclusion

Socio-economic inclusion is a core component of victim assistance that enables EO survivors and PWDs to rebuild their lives and participate fully in society. After medical treatment and initial recovery, attention must turn to empowering survivors through education, livelihood support, social integration, and protection measures. The goal is to help individuals live independently, securely, and with dignity, as equal members of their communities. **Key areas and actions under socio-economic inclusion include:**

Education Access:

Survivors and other persons disabled by EO should have opportunities to continue their education and build knowledge/skills. This includes facilitating return to school for children and youth (with reasonable accommodations as needed, such as accessibility adaptations like wheelchair ramps, accessible WASH facilities or modified curricula for those with cognitive/sensorial impairments) and offering adult education or literacy classes for those who missed schooling. Both formal education (primary, secondary, tertiary) and non-formal education (such as community-based skills classes or vocational education centers) should be made accessible, and with the goal of reducing drop-out rates and ensuring that people with disabilities are accompanied along their journey from education to work. AMS should work towards inclusive education systems where teachers are trained to support children with disabilities and where scholarships or financial support are available if needed (for instance, covering school fees or supplies for survivors from low-income families). There needs to be an accessible and quality training services for all

Economic Empowerment:

Many survivors face challenges in securing employment or generating income, especially if they have impairments that limit the type of work they can do or if they face discrimination. VA programs should include robust economic reintegration support. This can involve: vocational skills training (e.g. learning a new trade or craft that is compatible with the survivor's abilities), soft skills and business training (like basic business management, marketing, or interview skills), capacity building on sustainable, climate-resilient agricultural production and local ecosystems, job placement services (connecting survivors with employers and advocating for their hiring), and entrepreneurship or income-generating projects (such as providing seed grants, tools, or micro-credit loans to start market-aligned small businesses or livelihood activities). AMS are encouraged to leverage existing public employment services and microfinance institutions, or partner with NGOs that specialize in economic inclusion, to create tailored opportunities for EO survivors and PWDs. Furthermore, promoting inclusive workplaces through awareness and incentives can help survivors secure long-term employment. It is imperative for AMS to work regularly with economic stakeholders such as Employment Agencies, Chambers of Commerce, Business Associations, HR Networks, and Companies for jobs and internships.

Social Protection Measures:

Survivors and other persons disabled by EO should have opportunities to continue their education and build knowledge/skills. This includes facilitating return to school for children and youth (with reasonable accommodations as needed, such as accessibility adaptations like wheelchair ramps, accessible WASH facilities or modified curricula for those with cognitive/sensorial impairments) and offering adult education or literacy classes for those who missed schooling. Both formal education (primary, secondary, tertiary) and non-formal education (such as community-based skills classes or vocational education centers) should be made accessible, and with the goal of reducing drop-out rates and ensuring that people with disabilities are accompanied along their journey from education to work. AMS should work towards inclusive education systems where teachers are trained to support children with disabilities and where scholarships or financial support are available if needed (for instance, covering school fees or supplies for survivors from low-income families). There needs to be an accessible and quality training services for all

Social Inclusion and Community Participation

Beyond material support, it's important that survivors remain part of their communities and social circles. VA service providers should promote and facilitate the participation of EO survivors and PWDs in all aspects of community life – from family activities and local events to cultural ceremonies, sports, and religious or leisure activities. This may involve addressing physical barriers (making venues accessible, providing transportation to events) as well as attitudinal barriers. Unfortunately, survivors and PWDs can face stigma or discrimination that leads to isolation. Programs should therefore include community sensitization to dispel myths and stereotypes about disability. This can be done through public awareness campaigns, school programs highlighting inclusion, or showcasing success stories of survivors who are thriving. Disability rights, socio-economic and equality training, specifically led by disabled persons organizations (DPOs) can be done to VA survivors, other members of the community with disabilities and their households, as well as to local community leadership. This training is key since most have very little familiarity with disability from a rights-based perspective within the community and even among local persons with disabilities themselves. It can expose them to potential role models and foster an important sense of self-worth. Encouraging survivors to take on visible roles in the community (like joining village committees, speaking at events, or leading peer support groups) can also shift perceptions and demonstrate their capabilities. Healthy family relationships should be supported through counseling or family inclusion in activities, particularly to prevent issues such as domestic violence, neglect, or undue burden on certain family members. If signs of gender-based violence or abuse against a survivor (who might be seen as more vulnerable) emerge, VA providers must coordinate with appropriate protection services to address it promptly. Ultimately, the aim is to foster an environment where survivors are respected, feel that they belong, and can contribute to society without discriminati

