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ASSESSING UKRAINE'S VICTIM ASSISTANCE CAPACITIES

Background image: Child EO victim in Svatove, Luhansk region.
Image courtesy of © UNICEF / Filippov / 2019.

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Child EO victim in Svatove, Luhansk region.
Image courtesy of © UNICEF / Filippov / 2019.

Six years into the protracted crisis, explosive ordnance (EO) contamination continues to affect Ukrainian communities. Consequent to the conflict between the government of Ukraine and the so-called *de facto* authorities in the Donetsk and Luhansk regions, EO affects an estimated 7,000 square kilometers of land in government-controlled areas (GCAs).¹ Even without complete data from the non-government-controlled areas (NGCAs), Ukraine ranks among the five most affected places in the world for EO casualties.² But for EO victims³ the path forward remains fraught with difficulties. According to the International Mine Action Standards (IMAS),⁴ victim assistance (VA) requires a long-term commitment, a responsibility that state institutions bear. The present article, encapsulating an

assessment conducted in 2018 and 2019,⁵ highlights the crucial incapacities of the primary VA duty-bearers in Ukraine and puts forth the corresponding lessons learned.

The needs of child EO victims are at the center of our analyses of local VA capacities. Danish Refugee Council-Danish Demining Group's (DRC-DDG) internal database⁶ shows 2,060 casualties (resulting from 1,126 incidents) from June 2014 to September 2020; 151 of these were children. Picking up, tampering with, and playing with EO—behaviors characteristic of children—is the third most frequent known cause of EO casualties in Ukraine. Children from poverty-stricken regions are regularly attracted to EO in order to sell them for scrap metal or souvenirs.⁷ The impact of hostilities on educational infrastructure remains on the rise: some fifty conflict-related incidents have been reported in 2019. When compared to 2018, this constitutes a nearly 200 percent rise.⁸ The presence of military forces within a 1-kilometer radius of educational facilities as well as the infrastructural destruction caused by the ongoing conflict forces some children to cross the EO-ridden contact line every day to attend classes.⁹

Although full clearance is years away, Ukraine is making tangible progress. It has joined important mine action- and VA-related conventions and ensures basic rights to its population through its constitution (and related social protection laws).¹⁰ Ukraine has also adopted the Law of Ukraine “On Mine Action,” hereinafter referred to as the mine action law (MAL), on 6 December 2018. Ukrainian Parliament has recently adopted an amendment to MAL (Draft Law No. 2618, adopted on 17 September 2020). However, as of December 2020, it has not yet been signed by the President of Ukraine.¹¹ To a certain extent, inter-agency communication and coordination on VA exist with social protection units, sanatoriums, rehabilitation centers, and regional-level hospitals currently serving as essential VA intermediaries. Ukraine is also steadily implementing the state-wide inclusion reform (i.e., “The New Ukrainian School”), improving access to education for children with special educational needs. Finally, the government is open to and cooperative with the international mine action community. As a result, DRC-DDG was able to holistically assess the remaining VA gaps.

The assessment took international policies and guidelines as the theoretical background for its research. These included the UN Policy on Victim Assistance in Mine Action¹² and the United Nations Children's Fund (UNICEF) Guidance on Child Focused Victim Assistance.¹³ DRC-DDG used these as a framework for the design of the assessment, thereby covering the following topics: laws and policies, data collection, emergency and continuing medical care,

