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REVCON POLICY BRIEF

Presented at the First Review Conference on the Implementation of the UN Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects, New York, 26 June–7 July 2006

The Skeleton in the Closet
Survivors of Armed Violence

INTRODUCTION

Providing for the needs and rights of the girls and boys, men and women who survive gun violence is a self-evident, daily reality for organisations—governmental and non-governmental—working at the local level. The silence on the issue of assistance to survivors in the UN process on small arms control therefore stands in sharp contrast. Only in July 2005, at the Second Biennial Meeting of States to consider the implementation of the Programme of Action, did governments make statements referring to victim assistance as an important consequence of the illicit trade in small arms and light weapons *in all its aspects*. Attention to this issue is long overdue.

The challenge goes beyond financial assistance to include the reintegration of survivors into their communities, ensuring positive economic prospects and a return to a healthy life. Much can be learned in this regard from other processes, including the landmines and explosive remnants of war (ERW) processes, which explicitly address the issue.[1] State Parties to the Mine Ban Treaty have defined in detail what victim assistance entails, including data collection; emergency and continuing medical care; physical rehabilitation; psychological support; socio-economic reintegration and vocational training; and disability law and policies.[2] Similar definitions are applicable for those injured with small arms or light weapons.

Exploiting synergies with other weapons control processes is particularly important for implementation, as strict categorisation of survivors according to the origin of the injury (from a landmine, ERW or a gun) is neither practically possible, nor ethically acceptable.[3] Instead, a more challenging task is to ensure that response systems are in place for *all* victims of armed violence. A key lesson from the landmines process is that whilst a disability-specific track might be required, assistance to survivors also needs to be part of the overall national health, poverty and crime reduction and development strategies, and not developed in isolation or competition with often limited resources. This twin-track approach has now been widely adopted with much success in the implementation of mine victim assistance programmes.

This policy brief seeks to bring to attention the plight of survivors of small arms violence, and identify their medical, psychological, social and economic needs. Considering assistance to survivors through a wider development and violence prevention lens, it suggests linkages that need to be built with other government agencies and priorities. Drawing lessons from the landmines process in particular, a number of successful approaches can be replicated or supported. Finally, given the dearth of information currently available on this issue, it suggests a number of areas where action-oriented research should be prioritised.

At the RevCon, States should recognise that . . .

1. Addressing the consequences of the illicit trade in small arms and light weapons in all its aspects requires responding to the needs and rights of people who survive small arms related violence.
2. These needs include emergency and continuing medical care; physical rehabilitation; psychological support; socio-economic reintegration and vocational training; and disability laws and policies.
3. While men are the largest number of disabled survivors, women and girls suffer many forms of gun related violence such as sexual violence at gunpoint, and have to cope with the trauma and stigma, in addition to assuming the bulk of the care giving roles.
4. Links can be built and strengthened with other relevant processes, including the Draft Disability Convention, the implementation of the Mine Ban Treaty's and Explosive Remnants of War Protocol provisions on assistance to survivors.
5. Data collection and action-oriented research are needed to better understand the extent of the challenges faced and to generate policy-relevant information.

VICTIM OR SURVIVOR?

People affected by small arms related violence will move from being victims to survivors as they recover from trauma, reclaim their lives, and enjoy their rights. The often targeted misuse of small arms (in family violence, war zones, gang fights) adds another layer to the definitional issues—distinct from the indiscriminate nature of attacks from landmines and ERW. The term 'survivor' bears a more positive connotation, recognising the rights of individuals to be fully participating citizens in their communities. However surviving armed violence is not solely contained to individuals; rather it has consequences for families, communities, and socio-economic activity. Aside from direct victims, the well-being and coping mechanisms of those who are related to, work with, or are associated with someone who has survived armed violence, can also be greatly affected. Men and women often experience this in distinctly different ways. Whilst most direct casualties of small arms violence are men, women are overwhelmingly exposed to other forms of trauma such as sexual violence at gun point. In addition, women often perform a disproportionate and under-recognised care-giving role within families and the broader community in which they live.

