Government of the Islamic Republic of Afghanistan

REPORT

OF

FIRST NATIONAL LANDMINE VICTIM ASSISTANCE WORKSHOP

Hosted by

Ministry of Foreign Affairs

KABUL, AFGHANISTAN

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FIRST NATIONAL LANDMINE VICTIM ASSISTANCE WORKSHOP REPORT

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Acknowledgements:

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For further information:

On the national workshop, contact:
Susan Helseth
Senior Technical Advisor for Mine Risk Education and Victim Assistance
UN Mine Action Centre for Afghanistan
Email: susan@unmaca.org

On victim assistance in the context of the AP Mine Ban Convention, contact:
Sheree Bailey
Victim Assistance Specialist
Geneva International Centre for Humanitarian Demining
Email: s.bailey@gichd.ch

Background:

Landmine victim assistance is a complex issue. In Afghanistan, the complexities are exacerbated by the paucity or low quality of services within all areas of assistance including health care, social services, education and human rights.

Lack of access to emergency services and health facilities in remote areas together with the lack of equipment, medicines, and adequately trained health and rehabilitation personnel, and insufficient levels of funding often prevent mine victims and other people with disabilities from receiving the care and rehabilitation services they need to survive and reintegrate into Afghan society.

At the First Review Conference of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction (AP Mine Ban Convention), in Nairobi, Kenya, from 29 November to 3 December 2004, Afghanistan was one of 24 States Parties[1] that indicated that they had significant numbers of mine survivors and the "the greatest responsibility to act, but also the greatest needs and expectations for assistance" in providing adequate services for their care, rehabilitation and reintegration.[2] As a result, Afghanistan has become "a more focused challenge" for States Parties in the period up to the Second Review Conference in 2009.[3]

States Parties at the First Review Conference adopted a clear understanding of principles to guide their victim assistance efforts. Four statements are particularly important:

- victim assistance "does not require the development of new fields or disciplines but rather calls for ensuring that existing health care and social service systems, rehabilitation programmes and legislative and policy frameworks are adequate to meet the needs of all citizens – including landmine victims;"
- "….the call to assist landmine victims should not lead to victim assistance efforts being undertaken in such a manner as to exclude any person injured or disabled in another manner;"
- "assistance to landmine victims should be viewed as a part of a country's overall public health and social services systems and human rights frameworks;" and,
- "….providing adequate assistance to landmine survivors must be seen in a broader context of development and underdevelopment…."[4]

The First Review Conference also adopted the ambitious five-year *Nairobi Action Plan* for the period 2005 to 2009. With respect to victim assistance, the *Nairobi Action Plan* aims to "enhance the care, rehabilitation and reintegration efforts" through eleven "actions" directed at both mine-affected and non-affected States Parties. The Plan of Action commits mine-affected States Parties, including Afghanistan, to do their utmost to establish and enhance health care services needed to respond to the immediate and ongoing medical needs of mine victims; to increase national physical rehabilitation capacities; to develop capacities to meet the psychological and social support needs of mine victims; to actively support the socio-economic reintegration of mine victims; to ensure that national legal and policy frameworks effectively address the needs and fundamental human rights of mine victims; to

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[1] *Review of the operation of the status of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction: 1999-2004*, (Part II of the Final Report of the First Review Conference of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, Nairobi, 29 November – 3 December 2004, APLC/CONF/2004/5, 9 February 2005), p. 33, paragraph 85. Ethiopia's ratification of Mine Ban Convention on 17 December 2004 increased the number to 24.

[2] *Ending the suffering caused by anti-personnel landmines: Nairobi Action Plan 2005-2009*, (Part III of the Final Report), p. 99, paragraph 5.

[3] *Review of the operation of the status of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction: 1999-2004*, p. 33, paragraph 86.

[4] *Review of the operation of the status of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction: 1999-2004*, pp. 27-28, paragraphs 65-67.

develop or enhance national mine victim data collection capacities; and to ensure that in all victim assistance efforts, emphasis is given to age and gender considerations. Donor States Parties committed to provide external support to assist mine-affected States in the care, rehabilitation and reintegration of mine victims. All States Parties committed to monitoring and promoting progress in achieving the victim assistance goals and ensuring the effective participation of mine victims in the work of the Convention.[5]

The AP Mine Ban Convention's Standing Committee on Victim Assistance and Socio-Economic Reintegration (SCVA) has been integral to advancing understanding and identifying the needs in relation to mine victim assistance among the States Parties.

In 2005, the SCVA, under the leadership of Nicaragua and Norway, increased its efforts to ensure the successful implementation of the Convention and concrete progress in meeting the needs of landmine victims before the Second Review Conference in 2009. In early 2005, the Co-Chairs developed a questionnaire, in consultation with the Convention's Implementation Support Unit and key stakeholders, including the International Campaign to Ban Landmines and the International Committee of the Red Cross, to assist the 24 most affected States Parties, including Afghanistan, in developing a plan of action in relation to mine victim assistance.

The questionnaire called for responses to four key questions: what is the situation in 2005 in each of the six main thematic areas of victim assistance?; what does the state wish the situation to be in each of the six thematic areas by 2009?; what are the plans to achieve these objectives in each of the six thematic areas by 2009?; and what means are available or required to implement these plans?[6] The Co-Chairs sent the questionnaire to the 24 States Parties in March 2005 which the aim that these States Parties produce objectives that were specific, measurable, achievable, relevant, and time-bound, or SMART, before the Sixth Meeting of the States Parties (6MSP) in Zagreb, Croatia, from 27 November – 2 December 2005.

The questionnaire was viewed by the Government of Afghanistan as an opportunity to articulate specific, measurable and realistic objectives that would be relevant to the disability sector as a whole, to undertake activity planning to achieve these objectives, to estimate the costs and the means to implement these plans, and to identify capacities to monitor, evaluate and reassess the plan as required.

To facilitate the task of completing the questionnaire, in November 2005 UNICEF recruited a consultant to come to Afghanistan to assist the government in the process. Through consultations with relevant ministries and colleagues from UN and other international and national agencies working in the disability sector, inputs were provided for the first draft report that included a situation analysis and objectives. This draft report was presented to the 6MSP at the end of November. The *Zagreb Progress Report* adopted by States Parties at the 6MSP, contained a lengthy annex which summarized the responses made by Afghanistan and most of the other relevant States Parties. (See Annex A)

However, the *Zagreb Progress Report* acknowledged that the questionnaire "is not an end-product but rather an initial step in a long-term planning and implementation process."[7] At the 6MSP, Afghanistan, together with Switzerland, assumed the important role of Co-

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[5] *Ending the suffering caused by anti-personnel landmines: Nairobi Action Plan 2005-2009*, pp. 99-101, paragraph 5.

[6] The six thematic areas of victim assistance are: Understanding the extent of the challenge (data collection); Emergency and continuing medical care; Physical rehabilitation; Psychological support and social reintegration; Economic reintegration; and, Laws and policies.

[7] *Achieving the Aims of the Nairobi Action Plan: The Zagreb Progress Report*, (Part II of the Final Report of the Sixth Meeting of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, unofficial version, 2 December 2005), p. 27, paragraph 72

Chair of the SCVA. In this capacity, Afghanistan aimed to lead by example and develop a plan of action to meet the needs of landmine victims and other people with disabilities.

Under the leadership of the former Deputy Minister of Foreign Affairs, Dr. Haider Reza, Afghanistan launched a process to revise the information presented in the *Zagreb Progress Report* and increase the level of inter-ministerial coordination and cooperation within the disability sector to develop a national plan of action that would assist mine survivors and other people with disabilities. Several meetings were convened with representatives from the Ministries of Public Health, Martyrs and Disabled, Labor and Social Affairs, Education, and Foreign Affairs, and other key actors.

In 2006, with *process support* provided by the Implementation Support Unit (funded by Switzerland), Afghanistan has continued to make progress towards developing a plan of action, with the involvement of relevant ministries, international agencies, national organizations, and mine survivors.

The UNMACA has played a key role in facilitating the process to review and elaborate on the responses to the questionnaire through consultative work with ministries and implementing agencies. A second draft, which included inputs from key actors, was presented to the States Parties at the intersessional meeting of the SCVA in Geneva in May 2006. (See Annex B)

This revised document provided the foundation for discussions at the National Landmine Victim Assistance Workshop.

Workshop Objectives:

The primary aim of the workshop was to enable the Government of Afghanistan, in collaboration with relevant ministries and other key stakeholders in the disability sector, to develop a plan of action for the period 2006-2009 to address the needs of mine victims and other persons with disabilities. The plan of action will be presented to the Seventh Meeting of the States Parties (7MSP) to the AP Mine Ban Convention in September 2006.

Other objectives were to raise awareness of the rights and needs of people with disabilities in Afghanistan, and to provide the relevant ministries with a clear picture of the benchmarks and their responsibilities.

The First National Landmine Victim Assistance Workshop:

On 6-8 August 2006, the first National Landmine Victim Assistance Workshop in Afghanistan was convened and hosted by the Ministry of Foreign Affairs at their offices in Kabul to review, revise and enhance the initial responses to the Victim Assistance questionnaire. (See Annex C) The workshop brought together some 90 stakeholders, including representatives from the ministries of Public Health, Martyrs, Disabled and Social Affairs, Economy and Labor, Transport, Energy and Water, Public Works, and Foreign Affairs, the Department of Disaster Preparedness, eight international agencies, and around 20 national and international non government organizations, including several that represent people with disabilities. (See Annex D) The opening of the workshop was also covered by several representatives of local and international media outlets.

The main language of the workshop was Dari; however, simultaneous translation in English, Dari and Pashtu was provided.

His Excellency Deputy Minister of Foreign Affairs, Mr. Mahmoud Saikal, welcomed participants to the meeting. Mr. Saikal reiterated the Government's commitment to the obligations of the AP Mine Ban Convention including those in support of landmine victims. He highlighted the great progress the Afghanistan Mine Action Program has made but stressed the need for increased assistance to landmine victims and other people with disabilities. He told participants that the workshop provided a great opportunity for government ministries, international agencies, and non governmental organizations to work

together to promote substantial movement forward on issues relating to people with disabilities. The timing of the workshop was particularly important as it could provide the relevant ministries with a clear picture of the benchmarks, their responsibilities, and the way forward in finalizing National Development Strategies based on the London Compact. (See Annex E)

Deputy Ministers of Public Health, His Excellency Dr. Faizullah Kakar and Her Excellency Dr. Nadera Hayat, and His Excellency Mr. Hadi Hadi, Deputy Ministry of Martyrs, Disabled and Social Affairs also participated in the opening of the workshop. The Deputy Ministers spoke of their Ministry's long term commitment to the development and implementation of integrated programs and the inclusion of people with disabilities into all sectors of Afghan society.

H.E. Dr. Kakar informed participants that the Ministry of Public Health (MoPH) would soon launch its disability strategy. Dr. Kakar identified key areas of concern as being access to health facilities and improving emergency first aid and first responses. He reiterated the importance of ensuring that victim assistance activities were integrated into public health strategies and should not lead to discrimination for or against any particular group. Dr. Kakar also called for more research to be conducted on the impact of landmines on public health.

H.E. Dr. Nadera Hayat also informed participants of the MoPH strategy that was looking at the treatment and prevention of disability, and the key role of physiotherapy. She added that the MoPH welcomed the support of advisors in the development and implementation of policies and services.

H.E. Mr. Hadi Hadi told participants that the workshop was important as it would enable all stakeholders to review past performance in relation to assisting mine victims and plans for the future. He was concerned that support for mine victims in the past had taken more of a welfare and charity approach as opposed to addressing the human rights and development dimension, and stated that this approach was not only unsustainable but also demeaning of dignity, esteem and rights of people with disabilities. Mr. Hadi Hadi stressed that the needs of people with disabilities must be integrated within the national planning processes and addressed on the basis of sound national policy and legal frameworks. He spoke of the work being undertaken by the Ministry of Martyrs, Disabled and Social Affairs (MoMDSA), in conjunction with major stakeholders, to review existing policies and develop new initiatives that aim at ensuring that the issue of disability is situated within the framework of national development and human rights.

Ms. Sheree Bailey, Victim Assistance Specialist from the Geneva International Centre for Humanitarian Demining, introduced the international context of the workshop by providing an overview of the AP Mine Ban Convention and Victim Assistance. She told participants that the Convention has been described as a "victory for humanity [and] the cause of humanitarian values in the face of cruelty and indifference." She spoke of the commitment of the States Parties to do their utmost to meet the needs of mine victims and other people with disability through adequate health care services, physical rehabilitation, psychological and social supports and support to socio-economic reintegration and by ensuring basic human rights. Ms. Bailey also reviewed the victim assistance questionnaire process and the work of the Standing Committee on Victim Assistance and Socio-Economic Reintegration (SCVA). She reminded participants that meeting the needs of mine victims and other people with disabilities will require the committed and coordinated efforts of all the relevant ministries and key actors in the disability sector.

Dr. Flavio Del Ponte, representing the Co-Chairs of the SCVA, and the Senior Medical Advisor at the Swiss Agency for Development and Cooperation in Geneva, informed participants of the strategy and work of the Co-Chairs in 2006. In particular, he spoke of the seven essential steps that had been developed, in collaboration with key actors, for emergency first response actions when responding to landmine casualties and other traumatic injuries.

Dr. Del Ponte also stressed the importance of inter-ministerial coordination and cooperation in pushing forward the initiatives that would be developed at this workshop.

Ms. Susan Helseth, UNMACA's Senior Technical Advisor for Mine Risk Education and Victim Assistance reminded participants of the Government's efforts in developing its own millennium development goals and the Afghanistan National Development Strategy (ANDS) on which the London Compact is based. She outlined the areas within ANDS where disability issues are raised and how ultimately, the responsibility for meeting the needs of the population, including people with disabilities lies with the government through coordination and collaboration between all relevant ministries. She stressed that the work that would be done in the workshop on identifying objectives and developing a plan of action had the potential to assist the government to achieve its goals through highlighting concrete benchmarks that will ensure measurable improvements in the delivery of services and towards the protection of the rights and dignity of persons with disabilities throughout Afghanistan.

Overview of the Key Elements of Landmine Victim Assistance:

Before undertaking the core task of the workshop – developing a plan of action – participants were introduced to the key elements of landmine victim assistance.

Within the framework of the AP Mine Ban Convention, a comprehensive, integrated approach to victim assistance is promoted. This framework rests on a three-tiered definition of a landmine victim. This means that a "mine victim" includes directly affected individuals, their families, and their communities. Therefore, victim assistance should encompass a wide range of activities that benefit individuals, families and communities.

The First Review Conference of the Convention emphasized that mine survivors are part of a larger community of persons with injuries and disabilities from other causes, and victim assistance efforts should be beneficial for this larger group of persons with disabilities.

It has generally been agreed by the main stakeholders that the key elements of victim assistance include:

- data collection to understand the extent of the challenge;
- emergency and continuing medical care, including first aid and the management of injuries in the immediate aftermath of a landmine explosion or other traumatic injury, surgery, pain management, acute hospital care, and the ongoing medical care needed for the physical recovery of the injured person;
- physical rehabilitation, including the provision of services that promote rehabilitation such as physiotherapy, and the supply of prosthetics, orthotics and other assistive devices;
- psychological support and social reintegration, including formal and informal counseling, sports, associations of people with disabilities, inclusive education, and other activities that assist mine survivors and the families of those killed or injured to overcome the psychological trauma of a landmine explosion, adjust to their disability, and promote their social well-being;
- economic reintegration, including education, vocational training, creation of employment and other income generating opportunities, micro-credit schemes, the development of community infrastructures to reflect the local economic reality, and activities that improve the economic status of mine survivors and other people with disabilities and raise awareness so that people with disabilities can enjoy equal opportunities for employment and other services; and
- laws and public policies that promote effective treatment, care and protection of people with disabilities.

It was stressed to participants that in their discussions to develop a victim assistance plan of action, services should be intended to benefit all people with disability in Afghanistan and be embedded in the national health and social services systems. Furthermore, it was

understood that to ensure sustainability it was essential that the government takes ownership of the plan and that the relevant ministries coordinate their activities to avoid duplication and ensure a holistic approach to meet the needs of the population, including people with disabilities.

