



# MITIGATING THE IMPACT OF EXPLOSIVE ORDNANCE ON CHILDREN THROUGH COLLABORATIVE HUMANITARIAN ACTION



“Explosive Ordnance Child Victims: Prevention and Response Package” including guidance, tools and resources for inclusion in the humanitarian programme cycle in explosive ordnance contaminated contexts

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## 1. Introduction to the Guidance

The guidance aims to support key stakeholders to strengthen risk reduction and the response to the needs of child victims<sup>1</sup> of explosive ordnance (EO)<sup>2</sup> throughout humanitarian programme cycles (HPC). For the purpose of this guidance, the focus of prevention efforts is on targeted and inclusive explosive ordnance risk education (EORE) for children, and the focus of response is on improving access to services for child victims.

The objective is to make humanitarian programming more responsive to the impact of explosive ordnance on children in any given context, and especially in high priority countries. The sequencing focuses on the established steps in the HPC, including the development of humanitarian needs overviews (HNO) that lead up to informing the design of humanitarian response plans (HRP).

The document follows the IASC Guideline on HPC implementation, the methodology of the Step-by-Step guide for Humanitarian Needs Overviews and Humanitarian Response Plans and aligns with the approach of “Guidance to strengthen disability inclusion in humanitarian response plans”. It is meant to be considered in an integrated way with reference to existing guides and not as a separate strand of work.

The content, as well as all annexes and recommendations are derived through ProCap deployment process in close consultation with key stakeholders. It also seeks to build on commitments and recommendations made in February 2020 during two milestone events - the Humanitarian Networks and Partnerships Week and the annual meeting of Mine Action National Directors and UN Advisers.

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<sup>1</sup> “The term ‘Victim’ refers to persons either individually or collectively who have suffered physical, emotional and psychological injury, economic loss or substantial impairment of their fundamental rights through acts or omissions related to the use of EO. Victims include people injured and killed, their families, and communities affected by EO. (IMAS 13.10)

The term ‘Survivor’ refers to a woman, girl, boy or man who has suffered injury as a result of an accident caused by EO and survived.

The term ‘Survivor’ should be used in relation to those individual women, girls, boys and men who have been injured and possibly impaired as a result of an accident with EO. However, the term ‘Victim’ continues to be used when referring to the broader groups of victims and to avoid ambiguity with applicable legal obligations given that the term appears in legal instruments.” (IMAS 13.10)

As such, all references to “child victims” is inclusive of “child survivors”, “direct” or “indirect victims” as also defined in IMAS 13.10.

<sup>2</sup> Explosive Ordnance refers to ‘mines, Explosive Remnants of War (ERW), including cluster munitions and Improvised Explosive Devices (IEDs)’ as defined in the UN Mine Action Strategy 2019-2023

## 2. Rationale for inclusion of Explosive Ordnance Child Victims in the Humanitarian Programme Cycle

The proportion of direct and indirect child victims<sup>3</sup> of EO has been on the rise since 2007<sup>4</sup>, attributed at least in part due to increased production and use of victim-activated IEDs in conflict settings. The ongoing risk posed by EO for children and the range of assistance<sup>5</sup> that child victims need is not holistically or systematically addressed in humanitarian response plans. The lack of systematic analysis of overall needs of EO victims in general and child victims in particular impedes evidence-based articulation of required funding and programming by the humanitarian community.

Moreover, it is recognized that the Collective Outcomes (please see adjacent text box) agreed on by Child Protection (CP), Mine Action (MA) Areas of Responsibility (AoRs) and Education and Health Clusters require a concerted and cross-sectoral response that goes beyond the mandate of any single sector. As such a common strategic understanding of what is required to prevent child casualties, enhance resilience, rights and recovery of victims in high priority contexts is urgent and is only possible through an integrated approach in such contexts.

Child victims with disabilities<sup>6</sup> often face the same risks and have many of the same needs as other children with disability, created by factors such as environmental barriers, stigma and discrimination, as well as the design and delivery of humanitarian assistance itself. In this sense, inclusion of child victims is essential as a part of overall disability inclusion in humanitarian action. However, given the specific nature of the physical and psychological trauma caused by explosive

### INTER-CLUSTER 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 & psycho-social support (MPHSS) of both child survivors and their caregivers;
4. **Social Inclusion:** Increase inclusion of child survivors in family, community and school life.