IN THE PROGRAMME OF ACTION

Victim assistance is not explicitly referred to in the Programme of Action. The document refers to some categories of people victimised by small arms misuse, such as women, children and the elderly (Preamble, para. 6; Section II, para. 22), and recognises the crime prevention, humanitarian, health and development dimensions of the small arms issue (Preamble, para. 15). It does not however elaborate on the needs of survivors. Similarly, while the disarmament, demobilisation and reintegration (DDR) of ex-combatants is encouraged (Section II, para. 21), no mention is made of civilian survivors of armed conflict.

> "We recall that at the 2001 UN Conference, issues such . . . assistance to victims of gun violence could not be resolved. It is our hope, therefore, that member states will adequately address these issues at the Review Conference with a view to resolving them within the framework of the PoA."
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> **—Indonesia statement at January 2006 PrepCom[4]**

A game of basketball in La Antigua, Guatemala, April 2006. 'Fundación Transiciones' is an NGO that helps people with disabilities become confident and proactive 'survivors'. About 20% of Transiciones' 'client base' is disabled due to gunshot wounds—as a result of gang violence, civil war, and accidents. Photo by Heidi Schumann

THE REALITY

- Violence, including homicide and suicide, and other injuries account for 9% of global mortality and is a leading cause of disability.[5]
- More than 90% of gun-related homicides occur among men.[6]
- The UN estimates that approximately 10% of the population of the world—about 600 million people—are affected by disabilities.[7] No global data is available on the proportion of those disabilities resulting from firearm-related violence.
- One study by the International Rescue Committee in one of the world's largest refugee camps found that gun shot injuries was the single largest cause of physical disability, with 32.4% of all cases.[8]
- About 80% of people with disabilities live in low-income nations.[9]

BEFORE YOU ASK . . .

1. Is this related to the Programme of Action or its implementation? What has it got to do with this process?
The Programme of Action explicitly encourages governments to tackle the illicit trade *in all its aspects,* and dealing with the human cost falls squarely within that. Governments are encouraged to undertake a range of initiatives related to small arms control, and have systems of varying strength already in place to tackle this particular issue—regardless of the government's economic status or outlook. Addressing this issue entails examining those services or assistance to others to do so, and filling the gaps that exist.

2. How can anyone distinguish victims of illicit and licit small arms use? Surely this is impossible!
It is not impossible—if ammunition was fully traceable—rather it is an inappropriate use of resources. The Mine Ban Treaty and other processes have established, through the will and leadership of governments, the principle of non-discrimination for assistance. This applies equally to small arms related violence. Indeed the 2004 Mine Ban Treaty Review Conference affirmed that "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 service systems and human rights frameworks."[10]

3. Don't we have more pressing matters to deal with?
If now is not the time, when is? A few references can be included in the Outcome Document to encourage those States who are interested in better tackling this issue —of which there is a growing group—to press ahead in the coming years with research, inclusion in national action plans and other implementation activities. It is also an opportunity to rectify an omission from the Programme of Action of a clear reference to the millions who survive small arms related violence all over the world—either through the illicit trade and therefore illicit use, or the misuse of legally-held weapons.

> "Our challenge then is clear. It is to back up the political will—our shared commitment—to fully implement the Programme of Action, with resources required to . . . meet the full range of physical, psychological and social needs of survivors and provide them with the skills so they can be reintegrated into their societies as full productive members."
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> **—Canada statement at the January 2006 PrepCom**