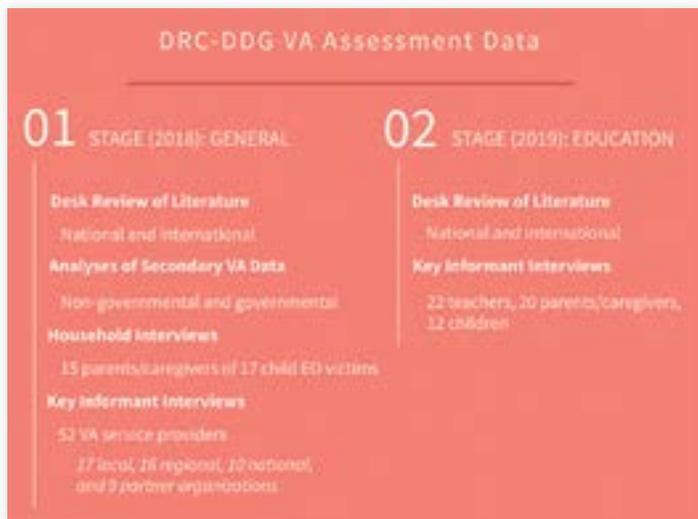


Figure 1. Accumulated Data on VA Assessment in Ukraine.
Figure courtesy of © DRC-DDG.

rehabilitation, psychological and psycho-social support, and socioeconomic inclusion (focusing on education). For this article, we found it pertinent to also share drawbacks and lessons learned about conducting VA assessments. Finally, we have adjusted the terminology of the article to conform with IMAS 13.10 Victim Assistance (First Edition), published earlier in 2020.¹⁴

METHODOLOGY AND LIMITATIONS

The two-stage assessment employed a mixed-method research approach, including secondary data analyses as well as qualitative and quantitative research tools. In the first stage (2018), the team used a questionnaire (with multiple choice, open-ended, yes/no, and Likert-type questions)¹⁵ for household interviews with parents or caregivers of child EO victims and semi-structured key informant interviews (KIIs) for institutional VA stakeholders. Although difficult to locate EO victims due to stigma, fear, and the lack of a database recording casualty data, snowball sampling¹⁶ was used to reach fifteen parents or caregivers of seventeen child EO victims (from one to seventeen years old) while duty-bearing VA service providers ($n = 52$) were gathered from three levels: national, regional, and local.¹⁷ For triangulation, secondary data analyses were performed using institutional and internal DRC-DDG sources as well as a desk review of related reports from other humanitarian and development organizations. The second stage (2019) focused on national educational capacities for child EO victims. Here, too, household and KIIs were utilized to contact fifty-four interviewees (twelve children, twenty-two teachers, and twenty caregivers) using a purposive sampling¹⁸ (see Figure 1). For both stages, the two regions of Luhansk and Donetsk were chosen due to the frequency of child EO accidents (see Figure 2). Although the assessment aimed to be comprehensive, certain limitations are noteworthy.

Capacity assessment was constrained by timeframes and wide geographical spread, availability and quality of data, as well as demographics. Each stage of the assessment lasted for three months; however, the conflict-affected areas stretch over 427 kilometers. The nature of a small-sized team, as well as safety and logistical issues, meant that a

more in-depth study was beyond reach. The lack of a nationally-owned, EO-casualty database additionally hampered the identification of potential interviewees. Regardless, the DRC-DDG assessment—supported by the German government and United Nations International Children’s Fund (UNICEF)—continues to be the only review of national Ukrainian VA capacities.

GAPS IN UKRAINIAN NATIONAL VA CAPACITIES

Laws and Policies. The root cause for many VA incapacities emerges from the underdeveloped legal environment. For any national provision, governments are required to adopt necessary laws, secure budgets, and develop policies, regulations, and procedures. For VA in Ukraine, this is yet to become the case. For years, the Ukrainian response remained *ad hoc*, uncoordinated, and misaligned with best practices from abroad. Not until late 2018, did the government adopt MAL,¹⁹ as of December 2020, its implementation remains troublesome. For VA, two significant challenges exist in the Ukrainian legal framework: unenforced existing provisions and gaps within them.

The current version of MAL provides for a number of services to EO victims but lacks the crucial legal documents, by-laws, and procedures for its implementation. For instance, MAL secures rights to medical, psychological, professional, and social assistance for all EO victims;²⁰ however, there is no complex system or protocol for the general provision of VA at the state level.²¹ Officials are obliged to act exclusively as defined by national regulations.²² Thus, EO victims either receive assistance at the discretion of local administrations, or simply do not. Many crucial legal documents (e.g., a national mine action strategy) are also missing. Finally, by-laws (i.e., procedures, orders, and directions) required to provide a framework for a national mine action authority and national mine action center are absent. Crucial gaps in the existing legislation are likewise commonplace.