Victim Assistance in Afghanistan:

Afghanistan is one of the most mine-affected countries in the world and life can be hard not only for mine survivors and other people with disabilities but also for their families. Before making plans to address an issue it is essential to understand the extent of the challenges faced. Part I of the information provided by Afghanistan in the *Zagreb Progress Report* deals with the goal of defining the scale of the challenge faced, identifying the needs, monitoring responses to the needs, and evaluating the responses. Jean-Francois Trani from Handicap International informed participants of the results of the recently completed National Disability Survey for Afghanistan (NDSA). The findings of the NDSA will assist in identifying some of the main issues faced by people with disabilities and the gaps in services available. In relation to the casualties caused by landmines and explosive remnants of war (ERW), the International Committee of the Red Cross (ICRC) is the main provider of data in Afghanistan. The ICRC began data collection in 1998 and now provides about 90 percent of the data in the UNMACA database. Zaman Noori, Manager of the ICRC's Mine Action Program, presented information about their data collection system and some of the results. The information provided in these presentations was used to update the report.

To provide practical examples of the elements of landmine victim assistance and the cross cutting issues faced by people with disabilities, some of the main providers of services in Afghanistan were invited to make brief presentations on their work: Abdulrahim Ferotan from the Afghan Red Crescent Society (first aid and emergency care); Najmuddin and Alberto Cairo from the ICRC (physical rehabilitation and socio-economic reintegration); Zamarai Saqeb from the Swedish Committee for Afghanistan – SCA (primary health care, community based rehabilitation, psychological support, and social and economic reintegration); Abdul Nasir from the Afghan Amputee Bicyclists for Rehabilitation and Recreation – AABRAR (physical rehabilitation and socio-economic reintegration); and Saifudin Nezami from Handicap International's Community Centre for Disabled (socio-economic reintegration). The floor was then opened for discussion and other participants including the MoPH, Kabul Orthopedic Organization, and UNDP's National Program for Action on Disability (NPAD) provided additional information.

Working Groups:

The real work began on Day 2 with participants breaking into five small working groups of 15-20 participants. Each group, facilitated by an experienced national officer, focused on one of the key elements of landmine victim assistance:

- Emergency and continuing medical care – Dr. Zia Bina (UNDP/NPAD)
- Physical rehabilitation – Ahmad Farid (HI) and Razi Khan Hamdard (UNDP/NPAD)
- Psychological support and social reintegration – Zemarai Saqeb (SCA)
- Economic reintegration – Zabihullah Haider (UNMACA)
- Laws and public policies – Samiulhaq (UNDP/NPAD)

The basis for discussion in the working groups was the revised information from the *Zagreb Progress Report*. The working group facilitators were tasked with achieving three main aims: (See Annex F)

1. Review the Status column of the information in the *Zagreb Progress Report* to determine if this represents the true situation in Afghanistan
    - Recommend changes as appropriate

2. Review the Objectives to determine if these represent the actions, change or improvement in the situation that are desired by 2009
    - Are the Objectives achievable in the timeframe?
    - If all Objectives are not achievable which Objectives should be given priority?
    - Should priority be given to other objectives? If so, what are these objectives?
3. Discuss how to achieve the objectives – develop the plan to achieve objectives
    - Identify which government ministry has responsibility for oversight/achievement of each objective.
    - Identify which agencies/organizations could implement activities on behalf of relevant ministry, as appropriate, to achieve each objective.
    - Identify what these activities could be.
    - What should the role of inter-ministerial coordination be in achieving the objectives?
    - Make recommendations on improving inter-ministerial coordination in meeting the needs of people with disabilities.

Participants reported that the working group sessions had been very productive, and although the work was sometimes hard, the outcomes were promising. Some groups requested additional time the following day to finalize their discussions.

On the final day, time was available for some of the working groups to present the results of their discussions and to allow others to make comments. All the notes and flipcharts produced by the working groups were used to produce Afghanistan's Victim Assistance Plan of Action 2006-2009. (See Annex G)

Closing remarks:

Ms. Susan Helseth thanked the participants for their committed and passionate involvement in the workshop. She reported that success had been achieved, the information provided for the *Zagreb Progress Report* would be revised, and that the dedication of the colleagues involved had taken this process forward. Ms. Helseth told participants that the revised document would be sent for comment prior to finalization and presentation to the relevant ministries for endorsement. Afghanistan's Plan of Action would then be presented to the Seventh Meeting of the States Parties to the AP Mine Ban Convention in Geneva, Switzerland in September 2006. She thanked H.E. Mr. Saikal and the staff of the Ministry of Foreign Affairs for their efforts in hosting the workshop, and all the ministries for their high level of participation. Ms. Helseth reiterated that the outcomes of the workshop would provide concrete benchmarks that will ensure the delivery of services and protection of the rights and dignity of persons with disabilities throughout Afghanistan.

Dr. Flavio Del Ponte, on behalf of the Co-Chairs of SCVA, stated that he was encouraged by the level of participation in the workshop. It was an example of inter-ministerial cooperation and planning that would be passed along to other countries working for the same outcomes and results in their victim assistance activities.

His Excellency Mr. Saikal closed the workshop by highlighting several points, including that the issue of disability must be given greater priority within all government ministries. In addition, he acknowledged that the Ministry of Foreign Affairs and other Ministries must do more to address the issue of accessibility to its buildings, and that providing adequate assistance to people with disabilities, and promoting their medical and physical rehabilitation, and social and economic reintegration must take a holistic approach and this could not be done without collaboration and coordination between all relevant ministries and other actors. He reiterated that it was essential that the relevant government ministries take ownership of the plan and reminded participants that there was still much work

to be done to turn the proposed objectives and actions into a concrete and fully implemented plan. Mr. Saikal concluded by thanking all those who participated in, supported and facilitated the workshop. (See Annex H)

Workshop Outcome and Key Recommendations:

The principal outcome of the First National Landmine Victim Assistance Workshop was the elaboration of the report, *Addressing the rights and needs of mine survivors and other persons with disabilities: The Islamic Republic of Afghanistan's objectives and plan of action for the period 2006-2009*. (See Annex G) The Plan of Action will be presented to the Seventh Meeting of the States Parties to the AP Mine Ban Convention in September 2006.

The Plan of Action was based on extensive deliberations at the workshop, and through inter-ministerial and key stakeholder consultations afterwards. The Plan of Action charts a realistic and achievable way forward for the enhancement and expansion of current services for all people with disabilities, including landmine survivors, and their integration into social, educational and economic opportunities.

Once endorsed by the relevant ministries, the final stage is to prepare the budget for implementation of the Plan and to harness the support of the donor community to ensure that the Plan becomes a reality.

It is hoped that the consultative nature of this process will solidify the national ownership of recommendations and obligations elaborated, will support the achievement of the Millennium Development Goals, and will be integrated into the National Development Framework.

Key recommendations from this process include:

- Disability focal points should be identified and supported in key ministries;
- Awareness-raising activities are needed to make the issue of disability a higher priority in key ministries;
- Economic reintegration requires additional focus and the engagement of service providers that are not currently seen as serving the disability sector;
- Opportunities for on-going discussion on a regular basis of key issues relating to persons with disabilities should be created; for example, through regular meetings of the working groups; and
- A national disability coordination mechanism is needed to facilitate inter-ministerial collaboration and coordination, and to monitor and report on activities of all stakeholders.

In addition, a national capacity to maintain a victim assistance perspective within the disability sector, to monitor progress of Convention obligations and the objectives set out in the Plan of Action, and for continued advocacy activities on the rights of mine survivors and other people with disabilities should be a permanent component of the Government's Mine Action Program for Afghanistan.

Once implemented, Afghanistan's Plan of Action has the potential to make a significant difference to the daily lives of landmine survivors and their families. It will also benefit the disability sector as a whole by setting forth a positive planning process and establishing achievable benchmarks for a national disability program. By engaging the disability sector in this process and implementing the plan, Afghanistan can ensure that landmine survivors and other people with disabilities are fully integrated into Afghan society thus meeting their obligations under the AP Mine Ban Convention.

Annex A – Extract from the *Zagreb Progress Report*

Zagreb Progress Report

Annex V: Victim assistance objectives of the States Parties that have reported the responsibility for significant numbers of landmine survivors

Afghanistan

Part 1: Understanding the extent of the challenge faced		
Goal:	**Status:**	**Objectives:**
Define the scale of the challenge, identify needs, monitor the responses to needs and evaluate the responses	Afghanistan is one of the most mine-affected countries in the world, with an estimated number of over 100,000 people killed or injured by mines since 1979. The current number of approximately 1,100 new mine/UXO casualties per year (or 92 per month) is a significant decrease from 1993 (600 to 720 monthly), 1997 (300 to 360 monthly) and 2000 (150 to 300 monthly). According to the Afghanistan Landmine Impact Survey (ALIS), 17 percent of landmine/UXO casualties are children between 5 and 14 years of age; 50 percent are under the age of 18. About 90 percent of casualties are male. Mine/UXO casualty data collection began in 1998 and is an ongoing process on a national level in all impacted areas. Agencies collecting this data utilize a standardized format. Strengthening of the Ministry of Public Health (MoPH) information management systems to include injury surveillance is in the development stages. Data on mine casualties is collected primarily by the International Committee of the Red Cross (ICRC) which provides the UN Mine Action Program with 90 - 95 percent of its information on casualties. Mine casualty data is provided by 490 health facilities supported by several agencies and organizations, including the MoPH, Afghan Red Crescent Society, International Federation of Red Cross and Red Crescent Societies, ICRC Orthopedic Centers and more than a dozen NGOs and organizations. The available data is used by many of the organizations working with mine/UXO survivors and reporting mechanisms are being strengthened to provide data to relevant end users. No comprehensive nation-wide survey has been done of persons with disabilities through the Ministry of Martyrs and Disabled (MMD). In 2003 and early 2004, the MMD conducted a survey and collected data on 86,354 persons with disabilities in 33 of the 34 provinces. As of February 2004, approximately 18 percent of persons with disabilities recorded by the MMD were mine survivors. Handicap International completed fieldwork in early 2005 for a National Disability Survey based on a random national cluster methodology. Results of this survey	▪ Maintain and keep up-to-date information in the the Afghanistan Landmine Impact Survey database through a "sentinel surveillance system." ▪ Analyze the results of the National Disability Survey in early 2006 to assess if it will be useful in programme planning and setting national priorities for delivery or expansion of health care, rehabilitation and reintegration services. ▪ Include disability in the national statistical survey and census. ▪ Collect information about persons with disabilities and create a database on all disability services available in Afghanistan. ▪ Establish and begin to implement an injury surveillance system in which landmine survivors and other persons with disabilities are tracked through the national health system, from 2005.

	should be finalized by December 2005 or January 2006 and will be shared and consulted with the MMD and the National Programme for Action on Disability (NPAD) prior to publication in 2006. Currently there is insufficient data available for policy making on the socio-economic conditions of persons with disabilities. The national census does not have statistics regarding persons with disabilities, their occupations, socio-economic status, education, etc. The next national census is planned for 2007 and efforts are being made to include questions on disability in the census.	
Part 2: Emergency and continuing medical care		
Goal: Reduce deaths by stabilizing medical conditions and minimizing physical impairments in emergency settings that could result from injury	**Status:** The Ministry of Public Health (MoPH) delivers health services through the implementation of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services. Some of the problems of the current health care services include lack of trained manpower, lack of standard equipment, lack of adequate accommodation in the hospitals, and insufficient primary health care in the rural areas. The Landmine Impact Survey found that only ten percent of mine-impacted communities had healthcare facilities of any kind. Basic first aid services are available through district clinics. Trauma care specialists are not widely available. Serum is available in most places and considered very safe. Blood transfusions are limited to only a few hospitals and considered safe. Very few ambulances are available. Local transport by taxi or donkey is available to most. Travel to hospitals / clinics can take between one hour to 3 days depending on location of the incident, road and weather condition and accessibility of transport. Amputation / trauma surgery is available though the quality is questionable in some cases. There is lack of equipment and supplies in health facilities and quality of services is lacking and varies by location. Access to pain medication is relatively easy and often unregulated. Training or refresher courses are required for most surgeons. No formal training in the care of traumatic injuries is currently available in-country. Access to corrective surgery and post-amputation revisions is available only in major hospitals. Eye and auditory medical care is very limited, except in big cities. All amputees are referred to rehabilitation services, which are available in 20 out of 34 provinces. Mine casualties will not be turned away or denied services; however long term care is more difficult due to costs of health care, transportation and lodging. Women may be denied care either by family or refusing treatment themselves from male practitioners. Services are available equally to all; however cultural barriers are	**Objectives:** ▪ Assess the services in heavily mine/UXO-impacted rural areas in relation to emergency first aid and medical transportation needs and develop plans to address the needs in areas where assistence is insufficient or non-existent in order to reduce the mortality rates of mine/UXO casualties. ▪ Improve coordination among relevant actors at the national, regional and local levels. ▪ Ensure that disability remains one of the top priorities in the current policy and strategy of the Ministry of Public Health for 2005-2009. ▪ Develop a trained work force in the Ministry of Public Health in terms of disability to take the lead and responsibility in the field of rehabilitation activities. ▪ Design a package of disability services for the country. ▪ Ensure adequate attention is paid to women with disabilities in health care. ▪ Equip the hospitals with trained human resources and with the required equipment. ▪ Develop the primary health care system in rural areas using the provisions in the basic package of health care services.

	known to restrict women and girls from services as female doctors and practitioners may not be available. National coordination mechanisms involving all relevant actors are not currently in place. In the existing BPHS, disability is the 6th component of the package and includes the following services: 1. Information / Education / Communication, awareness, care seeking; 2. Home-based services for paraplegic cases; 3. Outpatient physiotherapy (screening and treatment); 4. Inpatient physiotherapy; 5. Orthopedic services (diagnosis); 6. Production of orthoses, fitting and training; and 7. Production of prostheses, fitting and training. In the National Health Policy for 2005-2009, disability issues have been moved from the second tier to the first tier in the BPHS.	▪ Ensure that all institutions for training of medical and paramedical health functionaries and pre-school educators, include programs of training in disability prevention, early detection and timely interventions through medical and social rehabilitation. ▪ Develop support services such as special education, clinical psychology, physiotherapy, occupational therapy, audiology, speech pathology, vocational counselling and ensure that trained human resources are available.
Part 3: Physical rehabilitation		
Goal: To restore maximum physical functional ability for landmine survivors, including the provision of appropriate assistive devices.	**Status:** Rehabilitation services for all persons with disabilities, regardless of the cause, are a part of a broader welfare policy and a combination of medical and social services. About 20 to 40 percent of mine/UXO survivors have access to rehabilitation services. With the exception of services provided by international organizations, for example the ICRC and international NGOs, rehabilitation services are very minimal and limited to only urban areas. There is not an extensive Community Based Rehabilitation (CBR) network or programme in Afghanistan, except that provided by some international NGOs. The rehabilitation needs of mine/UXO survivors and other persons with disabilities are not being met. Disability services exist in 20 of the 34 provinces, physiotherapy services in 19 provinces, orthopaedic workshops in 10 provinces, economic reintegration activities in 13 provinces, and community-based rehabilitation in 12 provinces. The ICRC is the principal provider of services to mine/UXO survivors with activities at its orthopaedic centres in Kabul, Mazar-i-Sharif, Herat, Jalalabad, Gulbahar and Faizabad. The centres fit upper and lower limb prostheses and orthoses, provide free medical care, physical rehabilitation, psychosocial support, vocational training, micro-credits for small business, and public awareness services related to government rules and programs. All services are free of charge. Rehabilitation services are also provided by several NGOs including the Swedish	**Objectives:** ▪ Increase access of mine/UXO survivors to services to 80 percent, and increase output of prosthetic and orthotic workshops by 30 percent. ▪ Improve accessibility by opening rehabilitation centers in every province on the basis of need and accessibility, and with trained personnel and equipment. ▪ Establish physical therapy clinics in the district, provincial and regional hospitals as well as extending services to health centers to reach 70 percent coverage and to be more community based. ▪ Increase the number of trained female workers for the rehabilitation of female mine/UXO survivors. ▪ Develop rehabilitation programmes, including follow-up, taking into account the medical and social rehabilitation of persons with disabilities. ▪ Extend functional community based rehabilitation (CBR) services to rural areas, examining and