Public Awareness and Engagement:

Organizing events and campaigns is an effective way to address the broader societal challenges that survivors face. VA stakeholders (possibly led by NMAA or NGOs) should conduct awareness campaigns to reduce stigma and promote the rights of survivors and PWDs. This could include media campaigns (TV, radio, social media) highlighting positive messages about inclusion, community events like Disability Days or sports tournaments featuring survivors, and workshops with local leaders about the importance of equal opportunities. Public commitments by authorities – for example, mayors ensuring public facilities are accessible – can be sought during these events. Moreover, peer-to-peer advocacy by survivors themselves can be powerful: Survivor networks in ASEAN (if available) can share experiences and advocate for policy changes or community support. By tackling negative attitudes and lack of information, these efforts strive for a transformative impact, where communities not only accept survivors but actively empower them.

Special Consideration for Vulnerable Groups:

In summary, socio-economic inclusion initiatives should empower EO victims/survivors and PWDs to attain independence and quality of life. By gaining education and skills, securing livelihoods, being protected by social safety nets, and engaging actively in community life, survivors can move forward from the incident and be recognized as equal and productive members of society.

5. Information Management

Accurate and efficient information management underpins all aspects of victim assistance. Having reliable data on EO victims/survivors, the services provided to them, and the outcomes achieved allows stakeholders to plan better, coordinate actions, and monitor progress over time. Each institution involved in VA (whether a government ministry, hospital, NGO, or rehabilitation center) may have its own system for collecting and storing data. However, for effective collaboration and policy development, AMS should strive toward some level of standardization or interoperability in information management related to victim assistance.

Key practices include:

Comprehensive Data Collection:

VA service providers should systematically collect data on each survivor from the point of intake onwards. This typically includes personal details, details of the EO incident, nature of injuries/disabilities, services rendered (medical, rehab, economic support, etc.), and follow-up status. Data collection isn't a one-time event but a continuous process as the survivor progresses through different services. It's important to also disaggregate data by sex, age, location, type of assistance, etc., which will allow analysis of trends (for example, how many survivors are of school age, how many received vocational training, etc.). High-quality data ensures that resource allocation and planning can be evidence-based, targeting areas or services with the greatest need.

National Information Management Systems:

To avoid fragmentation, AMS should consider establishing a centralized or coordinated information management system for victim assistance, at least at the national level. This could be as simple as a regular reporting mechanism where all VA providers submit key data to the NMAA, or as complex as a shared database or online platform accessible by authorized stakeholders. The ideal scenario is a common database where each survivor's case can be tracked across services and organizations – for example, the system might show that Survivor X received emergency care at Hospital A, was fitted with a prosthetic by Organization B, and is now in a vocational training program by Ministry C. Such a system enhances continuity of care and helps identify any gaps (if Survivor X hadn't yet received psychosocial support, the system makes that visible to coordinators). Setting up a unified system requires agreements on data sharing, common data definitions, and privacy protections. NMAA (or the lead VA agency) should convene stakeholders to discuss anddesign this system, possibly learning from other countries' experiences or utilizing existing templates (some countries use IMSMA – Information Management System for Mine Action – modules for victim data, or adapted health information systems). If a full nationwide system is not immediately feasible, interim measures like standard report templates or periodic coordination meetings to share data can be implemented.

