HUMANITARIAN ACTION TO EMPOWER THE MOST VULNERABLE SOCIAL GROUPS IN DISASTERS AND COMPLEX EMERGENCIES

HUMANITÁRIUS SEGÍTSÉGNYÚJTÁS A LEGSEBEZHETŐBB TÁRSADALMI CSOPORTOK MEGERŐSÍTÉSÉRE KATASZTRÓFÁK ÉS KOMPLEX VESZÉLYHELYZETEK SORÁN

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Abstract

This paper deals with the well documented problems of the most vulnerable and invisible social groups in disasters and complex emergencies, however, changes the focus of attention and action, furthermore analyses the possibilities of turning these threats into opportunities of empowerment. We identify the most vulnerable social groups – ethnic/religious minorities; children, pregnant and lactating women and children with disabilities – and investigate the impact of threats on them in selected disasters/complex emergencies. Empirical evidence has been collected about good practices on how to include the empowerment of these groups in humanitarian operations in these emergencies. These implemented operations show how humanitarian relief and development can be turned into a long-term opportunity of cooperation and empowerment of the most vulnerable communities.

Keywords

humanitarian action, vulnerable social groups, people with disability, development and empowerment, disasters and complex emergencies

Absztrakt

Ez a dolgozat a katasztrófáknál és komplex veszélyhelyzetekben a legsebezhetőbb és „láthatatlan” társadalmi csoportok jól dokumentált problémáival foglalkozik, azonban fel kívánja cserélni a figyelem és a cselekvés fókuszát, továbbá azt vizsgálja, hogy ezeket a fenyegetéseket hogyan lehet ezen csoportok fejlődésének a lehetőségévé változtatni. Azonosítjuk a legsebezhetőbb társadalmi csoportokat – etnikai/vallási kisebbségek; gyermekek, várandós és szoptató anyák; valamint gyermekek –, és vizsgáljuk a veszélyek okozta fenyegetettségüket néhány kiválasztott katasztrófánál/komplex veszélyhelyzetben. Empirikus bizonyítékokat gyűjtöttünk a jógyakorlatokra, hogyan lehet a humanitárius tevékenységek részévé tenni ezeknek a csoportoknak a megerősítését. Ezek a végrehajtott programok bizonyítják, hogyan válhat a humanitárius segélyezés és fejlesztés a legsebezhetőbb közösségek számára az együttműködés és megerősítés hosszútávú lehetőségévé.

Kulcsszavak

humanitárius tevékenység, sebezhető társadalmi csoportok, fogyatékkal élők, fejlesztés és megerősítés, katasztrófák és komplex veszélyhelyzetek

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Stakeholders of humanitarian response, both organisations and individuals agree that the most vulnerable groups in complex emergencies are children (especially those under five years), pregnant and lactating women, the elderly, women in general, people with disabilities, the geographically or culturally isolated, „second class citizens" for racial reasons, ethnicity, religion or political position. Most of the times and in most of the countries they had been vulnerable before the disaster happened or the complex emergency started and the disaster or complex emergency just worsened their situation.

The Pan American Health Organization maintains in Recommendations for the Care of Mentally or Physically Challenged Persons, and the Elderly in Emergencies that "in emergencies, the limited mobility of pregnant women, children, mentally or physically challenged persons, and the elderly mean that these groups are more at risk from the phenomena"[19].

This paper discusses three specifically vulnerable groups in society who are exposed to significantly higher risk than the majority of the population in complex emergencies, and analyses good practices from the experiences of Hungarian Baptist Aid, a major Hungarian relief, development and educational organization, how humanitarian relief and development can be turned into a long-term opportunity of cooperation and empowerment of the most vulnerable and invisible communities:

- Ethnic/religious minorities in conflict
- Children, pregnant and lactating women
- Children with disabilities