	Committee for Afghanistan, Sandy Gall's Afghanistan Appeal, Handicap International, the Kabul Orthopaedic Organization, the Afghan Amputee Bicyclists for Rehabilitation and Recreation (AABRAR) and other national and international NGOs. Access to rehabilitative care is available free of charge. Distance and related costs (transport, accommodation, escort for women) can be problematic in areas where services are not available. Waiting periods for treatment range from immediate care to 30-45 days. Currently there are approximately 200 physiotherapists, 126 orthopaedic technicians and 105 artisans providing services in 20 of the 34 provinces. However, physical rehabilitation facilities need to be located in each large city or main town in at least 30 of the 34 provinces. All prosthetic and orthotic aids are produced locally, with raw materials often being imported due to lack of availability of quality materials on the local market, by numerous rehabilitation agencies, including ICRC, local and international NGOs. Coordination is good among disability stakeholders (IOs and NGOs, UN, DPOs, etc) but inter-Ministerial coordination and the technical capacity of the relevant Ministries (MMD, MoPH, MOLSA and MoE) is weak. The MMD recently established an NGO coordination unit, which will help in the coordination of all relevant actors.	adopting international best practices with necessary adjustments to the Afghanistan context.
Part 4: Psychological support and social reintegration		
Goal: To assist landmine survivors, including children, to resume their role in the community by helping them cope with psychosocial adjustment issues and assisting them to regain and maintain a healthy and positive outlook on life.	**Status:** There are few pyschosocial support activities in Afghanistan and very limited information is available. No counselling is available on the national level. Some initiatives exist through the ICRC and NGOs directed at specific needs or one-off projects. There is also limited peer support through service providers who employ large numbers of persons with disabilities. There is no coordination of all relevant actors on a national level. The majority of persons with disabilities are illiterate or semi-literate and the participation of children with disabilities in education is very poor. Though mine/UXO survivors are encouraged to complete their education, this is limited to what is available in the communities. Additionally, many people never attended school prior to becoming disabled in a mine/UXO incident so do not have basic skills to build upon. Integration of children with disabilities does occur. However, there is little to no training available to teachers on the particular needs of disabled children. The Ministry of Education has no separate programmes of inclusive or exclusive	**Objectives:** ▪ Bring together relevant line Ministries and actors to address the large gap in psychosocial support services in the country. ▪ Include the issue of Women with Disabilities in the process of National Census, data collection, and polices of training, education, and employment. ▪ Conduct awareness programs throughout the country to inform the people of the rights of women with disabilities and advocate for avoidance of domestic violence against women with disabilities. ▪ Adopt and implement the objectives of the National Disability Strategy in relation to the education of children with disabilities.

	education for children with disabilities. The Ministry suffers from a lack of school buildings, infrastructure, trained teachers and sufficient budget provisions. NGOs are doing some work, but without supervision or direction; the programs are not well coordinated. Even though primary education has been made compulsory in the Constitution, its implementation is far from satisfactory. There are no well-designed incentives for parents to send their children to schools. The draft National Disability Plan includes seven specific objectives relating to the education of children with disabilities.	
Part 5: Economic reintegration		
Goal: To assist landmine survivors to either return to their pre-injury occupation, or prepare for and find suitable employment.	**Status:** According to the Afghanistan Human Development Report 2004, approximately 53 percent of Afghans live below the poverty line and the average person spends approximately 80 percent of their income on food. It also noted that "a survey conducted by the Ministry of Labour and Social Affairs and the International Rescue Committee (IRC) found high unemployment among disabled people, estimated at 84 %. The lack of legislation to protect the rights of the disabled has also led to institutional discrimination." The Ministry of Martyrs and Disabled (MMD) is playing a key role in mainstreaming persons with disabilities in coordination with the Ministry of Labour and Social Affairs (MoLSA), the Ministry of Public Health (MoPH), and the Ministry of Education (MoE). As of April 2005, eight vocational training schools had been established. Persons with disabilities, registered by the MMD, receive welfare payments at the rate of 300 Afghanis per month (about $6). Persons with less than 50 percent disability receive 150 Afghanis per month. The Ministry of Finance releases the budget on the basis of requests from the MMD directly to the provinces who pay the benefit once every quarter. There are no contribution-based schemes in the country. The Afghanistan Landmine Impact Survey (ALIS) data on recent casualties indicated that unemployment among mine survivors increased by 38 percent after the incident. There were notable decreases in the percentage of survivors who continued to be farmers, herders, military personnel, deminers, and labourers – all occupations requiring mobility over difficult terrain (a challenge for amputees) – and increases in the numbers of survivors doing household work and being unemployed. MoLSA has adopted disability as a critical component of its efforts in vocational skills training and employment-related services. MoLSA wants to increase awareness	**Objectives:** ▪ Develop a combination of different programmes that address a continuous supply of income to vulnerable groups and effective delivery systems restructured on the basis of need and best practices in order to address the issue of mainstreaming. ▪ Develop a package of programmes including employment, vocational training, self-employment and other assistance, including an increase in the welfare payments, to bring disabled people above the poverty line. ▪ Put in place systems and strengthen field offices of relevant ministries for better benefit delivery and increase the capacity of personnel involved in service delivery. ▪ Increase vocational training facilities, equipped with adequate human resources for vocational training, counselling and assistance on employment generation issues. ▪ Develop courses in vocational training for persons with disabilities with due importance to their functional ability and the market needs. ▪ Design and implement income-generation programmes after training with the support of the Government, NGOs and the Private Sector.

	and improve institutional capacity to ensure that it can provide disability-related vocational skills training and employment-related services nation-wide. MoLSA is in the process of developing its capacity to implement programs focused on the disabled including vocational training and employment, technical assistance, staff development and training, policy development, curriculum development/training materials, development/resource materials development, and monitoring and evaluation. The UNDP's National Program for Action on Disability is providing national and international technical advice on vocational training and employment-related issues to MoLSA. In addition, many NGOs, Japan's International Cooperation and Assistance (JICA), Afghan Korea VT Training Centre, World Bank and GTZ are extending support to MoLSA to develop and deliver vocational training programs for persons with disabilities. MoLSA has a presence in 32 of the 34 provinces with vocational training programs. Results to date have not been particularly good due to lack of adequate funding, lack of infrastructure and lack of employment opportunities after the training is completed.	▪ Enforce affirmative action in employment for persons with disabilities. ▪ Collect and maintain statistics on persons with disabilities in employment and self-employment.
Part 6: Laws and public policies		
Goal: To establish, implement and enforce laws and public policies that guarantee the rights of landmine survivors and other persons with disabilities	**Status:** Afghanistan currently has no law guaranteeing the rights of persons with disabilities or developing a barrier free and accessible society. The Constitution of Afghanistan provides some basic rights to disabled people and enables the government to enact a separate law for people with disabilities. Articles 22, 53 and 84 include some enabling provisions for mainstreaming persons with disabilities. The Ministry of Martyrs and Disabled (MMD) is the focal point for all issues relating to persons with disabilities, including mine survivors. Objectives of the MMD include: collecting data on persons with disabilities from all provinces to facilitate access to monthly pensions; advocating for the rights of persons with disabilities; development of new legislation to protect the rights of persons with disabilities; and facilitating access to vocational training courses. Other line Ministries involved in services for persons with disabilities include the Ministry of Public Health (MoPH), the Ministry of Labour and Social Affairs (MoLSA) and the Ministry of Education (MoE). Afghanistan developed a Comprehensive Disability Policy in 2003 through extensive consultations with relevant actors and line Ministries. The process of final approval by the Government was not completed. In May 2005, the MMD began a consultative	**Objectives:** ▪ Finalize the National Disability Policy (NDP) for Afghanistan in December 2005 or early 2006, and disseminate to all stakeholders including government ministries, international organizations, NGOs, Disabled Persons Organizations, and provincial and local authorities. ▪ Conduct a nation-wide awareness raising campaign on the new National Disability Policy beginning in 2006, with the MMD leading the process with other relevant line Ministries. ▪ Extract relevant sections on disability issues from the Afghanistan National Development Strategy for 2005 – 2009 (ANDS) and include this information in nation-wide awareness raising on the new National Disability Policy.

	process to develop a new National Disability Policy (2006-2008) for Afghanistan, which should be finalized by December 2005 or early 2006. The MMD is the lead Ministry in developing the policy, which is being done in close consultation with relevant line Ministries (MoPH, MoE and MoLSA), with technical support from UNDP through the National Programme for Action on Disability (NPAD). NPAD is a three-year programme, which UNDP began implementing on 1 April 2005. UNDP has also signed a Memorandum of Understanding with the Government of Afghanistan to provide technical support to build capacity of the Government and to help put in place systems for mainstreaming the lives of the persons with disabilities. The International Labour Organization is also active in Afghanistan. Afghanistan is currently undergoing an extensive inter-ministerial process to develop the Afghanistan National Development Strategy (ANDS) for 2005-2009. It will include mine action and disability issues, though, at this point, it is not known how extensively. ANDS will by finalized by January 2006. Afghanistan has developed a National Health Policy for 2005 – 2009. In the Basis Package of Health Services (BPHS), disability and mental health have been moved from the second tier to first tier, therefore it will be a higher priority for the coming five years. Presently all disability services are provided by national and international NGOs. The government's role in service delivery to persons with disability is minimal. The Government of Afghanistan therefore recognizes that policy implementation should be done in partnership with the NGOs working at the grass roots level. The disability movement in Afghanistan is still in its infancy. Massive illiteracy and extreme poverty, limited exposure and inadequate skills in institutional development are some of the problems faced by the movement. As a result the voice of persons with disabilities and their capacity to negotiate on behalf of their own interests in planning and decision-making is lacking. Afghanistan is a signatory to the Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region, and a signatory to the Biwako Millennium Framework for action towards an inclusive, barrier free and rights based society for persons with disability. Afghanistan also recognizes the World Programme of Action and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, and is participating in the negotiations on the UN Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.	▪ Build institutions for the specific needs of the disabled between 2006 and 2008. ▪ Draft and adopt a comprehensive law for persons with disabilities guaranteeing their rights and creating an accessible and barrier free society, with due importance to the rights of women with disabilities, and issues of discrimination. ▪ Register all NGOs working in the sector and develop a directory clearly indicating their place of work, functions, funding sources, and priority areas. ▪ Coordinate the work of NGOs in the country to avoid duplication in the delivery of disability care and services. ▪ Support the development and strengthening of national Disabled Person's Organizations through capacity enhancing programs to improve their skills in self-representation and advocacy. ▪ Develop training programmes for public servants in order to enhance the provision of disability friendly services. ▪ Provide financial support, training and exposure to local and national representatives of disabled persons within the means available. ▪ Develop strategies for effective mechanisms and efficient participation of disabled people in planning and decision making. ▪ Establish a Disability Desk in the Office of the President and at all levels of government. ▪ Promote and encourage the development of party policies and manifestos, within all political parties, relating to equalization of opportunities for persons with disabilities.

Annex B – Revised Extract from the *Zagreb Progress Report*

Revised Zagreb Progress Report – Afghanistan
Annex V: Victim assistance objectives of the States Parties that have reported the responsibility for significant numbers of landmine survivors – May 2006

Part 1: Understanding the extent of the challenge faced			
Goal:	**Status:**	**Objectives:**	**Plans to achieve objectives:**
Define the scale of the challenge, identify needs, monitor the responses to needs and evaluate the responses	As of December 2005, the UN Mine Action Center for Afghanistan's (UNMACA) IMSMA database had recorded 15,215 mine/ERW casualties since 1979; 2,627 people killed and 12,588 injured. However, data from the National Disability Survey in Afghanistan (NDSA) indicates that, based on an estimated population of 25 million people, there are about 49,300 landmine/ERW survivors in Afghanistan today; about 6.8 percent of the total number of people with disabilities. According to the Afghanistan Landmine Impact Survey (ALIS), 17 percent of landmine/ERW casualties are children aged between 5 and 14 years; 50 percent are under the age of 18. About 90 percent of casualties are male. Afghanistan is one of the most mine-affected countries in the world. The current estimate of approximately 100 new mine/ERW casualties per month is a significant decrease from estimates in 1993 (600 to 720 monthly), 1997 (300 to 360 monthly) and 2000 (150 to 300 monthly). Mine/ERW casualty data collection began in 1998 and is an ongoing process on a national level in all impacted areas. Data on mine casualties is collected primarily by the International Committee of the Red Cross (ICRC) through a network of 490 health facilities supported by several agencies and organizations, including the Ministry of Public Health (MoPH), Afghan Red Crescent Society, International Federation of Red Cross and Red Crescent Societies, ICRC Orthopedic Centers, and more than a dozen NGOs and organizations. The ICRC provides the UN Mine Action Program with 90 - 95 percent of its information on casualties. Agencies collecting data for ICRC utilize a standardized format which is slightly modified to fulfill IMSMA database reporting formats. The available data is used by many of the organizations working with mine/ERW survivors and reporting mechanisms are being strengthened to provide data to relevant end users. Data collected by the ICRC between 1998 and 2005 indicates that 17 percent of casualties were killed. Types of injuries include: amputation of one or more limbs (37 percent), head injuries (7 percent), abdominal injuries (5 percent); eye injuries (4 percent); and other injuries (30 percent). By December 2005, the six ICRC orthopedic centers had registered 22,599 landmine/ERW amputees for services. Strengthening of the MoPH information management systems to include injury	▪ Maintain an up-to-date database on landmine/ERW casualties in Afghanistan. ▪ Set priorities based on available information on the situation of mine survivors and other persons with disabilities, by the end of 2006, for delivery or expansion of health care, rehabilitation, education, and socio-economic reintegration services, and awareness-raising campaigns. ▪ Create an up-to-date database on all disability services available in Afghanistan by the end of 2006. ▪ Promote greater understanding of the socio-economic conditions of people with disabilities, including mine survivors. ▪ Integrate landmine casualty data into an injury surveillance mechanism, by 2009, in which persons with disabilities are tracked through the national	▪ Maintain the ICRC data collection network through to at least the end of 2008. ▪ Analyze the results of the NDSA and information contained in other mine/ ERW casualty databases. ▪ Send questionnaires to all agencies/NGOs working in the disability sector in Afghanistan, and compile an accessible database using the information received. ▪ Include questions on disability in the next national census. ▪ Identify key actors (for example, WHO or Centers for Disease Control) to assist MoPH in the development an appropriate

	surveillance is in the development stages. The Ministry of Martyrs and Disabled (MMD) has not undertaken a comprehensive nation-wide survey of persons with disabilities but has plans to do so in 2006/2007 if funding is available. Handicap International completed fieldwork in 2005 for a National Disability Survey based on a random national cluster methodology. Results of the survey will be finalized in early 2006 and shared and consulted with the MMD and the National Programme for Action on Disability (NPAD) prior to publication. Services are not equitably spread across all areas of the country as some people with disabilities lack appropriate care or must travel long distances to access it. Little is known about the current location of survivors or their demographics. Tracking only occurs when additional medical or rehabilitation services are accessed. There is insufficient data available on the socio-economic conditions of people with disabilities. However, it is recognized that people with a disability are among the most socio-economically vulnerable people in Afghanistan. The last national census does not provide statistics on persons with disabilities, their occupations, socio-economic status, education, etc. The next national census is planned for 2007 and efforts are being made to include questions on disability.	health system.	surveillance mechanism, starting from 2006.
Part 2: Emergency and continuing medical care			
Goal: Reduce deaths by stabilizing medical conditions and minimizing physical impairments in emergency settings that could result from injury	**Status:** The MoPH delivers health services through the implementation of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The EPHS has been implemented in only five hospitals due to a lack of funding. Some of the problems of the current healthcare services include acute shortages of specialized units, lack of proper buildings, lack of trained manpower, lack of standard equipment, lack of adequate accommodation in the hospitals, insufficient primary health care in the rural areas, and poor physical accessibility. Basic first aid services are available through district clinics; however, the ALIS found that only ten percent of mine-impacted communities had healthcare facilities of any kind. There is a lack of pre-hospital care available for mine casualties. Some NGOs provide first aid training in the care of traumatic injuries. All hospitals have an emergency room; however, the NGO-run Emergency Hospital in Kabul is the only civilian hospital with a specialized intensive care unit. Trauma care specialists are not widely available. Serum is available in most places and considered very safe. Blood transfusions are limited to district, regional and provincial hospitals. Testing of blood is not available at most district hospitals. Very few ambulances are available. Local transport by taxi or donkey is available to most. Travel to hospitals/clinics can take between one hour to three days depending on	**Objectives:** ▪ Create a directory of all emergency and continuing medical care services in mine/ERW-impacted rural areas by the end of 2006. ▪ Create a directory of all emergency and continuing medical care services in Afghanistan by the end of 2007. ▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by the end of 2006. ▪ Increase access to emergency pre-hospital response services in 50 percent of heavily	**Plans to achieve objectives:**