Surviving violence in Burundi

Gun violence is still a major cause of injury in Burundi. An estimated 100,000 to 300,000 weapons are in circulation, many having been distributed to civilians during the war. Records from a hospital for war wounded run by MSF Belgium show that in 2005, 25% of the case load was related to firearms injuries compared to 11% for grenades and 0.4% for landmines. Patients accessing treatment in public hospitals have to support the entire cost of treatment, and people are literally imprisoned in the hospital as long as the bill is not paid.[11] Treatment for gunshot injuries typically costs USD 100 or more—an impossible sum for most Burundians.[12] Even doctors, who earn USD 60 a month, would struggle to pay for treatment at the hospitals where they work. As a result, about 1 million people cannot access primary healthcare. Furthermore, no services exist to respond to longer-term rehabilitation and trauma counselling needs. As people with disabilities become a burden for their families, they even risk finding themselves rejected by the communities. The government acknowledges this situation but it has weak response capacity. International assistance for survivors is scarce: the most visible services offered are the classic reintegration packages for ex-combatants and child soldiers funded by the World Bank. No provisions were made in the peace agreement for civilians who have been injured or left disabled by the war or the continuing levels of violence since the peace agreement. They are in effect left behind as the country desperately wants to look towards the future.

KEY ISSUES AND RATIONALE FOR ACTION

The World Health Organisation estimates that "thousands of people are killed each year by those weapons, [and] millions more survive their injuries but are left with permanent physical disabilities and mental health problems."[13] As some 80% of people with disabilities live in low-income nations,[14] the provision of adequate services, from emergency medical care to long-term trauma care and rehabilitation services, and socio-economic assistance and vocational training, is, therefore, an issue of global concern.

The needs of survivors of armed violence are particularly acute in nations in transition from war. While peace agreements and assistance packages frequently include DDR programmes, as well as special attention to the needs of child soldiers, little to no provisions cater for civilian survivors of armed violence. This blatant neglect might stem from the discomfort of focusing on survivors in situations where most people want to move on from the war. While ex-combatants have some bargaining power and therefore attract attention, civilians are routinely overlooked. This situation not only leads to discrimination as care and rehabilitation packages are usually only available for ex-combatants, it also undermines recovery, perpetuates the cycle of poverty, contributes to the possibility of the resurgence of violence, and denies an important segment of the population a range of rights.

The right to health is indeed recognised and protected under international law, including in the Universal Declaration of Human Rights and in the International Covenant on Economic, Social and Cultural Rights, to which over 140 States are party. Providing medical and rehabilitation services to injured and disabled survivors of armed violence is therefore not an act of charity, but results from clear human rights obligations.

Focus on affected countries in the landmines process

The landmines process had its first Review Conference in 2004 in Nairobi, which provided an opportunity to examine implementation of the provision on survivor assistance. The outcome document of the Review Conference, the Nairobi Action Plan, identified 11 commitments in regard to survivor assistance. (See www.reviewconference.org for Final Report of Conference, including the Nairobi Action Plan.) Moreover, 24 States parties, thought to have the largest number of survivors, were selected for specific focus in the next four years. These include: Afghanistan, Albania, Angola, Bosnia and Herzegovina, Burundi, Cambodia, Chad, Colombia, Croatia, the Democratic Republic of the Congo, El Salvador, Eritrea, Ethiopia, Guinea-Bissau, Mozambique, Nicaragua, Peru, Senegal, Serbia and Montenegro, Sudan, Tajikistan, Thailand, Uganda and Yemen. Guided by a questionnaire, these countries have been charged with developing time-bound concrete objectives on how to provide effective assistance to survivors. The questionnaire is also a useful tool for other countries not part of the 24 and articulates six elements of survivor assistance: 1) Understanding the extent of the challenge faced (Data and information collection); 2) Emergency and ongoing medical care; 3) Physical rehabilitation; 4) Psychological support and social reintegration; 5) Economic reintegration, and 6) Laws and public policies. It is therefore not unfeasible for small arms foci to be added to these efforts in 24 nations in the coming years.