ETHNIC/RELIGIOUS MINORITIES IN CONFLICT: MUSLIM TAMILS IN SRI LANKA AND DISPLACED CHRISTIANS IN THE MIDDLE EAST

Muslim Tamils in Sri Lanka

The most persecuted religion in the world is Christianity [16] today, and the attacks on Christian churches and congregations at several locations of Sri Lanka at Easter in 2019 killing more than 250 people and injuring more than 500, proved that Christians living on the island do face lethal threats. The National Christian Evangelical Alliance of Sri Lanka (NCEASL) documented 94 attacks on churches, the intimidation of and violence against pastors and their congregations in 2019, and the obstruction of worship services, compared with 88 in 2018 [17].In retaliation of the Easter suicide attacks by the Islamic group National Thowheed Jamath, several mobs led by Buddhist monks and Sinhalese nationalists attacked and vandalized mosques, Muslim-owned businesses, and homes in May. The US State Department International Religious Freedom Report states that Sri Lankan "government officials continued to engage in systematic discrimination against religious minorities" and "government officials and police often sided with religious majorities and did not prevent harassment of religious minorities and their places of worship"[17], which meant persecution and harassment against Christian, Muslim and Hindu religious minorities. Focusing on disasters and complex emergencies in Sri Lanka, one of the marks of ethnic/religious minorities in these times are the Muslim Tamils, studied at the time after the 2004 tsunami.

The Sri Lankan Civil War broke out in 1983 between the government armed forces and the Liberation Tigers of Tamil Eelam (LTTE) that tried to establish 'Tamil Eelam', a separatist state [12].Unlike the majority Sinhalese and the minority Tamils, whose identity is based on language, history and traditions, Muslims in Sri Lanka have a special status as they identify primarily with their religion, Islam. Muslims are divided by several factors including language, residence on the island, profession, etc. Moreover, some Tamil nationalists still question whether there is a distinct ethnic group for Muslims or they are ethnic Tamils practising a different religion from the majority. As a result of pressure from both the Sinhalese and the Tamil groups, the apolitical Muslim community changed its attitude and strengthened its identity. Although they do have certain rights, Muslims are under-represented in the state structure, and they were not significant actors in Sri Lankan politics at the time of the 2004 tsunami.

The Muslim community had been frequently caught in the middle of conflict. Many Muslims in Sri Lanka are Tamil speakers and populate the Eastern and Northern regions, a Tamil Eelam area. In addition to that, government policies alienated Muslim minorities, and at the same time, they were still targeted by armed separatists for their supposed role in conflict. No wonder that all sides treated Muslim groups with suspicion and did not make them parties to negotiations, while the problems of Muslim community were ignored and that caused severe consequences [12].

"With over 500,000 internally displaced persons, international agencies struggled to locate many of the 'refugees' [more precisely, internally displaced persons, IDPs] to deliver the appropriate humanitarian aid that is required"[13]. The underdevelopment of peripheral regions limited economic opportunities, thus IDPs were not self-reliant, were often sustained only by the World Food Program that fed 90% of the displaced [10]. The state and multilateral agencies were required to provide rehabilitation and reparations to destroyed villages and communities with particular attention in the Jaffna region[13].Muslims required insurances for maintaining their security in temporary settlements, coupled with security for their possessions [2]. Livelihood opportunities were not delivered free of political persuasion for displaced Muslims impeding them to become self-sufficient thus causing mental and physical vulnerability and insecurity. This created further social distance between the minority Muslim group and other majority groups.

Needless to point out again that the regions and settlements where the Muslims lived were the most neglected in the tsunami response, unfortunately not only by programs implemented by the Sri Lankan government but by the international humanitarian community as well. While the Hungarian Baptist Aid focused on the region stretching from Colombo to Hambantota with emergency medical assistance, emergency humanitarian assistance, house reconstruction and livelihood, then later with major long-term education, child protection and agricultural programs among the Sinhalese and Christian population, and worked on the island for several years; neither did we lose sight, nor focus to empower the "invisible" and vulnerable group in the East. I worked in Sri Lanka over an extended time in 2005, and visited the neglected areas of Ampara, Kalmunai and Batticaloa region in the East Coast again 16, 26 and 38 months after the tsunami, it was evident that neither the relief, nor the rehabilitation efforts in this region were nowhere close to that of Colombo, Galle and Hambantota.