<sup>3</sup> The term 'Direct Victim' refers to those people who suffered an accident with EO, also denoted as 'Casualties.' (Or those "injured"), and the term 'Indirect Victim' refers to family members of people injured and killed, as well as people living in areas affected by EO (IMAS 13.10)

<sup>4</sup> <http://www.the-monitor.org/media/3073853/Children-Info-11-19.pdf>

<sup>5</sup> The term 'Victim Assistance (VA)' is used in the humanitarian mine action sector, which refers to a set of activities addressing the needs and rights of EO victims and comprises data collection, emergency and ongoing medical care, rehabilitation, psycho-social support, socio-economic inclusion and laws and policies (IMAS 13.10).

<sup>6</sup> Child victims to disabilities refers to children living with a disability caused by an explosive ordnance related accident

violence, they also require specific types of specialized assistance that is not necessarily required by all children with disabilities.

## The Role of Data

One of the most frequent challenges in humanitarian settings is systematically attaining required levels and types of data, accompanied by periodic analysis - without which adequate response planning is rarely possible.

This can be particularly challenging for cross-cutting issues such as those pertaining to the impact of explosive ordnance in children. If humanitarian action is to succeed in reducing the rate of children being killed and maimed by EO, provide life-saving and longer-term assistance needed by victims, it will have to be informed by high quality data and analysis at the inter-sectoral level.

However, humanitarian settings are often characterized by urgency and constrained capacity for primary data collection. Therefore, it is important that data on children at risk of an accident with EO and child victims be mainstreamed into existing tools with a focus on utility. In addition to protection mainstreaming, the role of data is also crucial in order to maintain Accountability to Affected Populations.

The systematic inclusion of inter-sectoral analysis concerning the risks and needs of children in contexts contaminated by explosive ordnance will facilitate such accountability. It will also inform decision-making processes at different levels among humanitarian actors, donors, and affected communities alike.

Tables 1 & 2 below set out the type of data required to inform HNOs, following the principle that only information that is needed to promote quality and accountability in programming, and only that which will be acted upon should be collected.

*Collecting data on EO victims is essential to keep track of treaty obligations. The Oslo Action Plan for the Anti-Personnel Mine Ban Convention (APMBC) calls for "Action #35: Establish or strengthen a centralised database that includes information on persons killed by mines as well as on persons injured by mines and their needs and challenges, disaggregated by gender, age and disability, and make this information available to relevant stakeholders to ensure a comprehensive response to addressing the needs of mine victims".*

*The Dubrovnic Action Plan for the CCM from 2015 includes the following action: "Collecting all necessary data, on an ongoing basis, disaggregated by sex and age, assessing the needs and priorities of cluster munition victims, establishing mechanisms to refer victims to existing services, and identifying any methodological gaps in the collection of data. Such data and needs assessment should be made available to all relevant stakeholders and be integrated into or contribute to national injury surveillance and other relevant data collection systems for use in programme planning.*

*UN agencies have an important role in supporting states to meet these commitments and the UN Strategy on Mine Action specifically prioritizes Sex & Age Disaggregated (SAD) Data and provides a mechanism for collecting and analyzing casualty data across all affected countries with a UN Mine Action presence.*

**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>  |

### 3. Humanitarian Needs Overview Process

#### STEP 1 Agree on the scope and focus of the analysis

1.1 Integrate to Joint Analytical Frameworks and plan based on the key questions needed to inform planning and decision-making:

In order for children at risk and child victims to be considered, humanitarian actors need to have the information they require to inform response planning.

Begin with a reflection and analysis about what inter-sectoral information concerning EO impact on children needs to be known to promote their inclusion in the humanitarian response. Such information should include a range of data regarding children at risk, the number of child victims and circumstances surrounding EO accidents and incidents, their situations, needs as well as capacities and views.

This should help to consider how effective the response has been in reducing vulnerability and enhancing resilience of child victims. Moreover, it will also enhance understanding of how the views and perceptions of child victims may differ from other population groups/sub-groups.