Regular Reporting and Analysis:

All organizations implementing VA programs should report their activities and findings to the national coordination body (e.g., NMAA) on a regular basis, such as quarterly or bi-annually. These reports should include statistics (number of survivors assisted, types of services given, etc.), qualitative results (success stories or challenges), and any identified needs that are beyond the organization's capacity. A **standard reporting template** should be developed collaboratively so that each report covers similar information, making it easier to compile a national overview. The NMAA (or a designated M&E working group) should compile these inputs into summary reports and use them to monitor the overall progress of victim assistance in the country. This also contributes to fulfilling international reporting obligations (e.g., reporting on victim assistance in Mine Ban Treaty or CCM transparency reports, or SDG disability indicators). Regular analysis of the compiled data can highlight trends such as decreases or spikes in new victim numbers, or which provinces have unmet needs, thereby informing strategic decisions and donor priorities.

Data Storage and Security:

It is essential to store survivor data securely and maintain it over the long term. Each VA organization should keep both soft copies and hard copies of key documents (like assessment forms, case plans, referral letters, medical reports, consent forms, etc.) in an organized manner. Digital records should be backed up frequently (for instance, on external drives or secure cloud storage) to prevent loss. Physical records should be stored in a safe, dry place with restricted access. Given the sensitivity of personal data, strong measures must be in place to protect confidentiality – for example, password protection for digital files, and policies that only authorized staff can view case files. If a centralized database is used, it should have user access controls and possibly data encryption. Over time, maintaining this repository of information allows continuity even if staff change, and enables retrospective analysis (such as evaluating long-term outcomes for survivors many years later).

Remark: *In all information management activities, informed consent, privacy, and confidentiality are non-negotiable. Survivors should be informed about what data is collected on them and how it will be used. They should consent to their information being included in databases or shared among service providers (except in situations where sharing is required by law or immediate life-threatening necessity). Personal data protection regulations or policies in each country should be followed. Essentially, data should be used to help survivors – never to exploit or expose them.*

6. Monitoring & Evaluation

Ongoing monitoring and evaluation of victim assistance services is vital to ensure that programs remain effective and accountable to the survivors they serve. M&E allows practitioners to track each survivor's progress, measure the outcomes of services provided, and make improvements to assistance strategies over time. It also helps demonstrate the impact of victim assistance efforts to stakeholders, including government authorities and donors. In practice, M&E in victim assistance should involve:

Case Follow-Up and Monitoring:

VA service providers should conduct regular follow-up visits or contacts with EO victims/survivors and PWDs during the period they are receiving assistance (and in some cases, even after formal assistance ends, as a check-in). The frequency of monitoring might vary by case – for instance, a survivor undergoing active rehabilitation might be monitored monthly, whereas someone in a long-term economic inclusion program might be visited quarterly. During follow-up, staff assess whether the services delivered are still appropriate and meeting the survivor's needs. They will check on various aspects: Is the survivor's health improving? Are they using their prosthetic comfortably? Are they attending training sessions? Did the family receive expected social benefits? Follow-up is also an opportunity to identify any new needs or obstacles (for example, the survivor developed back pain from using crutches, or they moved to a new location and need to be linked with services there). By monitoring continuously, issues can be addressed promptly – such as adjusting a rehabilitation plan, replacing an assistive device, or providing additional counseling if new psychological issues surface.

Periodic Case Evaluations:

In addition to continuous monitoring, structured evaluations should be done at certain milestones. It is recommended that each survivor's case be formally evaluated at least twice during the assistance cycle: once around the midpoint of service provision, and once toward the end of the service period (for example, a few weeks before the case is expected to be closed). The mid-term evaluation allows the assisting organization and the survivor to reflect on progress: Are the goals in the case plan being met? Do any strategies need modification? If something isn't working (perhaps the survivor didn't benefit from a group training and needs more individualized support), the plan can be adjusted for the remaining period. The final evaluation assesses overall outcomes: Which goals were achieved? Is the survivor now self-sufficient in certain areas? What outstanding needs remain, if any? These evaluations should ideally involve input from the survivor and family, and use predefined criteria (like improvement in mobility, psychological well-being scores, income level, etc., depending on the case plan goals). Documenting these evaluations is important for accountability and learning. They inform whether the case can move to closure or if an extension/additional referral is warranted.