The Hungarian Baptist Aid received an indication of this group and started to provide immediate emergency relief from 30th December 2004, just a couple of days after the devastation of the tsunami. We continued the relief and rehabilitation activities for 18 months in different forms of water, food, livelihood, job creation, vocational and education programs aiming mainly at the children of the Muslim population of the Ampara, Kalmunai and Batticaloa region both at the institutional and individual level.

Displaced Christians in the Middle East

Another example of ethnic/religious minorities in complex emergencies are many of the refugees and IDPs in the Middle East who were persecuted for their faith and religious backgrounds (Christians, Yazidis and others) and were uprooted by conflict. Displaced Syrians are the largest number of forcibly displaced people in the world with 6.7 million IDPs and 6.6 million refugees; these two groups account for over half of the country's population. Turkey, Lebanon, Jordan, Iraq and Egypt are the major recipient countries with approximately 5.5 million Syrian refugees [25].Lebanon is the country with the largest number of refugees per capita in the world: an estimated 1.5 million Syrian refugees, a large percentage of them are Christians, approximately 18,000 refugees and asylum-seekers are from Iraq, Sudan and other countries in addition to the 200,000 Palestinian refugees under UNRWA mandate [24]. The vast majority of these refugees are women and children; many are widowed and orphaned because their Christian husband/father had been killed. One in four people in Lebanon is a Syrian refugee and one in three people is a refugee in general. According to UNHCR, 73 percent of Syrian refugees are living below the poverty line and 55 percent below the extreme poverty line [24].As the economic crisis in Lebanon continues, refugees will become more impoverished.

Lebanon is different from its regional neighbours in that respect that it has a high level of religious diversity and safeguards promoting religious freedom. Christians comprised 40 percent of Lebanon's population in 2015, however, this number decreased to 33 percent in 2019 [6].Lebanon is considered a relatively safe haven for people of all faith and religious backgrounds from several countries; persecuted Christians, Yazidis and other refugees from around the Middle East may find a place that will protect their right to religious expression. However, in the past years, harassment and atrocities against religious minorities increased, and while Christians in Lebanon do not face the same kind of persecution as Christians in other parts of the Middle East, the emigration trend among the Christian Lebanese youth has accelerated to an alarming condition.

The Hungarian Baptist Aid has been working with local partners since 2006 providing not only relief to the displaced in Lebanon and Syria (food and hygiene assistance, winterization items, health services), but has placed great importance on empowering individuals and education. Vocational trainings (sewing, hairdressing, AC and electricity installation and repair, adult literacy, and computer classes) and agricultural assistance have supported the individual dignity, self-reliance and sustainability of these people. Refugee and IDP children are traumatized, left their homes, friends and everything they held on to, behind and are also out-of-school. Education is not only about transferring basic knowledge; attending school provides displaced children with a safe place to play and develop, gives them hope for the future, provides routine and a sense of normalcy, a place to make friends and build social skills, serves as a protection tool by decreasing common risks for refugee

children such as abuse, child labour, early marriage, exploitation, trafficking, and radicalization. Through our local partners, non-formal education and psychosocial support have been provided in nine learning centers in Lebanon and in three child friendly spaces in Syria. We also support two Christian schools in the Bekaa Valley and in Beirut, the latter suffering great damage as a result of the port explosion on 4 August 2020. The Hungarian Baptist Aid immediately sent a team to provide not only humanitarian and emergency medical assistance, but also support the renovation of the damaged school building in Beirut. Many non-Christian children are also enrolled in Christian schools for quality education and for the mindset of teaching students to be lifelong learners and good citizens – based on Biblical values. Christian schools in Lebanon are role models of respect, tolerance and dialogue that are essential for durable peace in a country torn by sectarian conflict.

CHILDREN, MOTHERS, PREGNANT AND LACTATING WOMEN

Alberto Minujin et al in Children Living in Poverty rightly insist on the well-established phenomena that "children are the most vulnerable group in conflict and emergency situations. Children are too often forced to flee their homes, witness atrocities or even perpetrate war crimes themselves. Children are not responsible for war, yet it robs them of their childhood."[15] Disasters and armed conflict do not only deprive them of their immediate needs, such as shelter, proper nutrition, healthcare, but also of their future opportunities by disrupting or impeding their education, while affecting their whole lives by suffering from emotional, physical and sexual abuse.