1.2 Identify the data, indicators and other information required to answer these questions, and potential sources: Define specifically what type of data corresponds to the guiding questions and determine sources for such data, including governmental, humanitarian and development actors. Needs assessment plans should strive for data minimization, i.e. the collection of the minimal amount of viable data necessary to effectively complete the assessment and utilize already existing information.

Table 2 below cites some guiding questions to assist with this process. In addition, it also includes a list of data specifications that correspond to each main question, and potential sources for such data.

Given that each context is unique, it is likely that only some of the IM services and tools listed will be active. As such it will be important to determine what the information gaps are and how best to mainstream into humanitarian assessment tools in order to address these gaps.

Please refer to Annex D for non-abbreviated names under “sources”

**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<br/>Sex, Age, Disability Disaggregated (SADD) EO casualty data<br/>SADD data on type of injury and impairment of EO survivors<br/>SADD Data on occupation of accompanying adults<br/>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<br/>Type of place of the accident (e.g. school, forest, road, etc.)<br/>Type of devices<br/>Geographic locations of incidents<br/>Whether the area was marked or not<br/>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? What services have been received by child victims and what are their specific needs? What proportion of child victims overall had received EORE before the accident/incident</p> | <p>Activity at time of accident<br/>SADD on specific needs and services received by people critically injured, survivors<br/>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<br/>Physical, institutional, communication and social barriers (negative attitudes towards persons with disabilities)</p>   | <p>Service mapping: MHPSS service mapping, REACH, ACAPS, PHIS/HeRAMS<br/>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&amp;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 &amp; rehabilitation plans/ treatment plan.<br/>CP case management taskforce if existing or Rehabilitation agencies providing case management for survivors</p> |
| <p>Are EORE services available in schools? 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<br/>Data on knowledge, attitudes and practices of children in high-risk areas regarding EO</p>   | <p>EORE Data, Education Cluster IMS<br/>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>  |

### 1.3 Define and agree on agencies' and clusters/sectors' roles and responsibilities

Determine who will do what. At country-level it is recommended that a focal point is identified in either the MA, CP AoR to help align approaches. During the HNO process AoR and Cluster Information Management Officers (IMOs) have a key role to play. Clusters often face staffing shortages, therefore IMOs that are available across the MA & CP AoR, Education and Health Cluster should pool resources and extend support to achieve an inclusive HNO.

At global level it is highly recommended that designated focal point(s) in the Mine Action, Child Protection AoRs, Education and Health Clusters provide support and guidance as needed to country-level during the process.

## STEP 2 Review and analyse data and information and identify gaps

### 2.1 Review existing data, indicators, and other information to answer the key analysis questions

Prepare a data analysis plan.

Start with the data that already exists, specifically through developing, updating, and sharing sector-based secondary data reviews (SDR) across sectors and stock-taking data sources

Remember that in many humanitarian situations it is expected that more people will have disabilities, including because of EO accidents. For example, in Lebanon and Jordan alone 20% of Syrian refugees are

reported to have disabilities.<sup>7</sup> It is therefore important that any gaps in data on child victims with disabilities is recognized. Child victims who have disabilities may be even further excluded from needs assessment and other data collection

Remember, where personally identifiable data from secondary sources is available, informed consent and purpose-driven data sharing according to best practices and policies on sharing personally identifiable information is required. These principles are not changed when child victims are involved.

Use of secondary data should be complemented with active outreach to child victims who are not accessing services that are being used as sources of data on needs. Analysis of secondary data should also be informed by and validated with community and local experts, including survivors.

### 2.2 Identify critical gaps of data, indicators, and other information

After reviewing the available secondary data on child victims and planning assumptions, consider what information gaps exist for example regarding how many children are at risk, killed or injured, their needs (including barriers faced) and their views and perceptions (as outlined in Table 2).

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<sup>7</sup> <https://reliefweb.int/report/jordan/removing-barriers-humanity-inclusion-and-immap-publish-disability-assessment-syrian>

2.3 Determine how to bridge the critical data and information gaps and take action accordingly

Annex D presents a selection of existing needs assessment tools / data sources, with examples of how they can be used or adapted to improve understanding of the situation, needs and priorities of child victims and children at risk of explosive ordnance

Many assessment tools and IM systems collect or could potentially collect required data.

Based on the information-gaps identified, confirm which relevant needs assessment tools, frameworks and processes are active in the context that may address these gaps.