Data Recording and Use

All information gathered from follow-ups and evaluations should be entered into the information management system or recorded in the case file promptly. Keeping the data updated allows everyone involved in the case (with appropriate access) to stay informed about its status. On a broader level, compiling monitoring data from all cases can help program managers see aggregate results – for example, how many survivors have successfully gained employment after assistance, or common challenges that many survivors face (indicating an area where the program could be strengthened). This feeds into higher-level program evaluation and reporting (as discussed in the Information Management section). M&E data should actively be used to improve services – for instance, if many evaluations note that survivors needed more psychosocial support than initially provided, the program can decide to allocate more resources to that area or adjust the standard package of services.

Development of M&E Tools:

Just like assessment forms, monitoring and evaluation tools (such as follow-up visit checklists, evaluation questionnaires, and case closure forms) should be standardized at the national level. VA service providers across each AMS should collaborate to create common M&E forms and indicators. This ensures that when different organizations report on progress, they are using similar measurements (for example, all might use the same definition of what constitutes a "successfully economically reintegrated" survivor). Standard tools also help less-experienced organizations to conduct proper M&E by following a nationally approved template. NMAAs or lead agencies can provide training on these tools to ensure effective implementation. Common indicators might include metrics like: percentage of survivors who achieved their rehabilitation goals, percentage of survivors employed within one year of assistance, average improvement in quality-of-life scores, etc. Agreeing on such indicators helps AMS to evaluate and compare progress in a coherent way and contributes to regional understanding of victim assistance outcomes.

Remark:

As with all interactions, informed consent and confidentiality must continue during monitoring and evaluation. Survivors should be aware that their progress is being monitored and have consented to participate. They should feel free to voice honest feedback without fear of losing support. Any data collected during M&E is subject to the same privacy protections as initial data – it should be used respectfully and shared only in aggregated form or with anonymity when informing broader program reports.

6.1. Case Closure and Termination

Each victim assistance case will eventually reach a conclusion, either successfully or prematurely. It is important for VA programs to establish clear criteria and procedures for case closure or termination to ensure transparency and consistency in how decisions are made to end support for a survivor.

Duration of Support and Criteria Development:

At the outset of assistance, most programs define an expected period of support (for example, a rehabilitation program might be 12 months, or a scholarship might cover 1 school year). However, the actual duration should be flexible based on the survivor's progress. VA implementing agencies should develop criteria for case closure, which generally means the survivor has attained a certain level of recovery or self-sufficiency such that formal assistance is no longer required. Similarly, criteria for case termination (an unsuccessful or unplanned end of support) should be outlined – this might include situations like the survivor repeatedly refusing services, moving out of reach and not continuing the program, or other barriers that prevent further support. These criteria help case managers make objective decisions rather than arbitrary ones. For example, a criterion for closure might be "survivor is employed and earning above X income for 6 months," whereas a criterion for termination might be "survivor missed all follow-up appointments for 3 consecutive months and is unresponsive to outreach." It's important that these criteria are discussed with the survivor when starting the case plan, so they know what the program's expectations and limits are

Documentation:

When a case is closed or terminated, the responsible organization should complete a case closure (or termination) form that summarizes the assistance provided, outcomes achieved, and the reason for closure/termination. A copy of this form should be given to all relevant stakeholders who were part of the case – this could include the NMAA, the local authority, the referring agency, and the survivor themselves. For the survivor, this document can serve as a record of what was accomplished and contacts for future reference if they need help again. For the system, it provides data for analysis (e.g., how many cases closed successfully vs terminated) and ensures institutional memory. If the survivor later seeks additional assistance, this record can help new providers understand the history.