Even where the current MAL is implemented and necessary procedures are adopted, certain gaps weaken the state’s VA capabilities. For one, there is no provision on data collection. Unless defined in MAL, such data collection is both legally controversial and halts the coordination of responsible state bodies. Furthermore, MAL does not prescribe the adoption of a national mine action strategy or an action plan; without these, national VA is undermined. What is more, the state allocated a budget line for mine action activities only in 2019 and 2020 (approximately US\$185,000). While a separate line on “specialized assistance on prosthetics and rehabilitation” (approximately US\$1 million) was included, it is insufficient for the needs of the beneficiaries. Such a lagging legal environment is the common theme for many of the national VA capacity gaps discussed next.

Data Collection. The problematic EO casualty data collection is not limited to Ukraine as mirrored by examples in countries such as Afghanistan,²³ Bosnia and Herzegovina,²⁴ and Vietnam.²⁵ Similarly, the establishment of a reliable and complete EO casualty data collection system in Ukraine is in process. Currently, Ukraine has no central agency in charge of the latter, neither is it mentioned in MAL. The state capacity to evaluate the scope of required assistance

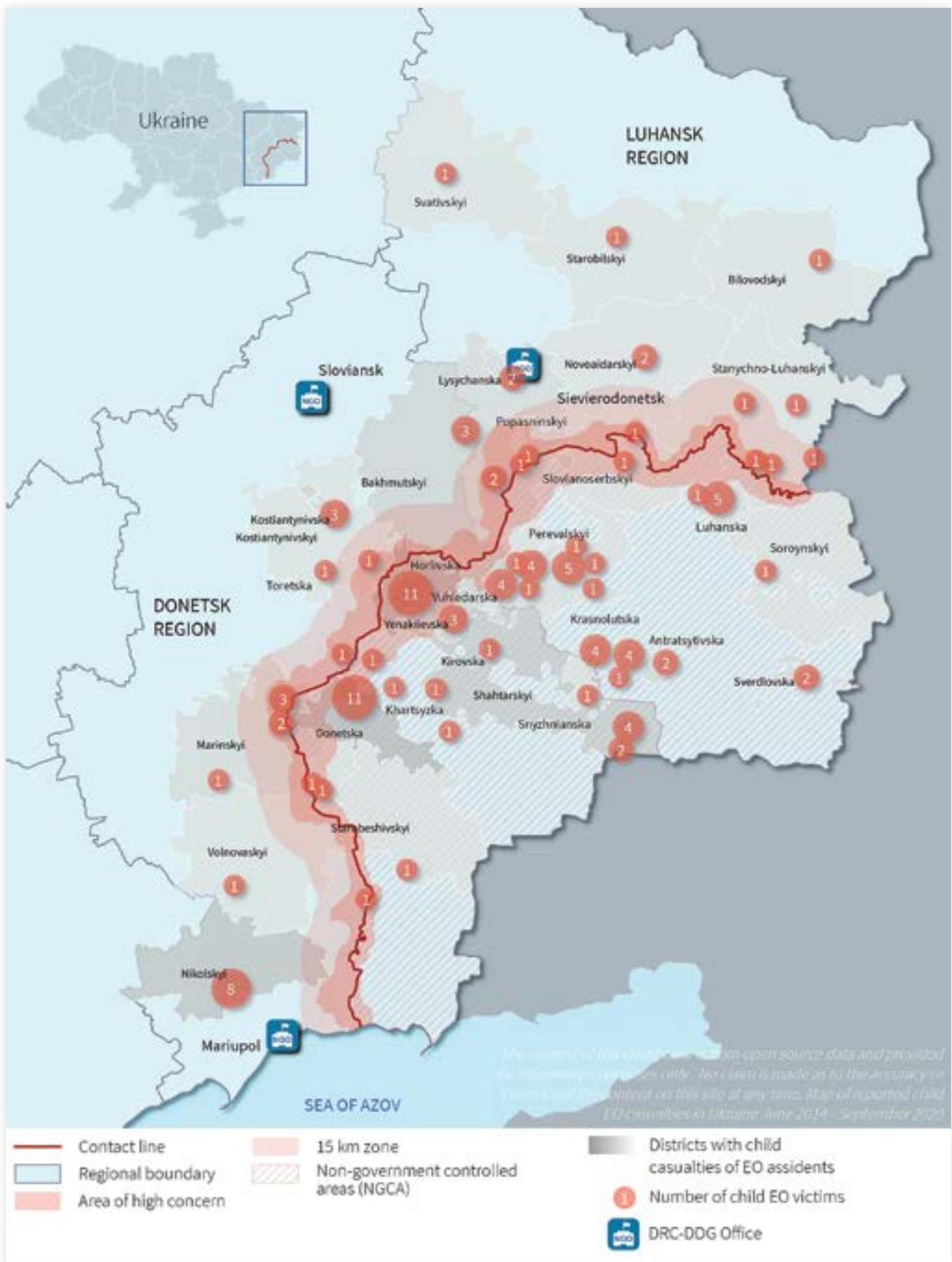


Figure 2. Reported child EO casualties in Ukraine (June 2014 - September 2020).
Figure courtesy of © DRC-DDG.

is further thwarted by the fact that healthcare facilities did not identify EO injuries under the International Classification of Diseases²⁶ at the onset of the conflict (only in 2018 was a protocol introduced obliging them to do so). As a result, EO victims injured before 2018 face difficulties proving the cause of injury when trying to obtain support. Without a comprehensive victim information system (VIS), it is likewise impossible to accurately quantify the cost of conflict-related disabilities to individuals, the economy, and society at large. The state is hence not only limited in ensuring compensation and assistance for the current EO victims but also in accurately evaluating VA needs for the future.