Source: Landmine Survivors Network, www.landminesurvivors.org/what_rights_minebantreaty.php

CRITICAL COMPONENTS

Critical components of a strategy to assist survivors of gun violence include strengthening the national health infrastructure to ensure the sustainability of assistance; ensuring access to affordable healthcare for example by establishing equity funds in connection with poverty reduction strategies; and building the capacity of health workers.[15] It is a long-term effort, and as such assistance to survivors is best considered beyond the framework of humanitarian assistance, to be integrated in broader reconstruction and development strategies, including violence prevention, public health, community development, human rights, good governance, and poverty reduction.[16] Importantly, lessons learned from the landmines process emphasise the need for a twin-track approach, disability specific when necessary, but also focusing on building up the overall health system of a country.

Another important aspect of assistance to survivors is the establishment of injury surveillance and data collection systems: "[d]ata on survivors is useful for identifying needs in particular areas and should lead to priority setting, adapting or introducing new programmes to meet the needs and rights of . . . survivors. The data are also a powerful lobbying and empowering tool for survivor groups and people with disabilities and should be made available to them in the appropriate format."[17]

SOLUTIONS IN ACTION

Many States already have experience with responding to the needs of survivors of other weapons systems, and structures and programmes therefore exist that can be tapped into. Some examples of such programmes are outlined below.

Data collection and injury surveillance

The scarcity of data on survivors of armed violence renders the provision of adequate services difficult. This obstacle was already faced a few years ago by organisations seeking to respond to the needs of mine victims. As a result, several countries have established comprehensive surveillance and data collection systems. For example, the Cambodia Mine/UXO Victim Information System is maintained by the Cambodian Red Cross and Handicap International.[18] Each survivor or their relatives is interviewed to collect information on casualties and the circumstances of the incident. Witnesses to the incident are also interviewed to crosscheck the information. Survivors are provided with information on available services. Monthly reports on casualties are then issued to facilitate the planning of actions. Such existing data collection systems could be emulated or extended to victims of small arms and light weapons. A recent report on assistance to victims of ERW acknowledges that "[i]n the longer term, the prospect of turning ERW and landmine casualty databases into more general disability or injury databases would be beneficial to better understand the disability situation and needs in a country."[19] This also applies to other surveillance injury systems.

National Action Plans

On small arms: As a first and practical step in fully implementing the Programme of Action, States could be incorporating survivors related foci in National Action Plans regardless of their context. Appreciating the scope and scale of needs nationally or in assistance programmes is critical and can be facilitated through the processes of developing such plans. Burundi has moved to include such a focus in its national action plan.

On mine action: Several countries have already initiated the process to put in place overall strategies of relevance to survivors of small arms and light weapons injuries. For example, the Croatian Mine Action Plan for 2005–2009 includes victim assistance and rehabilitation, mainly conducted by NGOs in cooperation with the Ministry of Health and the Ministry of Foreign Affairs.[20] In Mozambique, a draft national plan of action for disability is currently under review, and the mine action plan has been broadened to include all issues of violence and trauma, including family violence and road accidents.[21] In Uganda and Zambia, the main strategy is to mainstream mine victim assistance into development programmes.[22]

> "We can make substantial progress in the implementation of the Programme of Action by following the example of arrangements in the implementation of the Ottawa Convention on landmines where State Parties have assumed strong commitments to assist mine-affected States as part of their obligations under the Convention. The results have been most encouraging: at the meetings of State Parties each year, reports . . . show expansion in victim assistance. . ."
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> **—Nigeria statement at January 2006 PrepCom**

Linkages to poverty and development

As people with disabilities are so often the poorest of the poor,[23] they need to be a clear target of Poverty Reduction Strategy Papers (PRSP). It is therefore striking that improving the well-being and socio-economic prospects for the hundreds of millions of people with disabilities living in low-income nations does not feature as part of the Millennium Development Goals. For those surviving mines, ERW and small arms violence, economic independence is a vital concern. Bosnia and Herzegovina provides an example of one nation that has incorporated strategies for civilian war victims and combatants into its PRSP, setting key goals of improving services and socio-economic independence.[24]