Consultation and Decision Process:

Deciding to close or terminate a case should involve the National Mine Action Authority (NMAA) or the relevant coordinating body at either national or sub-national level (depending on the decentralization in each AMS). This ensures oversight and that the decision is sound. Additionally, any local authorities or partner organizations involved with the survivor should be consulted – for instance, if an NGO providing livelihoods support thinks the survivor could benefit from extended help, that perspective should be considered before closure. Conversely, if a survivor is not cooperating, perhaps a community leader or local official could assist in re-engaging them before deciding on termination. A multidisciplinary case review meeting can be held for complex cases, including medical, psychosocial, and livelihood staff to collectively decide the way forward. Transparency with the survivor and family is also key: ideally, the decision to close a case as "successful" is mutual, with the survivor feeling confident to continue independently. If terminating due to lack of engagement, the reasons should be explained to the extent possible.

Follow-On Actions for Unsuccessful Cases:

In the event a case is terminated without meeting its intended goals (for example, the survivor's situation did not improve or they dropped out of the program), the VA implementing agency should not abandon the survivor entirely. Where possible, they should refer the individual to another institution or support mechanism for further assistance. For instance, maybe a government program couldn't help a survivor find a job and terminates the case; that survivor could be referred to an NGO specializing in job placement for people with disabilities. Or if a survivor disengaged due to personal issues, perhaps a community-based organization or local social worker could keep an eye on them and provide periodic support. The aim is that even if one channel of assistance closes, the survivor still has pathways to seek help through other means. NMAAs can play a coordinating role here by receiving information on terminated cases and trying to match those individuals with alternative services where available.

7. TECHNICAL INNOVATION IN VICTIM ASSISTANCE

In the modern era, leveraging technology and innovation can significantly enhance the reach and quality of victim assistance services. AMS are encouraged to embrace new technologies and innovative approaches as a means to overcome challenges such as limited resources, remote populations, and the need for specialized care. By integrating innovation into traditional victim assistance, service providers can improve efficiency, accessibility, and even introduce cost-effective solutions. Some avenues for technical innovation include:

Digital Health and Tele-rehabilitation:

Bringing medical and rehabilitative expertise to remote or underserved areas through technology can be game-changing. Telemedicine platforms (via video calls or mobile health apps) allow doctors, physiotherapists, or mental health professionals to consult with survivors remotely, reducing the need for travel and enabling follow-up care at the community level. For example, a survivor in a rural village could have their wound recovery monitored by a specialist from the capital, or receive counseling sessions over the phone/internet. Likewise, tele-rehabilitation tools – such as apps that guide patients through physical therapy exercises or wearables that track their progress – can supplement in-person sessions. This hybrid approach ensures continuity of care when survivors cannot frequently visit clinics. AMS should explore partnerships with telehealth providers or develop national telemedicine guidelines to incorporate these services securely and effectively.

Mobile Applications and Information Platforms:

Developing user-friendly mobile apps or online platforms can empower survivors and their families with information and easier access to services. For instance, a national VA mobile application could contain a directory of services (using geo-location to show the nearest hospital or rehab center), educational materials on injury care and rights for PWDs, and perhaps a portal for survivors to request assistance or appointments. Some platforms might allow survivors to track their case status or communicate with case managers through chat features. At a broader level, digital platforms can improve coordination – imagine a secure online system where different service providers update a survivor's status (e.g., hospital adds discharge summary, prosthetic center notes device provided, training center notes course enrollment), creating an integrated care timeline accessible to authorized users. Not only do such innovations streamline case management, they also help survivors navigate what can be a complex support system. Even simple technology like bulk SMS messaging can be used by authorities to send reminders (for medication, appointments) or disseminate announcements (like dates for mobile clinics in an area).