	location of the incident, road and weather condition and accessibility of transport; however, an average of 5-6 hours in reported. Amputation / trauma surgery is available though the quality is questionable in some cases. There is lack of equipment and supplies in health facilities and the quality of services is lacking and varies by location. Although access to pain medication is relatively easy in some areas, only about 20 percent of mine casualties have access to pain relief. Plans are currently being developed to improve emergency preparedness in the Kabul area. Training or refresher courses are required for most surgeons. No formal training in the care of traumatic injuries is currently available in-country. There is also a need for training of nurses and paramedics in the care of traumatic injuries at the district hospital level. The NGO Emergency provides short-term training for surgeons and nurses, in collaboration with the MoPH and the Kabul Nursing School. Access to corrective surgery and post-amputation revisions is often needed but is available only in major hospitals. Eye and auditory medical care is very limited, except in big cities. All amputees are referred to rehabilitation services, which are available to varying degrees in 19 of the 34 provinces. Mine casualties will not be turned away or denied services; however long term care is more difficult due to costs of health care, transportation and lodging. Women may be denied care either by family or refusing treatment themselves from male practitioners. Services are available equally to all; however cultural barriers are known to restrict women and girls from services as female doctors and practitioners may not be available. National coordination mechanisms involving all relevant actors are not currently in place. In the National Health Policy for 2005-2009, disability issues have been moved from the second tier to the first tier in the BPHS. Disability is the 6th component of the BPHS package and includes the following services: 1. Information / Education / Communication, awareness, care seeking; 2. Home-based services for paraplegic cases; 3. Outpatient physiotherapy (screening and treatment); 4. Inpatient physiotherapy; 5. Orthopedic services (diagnosis); 6. Production of orthoses, fitting and training; and 7. Production of prostheses, fitting and training.	mine/ERW-impacted rural areas in order to reduce the mortality rate of mine/ ERW casualties (not killed immediately by the explosion) by 75 percent by 2009. ▪ Develop an emergency evacuation capability in 50 remote districts by 2009. ▪ Expand the implementation of the EPHS to 15 hospitals by 2009. ▪ Train at least 50 trauma care specialists, including surgeons, anesthetists, and nurses, by 2009. ▪ Increase the capacity of MoPH personnel, in terms of disability, to take the lead in the coordination of rehabilitation activities by 2009. ▪ Design and implement a Basic Package of Disability Services for the country by 2007. ▪ Expand the primary healthcare system in at least 50 remote rural areas using the provisions in the BPHS by 2009. ▪ Equip hospitals and health clinics serving at least 50 percent of heavily mine/ERW-impacted rural areas with adequately trained personnel, equipment and supplies by 2009. ▪ Include appropriate training on disability issues, including disability prevention, early detection and interventions	

		through medical and social rehabilitation, in the curriculum for all institutions providing training for medical and paramedical health personnel by 2009. ▪ Provide support services, such as clinical psychology, physiotherapy, occupational therapy, audiology, speech therapy, and counseling, with adequately trained personnel in major hospitals in at least five provinces by 2009. ▪ Increase the number of trained female healthcare providers by 50 percent by 2009 to improve services available for women with disabilities. ▪ Maintain disability as one of the top priorities in the work of the MoPH during the period 2005-2009, and beyond.	
Part 3: Physical rehabilitation			
Goal: To restore maximum physical functional ability for landmine survivors, including the provision of appropriate assistive devices.	**Status:** Rehabilitation services for all persons with disabilities, regardless of the cause, are a part of a broader welfare policy and a combination of medical and social services. However, the rehabilitation needs of mine/ERW survivors and other persons with disabilities are not being met. Only 20 to 40 percent of people with disabilities are believed to have access to rehabilitation services. With the exception of services provided by international organizations, for example the ICRC, rehabilitation services are very minimal and limited to only urban areas. There is not an extensive Community Based Rehabilitation (CBR) network in Afghanistan. Many persons with disabilities are unaware of the services that are available. In 2005, disability services were available in 19 of the 34 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Faryab, Ghazni, Herat, Jozjan, Kabul, Kandahar, Kunar, Kunduz, Laghman, Logar, Nangarhar, Parwan, Samangan, Takhar, and Wardak): physiotherapy services in 19 provinces; community-based rehabilitation in 12 provinces (Badakhshan, Baghlan, Balkh, Ghazni, Jozjan, Kabul, Kunduz, Logar,	**Objectives:** ▪ Create a directory of all physical rehabilitation services in Afghanistan by the end of 2006. ▪ Disseminate the directory of physical rehabilitation services in Afghanistan to all mine/ERW-affected communities by the end of 2007. ▪ Increase access to physical rehabilitation services to at least 50 percent of persons with disabilities by 2009. ▪ Increase the output of prosthetic	**Plans to achieve objectives:**

	Nangarhar, Samangan, Takhar, and Wardak); and 14 orthopedic workshops in 10 provinces (Badakhshan, Balkh (2), Faryab, Ghazni, Herat, Kabul (3), Kandahar, Nangarhar (2), Parwan, and Takhar), including the MoPH-run Technical Orthopedic Centre in Kabul. However, physical rehabilitation facilities need to be located in each large city or main town in at least 30 of the 34 provinces. In 2004, 87,131 people were assisted with orthopedic devices and physiotherapy, including 37,930 people without disability receiving physiotherapy; 7,132 were fitted with prostheses and 13,473 with orthoses. This represents a significant increase from 48,118 people (14,609 people without disability) assisted in 2001, including 8,407 people fitted with prostheses and 9,520 with orthoses. The ICRC is the principal provider of services to mine/ERW survivors with activities at its 6 orthopedic centers in Kabul, Mazar-i-Sharif, Herat, Jalalabad, Gulbahar and Faizabad. The centers fit upper and lower limb prostheses and orthoses, and provide free medical care, physical rehabilitation, psychosocial support, vocational training, micro-credits for small business, and public awareness services related to government rules and programs. Rehabilitation services are also provided by several NGOs including the Swedish Committee for Afghanistan, Sandy Gall's Afghanistan Appeal (SGAA), Handicap International, the Kabul Orthopedic Organization, Afghan Amputee Bicyclists for Rehabilitation and Recreation (AABRAR), Association for Aid and Relief/Japan (AAR), International Assistance Mission (IAM), Guardians, Physiotherapy and Rehabilitation Support for Afghanistan (PARSA), Serving Emergency Relief and Vocational Enterprises (SERVE). Access to rehabilitative care is available free of charge. Distance and related costs (transport, accommodation, and escorts for women, etc) can be problematic in areas where services are not available. Access to services is immediate in most cases; however, waiting periods of 30-45 days have been reported in areas with limited services. There are approximately 200 physiotherapists and physiotherapy assistants, 126 orthopedic technicians and 105 artisans providing services in 19 of the 34 provinces. Training of technicians and physiotherapists is provided by ICRC. Physiotherapy training is also provided by IAM and SGAA through the Institute of Health Sciences in support of the MoPH. All prosthetic and orthotic aids are produced locally, with raw materials often being imported due to lack of availability of quality materials on the local market, by rehabilitation agencies, including ICRC, and local and international NGOs. Informal coordination exists among disability stakeholders, but could be improved. Inter-Ministerial coordination and the technical capacity of the relevant Ministries (MMD, MoPH, Ministry of Labor and Social Affairs (MoLSA) and Ministry of	and orthotic workshops by at least 10 percent per year. ▪ Improve accessibility in provinces without disability services by establishing appropriate services in one additional province each year. ▪ Improve accessibility in at least five provinces without disability services by 2009 through the provision of transport to appropriate physical rehabilitation facilities. ▪ Improve accessibility in provinces with disability services by establishing mobile outreach units that visit at least 50 percent of remote heavily mine/ERW-impacted areas by 2009. ▪ Establish physical therapy clinics, with adequately trained personnel, in at least 10 percent of district, provincial and regional hospitals by 2009. ▪ Increase the number of trained physiotherapists and technicians by at least 20 percent each year, ensuring that at least 50 percent of trainees are people with a disability. ▪ Increase the number of trained female rehabilitation providers by 50 percent by 2009 to improve services available for women with disabilities. ▪ Provide refresher training to at least 10 percent of rehabilitation	

	Education (MoE)) are weak. In 2005, MMD established an NGO coordination unit, which is intended to assist in the coordination of all relevant actors.	providers per year. ▪ Extend functional CBR services according to the BPDS plan, with adequately trained personnel and that are appropriate to the Afghanistan context, to at least 50 additional communities by 2009. ▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by the end of 2006.	
Part 4: Psychological support and social reintegration			
Goal: To assist landmine survivors, including children, to resume their role in the community by helping them cope with psychosocial adjustment issues and assisting them to regain and maintain a healthy and positive outlook on life.	**Status:** It is recognized that post-traumatic stress disorder is common among people with disabilities caused by traumatic injury. However, there are few psychosocial support activities in Afghanistan or guidelines for mental health. No counseling is available on the national level. Some initiatives exist through the ICRC and NGOs directed at specific needs or one-off projects. There is also limited peer support through service providers who employ large numbers of persons with disabilities. There is a lack of awareness within the general population on disability and access issues, the lack of opportunities for people with a disability, and on the capacity of people with disabilities to be productive members of their community. The MoPH Coordination Group on Health (CGHN) is discussing the issue of disability and the psychosocial situation in Afghanistan. There is no coordination of relevant actors on a national level. The majority of people with disabilities are illiterate or semi-literate. The participation of children with disabilities in education is very poor. Though mine/ERW survivors are encouraged to complete their education, this is limited to what is available in the communities. Additionally, many people never attended school prior to becoming disabled in a mine/ERW incident so do not have basic skills to build upon. Integration of children with disabilities does occur. However, there is little to no training available to teachers on the particular needs of disabled children. The MoE has no provisions for developing appropriate curricula or providing resources to encourage inclusive education for children with disabilities. The Ministry suffers from a lack of school buildings, infrastructure, trained teachers and sufficient	**Objectives:** ▪ Create a directory of all psychological support and social reintegration services in Afghanistan by the end of 2006. ▪ Disseminate the directory of psychological support and social reintegration services in Afghanistan to all mine/ERW-affected communities, as appropriate, by the end of 2007. ▪ Establish a mechanism to address the huge gap in psychosocial support services and improve coordination among relevant actors at the national, regional and local levels by the end of 2006. ▪ Introduce a program to provide formal training for social workers in Afghanistan by the end of 2007. ▪ Expand programs for sport for people with disabilities, on an	**Plans to achieve objectives:**

	budget provisions. The NDSA revealed a huge gap between access to education for children with disability and children without disability. Two schools offer exclusive education – one for deaf and one for blind children. NGOs are doing limited work in 14 provinces (Badakhshan, Baghlan, Balkh, Ghazni, Herat, Jozjan, Kabul, Kandahar, Kunduz, Logar, Nangarhar, Samangan, Takhar, and Wardak), but without supervision or direction; the programs are not well coordinated. Even though primary education has been made compulsory in the Constitution, its implementation is far from satisfactory. There are no well-designed incentives for parents to send their children to schools. The draft National Disability Policy (NDP) includes specific objectives relating to the education of children with disabilities.	ongoing basis. ▪ Conduct awareness-raising programs throughout the country on the rights and capacities of people with disabilities, and in particular women with disabilities, in 2006 and 2007. ▪ Ensure that at least ten schools per year are made accessible to children with disabilities and conduct awareness-raising activities in those schools for teachers and students on the rights and capacities of children with disabilities. ▪ Implement the actions of the NDP in relation to the education of children with disabilities by the end of 2008.	
Part 5: Economic reintegration			
Goal: To assist landmine survivors to either return to their pre-injury occupation, or prepare for and find suitable employment.	**Status:** According to the *Afghanistan Human Development Report 2004*, approximately 53 percent of Afghans live below the poverty line and the average person spends approximately 80 percent of their income on food. It also noted that "the lack of legislation to protect the rights of the disabled has also led to institutional discrimination." The NDSA found that 70 percent of people with a disability aged over 15 years are unemployed; 53 percent of males and 97 percent of females. In comparison, 25 percent of men and 94 percent of women without disability are unemployed. The ALIS data on recent mine/ERW casualties indicated that unemployment among mine survivors increased by 38 percent after the incident. There were notable decreases in the percentage of survivors who continued to be farmers, herders, military personnel, deminers, and laborers – all occupations requiring mobility over difficult terrain (a challenge for amputees) – and increases in the numbers of survivors doing household work and being unemployed. The MMD is playing a key role in mainstreaming persons with disabilities in	**Objectives:** ▪ Create a directory of all economic reintegration services in Afghanistan, including micro-finance providers, and vocational training and employment centers, by the end of 2006. ▪ By 2008, the national employment agencies will protect, promote and report the number and percentage of persons with disabilities in income-earning employment. ▪ Construct and implement programs in six new MoLSA vocational training centers by	**Plans to achieve objectives:**

	coordination with MoLSA, MoPH, and MoE. MoLSA has adopted disability as a critical component of its efforts in vocational skills training and employment-related services. MoLSA aims to increase awareness and improve institutional capacity to ensure that it can provide disability-related vocational skills training and employment-related services nation-wide. MoLSA is in the process of developing its capacity to implement programs focused on people with disabilities including vocational training and employment, technical assistance, staff development and training, policy development, curriculum development/training materials, development/resource materials development, and monitoring and evaluation. The NPAD is providing national and international technical advice on vocational training and employment-related issues to MoLSA. In addition, many NGOs, Japan's International Cooperation and Assistance (JICA), Afghan Korea VT Training Center, World Bank and GTZ are extending support to MoLSA to develop and deliver vocational training programs for persons with disabilities. MoLSA has opened 13 vocational training centers; 10 percent of beneficiaries are currently people with disabilities. MoLSA has a presence in 32 of the 34 provinces with vocational training programs. Results to date have not been particularly good due to lack of adequate funding, lack of infrastructure and lack of employment opportunities after the training is completed. Employment support and vocational training programs are also being conducted by international agencies and NGOs in 13 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Ghazni, Jozjan, Kabul, Kunduz, Logar, Nangarhar, Samangan, Takhar, and Wardak). As of April 2005, eight vocational training schools had been established by NGOs in cooperation with the MMD. At least 5 percent of employees in Government offices should be people with a disability. Persons with disabilities, registered by the MMD, receive welfare payments at the rate of 300 Afghanis per month (about $6). People registering for pensions are referred to the MoPH for an assessment of the degree of disability. Persons with less than 50 percent disability receive 150 Afghanis per month. No payment is made to people with less than 35 percent disability. It is acknowledged that the allowance is too low to provide a basic standard of living. In 2005, 208,833 people were receiving welfare payments from MMD; about 50 percent are people with mostly war-related disabilities. The Ministry of Finance releases the budget on the basis of requests from the MMD directly to the provinces; benefits are paid quarterly. There are no contribution-based schemes in the country.	the end of 2009 in Kabul (3), Herat, Kunar, and Nangahar ▪ Start new vocational training programs in Ghor, Paktia, Kandahar, Faryab, and Ghazni between 2007 and 2009. ▪ Mainstream people with disabilities, including mine survivors, in a package of MoLSA-supported programs including employment, vocational training, micro-credits, self-employment and other assistance, in the period 2006-2009. ▪ At least 20 percent of all vocational training in Afghanistan will be provided to people with disabilities by 2009. ▪ Establish a MoLSA-supported mechanism for collecting information on employment opportunities for people with disabilities in the government and private sector in Kabul by the end of 2006 (expanding to all provinces by 2009), and encourage affirmative action in the employment of persons with disabilities in all sectors. ▪ Establish a mechanism by the end of 2006 to ensure that vulnerable families with a disabled family member or families where the main provider has been killed in a mine/ERW explosion have access to economic reintegration	

