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Surviving Armed violence

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The Geneva Declaration on Armed Violence and Development (2006) recognizes that ‘armed violence kills—directly and indirectly—hundreds of thousands of people each year and injures countless more, often with lifelong consequences’. Indeed, an estimated 740,000 lives are lost each year to armed violence, including some 526,000 as a direct result of such violence (Geneva Declaration Secretariat, 2011a, p. 43). Survivors, on the other hand are, quite literally, ‘countless’. Ratios ranging from one to eight survivors for every fatality are circulating (Small Arms Survey, 2012, pp. 92–94), but there is no reliable estimate of their numbers.

The arms and explosives used to commit armed violence are addressed in a number of legally and politically binding instruments on, for example, landmines, cluster munitions, and small arms and light weapons, to name only a few. ‘Victim assistance’, however, has so far only been addressed in connection with explosive weapons. This is problematic because between 42 and 60 per cent of lethal violence around the world is committed with firearms (Geneva Declaration Secretariat, 2008, p. 67; UNODC, 2011, p. 10). Limiting the focus to particular types of weapons victimisation may lead to a range of unintended and discriminatory outcomes—such as the inability to access support because funding for a particular programme relates to only one weapons type. In the lead-up to the renewal of the Millennium Development Goals in 2015—this time with a solid focus on armed violence, disability, and development—what is needed is rather a strategy for all



Joe Davis, who was paralysed as a result of a shooting, leads a protest march against gun violence in Philadelphia, USA. © Mark Stehle/AP, October 2007.

This Geneva Declaration Policy Paper is one of a series designed to support policy decisions for the ongoing debates about the development framework that will follow the Millennium Development Goals. This series will position armed violence reduction and prevention in the broader context of sustainable development to show how dealing with violence can have a positive developmental impact. Based on current evidence, the papers seek to highlight approaches that, it is believed, will reduce and prevent armed violence.

These Policy Papers are produced by the Secretariat of the Geneva Declaration, and their contents do not imply endorsement by the countries that have adhered to the Geneva Declaration.

survivors of armed violence that is inclusive, non-discriminatory, and effective.

Signatories of the Geneva Declaration are well placed to spearhead such a strategy. Indeed, in 2011 participating states committed to

recogniz[ing] and ensur[ing] the rights of victims of armed violence in a non-discriminatory manner, including, inter alia, provision for their adequate care and rehabilitation, as well as their social and economic inclusion (Geneva Declaration Secretariat, 2011b, para. 10.e).

This Policy Paper explores some of the issues that should be considered in such a strategy in order to respond more effectively to the rights and needs of survivors of armed violence. The paper is divided into three sections, addressing in turn issues related to health care, justice, and social protection. Each section explores major elements and provides examples of good practice.² A number of policy recommendations are offered by way of conclusion.

Health care

The right to health is firmly enshrined in international human rights and humanitarian law. In cases of injury and trauma (direct victimization), health care starts with timely and effective emergency medical assistance to save lives and reduce impairments. However, just getting to a medical facility in many countries is problematic. The World Health Organization estimates that some 50–80 per cent of traumatic deaths occur prior to hospitalization in low- and middle-income settings (Mock, 1998, pp. 802–12). Significant improvements to trauma response systems can be achieved through simple and often low-cost measures, such as having one national emergency phone number and coordinating ambulance services (WHO, 2005).³ First responders can also make a difference: these are not always trained medical personnel, but can include community leaders or pharmacists, for example. They can benefit from targeted first aid training and accurate information on which hospitals have appropriate trauma-care facilities (WHO, 2004, pp. 75–78; 2005, pp. 21–28, 41–42).

Once the injured person is in a medical

Box 1 Defining ‘victim’ and ‘survivor’

The term ‘victim’ is only used in this paper in a legal sense, in connection with criminal justice processes, recognizing the ground increasingly gained by ‘victims’ rights’. In all other contexts the term ‘survivor’ is preferred for its empowering connotation and in order to recognize developments in this area related to people directly affected by violence and crime. Survivors are defined as persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss, or substantial diminution of their fundamental rights due to the misuse of arms or explosives. This includes, where appropriate, the immediate family or dependants of the direct victim and persons who have suffered harm in intervening to assist victims in distress or to prevent victimization.⁴ This definition also covers indirect victimization (e.g. witnessing crime, losing a loved one to armed violence, etc.). It also considers additional harm suffered through inappropriate responses, such as negative treatment from and attitudes among police that reinforce trauma, generally referred to as secondary victimization.

facility his/her chances of survival depend on the material and human resources available. Raising the standards of trauma care is a leading priority to save lives, but also to reduce the probability and level of future impairment (Kroll et al, 2014, p. 87).⁵ The careful coordination and reassessment of resource allocation are important, but inexpensive first steps in improving responses. Professional associations of trauma surgeons have a key role to play in setting standards and developing training programmes, and should be supported.⁶ New techniques leading to improved survival rates have been developed in crime- and conflict-affected areas where resources are limited. Damage control surgery, for example, was developed in areas with high rates of gun crime, leading to innovations such as the ‘Bogotá bag’—a simple plastic sheet stitched into the abdominal wall instead of closing the abdomen, which stabilizes patients and buys time before the main surgical

intervention (Hardcastle et al., 2014, pp. 72–73). Such innovations should be publicized and adopted more widely.