This latent vulnerability can pave the way for real dangers compromising the well-being of children. Additionally, the wellbeing of children has a long-term effect on the development of society. Reaching out to children is therefore of great importance: it is not only a requirement of humanity and social justice, but "represents an essential element of any development strategy which aims to reduce the prevalence and structural reproduction of poverty overall"[29].

In order to develop a strategy to target children in complex emergency situations, we need to conceptualize our approach for children in general. White continues to suggest that there are two main approaches to be found:

- considering children basically as individuals, as a social group with their own rights, needs and entitlements
- considering children as a part of a social group – most importantly, the family – and emphasising their embeddedness[29].

However, we need to tailor assistance specifically to children – one of the most vulnerable groups – while maintaining a holistic approach and not separating our assistance from the support to the social structures ensuring the safety and wellbeing of children. Sarah White goes on to argue that "a mother and her children constitute the basic unit, to which the children's fathers and other relatives are attached in a variety of arrangements"[29]. It is especially the type of these arrangements that accounts for a specific family model – which is of course mostly different from the one that shaped the minds of relief workers.

Similar observation applies to the other category of vulnerable persons in a complex emergency: pregnant women, women with small children (lactating women) and to some extent women in general. The special needs in health services and nutrition also need to be

addressed in emergencies, and it is important to find the way how these groups may be targeted and supported both as a part of the family, and also individually in a very well targeted manner.

Afghanistan

The Hungarian Baptist Aid has implemented several projects in complex emergencies with a special focus on children and maternal health. An example of this is our work in Afghanistan that alloys the attributes of a development project and of humanitarian assistance. The first humanitarian assistance was delivered in the autumn of 2001. In the coming years several health and education programs were delivered focusing especially on women. The Hungarian Baptist Aid began the training of qualified mid-wives in the province of Baghlanin in 2007 as severe shortage was reported in their numbers. Midwives were important and respected in the Afghan society, however, only 467 birth attendants[22] remained in the country of 26 million by 2002; the rest of them died or fled abroad, although the estimated number necessary to provide only the basic services in the country was 8,000-10,000. The number of 'graduated midwives' according to the Afghan Midwifery Education and Accreditation Board report rose to 3,001 by 2012 [11].Just 8 percent of women delivered their babies with the assistance of a midwife in 2002, 19 percent in 2006, and the Ministry of Public Health's 2010 survey already showed that 34 percent of deliveries were attended by skilled birth attendants[11].Afghanistan's maternal mortality ratio was the highest in the world: 1,800 deaths per 100,000 live births in 2000 and 1,400 deaths per 100,000 live births in 2008, in Chad and Sierra Leone 1,300 deaths per 100,000 live births in 2000, while Hungary's maternal mortality ratio is only 10 deaths per 100,000 live births[31].

The Afghan Ministry of Public Health together with the WHO and the Johns Hopkins Program for International Education in Gynaecology and Obstetrics developed the 18-month-long Community Midwives Education Program. The Hungarian Baptist Aid and its local partners used this program to contribute to the achievement of the following Millennium Development Goals:

- promoting gender equality and empowering women,
- reducing child mortality and
- improving maternal health.

The objective of this project was to reduce infant and maternal mortality and contribute to the wellbeing of mothers and their children through the training of healthcare staff. The following is a selection of the 27 modules taught: the role of the community midwife, nutrition, anatomy, family planning and reproductive health, immunizations, hygiene and prevention of infections, pre-natal care, STDs, care for rape victims, delivery, complications, care for the newborn, care for children with birth defects and disabilities, supervision, ethical challenges.

Children who die before they would be born, or are born with disabilities, or die within weeks of their birth, and their mothers who might also die or fall ill after giving birth, are the invisible vulnerable group of this complex emergency. An important element of the project was that it also contributed to the integration of women on the labour market since it provided women with a profession with growing demand for midwives in rural Afghanistan.