Emergency and Continuing Medical Care. While emergency care is oftentimes provided at local and district levels, it is the expense of continued medical care and a lack of specialists and equipment that remain problematic and disproportionately affect rural areas. The majority of interviewed victims requiring continuing medical care had to transfer to regional hospitals; lacking external support, many EO victims and their families continue to struggle with such transitions. Moreover, there exists a general shortage of specialists and equipment to treat EO-related traumas in conflict-affected regions. In some of the assessed cases, this led to errors in treatment and the deterioration of victims' conditions. But as noted by the World Health Organization (WHO), for the EO victims and their families it is currently "impossible to assess the quality and capacity of medical facilities in Donetsk and Luhansk regions because of subjective perceptions of quality." The biggest deficiencies have been identified in rural areas due to the long distances that need to be travelled to access adequate medical facilities. This is further exacerbated by the fact that most EO accidents in Ukraine occur in rural areas among a population that is more economically fragile.²⁷

Rehabilitation. Rehabilitation in Ukraine has gaps in individual planning, full-cycle prosthetic provision, informational awareness, and state-assigned budgeting. All EO victims with physical disabilities interviewed received an individual rehabilitation plan (IRP), informing them of access to rehabilitation facilities and prosthetic services. Yet, these plans have rarely been made concrete in practice. EO victims also faced difficulties receiving relevant rehabilitation due to omissions or inaccuracies in IRPs. Thus, no interviewed EO victim was availed the full cycle of prostheses: preparation, adjustments, maintenance, and replacement. The procedures for obtaining such assistive devices are not interlinked. As a result, prostheses provided to children are exclusively cosmetic rather than functional. While functional prostheses would provide children with increased mobility, they are more costly and require periodic changes. Their provision and application is also highly specialized and tailored. Fitting would require multiple trips to regional hospitals, making it even more inaccessible for low-income families. Additionally, a reluctance among social protection specialists to fully inform families of rehabilitation services is customary due to a lack of funding. "If the government aims to save money, there will obviously be less incentives to inform families of the available services," stated an interviewed child protection expert. Finally, state funding for the rehabilitation of children is limited. As reported by social protection specialists, the amount provided by the