Assistive Technology and Prosthetics:

Advances in assistive technologies are rapidly expanding opportunities for persons with disabilities. AMS should keep abreast of and consider investing in innovative prosthetic and rehabilitation technologies. For example, 3D printing technology now allows for quicker and more affordable production of prosthetic limbs and custom orthopedic parts – pilot projects could be initiated to produce prosthetics locally at lower cost. Modern prosthetic components (like microprocessor knees or energy-storing feet) can greatly improve mobility and comfort for amputees, though cost can be a barrier; however, seeking donor support or public-private partnerships might make these available to some survivors. Additionally, other assistive devices such as electric/motorized wheelchairs, hearing aids, or communication devices for those with hearing/speech impairments have seen technological improvements. Each AMS should evaluate which innovations are relevant to their context (taking into account cost, maintenance, and technical support needs) and potentially collaborate regionally to procure or develop these technologies. Even simple innovations like improved crutch designs or smartphone-based applications for the visually impaired (using audio cues) can be life-changing for survivors. Embracing appropriate technology ensures that assistance services don't remain static but evolve with the times to offer better outcomes.

Information Management Systems (IMS):

As noted in the Information Management section, employing modern software solutions can revolutionize how data is handled. Innovative IMS may include cloud-based databases accessible in real-time by multiple stakeholders, or the use of GIS (Geographic Information Systems) to map survivor data and service locations for strategic planning. Some countries have explored dashboard systems that visually display key indicators (e.g., number of new victims this month, number receiving each service, etc.) to aid decision-making. Additionally, mobile data collection tools (like smartphone apps for field staff to input data directly from the field) can improve data accuracy and timeliness. Technology can also assist in monitoring and evaluation – for example, sending automated SMS surveys to survivors to gather feedback on services, which can complement in-person evaluations. By adopting these tech-driven approaches, AMS can enhance collaboration and responsiveness in their VA programs.

E-Learning and Capacity Building:

Technical innovation isn't only for direct survivor services; it can also improve how we train and equip those who deliver services. E-learning platforms and virtual training modules enable widespread capacity building for VA practitioners across ASEAN. For instance, an online course on advanced prosthetic fitting or trauma counseling can be rolled out so that even providers in distant provinces can build skills without needing to travel. Webinars, virtual workshops, and communities of practice (hosted on platforms like Microsoft Teams or Zoom) allow experts and peers to share knowledge and mentor each other in real-time. Furthermore, creating digital knowledge repositories – where guidelines, research, case studies, and tools are stored – and making them accessible via a website or cloud drive for all AMS, ensures everyone has the latest information and best practices at hand. Over time, this can help elevate the overall standard of care by reducing knowledge gaps between regions.

In pursuing technical innovation, it's important for AMS to exchange experiences regionally. Through the ASEAN Victim Assistance Network (VAN) and ARMAC's facilitation, countries can share what has worked or not worked in terms of new technologies, and possibly pool resources for joint initiatives (such as a regional telehealth project or group procurement of devices). While technology is not a panacea and should complement (not replace) the human touch in assistance, it offers powerful tools to augment capacity and bridge gaps. By thoughtfully integrating innovation, ASEAN states can accelerate progress in victim assistance and ensure services keep pace with emerging needs and possibilities.

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Finally, thank you to everyone for your continued dedication to enhancing victim assistance in the region. It is our collective hope that this guideline will serve as a useful tool for practitioners and stakeholders, and ultimately make a positive impact on the lives of those affected by landmines and other explosive ordnance. Your commitment to this cause inspires us all and drives the mission of a safer, more inclusive ASEAN.

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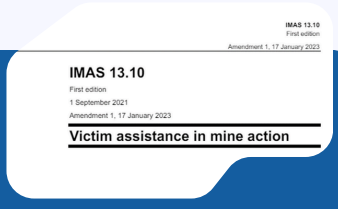

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