The multiplier effects of this project were especially important since the selected midwives returned to their rural communities after the training, thus the areas without obstetric care or without female health care personnel were provided with professionals. As the statistics cited above prove, a significant decrease in infant and maternal mortality was seen in the coming years as a result of the project.

Democratic People's Republic of Korea (North Korea)

The second program to serve as a case study is the one in the Democratic People's Republic of Korea (North Korea), which can be categorised as a prolonged and complex crisis. The Hungarian Baptist Aid worked in the DPRK from 1998 and selected children living in orphanages and in hospital care as its main target group, since even their very survival was dependent on external aid. When HBAid started to work in the DPRK in 1998 just after the great famine that had claimed the lives of approximately 1.5 million people, the under-five child mortality rate in the country was 72.9 deaths per 1000 live births in 1998, that decreased to 33 in 2005 and to 18.2 in 2018[27], while the same under-five child mortality rate in Hungary was 11.1 deaths per 1000 live births in 1998, 7.5 in 2005 and 4.3 in 2018[28].

"The imperialist propaganda tries to make the world believe that two million people died of hunger in our country in the last few years – this is certainly a lie. The subsequent natural disasters unfortunately claimed 220,000 lives according to our government's data", the general director of the Flood Damage Rehabilitation Committee informed me at a business dinner in the five-star Koryo Hotel in February 2002. Jean Ziegler, the UN Human Rights Special Rapporteur on the Right to Food said at a press conference held with the World Food Program in Geneva on 7th April 2004 that the North Korean humanitarian "tragedy has been going on for almost ten years, and according to secondary sources, five to seven percent of the total population died of hunger, malnourishment and related illnesses."[7]Considering the population of approximately 22 million, this means 1.1–1.54 million deaths [18]. A UNICEF colleague told us in a confidential conversation in 2002 that their findings showed that nine out of ten children were malnourished, six were starving and one died of hunger.

Considering the limits of humanitarian work imposed by the political structures of the country, humanitarian assistance had to focus on the support of institutions, but at the same time assurances had to be met that the target audiences were reached and the resources were not wasted or diverted by the regime. For these very reasons, HBAid rehabilitated the kitchens and donated washing machines to the orphanages in Sariwon city, 80 km south of the capital, Pyongyang. Other targeted assistance included food aid in the form of high-nutrition baby food and high-energy biscuits, furthermore, nappies, shoes, winter and summer clothes for children were provided, since these were indispensable for the wellbeing of infants and children (in this case due to their very survival), and also unlikely to be diverted from our target group. HBAid donated school supplies and toys to children both in child care institutions and those in hospitals, in addition to X-ray, ultrasound and laboratory equipment, surgical tools, IV fluids and special medications to the paediatric hospital and the provincial hospital of North Hwanhae Province.

Nias, Indonesia

As a third example, let us analyse a project that initially did not target the vulnerable populations discussed here, but a significant element still benefited them. The Hungarian Baptist Aid provided emergency and mid-term medical assistance to the inhabitants of the island of Nias, Indonesia in 2005-2006. 400,000 people live on this small island, most of them in several hard-to-access villages without any health care institutions or with as little as a minor health check-point and most islanders are unable to seek medical care on the island of Java. The surfing island, severely hit by the 2004 Christmas tsunami, was gravely damaged again three months later by the 2005 Easter earthquake in March, causing immense suffering and traumas for the population.

Since Nias had only one hospital in each of the two cities, Gunungsitoli and Teluk Dalam, and a dozen doctors on the island, HBAid set up mobile health care facilities with both Hungarian medical professionals, doctors and nurses who had been hired from other islands of Indonesia. These mobile health care facilities were made accessible for most of the rural population on a regular basis. 37 percent of the people who received health care at these mobile clinics were children. We treated more than 40 pregnant women, lactating women and women with small children: they received pre-natal care, small surgeries, special vitamins and general counsel.

During the implementation phase of the project the significant impact on these specific target groups was identified. However, as a lesson learnt from this project, a greater emphasis on these vulnerable groups in the planning phase could have strengthened the project, and an additional child-centered element could have contributed to the multiplication of the effects.