		programs. ▪ Introduce a new national needs-based pension program for critically vulnerable women and men with disabilities by 2008. ▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by the end of 2006.	
Part 6: Laws and public policies			
Goal: To establish, implement and enforce laws and public policies that guarantee the rights of landmine survivors and other persons with disabilities	**Status:** Afghanistan currently has no law guaranteeing the rights of persons with disabilities or on developing a barrier free and accessible society. The Constitution of Afghanistan provides some basic rights to people with disabilities and enables the government to enact a separate law for people with disabilities. Articles 22, 53 and 84 include some enabling provisions for mainstreaming persons with disabilities. The MMD is the focal point for all issues relating to persons with disabilities, including mine survivors. Objectives of the MMD include: collecting data on persons with disabilities from all provinces to facilitate access to monthly pensions; advocating for the rights of persons with disabilities; development of new legislation to protect the rights of persons with disabilities; and facilitating access to vocational training courses. MMD has a presence in all 34 provinces. Other line Ministries involved in services for persons with disabilities includes the MoPH, MoLSA, and MoE. Afghanistan developed a Comprehensive Disability Policy in 2003 through extensive consultations with relevant actors and line Ministries. In 2003/2004 a Basic Disability Package of services for the sector was developed. Throughout 2004 the MMD and all stakeholders also worked on a project to establish a National Disability Commission; an inter-ministerial administrative body aimed at enabling a more effective approach to disability. The process of final approval by the Government was not completed. In May 2005, the MMD began a consultative process to develop a new three-year National Disability Policy 1385-1388 (2006-2008) for Afghanistan, which will be finalized in early 2006. The aim of the policy is that by the end of 1387 (2008) "persons with disability will be integrated or specifically provided for within mainstream national services of health care, education, vocational training, paid and self-employed labour market opportunities, legal protection and associated administration, informational resources, political voice, social safety net and pension programmes, research initiatives and partnerships."	**Objectives:** ▪ Adopt the National Disability Policy (NDP) for Afghanistan in 2006. ▪ Conduct a nation-wide awareness raising campaign on the NDP and disability in 2006 and beyond, which includes raising awareness on the rights and capacities of persons with disabilities. ▪ Adopt a comprehensive law for persons with disabilities that guarantees their rights to medical care, rehabilitation, education, employment, social services, and an accessible and barrier free society free from discrimination, with due importance given to the rights of women with disabilities, by the end of 2007. ▪ Register all NGOs working in the disability sector and develop an up-to-date directory clearly indicating their place of work, functions, funding sources, and	**Plans to achieve objectives:**

	The MMD is the lead Ministry in developing the policy, which is being done in close consultation with relevant line Ministries (MoPH, MoE and MoLSA), with technical support from UNDP through the NPAD, a three-year program, which UNDP began implementing on 1 April 2005. The policy proposes the establishment of a National Commission for the Disabled with responsibility for coordination, monitoring and reporting on national disability-focused plans and programs. UNDP has signed a Memorandum of Understanding with the Government of Afghanistan to provide technical support to build capacity of the Government and to help put in place systems for mainstreaming the lives of the persons with disabilities. The International Labor Organization is also active in Afghanistan. Afghanistan has undergone an extensive inter-ministerial process to develop the Afghanistan National Development Strategy (ANDS) for 2005-2009. It includes mine action and disability issues. ANDS states that by the end of 2010 (1389), "increased assistance will be provided to meet the special needs of all disabled people, including their integration in society through opportunities for education and gainful employment." Almost all disability services are currently provided by national and international NGOs and agencies. The government's role in service delivery to persons with disability is minimal. The Government of Afghanistan therefore recognizes that policy implementation should be done in partnership with other key actors working at the grass roots level. The disability movement in Afghanistan is still in its infancy. Massive illiteracy and extreme poverty, limited exposure and inadequate skills in institutional development are some of the problems faced by the movement. As a result the voice of persons with disabilities and their capacity to negotiate on behalf of their own interests in planning and decision-making is lacking. Afghanistan is a signatory to the Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region, and a signatory to the Biwako Millennium Framework for action towards an inclusive, barrier free and rights based society for persons with disability. Afghanistan also recognizes the World Program of Action, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, and the 1983 International Labor Organization Convention 159 on Vocational Rehabilitation and Employment (Disabled Persons). Afghanistan is participating in the negotiations on the UN Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.	priority areas by the end of 2006. ▪ Develop and strengthen national Disabled Person's Organizations, on an ongoing basis. ▪ Establish a data bank of quality research and Afghanistan-specific information, and a resource center for disability by 2008. ▪ Establish a Disability Taskforce with MoPH by the end of 2006. ▪ Develop a mechanism to improve coordination, planning and decision making among all relevant actors, including people with disabilities, at the national, regional and local levels by the end of 2006, to avoid duplication in the delivery of disability services. ▪ Establish a National Commission for Disabled Persons by 2008 to coordinate, monitor and report on activities of all stakeholders. ▪ Establish a Disability Desk within the Office of the President to coordinate activities at all levels of government, by the end of 2007.	

Annex C – Workshop Agenda

First National Victim Assistance Workshop

Kabul, Afghanistan
6-8 August 2006

Day 1

Time	Activity	Speaker/Facilitator
08:30 - 09:00	Registration	
09:00 – 09:05	Recitation of Holy Koran	Zabihullah Haider
09:05 – 10:20	Welcome, introductory remarks + aims of workshop National context – Legislation and Policy General remarks	Deputy Minister of Foreign Affairs, H. E. Mr. Mahmoud Saikal Deputy Minister of Martyrs, Disabled and Social Affairs H.E. Mr. Hadi Hadi Deputy Minister of Public Health H.E. Dr. Faizullah Kakar Deputy Minister of Public Health H.E. Dr. Hayat
10:20 – 10:30	Introduction of Agenda	Mr. Khaled Zekriya, MoFA
10:30 – 11:00	Tea Break	
11:00 – 11:20	International context – Introduction to the Mine Ban Convention and Victim Assistance – Work of the Co-Chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration and their objectives	 Sheree Bailey, Implementation Support Unit, Geneva International Centre for Humanitarian Demining Dr. Flavio Del Ponte, Senior Medical Advisor, Swiss Agency for Development and Cooperation, Geneva
11:20 – 11:30 11:30 – 11:40	Review of revised Zagreb Report Workshop Process	Sheree Bailey, Implementation Support Unit, Geneva International Centre for Humanitarian Demining Susan Helseth, Senior Technical Advisor, Victim Assistance, UNMACA
11:40 – 12:30	Understanding the Challenge - National Disability Survey for Afghanistan - Data collection/injury surveillance	Introduction Jean-Francois Trani, Handicap International Zaman Noori, ICRC Discussion
12:30 – 14:00	Lunch Break	

14:00 – 16:00	Overview of key elements of victim assistance, current activities, and coordination with ministries	Introduction ARCS – Adbulrahim Ferotan ICRC – Najmuddin SCA – Zemarai Saqeb AABRAR – Abdul Nasir CCD – Saifudin Nezami Opportunity for ministries and other agencies/NGOs to briefly present their activities Discussion
16:00 – 16:15	Closing Remarks	

Day 2

Time	**Activity**	**Speaker/Facilitator**
09:00 – 09:15	Welcome + review of agenda	
09:15 – 10:45	Working Group Activities	
10:45 – 11:00	Tea Break	
11:00 – 12:30	Working Group Activities	
12:30 – 14:00	Lunch Break	
14:00 – 16:00	Working Group Activities	
16:00 – 16:15	Closing Remarks	

Day 3

Time	**Activity**	**Speaker/Facilitator**
09:00 – 09:15	Welcome + review of agenda	
09:15 – 09:45	Emergency + Continuing Medical Care - Working Group Presentation	Group leaders
09:45 – 10:15	Physical rehabilitation – Working Group presentation	Group leaders
10:15 – 10:45	Psychological/social support – Working Group presentation	Group leaders
10:45 – 11:00	Tea Break	
11:00 – 11:30	Economic reintegration – Working Group presentation	Group leaders
11:30 – 12:00	Legislation and policy – Working Group presentation	Group leaders
12:00 – 12:30	Next steps - Finalization of Afghanistan Action Plan Closing Remarks	Susan Helseth, Senior Technical Advisor, Victim Assistance, UNMACA Dr. Flavio Del Ponte, Senior Medical Advisor, Swiss Agency for Development and Cooperation H. E. Deputy Minister of Foreign Affairs, Mr. Mahmoud Saikal
12:30 – 14:00	Lunch	

Annex D – Workshop Participants

Ministry/Organization	Name
Ministry of Foreign Affairs	H. E. Deputy Minister Mr. Saikal
	Khaled Zekriya
	Nasir Andisha
	Noorzad Aziz
Ministry of Martyrs, Disabled and Social Affairs	H. E. Deputy Minister Mr. Hadi Hadi
	Naqibullah Hamdard
	Sayed Asghar Haidari
Ministry of Public Health	H.E. Deputy Minister Dr. Kakar
	H.E. Deputy Minister Dr. Nadera Hayat
	M. Naseer Babkerkhil
	Rhullah Nassery
Ministry of Economy and Labor	Asif Hurmat
Ministry of Interior	Zalmai Wardak
Office of Disaster Preparedness	Dr. Matin Adrak
Office of Disaster Preparedness/ Department of Mine Clearance	Abdul Haq
Afghanistan Permanent Mission to Geneva	Khalil Nasri
UNMACA	Daniel Bellamy
	Susan Helseth
	Najibullah Nassiri
	Samim Hashemi
	Zabiullah Haider
	Shams Ur Rahman
	Denise Duclaux
	Liza De Benedetti
	Massood Hamidzada
	Abdul Ghafar Mohibzada
UNDP/NPAD	Shaya Ibrahim
	Razi Khan Hamdard
	Ms. Palwasha
	Ms. Zakia
	Dr. Zia Bina
	Sami Ulhaq
	Phitalis Were
UNICEF	Najibullah Hameem
	Noriko Izumi
Swiss Agency for Development & Cooperation	Dr. Flavio Del Ponte
	Patrizia Palmiero
CIDA	Nasir Ebrahimkhail
	Farid Ahmad
AABRAR	Abdul Basir Toryalay
	Abdul Nasir
AAR Japan	Yama Hakimi
	Yasuo Numata
ACBL	Dost Mohammad Faizi
ACSF	Wagma Noori
	Mir Ahmad Qaneh

Afghan Disabled Union	Haji Omara Khan
	M. Rafiq Khan
Afghanistan Paralympics Foundation	Abdul Rahman Mohdi
	Hewad Akbari
AIHRC	Najib Zadran
	Zahidi
ANAB	Mohammad Ihsan Fayaz
	Hemayatullah
APTA	Rafiq Kohistani
ARCS	M. Zahir Walizada
	Mostafa Monawari
	Abdulrahim Ferotan
CCD	Saifuddin Nezami
	Miss. Khairia
	Haji Ahamad Shaw
	Hamidullah
	Niamatullah
	Miss Arifa
	Munir
	Miss Fatima
Clear Path International	Martha Hathaway
	Kristen Leadem
DDG	Chris Lang
	Michaela Bock Pederson
FWF	Akhtar Mohammad
GICHD	Sheree Bailey
Handicap International	Thierry Hergault
	Jean Francois Trani
	Parul Bakhshi
	Firoz Ali Alizada
	Ahmad Farid
	Denis Compingt
HN-TPO	Ghulam Nabi Akbari
ICBL/Landmine Monitor	Katleen Maes
	Mohammad Ershad
ICRC	Najmuddin
	Alberto Cairo
	Zaman Noori
	Abdul Jalil
SCA/SGAA	Anne Hertzberg
	Attiqullah
	Zemarai Saqeb
	Shah Mohmood

Annex E – Welcome and Opening Remarks – H.E. Mr. Mahmoud Saikal, Deputy Minister of Foreign Affairs

Excellencies, ladies and gentlemen

It is my great pleasure to welcome you to this, the first, National Landmine Victim Assistance Workshop to be held in Afghanistan. The aim of this workshop is threefold: to raise awareness of the rights and needs of people with disabilities; to develop a plan of action for the period 2006 to 2009 to address the rights and needs of people with disabilities in Afghanistan; and to provide the relevant ministries with a clear picture of the benchmarks and their responsibilities.

The Ministry of Foreign Affairs is very grateful to UNMACA, UNICEF, and the Swiss Agency for Development and Cooperation for the financial support that has made the workshop possible, and to Susan Helseth and her team at UNMACA for their efforts in the organisation of this workshop.

When Afghanistan acceded to the Ottawa Convention in September 2002, it accepted all the obligations that joining this legally-binding international convention entailed, including the responsibility to stop the use and production of antipersonnel landmines, to clear mines, to destroy stockpiles, to raise awareness of the dangers of landmines, and to assist the victims.

Great progress has been made. Since the mine action program began in 1989 more than 1.1 billion square metres of land have been cleared and returned to communities, more than 65,000 stockpiled antipersonnel landmines and more than 307,000 emplaced antipersonnel mines have been destroyed, and mine risk education programs have reached more than 16 million Afghans. According to UNMACA's IMSMA database, the number of new landmine and unexploded ordnance casualties has decreased by more than half from a documented 138 new casualties a month in 2001 to around 50 documented new casualties a month in 2006.

While this progress is encouraging, we must not lose sight of the fact that even though new landmine casualties are dropping, Afghanistan still has huge numbers of mine survivors and people with disabilities from other causes that are not receiving the assistance that many desperately need.

Afghanistan's proposed Mine Action Law recognises victim assistance to mean "all aid, relief, comfort and support provided to victims of mines, or victims of unexploded ordnance…, or to the surviving dependents of persons killed or seriously injured by mines, unexploded ordnance…, for the purpose of reducing the immediate and long-term medical and psychological implications of their trauma. Victim assistance includes rehabilitation and reintegration of victims and surviving dependents."

At the First Review Conference of the Ottawa Convention in Nairobi, Kenya, in November 2004, Afghanistan was identified as one of 24 States Parties that had reported responsibility for significant numbers of mine survivors. As a result, Afghanistan will receive more focused attention from the international community over the coming years with the goal of making progress in meeting the aims of the convention to provide assistance for the care and rehabilitation, and social and economic reintegration of mine victims before the Second Review Conference of the Convention in 2009.

Since December 2005, Afghanistan has been proud to serve as Co-Chair, along with Switzerland, of the Convention's Standing Committee on Victim Assistance and Socio-Economic Reintegration. I am very pleased to welcome our guests from Geneva, Dr. Flavio Del Ponte and Miss Patrizia Palmiero from the Swiss Agency for Development and Cooperation, and Khalil Nasri from the Afghan Mission in Geneva, who have been working closely on the work of the Standing Committee.

As Co-Chairs, we have based our activities on a strategy with four main objectives: support to the establishment of national objectives and plans in the 24 States Parties with responsibility for significant numbers of mine survivors; case studies on the role of inter-

ministerial coordination in the establishment of objectives and plans; promotion of quality of, and access to medical first aid for mine victims; and, a study on best practices on social and economic reintegration of all people with disabilities. Also participating in this workshop is Sheree Bailey, from the Implementation Support Unit of the Geneva International Centre for Humanitarian Demining, who has been supporting us in this work.