Consider how any or all these tools can be adapted to contribute to the exercise by mainstreaming comparable data fields across them. This will help the analysis process strengthen understanding of impact of EO on children in and EO contaminated contexts. In principle, where data related to disability is collected, as per the Washington Group Short Set of Questions, data that identifies survivors amongst this broader group should be collected as well.

2.4 Conduct an inter-sectoral analysis of existing data, indicators, and other information:

Once relevant data from both secondary and primary sources are consolidated and compiled, a final analysis and interpretation of results should take place. Existing and updated analytical frameworks pertaining to

the Mine Action and Child Protection AoR, Education and Health Clusters can provide direction during this process.

On one level, a statistical presentation of findings is necessary, primarily lead by IM specialists based on the guiding questions and information requirements decided upon during Step 1.

On another level, specialists from leading clusters and AoRs, including child protection, victim assistance, EORE, education and health response should review the findings and prepare prioritised recommendations for approval and further inclusion under relevant sections of the HNO.

### STEP 3 Review and obtain approval of analysis results and monitoring information

3.1 Present and obtain endorsement by decision-makers on the analysis results

The outputs from Step 2.4 will inform and be integrated into usual approval processes followed in clustered contexts. As necessary, these may include cluster / AoR strategic advisory groups, lead agency and HCT processes at country level.

3.2 Present and seek endorsement of decision-makers on the situation and needs data, indicators, and other monitoring requirements

Annex E follows the IASC Humanitarian Needs Overview template and illustrates where outputs of the above steps can be reflected in the HNO.

## 4. The Humanitarian Response Plan Process: Designing the Response

### STEP 4 Select priority humanitarian outcomes to address

#### 4.1 Review or update the analysis results from the HNO

The analytical process described at Section 2.4 will guide identification of the risks and needs of children who are affected by explosive ordnance.

#### 4.2 Decide which population sub-groups and geographic areas should be prioritized

Children at risk and child victims should be considered a population sub-group of whatever priority population group is identified. That is, if IDPs are a priority population sub-group, consider child victims and children at risk of EO related accidents as a sub-group. Beneficiaries and target groups, as defined in HNO / HRP should be coherent with Standardizing Beneficiary Definitions for the mine action sector,<sup>8</sup> yet extend beyond these definitions as the scope of responsibilities of the mine action sector for casualties is limited.

### STEP 5 Analyse response options and formulate strategic objectives

#### 5.1 Analyse response options

The needs analysis in the HNO will have identified various factors, risks and needs associated with the of impact of explosive ordnance on children. At the strategic planning phase, it is important to design a response that will address these factors to reduce vulnerability and heighten resilience of child victims. Four collective outcomes agreed by child protection, mine action,

education and health clusters offer further guidance in terms of the types of response options that may address the risks and needs identified.

Regarding child victims with disabilities, as with other children with disability, analysis of various factors rather than focusing on individual's impairment alone, recognizes the impact of environmental factors in creating vulnerability.

A key consideration for child victims is their adequate access to humanitarian assistance, and whether specific barriers exist in the way that the response is designed and delivered that limits this. It is important that this analysis is informed by the views and feedback of communities themselves.

#### 5.2 Formulate Strategic Objectives

The Strategic Objective level sets out higher level change that the humanitarian community aims to achieve to cover all people. However, in the description of strategic objectives it is relevant to reference the need to mitigate risks posed by explosive ordnance to children and to ensure that child victims with disabilities (as well as other children with disabilities) have equal access to assistance. This provides a good basis for inclusion to be reflected in cluster-level objectives, indicators, and targets.

#### 5.3 Identify Indicators to monitor the achievement of the strategic objectives

This should relate to discussions at SBD workshop on indicators (impact, outcomes etc.). Revised and standardized (non-exhaustive) indicators in line with HNO to form part of this guidance.

<sup>8</sup> Standard Beneficiary Definitions

#### 5.4 Define response approach and modalities

The collective outcomes out on page 4 of this document require an inter-sectoral approach that moves away from siloed sectoral responses. It is essential that prevention and response to the EO threat to children is considered as cross-cutting, to be considered across clusters, rather than being reflected as the responsibility of one sector (e.g. Mine Action).