On a side note, we have to mention, that during our 18-month program we faced the sad reality of the rejection of the "Do No Harm" principle [1] by several agencies of the international humanitarian community. The two hospitals, destroyed by the subsequent tsunami and earthquake, were flooded with expired or unknown agent medicines. Such a practice is not only useless and burdens the already overwhelmed capacity of the local health care system, but also creates environmental pollution and financial burden as the Indonesian authorities had to dispose of them, and that is exactly what the "donors" did not want to pay for in their home country.

CHILDREN WITH DISABILITIES

"In emergencies, the limited mobility of pregnant women, children, mentally or physically challenged persons, and the elderly mean that these groups are more at risk from the phenomena", underlines the Pan American Health Organization [19].

If we suppose that children are vulnerable in complex emergencies, then children with disabilities are even more so. Children with physical disabilities, accompanied by mental disorder and, in many cases, with speech impairment, are the truly invisible victims. Not only are they neglected, hidden, ashamed of, but as we ourselves have experienced in several countries, they are regarded and treated as not part of human society.

The Hungarian Baptist Aid started to be involved in the rehabilitation, aid and the empowerment of children with disabilities by actively promoting their integration into society in 1997 both in Hungary and abroad. We have realised that there is growing demand

in the support for motor disabled children especially in those countries where there is no capacity for the advocacy of the disabled because of the lack of the necessitated infrastructure and professionals as a result of the inordinate circumstances in society and/or the political and economic environment.

Function Language and Movement Education Program

HBAid professionals have developed the Function Language and Movement Education [23]Program based on the Hungarian Pető-method known world-wide for patients suffering from neural disorders (such as cerebral palsy, Parkinson-syndrome, sclerosis multiplex, etc.), for those who had a cerebral accident or suffered from a head injury. The program provides an opportunity for complex education of motor disabled children, their families, conductors [special education teachers for children with disabilities using the Pető-method] and of the prospective conductor assistants as well. Following the adaptation of the method, it enables the parents and local conductors to direct special therapy. Altogether, it allows the integration of motor disabled children into society and community, as well as the development and restitution of their human relations.

The Function Language and Movement Education Program is truly holistic and not only in the physical and educational rehabilitation of the children. Parents of children with disabilities also face another hardship: since the child requires 24-hour supervision in the majority of the cases, either one of the parents need to stay at home and cannot hold a formal job, thus the family has a loss of income, or an older sibling needs to stay at home impeding her/his further education or work opportunities. Thus, while providing education and development for disabled children through the day in the center, the FLAME program also serves as poverty alleviation for parents, who can return to the job market. Additionally, it provides another job opportunity for teachers, besides the great benefit of raising awareness about status and empowering children with disabilities in society.

The first target-country of the FLAME programme was Albania, where HBAid have established a rehabilitation center. In 2000 the program was expanded to Kosovo, establishing a FLAME center in Pristina. HBAid sent regular conductor teams to work with the disabled children in the refugee camps of the Western Sahara between 2002 and 2006. The FLAME center in Topolya, Vojvodina, Serbia was opened in September 2003. HBAid has implemented FLAME projects in Jordan for Iraqi and Jordanian disabled children and their teachers in 2005, a new center was established in Ma'an, and the institutions of our partners were founded in Amman and Aqaba, then in Iraq as well. HBAid continued to work with FLAME in Cambodia (Phnom Penh), Vietnam (Hanoi) and Mongolia in 2006-2007. HBAid extended its FLAME project to Kandal Province in Cambodia and to Sri Lanka in 2008. Several new centers were established in Bac Giang Province in Vietnam in 2008-2009, Haiti in 2011-13, later in Tay Ninh and Da Nang Provinces in Vietnam in 2016. All these initiations resulted in operational FLAME centers, teachers have been trained and the abilities, physical, speech and mental capacities and independence of disabled children have been greatly developed.

The FLAME program was the most extensive in Cambodia, Vietnam and Haiti of these countries, however, for the purposes of this paper we will analyse those in complex emergencies: Kosovo, Western Sahara and Iraq/Jordan.