As Co-Chair, Afghanistan wants to lead by example to show other affected States what can be achieved with political will and commitment from all actors in the disability sector. In December 2005, under the leadership of the Ministry of Foreign Affairs, Afghanistan launched an initiative to address the lack of coordination at the ministerial level within the victim assistance/disability sector with the aim of producing a national plan of action by September 2006. Several meetings were convened with representatives from the ministries of public health, martyrs and disabled, labour and social affairs, education, and foreign affairs, and other key actors. The revised Zagreb report, which will provide the basis of your discussions during this workshop, was a result of these and other meetings.

While developing a plan of action for landmine victim assistance serves to address our obligations under the Ottawa Convention, it also serves to address our much broader responsibility to all people with disabilities in Afghanistan. The First Review Conference of the Ottawa Convention made clear that assistance to mine victims should not exclude people with disabilities from other causes.

This workshop provides a great opportunity for government ministries, international agencies, and non governmental organisations to work together to promote substantial movement forward on issues relating to people with disabilities. This is particularly important during the time when National Development Strategies based on the London Compact must be completed.

A victim assistance plan of action should be fully integrated into long term public health and development strategies, taking into account elements of already developed plans for health care, rehabilitation, social services and the disability sector. Such a plan of action will benefit all persons with disabilities in Afghanistan and provide the relevant ministries with a clear picture of the benchmarks, their responsibilities, and the way forward.

As Co-Chair of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, Afghanistan intends to share its experience with other mine affected countries and present the outcomes of this workshop at the Seventh Meeting of the States Parties in Geneva, Switzerland, next month.

I encourage you all to take seriously the opportunity presented by this workshop to move forward the process of developing benchmarks and a clear plan of action to address the needs of people with disabilities in Afghanistan. The potential of your efforts over the next two and a half days to improve the quality of daily life of people with disabilities in Afghanistan cannot be underestimated. The aims of this national workshop are to reach agreement on the revised Zagreb Report's objectives and from that to develop a plan of action. Once this is done, the objectives and plan for each ministry will be set so they can then take responsibility for the outcomes, with the support of all relevant actors in the disability sector.

I wish you great success in your deliberations.

Annex F – Guidelines for Working Group Facilitators

WORKING GROUPS

AIMS OF THE WORKING GROUPS:

4. Review the Status column of the Zagreb Report to determine if this represents the true situation in Afghanistan
    - Recommend changes as appropriate

5. Review the Objectives to determine if these represent the actions, change or improvement in the situation that are desired by 2009
    - Are the Objectives achievable in the timeframe?
    - If all Objectives are not achievable which Objectives should be given priority?
    - Should priority be given to other objectives? If so, what are these objectives?

6. Discuss how to achieve the objectives – develop the plan to achieve objectives
    - Identify which government ministry has responsibility for oversight/achievement of each objective
    - Identify which agencies/organisations could implement activities on behalf of relevant ministry, as appropriate, to achieve each objective
    - Identify what these activities could be
    - What should the role of inter-ministerial coordination be in achieving the objectives?
    - Make recommendations on improving inter-ministerial coordination in meeting the needs of people with disabilities.

ROLE OF THE WORKING GROUP FACILITATORS:

- Be familiar with the content of the Zagreb Report, the situation in Afghanistan, and the key issues relevant to the subject
- Promote open discussion to achieve the aims of the working group
- Ensure that all participants have an opportunity to speak, if desired
- Monitor the time taken to ensure that all aims of the working group receive the necessary attention
    - Suggested time allocation for each aim
        - Review of Status – 20 percent
        - Review of Objectives – 30 percent
        - Plans to Achieve Objectives – 50 percent
- Report back to the plenary the outcomes of the discussions

ROLE OF THE WORKING GROUP NOTE-TAKERS:

- Accurately record the key issues raised and recommendations made in the discussions to enable the facilitator to present an overview of the discussions on the last day of the workshop and most importantly to enable the Zagreb Report to be amended to reflect the outcomes of the workshop.
- The note-taker should also identify the person or organisation making the comment/ recommendation.

Annex G – Afghanistan's Victim Assistance Plan of Action

Addressing the rights and needs of mine survivors and other persons with disabilities
The Islamic Republic of Afghanistan's objectives and plan of action for the period 2006-2009 – as of SEPTEMBER 2006

Part 1: Understanding the extent of the challenge faced				
Goal:	**Status:**	**Objectives:**	**Plans to achieve objectives:**	**Funding Needs:**
Define the scale of the challenge, identify needs, monitor the responses to needs and evaluate the responses	As of July 2006, the UN Mine Action Center for Afghanistan's (UNMACA) IMSMA database had recorded 15,595 landmine and explosive remnants of war (ERW) casualties since 1979; 2,663 people killed and 12,932 injured. About 92 percent of casualties are male. However, data from the National Disability Survey in Afghanistan (NDSA) indicates that, based on an estimated population of 25 million people, there are between 747,500 and 867,100 persons with severe disabilities in Afghanistan, of whom approximately 17 percent are war disabled (126,000 to 146,000). Between 52,000 and 60,000 people are landmine/ERW survivors; about 6.8 percent of the total number of people with disabilities. On average, one household in every five has a family member with a disability. Handicap International completed fieldwork in 2005 for the NDSA based on a random national cluster methodology. Results of the survey were finalized in early 2006 and have been shared with the Ministry of Labor, Social Affairs, Martyrs Families and Disabled (MoLSMD) and the National Programme for Action on Disability (NPAD) prior to publication. Afghanistan is one of the most mine-affected countries in the world. The current rate of approximately 55 new mine/ERW casualties recorded by UNMACA per month is a significant decrease from 138 new casualties a month documented in 2001. Mine/ERW casualty data collection began in 1998 and is an ongoing process on a national level in all impacted areas. Data on mine casualties is collected primarily by the International Committee of the Red Cross (ICRC) through a network of 490	▪ Maintain an up-to-date database on landmine/ERW casualties in Afghanistan. ▪ Set priorities based on available information on the situation of mine survivors and other persons with disabilities, by the end of 2006, for delivery or expansion of health care, rehabilitation, education, and socio-economic reintegration services, and awareness-raising campaigns. ▪ Create an up-to-date database on all disability services available in Afghanistan by mid 2007. ▪ Promote greater understanding of the socio-economic conditions of people with disabilities, including mine survivors. ▪ Integrate landmine casualty data into an injury surveillance mechanism, by 2009, in which persons with	▪ The ICRC will maintain its data collection network through to at least the end of 2008. ▪ UNMACA will continue to record mine/ERW casualty data in its IMSMA database for the duration of the mine action program. ▪ Handicap International will analyze and disseminate the results of the NDSA to all relevant actors in the disability sector. ▪ MoLSMD will compile all existing information on agencies/NGOs working in the disability sector in Afghanistan, into an accessible database. ▪ MoLSMD will advocate for inclusion of questions on disability in the next national census. ▪ MoPH will identify key actors (for example, WHO or Centers for Disease Control) to assist in	

	health facilities supported by several agencies and organizations, including the Ministry of Public Health (MoPH), Afghan Red Crescent Society, International Federation of Red Cross and Red Crescent Societies, ICRC Orthopedic Centers, and more than a dozen NGOs and organizations. The ICRC provides the UN Mine Action Program with 90 - 95 percent of its information on casualties. Agencies collecting data for ICRC utilize a standardized format which is slightly modified to fulfill IMSMA database reporting formats. The available data is used by many of the organizations working with mine/ERW survivors and reporting mechanisms are being strengthened to provide data to relevant end users. Data collected by the ICRC between 1998 and December 2005 indicates that 17 percent of casualties were killed. Types of injuries include: amputation of one or more limbs (37 percent), head injuries (7 percent), abdominal injuries (5 percent); eye injuries (4 percent); and other injuries (30 percent). By December 2005, the six ICRC orthopedic centers had registered 22,599 landmine/ERW amputees for services. Strengthening of the MoPH information management systems to include injury surveillance is in the development stages. Services are not equitably spread across all areas of the country as some people with disabilities lack appropriate care or must travel long distances to access it. Little is known about the current location of survivors or their demographics. Tracking only occurs when additional medical or rehabilitation services are accessed. There is insufficient data available on the socio-economic conditions of people with disabilities. However, it is recognized that people with a disability are among the most socio-economically vulnerable people in Afghanistan. The last national census does not provide statistics on persons with disabilities, their occupations, socio-economic status, education, etc. The next national census is planned for 2007 and efforts are being made to include questions on disability.	disabilities are tracked through the national health system.	the development of an appropriate surveillance mechanism, starting from 2007.	

Part 2: Emergency and continuing medical care				
Goal:	**Status:**	**Objectives:**	**Plans to achieve objectives:**	**Funding Needs:**
Reduce deaths by stabilizing medical conditions and minimizing physical impairments in emergency settings that could result from injury	The MoPH delivers health services through the implementation of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). More than 80 percent of the population is reportedly covered with basic health care; however, actors in the field question the extent of coverage as many health facilities are physically inaccessible. The EPHS has been implemented in only five hospitals due to a lack of funding. Other problems of the current healthcare services include acute shortages of specialized units, lack of proper buildings, lack of trained manpower, lack of standard equipment, lack of adequate accommodation in the hospitals, and insufficient primary health care in rural areas. Basic first aid services are available through district health facilities; however, the ALIS found that only ten percent of mine-impacted communities had healthcare facilities of any kind. There is a lack of pre-hospital care available for mine casualties. Some NGOs provide first aid training in the care of traumatic injuries. All hospitals have an emergency room; however, the NGO-run Emergency Hospital in Kabul is the only civilian hospital with a specialized intensive care unit. Emergency hospitals are also located in Panjshir and Helmand provinces. NATO/ISAF forces plan to establish regional hospitals in Herat in August 2006, in Kandahar by end of the year and in other regions in near future. Trauma care specialists are not widely available. Serum is available in most places and considered very safe. Blood transfusions are limited to district, regional and provincial hospitals. Testing of blood is not available at most district hospitals. Very few ambulances are available. Local transport by taxi or donkey is available to most. Travel to hospitals/ health facilities can take between one hour to three days depending on location of the incident, road and weather	▪ Create a directory of all emergency and continuing medical care services in mine/ERW-impacted rural areas by the end of 2006. ▪ Create a directory of all emergency and continuing medical care services in Afghanistan by the end of 2007. ▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by the end of 2006. ▪ Increase access to emergency pre-hospital response services in all heavily mine/ERW-impacted rural areas in order to reduce the mortality rate of mine/ ERW casualties (not killed immediately by the explosion) by 75 percent by 2009. ▪ Develop an emergency evacuation capability in 50 remote districts by 2009.	▪ MoPH, in collaboration with UNMACA and other relevant actors, will compile all known information of available services in mine/impacted areas into an accessible database, and update as required. ▪ MoPH, in collaboration with other relevant actors, will compile all known information of available services into the accessible database created for mine/ERW-impacted areas and update as required. ▪ MoPH and other relevant actors will sign a Memorandum of Understanding, and meet on a regular basis to discuss key issues. ▪ MoPH, in collaboration with other relevant actors, will implement guidelines on trauma care and first aid, and coordinate with all actors in the field on the care of traumatic cases. ▪ MoPH, in collaboration with other relevant actors including ISAF, will ensure that the infrastructure to provide emergency evacuation is available.	

	condition and accessibility of transport; however, an average of 5-6 hours in reported. ISAF/NATO plans to evacuate war/mine casualties from the incident site to hospital within two hours. Amputation / trauma surgery is available though the quality is questionable in some cases. There is lack of equipment and supplies in health facilities and the quality of services is lacking and varies by location. Although access to pain medication is relatively easy in some areas, only about 20 percent of mine casualties have access to pain relief. The medicines proposed in the BPHS are insufficient to treat mine victims and other traumatic injuries. Plans are currently being developed to improve emergency preparedness in the Kabul area. Training or refresher courses are required for most surgeons. No formal training in the care of traumatic injuries is currently available in-country. There is also a need for training of nurses and paramedics in the care of traumatic injuries at the district hospital level. The NGO Emergency provides short-term training for surgeons and nurses, in collaboration with the MoPH and the Kabul Nursing School. A training program on war-related medicine is available in some hospitals. Access to corrective surgery and post-amputation revisions is often needed but is available only in major hospitals. Eye and auditory medical care is very limited, except in big cities. All amputees are referred to rehabilitation services, which are available to varying degrees in 19 of the 34 provinces. Some home-based health care is provided by the ICRC and Swedish Committee for Afghanistan Mine casualties will not be turned away or denied services; however long term care is more difficult due to costs of health care, transportation and lodging. Women may be denied care either by family or refusing treatment themselves from male practitioners. Services are available equally to all; however cultural barriers are known to restrict women and girls from	▪ Expand the implementation of the EPHS to 20 hospitals by 2009. ▪ Train at least 50 trauma care specialists, including surgeons, anesthetists, and nurses, by 2009. ▪ Increase the capacity of MoPH personnel, in terms of disability, to take the lead in the coordination of rehabilitation activities by 2009. ▪ Develop guidelines to implement BPHS Disability Services for the country by 2007. ▪ Improve access to the primary healthcare system in at least 50 remote rural areas by 2009. ▪ Equip hospitals and health facilities serving at least 50 percent of heavily mine/ERW-impacted rural areas with adequately trained personnel, equipment and supplies by 2009. ▪ Include appropriate training on disability issues, including disability prevention, early detection and	▪ MoPH, in collaboration with other relevant actors, will fully implement the EPHS in the hospitals specified. ▪ MoPH, in collaboration with other relevant actors including the NGO Emergency, will develop and implement a training program in Afghanistan, and also identify opportunities under overseas fellowship programs. ▪ MoPH, in collaboration with other relevant actors, will organize and implement awareness-raising and training courses, on an on-going basis. ▪ MoPH, in collaboration with other relevant actors, through the Disability Taskforce will finalize and implement the disability guidelines. ▪ MoPH, in collaboration with the Ministry of Transport and organizations active in remote rural areas, will establish transportation services to health care facilities. ▪ MoPH, in collaboration with other relevant actors, will implement the provisions of the BPHS and EPHS. ▪ MoPH, in collaboration with the Institute of Health Sciences and other relevant national and	

	services as female doctors and practitioners may not be available. National coordination mechanisms involving all relevant actors are not currently in place, and coordination between government health sections is weak. In 2006, MoPH established a disability taskforce with the objectives of: improving coordination and cooperation between different sections of MoPH, MoLSMD, and disability organizations and service providers; raising the priority and awareness of disability issues; resolving outstanding issues relating to disability; establishing a disability department; and resource mobilization and sensitization of donors to support disability services within the BPHS and EPHS. In the National Health Policy for 2005-2009, disability issues have been moved from the second tier to the first tier in the BPHS. Disability is the 6th component of the BPHS package and includes the following services: 8. Disability awareness, prevention and education. 9. Home visit program for paraplegics (in urban settings). 10. Treatment of war injuries, traumatic amputations and prostheses patients. 11. Treatment of disabled children with physical anomalies. 12. Assess, treat and refer disabled and physically impaired patients. 13. Inpatient and outpatient physiotherapy, and orthopedics diagnosis. 14. Referrals for fitting and training in the use of orthotics and prosthetics.	interventions through medical and social rehabilitation, in the curriculum for all institutions providing training for medical and paramedical health personnel by 2009. ▪ Provide support services, such as clinical psychology, physiotherapy, occupational therapy, audiology, speech therapy, and counseling, with adequately trained personnel in major hospitals in at least five provinces by 2009. ▪ Increase the number of trained female healthcare providers by 50 percent by 2009 to improve services available for women with disabilities. ▪ Maintain disability as one of the top priorities in the work of the MoPH during the period 2006-2009, and beyond.	international organizations, will finalize the disability education curriculum. ▪ MoPH, in collaboration with other relevant actors, will implement the provisions of the BPHS, EPHS, and the disability guidelines. ▪ MoPH, in collaboration with other relevant actors, will ensure that the representation of women in healthcare training programs is increased, including through a program to ensure that women have the opportunity to attain the necessary educational prerequisites. ▪ MoPH, in collaboration with other relevant actors, will continue regular contact, including through the disability taskforce, to discuss and resolve problems relating to disability issues.	
Part 3: Physical rehabilitation				
Goal: To prevent disability and restore maximum physical	**Status:** Rehabilitation services for all persons with disabilities, regardless of the cause, are a part of a broader welfare policy and a combination of medical and social services. However, the rehabilitation needs of mine/ERW survivors and other	**Objectives:** ▪ Create a directory of all physical rehabilitation services in Afghanistan by the end of 2006.	**Plans to achieve objectives:** ▪ MoPH disability taskforce will develop a standard format for information and distribute to all relevant organizations. The	**Funding Needs:** ▪