Public health tax on firearms

Recognising that firearms represent a public health hazard, in December 2004 El Salvador introduced a tax on firearms similar to that imposed on tobacco and alcohol sales. Its proceeds go towards a 'Solidarity Fund for Health', to be invested towards health promotion, prevention of injuries, and medical consultations. It entered into effect in 2005

and its impacts have not yet been measured. Some USD 20 million is expected to be collected annually combined from all three items. Although the fund is not designed specifically for survivors of gun violence, it provides an interesting model of a policy of getting weapons owners to contribute to the costs of gun violence while levying additional resources for the public health budget.[25] This tax is applied to weapons either made in El Salvador or imported and sold in the country. Similar taxes could be generated in other States with weapons registration or owner licensing fees.

USAID Leahy War Victims Fund

In 1989, the US Agency for International Development created a fund to support and assist survivors of war violence. Named after Senator Patrick Leahy, who led its creation, the War Victims Fund focuses on cost-effective quality services for those injured in war in order to facilitate a return to work and community life.[26] It places a strong emphasis on "orthopaedic assistance within a framework of social and economic integration of the disabled", and works to strengthen national policies on disability in a wide range of countries including Angola, Sri Lanka, Lebanon, Nicaragua and Senegal. The work of the fund particularly aims to include people with disabilities in both the development and implementation of activities. Some USD 14 million is distributed annually to national, international and non-governmental organisations. The War Victims Fund provides a model for other donor agencies and governments to consider replicating.

> "At the beginning, family and friends were taking care of me, they came to visit, and were taking turns to watch over me. But now they are tired. It has been more than two years and a half that I have been here. They are not coming anymore, or only very rarely. My neighbours in the ward have taken over and take care of me now when I need something."
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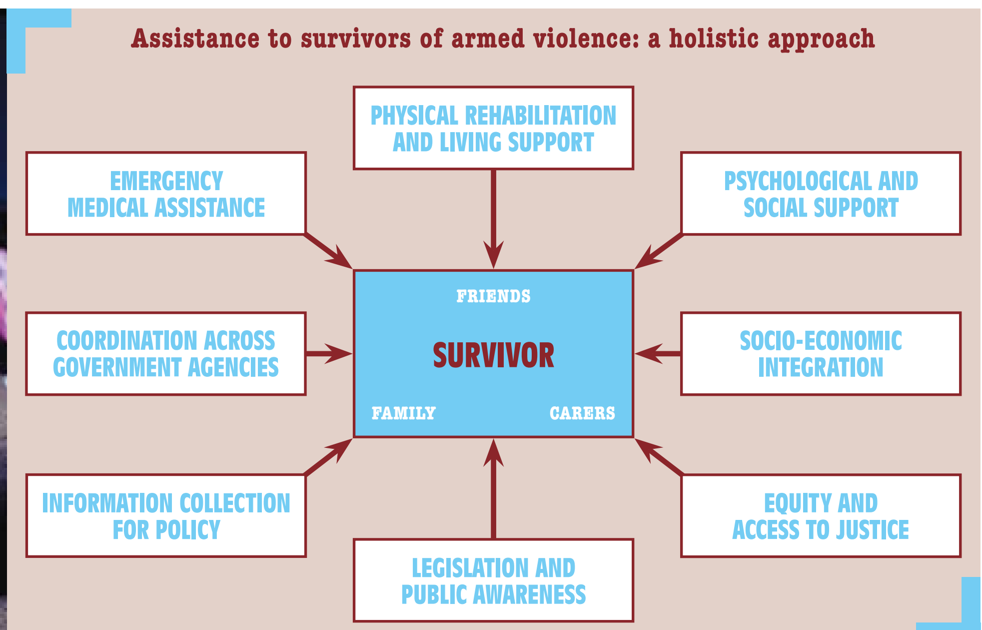
> **—Pierre Claver, 30 years old, Burundi, shot in the back while sitting in a bar with some friends in April 2003. Caught in crossfire between army and rebel fire he is paralysed and lived at the MSF Centre for Lightly Wounded, until it closed January 2006. The attack left two people dead and eight injured.[27]**

Public awareness campaigns

Both civil society and governments have developed a range of creative ideas to raise public awareness of the impact of small arms on the lives of people as an activity in implementing the Programme of Action. Given the significant levels of misunderstanding and ostracism that many individuals with disabilities experience, a focus can be added to awareness campaigns on the rights and contributions of those disabled by armed violence. De-stigmatisation is important for assisting survivors get back to work, community and family life.