Kosovo

In the Kosovo conflict roughly a million ethnic Albanians fled or were forcefully driven from Kosovo, several thousand were killed (the numbers and the ethnic distribution of the casualties are uncertain and highly disputed). The Mother Teresa Society reported 534,530 IDPs by 1st October 1998, 63% of these were estimated to be children and 25% to be women [8] by the NGO Centre for the Protection of Women and Children, as men and teenager boys often stayed behind to protect the family property, whilst women and children sought safety in the woods and hills.

"Kosovo also has the highest infant mortality rate in Europe at 23.6 per 1000 live births. The 1996 Multiple Cluster Indicator Survey for FRY [Former Republic of Yugoslavia] put the infant mortality rate at 16.8 and the under-five mortality rate at 19.4 [per 1000 live births]. The rate must almost inevitably have risen during the conflict due to the breakdown in already insufficient maternity services and post-natal care in the areas of conflict."[8] Children were already a vulnerable, high-risk group during the Kosovo war, but even more so disabled children. As Carolyn Hamilton reported "disabled children have suffered considerably during the conflict. Handicap International (HI) reports that the lists of children attending their community centers were no longer valid. Families were either missing or displaced or too terrified to re-register. Many of the centers had been destroyed and looted, including the wheelchairs. Many of the disabled children have catheters which need changing and the absence of medical attention may result in these children contracting kidney infections and sores."[8]

The Hungarian Baptist Aid, among other feeding, non-food, shelter and reconstruction projects, as a practical response to the urgent needs of the most vulnerable group, started to implement the FLAME (Function Language and Movement Education) program in July 2000. Katalin Szenczy, the project manager spent the first month evaluating the disabled children in and around Pristina to be able to pick those who would later be the beneficiaries of the program. The selection process was solely based on physical state, thus Albanian and Serbian beneficiaries could likewise participate, and this already had an enormous reconciliation effect on its own. Our FLAME specialists have worked with the children, developing their skills, physical, intellectual and emotional capacities and strengthening their coping mechanisms. However, at the same time they also trained the staff and volunteers of our local partner to be able to continue the FLAME program even after the Hungarian team left Kosovo. The Kosovar project leader was confidently trusted to take over the responsibilities of the program from the summer of 2001.

Western Sahara

Refugee camps are meant to be for emergencies, but protracted refugee situations are becoming almost the norm. The average time refugees spend in camps has extended to 17 years. Western Saharawi refugees still live in camps in a harsh, remote corner of Western Algeria. These camps were established in November and December of 1975 in order to provide food, shelter and medical care for the estimated 65,000 refugees who had fled their homeland after the Moroccan occupation of the Western Sahara territory. Negotiations to resolve the 29-year-old dispute in Western Sahara remained stalemated in 2003, forcing the by then 165,000 Saharawi to languish in Smara, Laayoune, Asward, and Dakhla refugee camps near the Algerian desert town of Tindouf. Hungarian law enforcement and military

officers were involved in stabilizing the region, according to Besenyő's research, 25 Hungarian police officers and 106 military personnel served in MINURSO, the United Nations Mission for the Referendum in the Western Sahara peace missions between 1995 and 2018 in several tours [3] [4].The world seems to have forgotten the Saharawi people who have struggled to survive in extreme conditions and unbelievable poverty for 45 years, by now, since the occupation.

Life is extremely harsh in the camps that grew into towns by now: with temperatures up to 55 degrees Celsius in July and August, sandstorms are frequent, drought is constant, and the rare torrential rains are devastating. Even soil is imported for the very limited agricultural production. Lambs and camels are kept in the camps, but goats are the most preferred animals, as they provide milk and can be consumed completely. As a result of the ailing circumstances, the lack of resources, food and vitamins; food insecurity prevails among the refugees who have limited opportunities for self-reliance and depend on humanitarian assistance for their survival. "The 2018 Food Security Assessment confirmed the dependence of the Sahrawi camp population on food assistance; 30 percent of the population is food insecure, while 58 percent is vulnerable to food insecurity. Only 12 percent of the Sahrawi population is food secure… WFP currently represents the main regular and reliable source of food for the Sahrawi refugees in Algeria"[30] even in July 2020. Families without livestock are more prone to hunger and malnutrition. By 2003 acute malnutrition rate has been above 10 percent for years, chronic malnutrition, typified by stunting, was more than 30 percent [26]. "Global acute malnutrition among children of 6-59 months increased from 4.7 percent in 2016 to 7.6 percent. The anaemia prevalence among children 6-59 months is 50.1 percent, and 52.2 percent among women of reproductive age." [30]