functional ability for landmine survivors, and other persons with disabilities, including the provision of appropriate assistive devices.	persons with disabilities are not being met. Only 20 to 40 percent of people with disabilities are believed to have access to rehabilitation services. With the exception of services provided by international organizations, for example the ICRC, rehabilitation services are very minimal and limited to only urban areas. There is not an extensive Community Based Rehabilitation (CBR) network in Afghanistan. Many persons with disabilities are unaware of the services that are available. In 2006, disability services were available in 19 of the 34 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Faryab, Ghazni, Herat, Jozjan, Kabul, Kandahar, Kunar, Kunduz, Laghman, Logar, Nangarhar, Parwan, Samangan, Takhar, and Wardak): physiotherapy services in 19 provinces; community-based rehabilitation in 12 provinces (Badakhshan, Baghlan, Balkh, Ghazni, Jozjan, Kabul, Kunduz, Logar, Nangarhar, Samangan, Takhar, and Wardak); and 14 orthopedic workshops in 10 provinces (Badakhshan, Balkh (2), Faryab, Ghazni, Herat, Kabul (3), Kandahar, Nangarhar (2), Parwan, and Takhar). However, the MoPH-run Technical Orthopedic Centre in Kabul is no longer functioning. Physical rehabilitation facilities need to be located in each large city or main town in at least 30 of the 34 provinces. In 2004, 87,131 people were assisted with orthopedic devices and physiotherapy, including 37,930 people without disability receiving physiotherapy; 7,132 were fitted with prostheses and 13,473 with orthoses. This represents a significant increase from 48,118 people (14,609 people without disability) assisted in 2001, including 8,407 people fitted with prostheses and 9,520 with orthoses. In addition, the ICRC assists around 3,000 paraplegics through a home care project. There is no functioning specialized center for paraplegics in Afghanistan. The ICRC is the principal provider of services to mine/ERW survivors with activities at its 6 orthopedic centers in Kabul, Mazar-i-Sharif, Herat, Jalalabad, Gulbahar and Faizabad. The centers fit upper and lower limb prostheses and orthoses, and	▪ Disseminate the directory of physical rehabilitation services in Afghanistan to all mine/ERW-affected communities by the end of 2007. ▪ Increase access to physical rehabilitation services by at least 10-20 percent for persons with disabilities by 2009. ▪ Increase the output of prosthetic and orthotic workshops by at least 5 percent per year, and improve the quality.	information submitted will be compiled into a booklet for dissemination. ▪ MoPH will coordinate delivery and dissemination of booklets through health facilities, the CBR network, agencies implementing the BPHS and EPHS, DPOs, and other disability organizations. Basic training about the use of the booklet will also be provided. ▪ MoPH will collaborate with all international and national organizations working in the field of physical rehabilitation and those implementing the BPHS and EPHS will: improve coordination and cooperation; disseminate information about existing services; improve referral systems; improve community participation through engaging shura and DPOs; create new facilities and sensitize donors for funding; expand outreach and community based programs; and make existing facilities barrier free. ▪ MoPH in collaboration with all organizations involved in the production of orthotics and prosthetics will: open new orthopedic centers, as appropriate; increase capacity of existing orthopedic	

	provide free medical care, physical rehabilitation, psychosocial support, vocational training, micro-credits for small business, and public awareness services related to government rules and programs. Rehabilitation and related services are also provided by several NGOs including the Swedish Committee for Afghanistan (SCA), Sandy Gall's Afghanistan Appeal (SGAA), Handicap International (HI), Kabul Orthopedic Organization (KOO), Afghan Amputee Bicyclists for Rehabilitation and Recreation (AABRAR), Association for Aid and Relief/Japan (AAR), International Assistance Mission (IAM), Physiotherapy and Rehabilitation Support for Afghanistan (PARSA), Serving Emergency Relief and Vocational Enterprises (SERVE), and Canadian Relief Foundation (CRF). Access to rehabilitative care is available free of charge. Distance and related costs (transport, accommodation, and escorts for women, etc) can be problematic in areas where services are not available. Access to services is immediate in most cases; however, waiting periods of 30-45 days have been reported in areas with limited services. There are approximately 200 physiotherapists and physiotherapy assistants, 126 orthopedic technicians and 105 artisans providing services in 19 of the 34 provinces. Training of technicians and physiotherapists is provided by ICRC and SCA. Physiotherapy training is also provided by IAM and SGAA/SCA through the Institute of Health Sciences in support of the MoPH. All prosthetic and orthotic aids are produced locally, with raw materials often being imported due to lack of availability of quality materials on the local market, by rehabilitation agencies, including ICRC, and local and international NGOs. Informal coordination exists among disability stakeholders, but could be improved. Inter-ministerial coordination and the technical capacity of the relevant Ministries (MoLSMD, MoPH, and Ministry of Education (MoE)) are weak. In 2006, MoPH established a disability taskforce with the	▪ Improve accessibility in provinces without disability services by establishing appropriate services in one additional province each year. ▪ Improve accessibility in at least five provinces without disability services by 2009 through the provision of transport to appropriate physical rehabilitation facilities.	workshops; increase outreach and mobile team services; increase/refresh the knowledge of orthopedic technicians through upgrading and continuous education programs; improve the quality of raw materials and components for orthotics and prosthetics; and improve the quality control of prosthetics and orthotics. ▪ MoPH will collaborate with all organizations working in the field of physical rehabilitation will: establish physical therapy services within the framework of the BPHS and EPHS; look for organizations willing and able to establish orthopedic workshops in the provincial hospitals within EPHS where no orthopedic workshop exists; and encourage organizations implementing the BPHS and EPHS to include physical rehabilitation within their activities. ▪ MoPH in collaboration with the Ministry of Transport will organize public transportation services for / from remote provinces. MoPH will also work in collaboration with organizations such as HI, ICRC and SCA to establish transportation services in provinces such as Ghore, Helmand, Aurozgan, Nooristan,	

	objectives of: improving coordination and cooperation between different sections of MoPH, MoLSMD, and disability organizations and service providers.		Paktika, Bagdis, etc.	
		▪ Improve accessibility in provinces with disability services by establishing mobile outreach units that visit at least 30 percent of remote heavily mine/ERW-impacted areas by 2009.	▪ MoPH in collaboration with organizations such as HI, ICRC and SCA will organize outreach and mobile teams to the areas of former front lines and very remote areas.	
		▪ Establish physical therapy clinics, with adequately trained personnel, in at least 5 percent of district, provincial and regional hospitals by 2009.	▪ MoPH in collaboration with organizations implementing the BPHS and EPHS in the district, provincial and regional hospitals will select and indicate the most needy areas and hospitals and to encourage the implementing organizations to include physical rehabilitation within their activities.	
		▪ Increase the number of trained physiotherapists and technicians by at least 5 percent each year, ensuring that at least 30 percent of trainees are people with a disability.	▪ MoPH in collaboration with the Institute of Health Sciences (IHS) and ICRC, Physical Therapy Institute (PTI), SCA/SGAA, KOO and HI will: start new classes; mobilize resources; and guarantee quota of 30 percent of students with a disability.	
		▪ Increase the number of trained female rehabilitation providers by 20 percent by 2009 to improve services available for women with disabilities.	▪ MoPH in collaboration with the IHS and ICRC, PTI, SCA/SGAA, KOO and HI will: select and recruit female students; guarantee quota of 20 percent of female students with a disability, and to identify ways to solve the problem of poor qualifications / education	

			of female students.	
		▪ Provide refresher training to at least 10 percent of rehabilitation providers per year.	▪ MoPH in collaboration with all organizations working in physical rehabilitation, including Afghan Physical Therapy Association (APTA), and under the umbrella of the IHS will: organize refresher courses and continuous education courses and teacher training; build linkages with international institutions (WCPT / ISPO); and share and coordinate training and expertise.	
		▪ Extend functional CBR services according to the basic disability services guidelines, with adequately trained personnel and that are appropriate to the Afghanistan context, to at least 50 additional communities by 2009.	▪ MoPH in collaboration with organizations working in CBR will: establish a national CBR network; train community workers; select 50 new community based networks on the agreed criteria; and mobilize resources.	
		▪ Establish a mechanism to improve coordination among relevant actors at the national, regional and local levels by mid 2007.	▪ MoPH in collaboration with all NGOs and organizations working in the field of physical rehabilitation and all ministries dealing with disability will: strengthen the disability taskforce of MoPH; ensure participation of all relevant actors in taskforce; ensure regular reporting and sharing of resources and expertise; and ensure involvement of people with disabilities in the work of the taskforce as much as	

			possible.	
Part 4: Psychological support and social reintegration				
Goal:	**Status:**	**Objectives:**	**Plans to achieve objectives:**	**Funding Needs:**
To assist landmine survivors, including children, to resume their role in the community by helping them cope with psychosocial adjustment issues and assisting them to regain and maintain a healthy and positive outlook on life.	It is recognized that post-traumatic stress disorder is common among people with disabilities caused by traumatic injury. However, there are few psychosocial support activities in Afghanistan or guidelines for mental health. The issue of mental health has been moved to the first tier under the revised BPHS. The MoPH Coordination Group on Health (CGHN) is discussing the issue of disability and the psychosocial situation in Afghanistan. However, activities are focused on Kabul and need to be expanded to other provinces. There is no coordination of relevant actors on a national level. Some initiatives exist through the ICRC and NGOs directed at specific needs or one-off projects. There are five centers in Kabul providing psychological support for all Afghans, including people with a disability; CARITAS runs 11 support centers. There is also limited peer support through service providers who employ large numbers of persons with disabilities. There is a lack of awareness within the general population on disability and access issues, the lack of opportunities for people with a disability, and on the capacity of people with disabilities to be productive members of their community. There are increasing opportunities for people with disabilities to participate in sporting activities. The Afghan Paralympic Foundation was established in 2003 and now has around 2,500 athletes in six provinces. However, there is a lack of suitable playgrounds, transport, equipment and trainers to expand programs. The majority of people with disabilities are illiterate or semi-literate. The participation of children with disabilities in education is very poor. Though mine/ERW survivors are encouraged to complete their education, this is limited to what is available in the communities. Additionally, many people	▪ Create a directory of all psychological support and social reintegration services in Afghanistan by the end of 2006. ▪ Disseminate the directory of psychological support and social reintegration services in Afghanistan to all mine/ERW-affected communities, as appropriate, by the end of 2007. ▪ Establish a mechanism to address the huge gap in psychosocial support services and improve coordination among relevant actors at the national, regional and local levels by the end of 2006. ▪ Introduce a training program, as part of the BPHS, for community healthcare and other service providers on psychosocial and disability issues by the end of 2007. ▪ Introduce a program to provide formal training for specialized social workers in Afghanistan by the end of 2007. ▪ Expand programs for sport for	▪ MoPH and MoLSMD, in collaboration with other relevant actors, will compile all known information of available services into an accessible database, and update as required. ▪ MoPH and MoLSMD, in collaboration with other relevant actors, will disseminate the directory through existing networks. ▪ MoPH and MoLSMD, in collaboration with other relevant actors, will create a taskforce that meets on a regular basis to discuss and take action on key issues. ▪ MoPH, in collaboration with other relevant actors, will strengthen the psychosocial unit in Kabul, develop guidelines on appropriate training, and identify implementing agencies to conduct training. ▪ MoPH, in collaboration with the Institute of Health Sciences and other relevant actors, will develop the curriculum for a two-year specialized training course for social workers. ▪ MoLSMD, in collaboration	

	never attended school prior to becoming disabled in a mine/ERW incident so do not have basic skills to build upon. Integration of children with disabilities does occur. However, there is little to no training available to teachers on the particular needs of children with disabilities. The MoE has no provisions for developing appropriate curricula or providing resources to encourage inclusive education for children with disabilities. The Ministry suffers from a lack of school buildings, infrastructure, trained teachers and sufficient budget provisions. The NDSA revealed a huge gap between access to education for children with disability and children without disability. Two schools offer exclusive education – one for deaf and one for blind children. NGOs are doing limited work in 14 provinces (Badakhshan, Baghlan, Balkh, Ghazni, Herat, Jozjan, Kabul, Kandahar, Kunduz, Logar, Nangarhar, Samangan, Takhar, and Wardak), but without supervision or direction; the programs are not well coordinated. Even though primary education has been made compulsory in the Constitution, its implementation is far from satisfactory. There are no well-designed incentives for parents to send their children to schools. The draft National Policy Framework for Action on Disability includes specific objectives relating to the education of children with disabilities.	people with disabilities, on an ongoing basis. ▪ Conduct awareness-raising programs throughout the country on the rights and capacities of people with disabilities, and in particular women with disabilities, in 2007 and beyond. ▪ Develop a comprehensive plan for inclusive and exclusive education for children with disabilities by 2008. ▪ Ensure that all new school buildings and at least ten percent of existing schools per year are made physically accessible to children with disabilities. ▪ Conduct awareness-raising activities in schools for teachers and students on the rights and capacities of children with disabilities. ▪ Develop the curriculum for primary level inclusive and exclusive	with other relevant actors, will advocate for increased resources and facilities, and to encourage the inclusion of sporting activities in the school curriculum. ▪ MoLSMD, in collaboration with other relevant actors, will develop and coordinate a campaign using radio, television, print media, workshops, a mobile theater, and special activities such as a Disability Week. ▪ MoE, in collaboration with other relevant actors, will conduct a needs assessment for gender-sensitive primary inclusive and exclusive education. ▪ MoE, in collaboration with other relevant ministries and actors, will ensure that appropriate accessibility aids for girls and boys with disabilities are provided in school buildings, classrooms and toilets. ▪ MoE, in collaboration with other relevant actors, will develop short courses on disability awareness and rights for inclusion in the school curriculum. ▪ MoE, in collaboration with other relevant actors, will	

		education by 2008. ▪ Establish a teacher training program for inclusive and exclusive primary education by 2008. ▪ Increased accessibility to sporting and social activities, and schools for people with disabilities in all major cities in Afghanistan by 2009.	research and adapt international training materials for gender-sensitive primary inclusive and exclusive curricula. ▪ MoE, in collaboration with other relevant actors, will introduce a teacher training program for men and women using modern teaching methods that are appropriate for inclusive and exclusive primary education. ▪ Ministry of Transport, in collaboration with other relevant actors, will increase the number of specially equipped buses to provide transportation for people with disabilities and their families to sporting and social activities and schools.	
Part 5: Economic reintegration				
Goal: To assist landmine survivors to either return to their pre-injury occupation, or prepare for and find suitable employment.	**Status:** According to the *Afghanistan Human Development Report 2004*, approximately 53 percent of Afghans live below the poverty line and the average person spends approximately 80 percent of their income on food. It also noted that "the lack of legislation to protect the rights of the disabled has also led to institutional discrimination." The NDSA found that 70 percent of people with a disability aged over 15 years are unemployed; 53 percent of males and 97 percent of females. In comparison, 25 percent of men and 94 percent of women without disability are unemployed. The Afghanistan Landmine Impact Survey data on recent mine/ERW casualties indicated that unemployment among mine survivors increased by 38 percent after the incident.	**Objectives:** ▪ Create a directory of all economic reintegration services in Afghanistan, including micro-finance providers, and vocational training and employment centers, by the end of 2006. ▪ By 2008, national employment agencies will protect, promote and report the number and percentage of persons with disabilities in income-earning employment.	**Plans to achieve objectives:** ▪ MoLSMD, in collaboration with other relevant actors, will compile all known information of available services into an accessible database, and update as required. ▪ MoLSMD, in collaboration with other relevant actors, will set up a monitoring, analysis and reporting mechanism for collecting information on employment opportunities for people with disabilities in the government and private sector	**Funding Needs:**