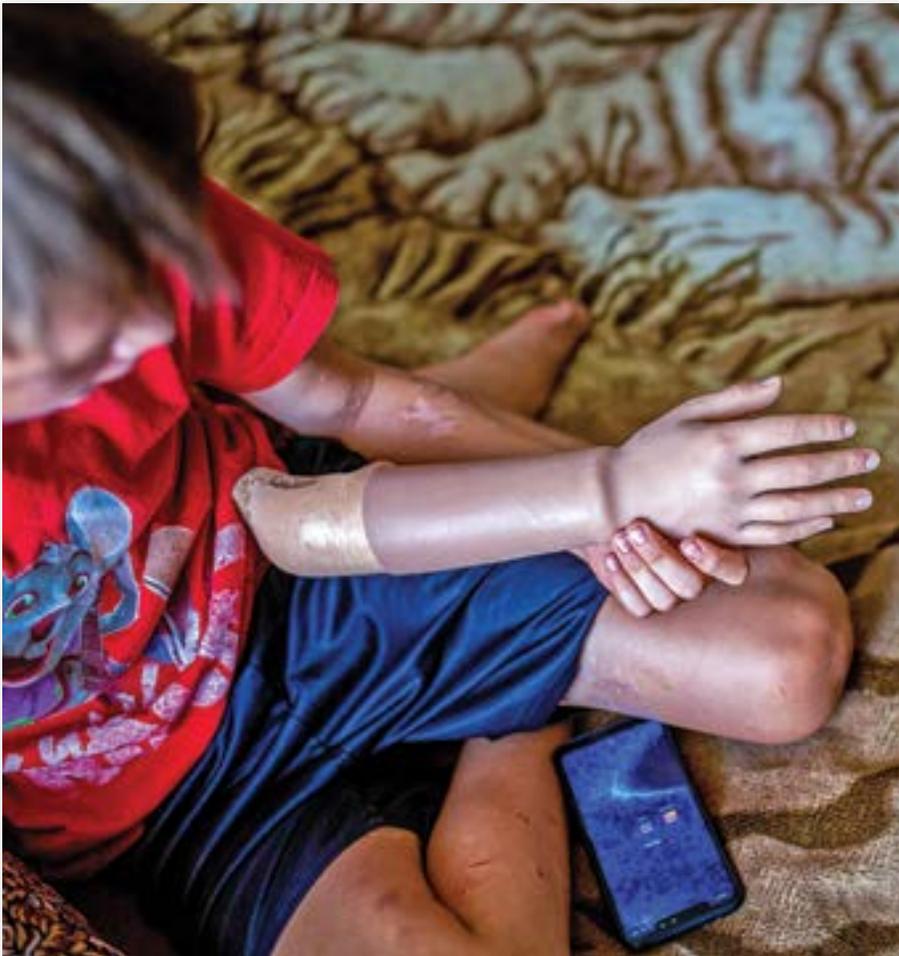
government is normally enough to cover one rehabilitation session annually; however, a child usually needs four.

Psychological and Psycho-Social Support. Ukrainian child EO victims are not supported by an established system of psychological aid or qualified professionals, with distrust for such services prevalent among the population. While MAL asserts rights to psychological and social aid to every EO victim, the majority of them fall short of its full extent. Of the seventeen assessed cases, only eight received psychological support. It was rendered either as generic psychological assistance or therapy at a hospital, emergency psychological counselling post-accident, or as psychological therapy in sanatoriums during rehabilitation, at their schools, or by a non-governmental organization (NGO). Without an established system of psychological aid, rehabilitation and other psycho-social assistances are provided solely from local resources. As expressed during our interviews with national and international NGOs and governmental stakeholders, the latter lack the requisite professional capabilities, as most psychologists operating in eastern Ukraine do not have experience in counselling trauma and are uncertain of their ability to provide such counseling. A further problem is the distrust of psychological counselling, caused by both the underestimation of psychological risks and burdens as well as the costs of such services. It is, therefore, common for families (as well as doctors, teachers, and social workers) to be prejudiced against psychological assistance, underreport their need for it, and reluctantly recognize it as a priority. "He became more reserved and aggressive ... No, we are not going to contact a psychologist, we do not need it," mentioned one mother.