Suzy, 27 years old, Guatemala, April 2006. In 2001 she was home when some children sought shelter in her house from gang members. The gang members fired through her window and she was shot in the spine. Photo by Heidi Schumann

Healing trauma and bearing witness

Support for victims of violence includes relief from and coping with the traumatic memories of armed violence, and strengthening the ability to re-establish social networks and normal every-day functions. The VIVO foundation has developed a treatment module in which survivors are assisted to integrate fragmented traumatic memories into a coherent recollection.[28] The objectives of this therapy are to heal trauma, promote reconciliation, and contribute testimonies, subject to agreement by the survivor, for the prosecution of criminal activities, human rights violations, war crimes and awareness-raising purposes. It has been applied in Uganda, Sri Lanka and Afghanistan, and research has demonstrated that community members can be trained to apply such psychotherapeutic assistance successfully to their own peers, and can break cycles of violence.

POLICY RECOMMENDATIONS

1. Identify gaps in service provision, including pre-hospital and hospital care, physical rehabilitation, and psycho-social support, and include them in national action plans on small arms, health, development, or poverty reduction strategies.

2. Support the development of injury surveillance systems, or expand on existing mine and ERW injury databases.

3. Include provisions for civilian survivors of armed violence in peace agreements and peace processes.

4. Support employment and income generation opportunities for survivors of armed violence, including families of people with disabilities.

5. Involve survivors in the development and implementation of programmes and policies.

6. Strengthen the links between the UN small arms process, other weapons control processes, and action around injury prevention and victim assistance, including people with disabilities.

SUGGESTIONS FOR ACTION AND FURTHER RESEARCH

1. Sustaining information collection—In war affected situations in particular many international agencies leave once the emergency is over and do not pass on data collected on deaths, injuries, peaks of violence, etc, for example for the development of national health and development strategies. Guidelines on consistent information collection, as well as appropriate strategies to hand over this information to national agencies, should also be considered.

2. Encouraging action-oriented research—There is an array of possible themes for investigation in the coming years, including:

- Approaches to incorporating survivors needs and rights into small arms national action plans, health, violence prevention and development strategies;
- Identifying good practices for post-hospital care in low-income settings;
- Responding to psychological trauma in settings with weak mental health services;
- Developing national funds and taxes for supporting government activities to meet the needs of survivors;
- Exploring the gender dimensions of surviving armed violence, and care-giving;
- Focusing on perpetration of armed violence, and strategies to reduce re-perpetration.

3. Developing synergies with mine and ERW action—Mine and ERW victim assistance has been given a substantial head start over other weapons processes through the political will and attention of governments and civil society. Given a large degree of crossover in numerous settings with the needs of survivors of gun violence, the development of synergies and operational guidance is now possible. □

ENDNOTES

1 Art. 6.3 of the *Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction* (Mine Ban Treaty) provides that ‘Each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programs.’