During the HNO process, inter-sectoral information-sharing and analysis will facilitate consultations in designing the response across sectors. Two main approaches to consider are:

1. **Mainstreaming:** Following the principle of equal access to assistance, services in general should take into consideration the extent to which children at risk of EO related accidents and child victims are included among beneficiaries, and if barriers exist for access on an equal basis as people in need. This is as relevant for services such as WASH, Food Security and Livelihoods support and others as it is for Protection, Health and Education. Mainstreaming is also an opportunity to keep track of EO child victim beneficiaries across sectors regardless of whether they were directly targeted or not. Moreover, indirect risks faced by child victims ought to be considered (unaccompanied children due to parents death caused by EO related accidents, children living with parents who have disabilities as a result of EO accidents, other protection issues arising from victim status) as such services such as case management and referrals may be instrumental for mainstreaming the response.
2. **Direct services:** On the other hand, for a number of risks and needs identified during HNO processes a mainstreaming approach only may not be sufficient.

On the prevention side, specific and targeted explosive ordnance risk education programmes may be needed based on evidence of risks and trends identified in any given context. Specific profiles and populations groups in varying geographic areas may be considered more at risk than in others, and EORE interventions designed accordingly.

On the response side, specific and targeted services are needed for child EO casualties. These include life-saving medical emergency interventions and ongoing medical care as well as physical rehabilitation (including prosthetics & orthotics and accompanying assistive devices)), MHPSS and other services. Specific challenges may exist in terms of access to education and other social activities, and may require interventions both with the child and their family, as well as with schools and the broader community.

The design of prevention and response will benefit from a sound understanding of existing local capacities, presence and capacities of humanitarian actors and other service providers. Derived from this, an operational analysis of gaps in the response will inform prevention and response approaches accordingly.

Moreover, facilitate strong participation from community representatives and survivors themselves, for example, by ensuring participation of EO survivors in community consultations and, if necessary, taking steps to ensure consultation are accessible.

## STEP 6 Review and approve the strategic objectives and monitoring requirements

Mutually agreed inter-cluster strategic objectives should correspond to the needs identified throughout all previous steps.

Accountability to Affected Populations also implies transparent decision-making and the right for communities to know how and why decisions that affect them are made, including decisions Not To provide certain services.

Participation by survivor organizations and organizations of persons with disabilities, and other representatives from affected communities is important so as ensure their feedback on the proposed response is heard and integrated.

A coherent and standardized set of output level (HRP) indicators that can be reported against by any and all actors involved in the prevention and response to EO child casualties is essential for monitoring results in this regard. Table 3 presents a compilation of sample indicators for consideration depending on the specific context.

Inclusion of specific categories in beneficiary registration systems of humanitarian actors is essential to keep track and report on services provided to child victims and therefore fulfil monitoring requirement

## STEP 7 Formulate the activities and estimate the cost of the response plan

7.1 Elaborate the activities/ projects required to achieve the strategic objectives defined in the previous step: At this stage

there should be a much clearer idea of the core services that are required to address risks and needs associated with the impact of EO on children.

- Prevention: Explosive Ordnance Risk Education (EORE) entails the dissemination of “risk education safety messages”<sup>9</sup> which corresponds directly to collective outcome 1. The aim is specifically to reduce the number and rate of children having an accident with explosive ordnance. Activities may include face-to-face modalities (presentations, theatre pieces, cultural performances etc) whereby beneficiaries are reached directly (in the community or through formal education channels) with a targeted approach based on identified vulnerability, or through mass and digital media, ad hoc safety/risk education briefings, and other trainings;

- Reducing Mortality rate, i.e. number of children who do not survive an EO accident: In EO contaminated contexts, EORE will likely not be able to prevent 100% of accidents, including among children. Life-saving emergency medical services for those children who do have an accident include first aid, provision of safe blood and trauma surgery and ongoing medical care, including infection control and pain management. Support, training and provision of equipment to prepare locally affected communities to take quick action if accidents do occur and should also be considered as a important part of the process - especially given that first aid training of volunteers in EO affected communities has proven to reduce the mortality rate from around 30% to 12%.