	There were notable decreases in the percentage of survivors who continued to be farmers, herders, military personnel, deminers, and laborers – all occupations requiring mobility over difficult terrain (a challenge for amputees) – and increases in the numbers of survivors doing household work and being unemployed. The MoLSMD is playing a key role in integrating persons with disabilities into mainstream vocational training programs in coordination with MoPH and MoE. The former Ministry of Labor and Social Affairs (MoLSA) had adopted disability as a critical component of its efforts in vocational skills training and employment-related services. MoLSA aimed to increase awareness and improve institutional capacity to ensure that it could provide disability-related vocational skills training and employment-related services nation-wide. MoLSA was in the process of developing its capacity to implement programs focused on people with disabilities including vocational training and employment, technical assistance, staff development and training, policy development, curriculum development/training materials, development/resource materials development, and monitoring and evaluation. The UNDP National Program for Action on Disability (NPAD) is providing national and international technical advice on vocational training and employment-related issues to MoLSMD. In addition, many NGOs, Japan's International Cooperation and Assistance (JICA), Afghan Korea VT Training Center, World Bank and GTZ are extending support to the relevant ministries to develop and deliver vocational training programs for persons with disabilities. MoLSA opened 13 vocational training centers; 10 percent of beneficiaries are people with disabilities. MoLSA had a presence in 32 of the 34 provinces with vocational training programs. Results to date have not been particularly good due to lack of adequate funding, lack of infrastructure and lack of employment opportunities after the training is completed.	▪ Integrate people with disabilities, including mine survivors, in a package of programs including employment, vocational training, micro-credits, self-employment and other assistance, in the period 2006-2009. ▪ Ensure that at least 30 percent of vulnerable families that include a family member with a disability (or families where the main provider has been killed in a mine/ERW explosion) have access to economic reintegration programs by 2009. ▪ Improve coordination among relevant actors at the national, regional and local levels by mid-2007.	in Kabul by the end of 2006 (expanding to all provinces by 2008), and encourage affirmative action in the employment of persons with disabilities in all sectors. ▪ MoLSMD, in collaboration with other relevant actors, will review the strategy developed by the former MoLSA and develop a new strategy that will ensure that people with disabilities have access to existing and new programs that promote economic reintegration. ▪ MoLSMD, in collaboration with other relevant actors, will establish a mechanism to ensure that vulnerable groups have access to programs that promote their economic well-being. ▪ MoLSMD, in collaboration with all NGOs and organizations working in the field of economic reintegration, will: establish a disability taskforce to address issues relating to economic reintegration; ensure participation of all relevant actors in taskforce; ensure regular reporting and sharing of resources and expertise; and ensure involvement of people with disabilities in the work of	

	Employment support and vocational training programs are also being conducted by international agencies and NGOs in 13 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Ghazni, Jozjan, Kabul, Kunduz, Logar, Nangarhar, Samangan, Takhar, and Wardak). As of April 2005, eight vocational training schools had been established by NGOs in cooperation with MoLSMD. At least 5 percent of employees in Government offices should be people with a disability. Persons with disabilities, registered by the MoLSMD, receive welfare payments at the rate of 300 Afghanis per month (about $6). People registering for pensions are referred to the MoPH for an assessment of the degree of disability. Persons with less than 50 percent disability receive 150 Afghanis per month. No payment is made to people with less than 35 percent disability. It is acknowledged that the allowance is too low to provide a basic standard of living. In 2005, 208,833 people were receiving welfare payments from MoLSMD; about 50 percent are people with mostly war-related disabilities. The Ministry of Finance releases the budget on the basis of requests from the MoLSMD directly to the provinces; benefits are paid quarterly. There are no contribution-based schemes in the country.		the taskforce as much as possible.	
Part 6: Laws and public policies				
Goal: To establish, implement and enforce laws and public policies that guarantee the rights of landmine survivors and other persons with disabilities	**Status:** Afghanistan currently has no law guaranteeing the rights of persons with disabilities or on developing a barrier free and accessible society. The Constitution of Afghanistan provides some basic rights to people with disabilities and enables the government to enact a separate law for people with disabilities. Articles 22, 53 and 84 include some enabling provisions for mainstreaming persons with disabilities. The newly formed Ministry of Labor, Social Affairs, Martyrs Families and Disabled (MoLSMD) is the focal point for all issues relating to persons with disabilities, including mine survivors. Objectives of the MoLSMD include: collecting data on persons with disabilities from all provinces to facilitate	**Objectives:** ▪ Disability focal points in at least 4 key ministries by early 2007. ▪ Adopt a three-year national framework for action on disability in	**Plans to achieve objectives:** ▪ Disability focal points will be identified and provided with performance incentives in key ministries, including the MoLSMD, MoPH, and MoE, with the aim of establishing disability taskforces within each ministry that meet on a regular basis to address issues of concern. ▪ MoLSMD, in collaboration with other relevant actors, will	**Funding Needs:**

	access to monthly pensions; advocating for the rights of persons with disabilities; development of new legislation to protect the rights of persons with disabilities; and facilitating access to vocational training courses. MoLSMD has a presence in all 34 provinces. Other line Ministries involved in services for persons with disabilities include the Ministry of Public Health (MoPH), the Ministry of Education (MoE), the Ministry of Women's Affairs (MoWA), Ministry of Rural Rehabilitation and Development (MoRRD), and the Ministry of Finance (MoF). Afghanistan developed a Comprehensive Disability Policy in 2003 through extensive consultations with relevant actors and line Ministries. In 2003/2004 a Basic Disability Package of Services for the sector was developed. Throughout 2004 the former Ministry of Martyrs and Disabled (MMD) and all stakeholders also worked on a project to establish a National Disability Commission; an inter-ministerial administrative body aimed at enabling a more effective approach to disability. The process of final approval by the Government was not completed. In May 2005, MMD began a consultative process to develop a new three-year National Framework for Action on Disability 1385-1388 (2006-2008) in Afghanistan, which was finalized in early 2006. The aim of the framework for action is that by the end of 1387 (2008) "persons with disability will be integrated or specifically provided for within mainstream national services of health care, education, vocational training, paid and self-employed labour market opportunities, legal protection and associated administration, informational resources, political voice, social safety net and pension programmes, research initiatives and partnerships." The aims will be realized through integrating disability in public health and social services and through a community based approach. The MoLSMD was the lead Ministry in developing the framework, which was developed in close consultation with relevant line Ministries (MoPH, MoE), with technical support from UNDP through the NPAD, a three-year program, which	2006. ▪ Conduct a nation-wide awareness raising campaign on disability issues in 2007 and beyond, which includes raising awareness on the rights and capacities of persons with disabilities. ▪ Develop, adopt and implement a National Disability Policy by 2008. ▪ Draft and adopt a comprehensive law for persons with disabilities that guarantees their rights to medical care, rehabilitation, education, employment, social services, and an accessible and barrier free society free from discrimination, with due importance given to the rights of women with disabilities, by the end of 2007. ▪ Ratify the 1983 International Labor Organization Convention 159 on Vocational Rehabilitation and	review existing documents to develop a framework and lobby for its adoption. ▪ MoLSMD, in collaboration with other relevant actors, will develop and coordinate a campaign using radio, television, print media, workshops, and a mobile theater. ▪ MoLSMD, with support from a technical advisor, and in collaboration with relevant ministries and national and international organizations, will establish a taskforce to elaborate a comprehensive policy. ▪ MoLSMD, with support from a technical advisor, will work with the Ministry of Justice, organizations of people with disabilities and other stakeholders, to develop appropriate laws, and to repeal any existing laws that discriminate against persons with disabilities. Two committees have been established, one within MoLSMD and one within civil society, to elaborate the necessary components of the new legislation. ▪ MoLSMD, in collaboration with other relevant actors, will lobby the government to join	

	UNDP began implementing on 1 April 2005. The policy proposes the establishment of a National Coordination Body with responsibility for coordination, monitoring and reporting on national disability-focused plans and programs. The framework document is currently before the Cabinet for approval. UNDP has signed a Memorandum of Understanding with the Government of Afghanistan to provide technical support to build capacity of the Government and to help put in place systems for mainstreaming the lives of the persons with disabilities. The International Labor Organization is also active in Afghanistan. Afghanistan has undergone an extensive inter-ministerial process to develop the Afghanistan National Development Strategy (ANDS) for 2005-2009. It includes mine action and disability issues. ANDS states that by the end of 2010 (1389), "increased assistance will be provided to meet the special needs of all disabled people, including their integration in society through opportunities for education and gainful employment." Almost all disability services are currently provided by national and international NGOs and agencies. The government's role in service delivery to persons with disability is minimal. The Government of Afghanistan therefore recognizes that policy implementation should be done in partnership with other key actors working at the grass roots level. In 2005, MoLSMD established an NGO coordination unit, which is intended to assist in the coordination of non governmental actors in the disability sector. In 2006, the MoPH established a disability taskforce with the aim of improving coordination and cooperation between all actors in the disability sector. The disability movement in Afghanistan is still in its infancy. Massive illiteracy and extreme poverty, limited exposure and	Employment (Disabled Persons) by 2008. ▪ Sign and ratify the international convention on the rights of persons with disabilities and launch an awareness-raising campaign in all major cities. ▪ Develop and disseminate an up-to-date directory of all NGOs/agencies working in the disability sector indicating their place of work, functions, funding sources, and priority areas by the end of 2006. ▪ Develop and strengthen national Disabled Person's Organizations (DPOs), on an ongoing basis. ▪ Establish disability resource centers in the eight regions of Afghanistan by 2008.	the Convention. ▪ MoLSMD, in collaboration with other relevant actors, will lobby the government to join the Convention, and raise awareness in the general public through a campaign using radio, television, print media, workshops, and a mobile theater. ▪ MoLSMD will compile all known information on organizations working in the disability sector, and request new information as needed, with the aim of creating an accessible database for distribution to all relevant ministries and agencies. ▪ MoLSMD, in collaboration with all relevant stakeholders including the Independent Commission for Human Rights, Afghan Civil Society Forum, and UN and international agencies, will implement a program of training and capacity building for national DPOs. ▪ MoLSMD, in collaboration with other relevant stakeholders, will develop accessible centers to house information on disability issues, and equipment and other facilities for use by people with	

	inadequate skills in institutional development are some of the problems faced by the movement. As a result the voice of persons with disabilities and their capacity to negotiate on behalf of their own interests in planning and decision-making is lacking. Afghanistan is a signatory to the Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region, and a signatory to the Biwako Millennium Framework for action towards an inclusive, barrier free and rights based society for persons with disability. Afghanistan also recognizes the World Program of Action, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, and the 1983 International Labor Organization Convention 159 on Vocational Rehabilitation and Employment (Disabled Persons). Afghanistan was actively engaged in the negotiations on the UN Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.	▪ Establish a data bank of quality research and Afghanistan-specific information by 2008. ▪ Improve accessibility to all government buildings by 2009. ▪ Raise the priority given to disability issues within relevant government ministries by the end of 2006. ▪ Establish a Disability Coordination Body by 2008 to coordinate, monitor	disabilities, and produce newsletters on key issues. ▪ MoLSMD, in collaboration with other relevant stakeholders will: identify gaps in statistical, academic and action research to inform policy; promote relevant gender specific data collection and research; promote scholarships for disability studies including capacity building of in-country researchers; and to establish a database of multi-sector research to support national mainstreaming of disability issues. ▪ MoLSMD, in collaboration with other relevant stakeholders and design experts, will document problems in accessibility to government buildings and develop and implement a plan to overcome the problems. ▪ All relevant actors, including people with disabilities, will work in collaboration, to develop mechanisms to improve coordination, planning and decision making at the national, regional and local levels, to avoid duplication in the delivery of disability services. ▪ MoLSMD, in collaboration with key partners, will bring	

		and report on activities of all stakeholders. ▪ Disability-related benchmarks are articulated in the Afghanistan National Development Strategy by the end of 2006.	together all existing disability structures within relevant ministries to improve coordination, monitoring, and reporting on national disability-focused plans and programs. ▪ MoLSMD, in collaboration with all relevant ministries and other actors will ensure that benchmarks that promote the physical, psychosocial and economic well-being of persons with disabilities are included in the Afghanistan National Development Strategy.	

Annex H – Closing Remarks – H.E. Mr. Mahmoud Saikal, Deputy Minister of Foreign Affairs

Colleagues, ladies and gentlemen

I am sorry that my other responsibilities prevented me from participating in all the activities of this, the first, National Victim Assistance Workshop to be held in Afghanistan. Nevertheless I have been kept updated on the progress of the workshop and I am grateful for your enthusiasm and commitment to this process. The fact that several of the working groups asked for additional time to continue their discussions is ample proof of this.

Participation in the workshop has been strong with representation from the ministries of Public Health, Martyrs, Disabled and Social Affairs, Economy and Labour, Transport, Energy and Water, Public Works, and Foreign Affairs, the Department of Disaster Preparedness, eight international agencies, around 20 national and international non government organisations, including several that represent people with disabilities.

Several points have been made very clear to me. Firstly, the issue of disability must be given greater priority within all government ministries. The Ministry of Foreign Affairs, and I am sure many other ministries, must do more to address the issue of accessibility to its building. It is also clear that providing adequate assistance to promote the full medical and physical rehabilitation, and social and economic reintegration, of people with disabilities requires a holistic approach. This cannot be assured without collaboration and coordination between all relevant ministries and other actors. And, developing a national plan is a long term process that requires political will and commitment from all actors.

At the opening of the workshop the Deputy Ministers of Public Health, Excellencies Doctors Kakar and Nadera Hayat also stressed the need to improve emergency response mechanisms to respond to traumatic injuries and thereby save lives, to improve access to health facilities in remote areas, and to increase preventive measure to minimise the risk of disability. His Excellency, Deputy Minister of Martyrs, Disabled and Social Affairs, Mr. Hadi Hadi, also informed us about the new National Disability Policy. But this policy must be adopted and implemented before it will benefit persons with disabilities in Afghanistan.

On the first day of the workshop I stated that Afghanistan, as Co-Chair of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, wanted to lead by example to show other affected States what can be achieved in addressing the rights and needs of mine survivors and other people with disabilities. I am confident that the outcomes of this workshop will enable Afghanistan to do just that, lead by example, when we share our experience with other mine affected countries at the Seventh Meeting of the States Parties in Geneva next month.

However, although I believe the workshop can be considered a success, I understand that the task is not yet complete. As Susan Helseth has stated, it is essential that the relevant government ministries take ownership of the plan and agree to adopt the objectives that have been proposed and elaborate further the plan of action.

If possible, I propose to convene an inter-ministerial meeting to bring to together all the relevant ministries to review the revised document that will be produced as a result of your discussions. This document will provide the relevant ministries with a clear picture of the benchmarks and their responsibilities.

There is still much work to be done to turn the proposed objectives and actions into a concrete and fully implemented plan, but the Ministry of Foreign Affairs will support this process and assist in identifying focal points within each ministry to ensure that actions are implemented and monitored. Success in this process will serve to address our obligations to mine victims under the Ottawa Convention, but more importantly, it will also serve to address our much broader responsibility to all persons with disabilities in Afghanistan.

In conclusion, I would like to again thank UNMACA, UNICEF, and the Swiss Agency for Development and Cooperation for the financial support that has made the

workshop possible, and Susan Helseth and her team at UNMACA, and the many staff of the Ministry of Foreign Affairs who assisted in the organisation of the workshop. I also thank our international guests, Dr. Flavio Del Ponte and Patrizia Palmiero, for their participation, and also Khalil Nasri, from our Permanent Mission in Geneva.

And thanks to all of you for your participation over the past two and half days and for taking seriously the opportunity presented by this workshop to move forward the process of developing benchmarks and a plan of action. Government ministries, international agencies, and non governmental organisations must continue to work together to reach the ultimate goal of improving the quality of daily life of people with disabilities in Afghanistan.