2 *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,* APLC/CONF/2004/5, Part. II, para. 69

3 See International Committee of the Red Cross and World Health Organisation (2000), *Victim assistance: A public health response for landmine victims,* p. 2

4 For a full analysis of statements at the Preparatory Committee for the UN Conference to Review Progress Made in the Implementation of the PoA, January 2006 see HD Centre et al (2006), *Overview of Governmental Statements made at the small arms PrepCom*, available at www.hdcentre.org/UN+process+on+small+arms+control

5 This includes all deaths from violence, not only gun-related mortality. WHO (2000), *Injury: A leading cause of the Global burden of Disease*, Geneva

6 World Health Organisation (2002), *World Report on Violence and Health,* pp. 274–5

7 UN Statistics Division. Available at: unstats.un.org/unsd/disability/
8 International Rescue Committee (2003), *Report on the prevalence of disability among refugees at Kakuma refugee camp, Kenya*. Prepared by Victor Mung'ala Odera, 29 December. Unpublished. Based on a house-to-house survey in a population of 82,700 refugees from nine nations. Any person found to have a disability was surveyed. The number of people detected was 2,846, with physical disability the most common type.
9 Helander, E (1998), *Prejudice and dignity: An introduction to community-based rehabilitation.* UNDP, New York, 2nd edition.
10 *Final report of the First Review Conference of States Parties to the convention on the Prohibition of the Use, Stockpiling, Production, and Transfer of Anti-Personnel Mines and Their Destruction,* Nairobi, 29 November–3 December 2004, APLC/CONF/2004/5, para 66
11 Correspondence with Fabio Pompetti, MSF Belguim, 25 April 2006
12 *UNDP Human Development Report 2005,* Burundi. GDP per capita in 2003 was USD 648 http://hdr.undp.org/statistics/data/country_fact_sheets/cty_fs_BDI.html; See also, Large, Tim (2005), 'Burundi war victims deprived of health care – MSF', *Reuters AlertNet,* 27 October.
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14 Helander, E (1998)
15 Maes, Katleen and Sheree Bailey (2005), 'Providing appropriate assistance to the victims of Explosive Remnants of War', in UNIDIR, *Humanitarian perspectives to small arms and explosive remnants of war,* Geneva, p. 54
16 Swiss Agency for Development and Cooperation (undated), *Victim assistance: a comprehensive, integrated approach,* p. 1
17 Maes, Katleen and Sheree Bailey (2005)
18 See www.redcross.org.kh/services/cmvis.htm
19 Maes, Katleen and Sheree Bailey (2005)
20 *Landmine Monitor Report: Toward a Mine Free World* 2005
21 *Landmine Monitor Report 2005;* Swiss Agency for Development and Cooperation (undated), *Victim assistance: a comprehensive, integrated approach,* p. 12
22 *Landmine Monitor Report 2005*
23 UK Department for International Development (2000), *Disability, Poverty and Development,* February
24 *Bosnia and Herzegovina Poverty Reduction Strategy Paper, Mid term Development Strategy,* April 2004. Available at www.imf.org/external/pubs/ft/scr/2004/cr04114.pdf
25 Based on an unpublished background paper prepared for the HD Centre by Dr. Emperatriz Crespin, May 2006
26 See www.usaid.gov/our_work/humanitarian_assistance/the_funds/lwvf/
27 Courtesy of MSF Belgium, May 2006
28 This therapy is referred to as Narrative Exposure Therapy. Unpublished background paper for the HD Centre from Vivo Foundation (2006), *Psychological consequences of violent experiences through firearms.* See www.vivofoundation.net for more details

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UK Department for International Development (2000), *Disability, Poverty and Development,* February

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ABOUT THE CENTRE FOR HUMANITARIAN DIALOGUE

The Centre for Humanitarian Dialogue (HD Centre) is an independent foundation whose purpose is to prevent human suffering in war. Our humanitarian approach starts from the premise that preventing and resolving armed conflict is the surest means of doing so, and to this end we promote and facilitate dialogue between belligerents. Through our work, we seek to contribute to efforts to improve the global response to armed conflict. Our operational engagements are complemented by policy and analytical work focused on civilian protection, mediation techniques, transitional issues, and arms and security matters. The Human Security and Small Arms Programme began in 2001. It includes a range of projects that aim to draw attention to the human cost of small arms availability and misuse, and to identify policy options for action by governments and other actors.

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