- Increasing Personal Capacity: The core activities associated with this collective outcome are the provision of physical rehabilitation, MHPSS services, Prosthetics, Orthotics and provision other assistive devices for survivors;

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<sup>9</sup> IMAS 12.10 “Mine/ERW Risk Education, Technical Note 12.10/01 “Risk Education for Improvised Explosive Devices”

- Social Inclusion for Child survivors that have been out of school and also unable to participate in community, cultural and social life. Activities to enhance social inclusion within education could include provision of mobility, audio, visual assistive devices; teacher training on referral procedures and resources for child survivors of EO; teacher training on inclusive education approaches, covering physical and non-physical special needs and adaptations; school based MHPSS services and referrals; establishing/ensuring functional school based referral mechanisms; school-based anti-bullying/stigma activities. Identifying and addressing barriers to access, creating inclusive peer networks, building capacity of service providers..

Some core cross-cutting activities also play a key role, in particular, Child Protection Case Management (CPCM) is critical in order to

identify related cases and either address directly or through referral pathways the various protection, health, and educational needs of child victims, their parents and/or caregivers.

Moreover, all information, monitoring and analysis gained throughout the cycle should also contribute to and inform other core pillars of Mine Action, such as Clearance Prioritisation processes.

7.2 Estimate the cost of the response: Link to recommendation on costing exercise for child victims

Finalize and write up the response plan: Refer to Annex F which follows an outline of the HRP template with specific guidance on where/how child casualties prevention and response can be integrated in the document

**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<br>Other Trainings & services   |  |
| Reducing Mortality           | First Aid   | % of children having accidents that receive a first aid response<br>Survival rates   |
|                              | Trauma Surgery  | % of affected communities receiving training and equipment for first aid response  |
|                              | Training and Equipment  | % affected population having access to safe blood  |
|                              | Access to Safe Blood Cold Chains<br>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<br>% of survivors in need of other assistive devices who receive them   |
|                              | Provision of other assistive devices  | # child survivors receiving Rehab & MHPSS case management services (SADD breakdown)<br># 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<br># of MHPSS staff and volunteers who are providing direct services that are aware of referral resources & procedures. |
|                              | Clearance Prioritisation  | Square M Cleared, Marked, Surveyed that are in X proximity to schools<br>Square KM land released for use as playgrounds or education and cultural activity participated by children      |

## Key stakeholders in the HNO and HRP process

**Humanitarian Coordinator and Humanitarian Country Team (HC/HCT)** – the group of senior managers (Country Directors, Country Representatives, etc) and the designated senior lead for the response acting as the chair, taking strategic decisions concerning the overall response together.

**Implementing Organization or Agency (Cluster/ Sector Member)** – those national and international organizations implementing humanitarian programme activities who have chosen to participate in the IASC- Cluster/Sector Approach in a given context.

**Inter-Cluster/Sector Coordination Group (ICCG/ ISCG)** – the group of IASC-Cluster/Sector Coordinators (assigned by Lead/Co-lead Agencies) taking decisions together, with a representative of OCHA acting as the chair

**Cluster/Sector Lead and/or Co-lead Agency Coordinators (Cluster/Sector Coordinator)** – the designated agency, endorsed by the HCT (or other locally equivalent, multilateral humanitarian leadership group), leading coordination in a particular field of activity (Mine Action, Child Protection, Education, Health, Shelter, etc) and represented by an assigned Cluster/Sector Coordinator.

**Technical Working Groups** – the group of technical experts in assessment and analysis, covering critical fields of activity, constituted by (and with the endorsement of) the Inter-Cluster/Sector Coordination Group. These groups can be: an Assessment & Analysis Working Group, an Information Management Working Group or equivalent (mostly for the HNO) and a Response Analysis Group or equivalent (mostly for the HRP).

## List of Annexes

- A. Checklist (under development)
- B. Explosive Ordnance Child Casualties Information Requirements (GICHD)
- C. Associated Domains (GICHD)
- D. Mapping of Existing Assessment Tools / Data Sources
- E. Matrix on Inclusion in the Humanitarian Needs Overview
- F. Matrix on Inclusion in the Humanitarian Response Plan
- G. Good Practices Criteria
- H. Survey Results and Recommendations (under development)
- I. Analytical Frameworks (to be included once updated)
- J. Key Resources
- K. Terminology and Acronym