Of all the people in Western Sahara, people with disabilities, and their families are in the most destitute situation, because they have to struggle for the simplest things in life. They have to cope with social marginalization and ridicule. The circumstances hit them worse, approximately 20% of children with disabilities suffer from acute malnutrition. There are significant needs in Western Sahara for the establishment of equal opportunity for socially disadvantaged groups, and in particular equal opportunity for people with disabilities. We are still a long way off ensuring general education and rehabilitation for a wide range of handicapped children in Western Sahara. The infrastructure and social institutions, as well as the team of trained professionals are either weak or missing. There were two schools for children of special needs for the four camps in 2002: one in the Smarra camp and the other one in Laayoune.

The Hungarian Baptist Aid worked in the refugee camps of Western Sahara from 2001 to 2006. HBAid provided vitamins, livestock, medicines, shoes, school supplies and toys to fight malnutrition and support the healthy growth and education of the refugee children. Starting in 2002, our conductors surveyed and examined the motor disabled children as prospective students for the FLAME program; they registered 198 motor disabled children. Most of them were not able to attend school and take care of themselves, thus they were dependent on family support and felt to be a burden for their families. A building was furnished with special FLAME furniture and equipment in the Laayoun camp for the conductive education where HBAid conductors and nurses provided practical training sessions for the "physiotherapists" of the camps with the goal of helping the children walk better,

move and use their limbs more easily at first, and then to be integrated into the school system, until they were finally more independent and felt more confident in life.

Iraq and Jordan

Considering the Iraq conflict, the Hungarian Baptist Aid wanted to focus on a small, but important segment of an invisible vulnerable group of children with disabilities. The FLAME program was intended to be carried out in Iraq as part of transition to development, but the donor, the Hungarian Ministry of Foreign Affairs requested HBAid to implement the program in Jordan due to safety reasons. HBAid invited Iraqi specialists and doctors from Baghdad and the Iraqi countryside to Jordan to participate in the training in cooperation with several local partners in 2005. Again, the goal was to empower children with disabilities by assisting them in their day-to-day lives, promoting their social integration and raising awareness in the wider public about the grave importance of the development and education of children with disabilities.

The main objective of the program was the conductive education of Iraqi specialists, their preparation to work independently with children with disabilities, to be able to teach and develop them. Additionally, Jordanian teachers and specialists also received training and equipment for the benefit of the Jordanian children. After the training HBAid provided the necessitated special equipment and furniture to the Iraqi specialists and the Iraqi center was duly equipped to work with children with disabilities. As stated before, with having the training conducted in Jordan with Jordanian partners, an additional result was obtained: a new center was established in Ma'an, and the centers of our partners were founded in Amman and Aqaba with Jordanian teachers.

CONCLUSION

As underlined before, most of the stakeholders of humanitarian response, both organisations and individuals agree that the most vulnerable groups in complex emergencies are children (especially those under five years), pregnant and lactating women, the elderly, women in general, people with disabilities, the geographically or culturally isolated, the „second class citizens" for racial reasons, ethnicity, religion or political position. Most of the times and in most of the countries they had been vulnerable before the complex emergency started and the complex emergency just worsened their situation.

"Decisions made for the appropriate and timely protection of the most vulnerable groups, during and after emergencies can make the difference between suffering further physical and emotional harm", suggests the Pan American Health Organization [19].

It is for us, humanitarian workers and agencies that these groups of invisible vulnerable victims shall be visible, appropriately and adequately assisted and helped in order to gain back their "normal" lives or even a higher standard as soon as possible.

We, humanitarian professionals do not merely save lives and alleviate human suffering. We aim higher: to uphold and uplift human dignity even in the most challenging emergencies.

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