Socioeconomic Inclusion. The assessment focused particularly on the educational environment to identify gaps in child EO victims' socioeconomic inclusion. While most of child EO victims continued with education within one-to-three months after the incident (30 percent and 25 percent of interviewees, respectively), those with more severe injuries had to drop out due to ongoing medical care for at least six months to more than a year. Some children faced additional difficulties in their learning due to loss of skills as a result of severe traumas or amputations. Likewise, legislation remains to be fully implemented providing children with disabilities the same opportunity as their peers without disabilities. Despite a state-wide inclusion reform in the educational system, teachers from conflict-affected areas still reported a lack of knowledge, skills, and information on working with children with disabilities and no relevant training on inclusion in schools. Consequently, teaching staff and administrators are sometimes not ready or unwilling to include children with disabilities in their classes. Moreover, there are few (extracurricular) activities for child EO victims due to the absence of afterschool activities at schools, generally, and the lack of conditions and accessible facilities for children with disabilities, specifically.

RECOMMENDATIONS FOR VA CAPACITY BUILDING IN UKRAINE

Laws and Policies. Improving the legal environment for VA will necessitate amending MAL and its corresponding legal documents, assigning an evidence-based budget, and bolstering the legal support



Child EO victim in Svatove, Luhansk region.
Image courtesy of © UNICEF / Filippov / 2019.

to the state. Functional changes to MAL include, *inter alia*, developing a legal status for EO victims, introducing the necessary procedures at all VA stages, and establishing specialized state bodies to lead the national VA response.²⁸ More data-driven budget allocations would also be crucial. Lastly, it would be beneficial to dedicate adequate resources to legal VA (and mine action) capacities within the government to identify further gaps in legislation and help develop the required legal acts.

Data Collection. There is an acute need to put into place a standardized and centralized collection of EO casualty data given the many issues that arise from its absence. For this, a state policy should be developed and integrated with clear terms and with a distribution of responsibilities among the relevant stakeholders—as is the case in, for example, Cambodia. Such a database should be sex, age, and disability disaggregated, including causes of injuries and incidents from earlier stages of the conflict. It is important to include data on incidents that have taken place in NGCAs to ensure that victims have access to assistance in GCAs. As a result, it would be possible to amalgamate, verify, and report on the incident data via a centralized database and populate a VIS. Statistical information from such a national database should be available upon request to all relevant mine action and VA stakeholders. This will help better identify EO victims, assess the complexity and extent of VA needs, and aid further analyses.

Emergency and Continuing Medical Care. Emergency and continuing medical care for EO victims in Ukraine requires capacity building of medical staff, supervision of EO victims, and allocation of funds for travel expenses. To boost the specialist knowledge of doctors, a coordinated plan for their capacity enhancements ought to be developed and implemented. Training will need to be registered and monitored for refreshment and assessment of continued needs. Since families tend to put less priority into continued medical care, individual supervision of EO victims by medical staff is highly recommended. Medical staff should be aware of cases where ongoing treatment is required, and efforts should be made on both sides (caregivers and medical institutions) to ensure that child EO victims receive all necessary care. Due to frequent long-distance travel required for continuing treatments, the allocation of state funds could bring much-needed financial relief to EO victims and their families.

Rehabilitation. In terms of rehabilitation, we recommend an improved, full-cycled, tailor-made, and needs-based VA system. The current model⁵ should be replaced by an improved version in the provision, care, and main-

tenance of prostheses, aligned with international experience and featuring a broader array of technologies. Furthermore, a full-cycle, coordinated methodology for the registration and follow-on care of EO victims ought to be put into place and linked with records from other types of assistance provided (i.e., psycho-social, financial). The rehabilitation for EO victims also needs to be personalized. Patients should be supported from the initial injury all the way through recovery to exiting the system. A dedicated case manager should act as a focal point for each family so the process is streamlined and lessens the burden on the EO victims. Finally, EO victims need to receive equal prioritization for treatment as those injured by other means: support should be needs- rather than cause-based.

Psychological and Psycho-Social Support. Psychological and psycho-social support requires coordination, governmental strategies, awareness raising and advocacy, as well as a needs-based approach. Lessons learned from other countries²⁹ would be useful in developing a coordinated support system for EO victims in Ukraine. A dedicated governmental strategy and an allocated budget would ensure access to higher quality psychological treatment. To counteract the reluctance for this support, more awareness raising and advocacy of its importance in the post-traumatic treatment process should be garnered among national duty-bearers (especially schools in eastern Ukraine) and the general public. Lastly, ongoing counselling and psychological

support for EO victims should be identified as part of the overall rehabilitation and social inclusion plan for each victim and regularly reviewed throughout their path to recovery.

Socioeconomic Inclusion. The four main recommendations for improvements in the social and economic inclusion of EO victims are special approaches to education, capacity building of teachers, disability-centered extracurricular activities, and awareness raising. It is necessary to specify the particular learning objectives for EO victims comparative to their peers without disabilities; to establish individual training or online learning during their treatment; and to ensure their greater involvement in programs befitting their needs, including vocational assistance to enhance their employability. Since the response of teachers to the needs of EO victims fundamentally affects the quality of education and the environment at schools, supporting programs (such as inclusion training) for teachers and children ought to be implemented to build their technical and practical capacities. Regular awareness raising for parents, children, communities, and state representatives to broaden their knowledge on appropriate attitudes towards children with disabilities would also be beneficial. “People on the bus would avert their eyes upon seeing them so my children asked me to buy them balaclavas,” explained a parent of child EO victims. For the conflict-affected Donetsk and Luhansk regions, further efforts are likewise required in the development of specialized extracurricular programs as well as sporting and recreational facilities for EO victims and other people with disabilities.

CONCLUSION: FUTURE VA ASSESSMENTS

Taking into account various international policies and guidelines, the assessment of Ukraine’s VA looked at (1) gaps in the underpinning legal environment, (2) data collection, (3) emergency and continuing medical care, (4) rehabilitation, (5) psychological and psycho-social support, (6) and socioeconomic inclusion. However, given the limitations of the present assessment, more in-depth studies are recommended for particular segments of VA in the future. For example, it would be pertinent to assess the socioeconomic impact of accidents on child EO victims. The formative years in which child EO victims experience the incidents call for the identification of educational, career, and life prospects of children post-accident. Moreover, a more detailed look at the psychological impact of the armed conflict on the entire social strata would inform VA specialists how to better address psycho-social and psychological consequences. A further inquiry into the rehabilitation, prosthesis, and orthotics systems is likewise deemed key, especially for alignment with IMAS on VA (including physiotherapy, assistive devices, and occupational and speech therapy). Additionally, we recognize that future assessments of medical capacities ought to be conducted by medically-qualified personnel and benchmarked against good practices as illustrated elsewhere. ©

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Tetiana Shymanchuk worked for DRC-DDG in Ukraine from 2014 until 2020. From 2018, she was the Protection Programme Manager, managing projects addressing the needs in the conflict-affected Donetsk and Luhansk regions. During this time, she managed the UNICEF-funded Mine Victim Assistance project focusing on children. She was the coordinator and one of the principal authors of the mine victim assistance needs assessment. In 2009, she received a bachelor’s degree in management at the Azov Regional Institute of Management in Berdyansk, Ukraine.

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