Secondary victimization and discrimination occur when health-care providers (and others) are insensitive and/or partial in their care of survivors of armed violence. This can affect people rightly or wrongly perceived to be associated with a particular gang, armed group, party, or community. The stigmatization of gunshot patients based on their socio-economic profiles—e.g. poor young men from a particular ethnic background—is mentioned time and again by survivors of armed violence. It can act as an impediment to engagement in rehabilitation and self-care, leading to secondary health conditions and continued involvement in gangs if an individual perceives the social support on offer is judgemental (Devlieger and Balcazar, 2010).

Hospital stays can last weeks or months. Ideally, after a period in a medical facility, individuals will be moved to rehabilitation institutions. This is particularly important in cases of impairment, which is a common consequence of armed violence.⁷ However few countries have robust rehabilitation facilities; indeed in at least 62 countries no rehabilitation services are available (South-North Centre for Dialogue and Development, 2006, p. 32). Accessing prosthetic devices and other equipment needed by survivors is also problematic, e.g. in many low- and middle-income countries only 5–15 per cent of people with impairments are able to acquire assistive devices such as wheelchairs (WHO, n.d.a).

Psychological trauma is another critical—and overlooked—area for attention (see WHO, n.d.b). Armed violence has both physical and mental impacts. For those who survive such violence without physical injury, including through secondary victimization, attention/treatment is especially meagre. Guns are used to threaten and coerce—e.g. to kidnap for ransom or commit sexual violence—far more than they are used to kill. Mental-health challenges are also experienced by survivors who have to learn to live with permanent impairments, reduced



A doctor in the Democratic Republic of Congo's Equateur Province holds up an X-ray that shows where a bullet pierced a three-year-old girl's right lung.

© Gwenn Dubourthoumie, 2010

mobility, and the inability to care for themselves and others, which involves developing a new identity. The loss of independence can be particularly difficult for men, because it challenges their notions of masculinities and power.

When they are discharged from hospital individuals and caregivers must receive adequate information and support to prevent complications (such as pressure sores and urinary tract infections). In reality, survivors often die from such secondary conditions months or years after the initial violent incident. Sometimes civil society steps in to provide this information. Many of these initiatives fall into the category of community-based rehabilitation (CBR). Initially a strategy for delivering primary health-care and rehabilitation services to people living with disability in low-income countries, CBR is now viewed more broadly as a multisectoral approach to inclusive community-based development. Typical initiatives include the creation of self-help groups of people with, for example, spinal cord injuries or expanding the work of rehabilitation facilities to follow up discharged patients in their home environment.⁸

In many different contexts peer-mentor programmes are proving an important source of psychological and broader social support to survivors (Ljungberg et al., 2011; Hernandez, 2005). A vibrant example can be found in the work of the Transitions Foundation in Guatemala (Peters, 2014a, pp. 144, 148). The organization runs a wheelchair fabrication and repair workshop, prosthetics clinic, print shop, and classroom for local children living with disability. The workshop is used to teach skills to people living with disability—about half of them as a result of gun violence—while producing sturdy wheelchairs better suited to Guatemala's rough terrain than commercially available models. But more importantly, the centre provides a supportive environment where traumatized young people—overwhelmingly young men—can learn physical and mental self-care and other life skills from others who have suffered similar injuries and impairments.

Supporting the health-care system appears particularly challenging in war- or violence-affected low- and middle-income contexts where donors wield disproportionate influence over priorities. Humanitarian emergencies

require prioritizing service delivery, whether the government is involved or not. But when such emergencies drag on, donors and international agencies should always consider supporting and strengthening health systems as a whole. Channelling funds by disease or condition, or to particular health-care facilities, can unintentionally undermine the recipient government's coordination capacity and is not as effective as it could be in realising the established principle of non-discrimination.

Justice

Access to justice is another principle embedded in international human rights law. Victims have been historically sidelined in criminal justice processes in the West. In criminal matters the state effectively took the place of individual victims to mete out punishment; victims were practically irrelevant in this process. When the notion of individual human rights started appearing in Western thinking, they first extended to the accused. Guarantees of due process and the application of the rule of law were designed to ensure that the accused and convicted would be treated justly and humanely. A pivotal shift in many nations has been to reduce

perpetrator-centric justice processes and provide a greater voice to victims through two types of rights: procedural (e.g. the right to be kept informed and heard in court cases) and substantive (e.g. reparation).⁹

Enshrining victims' rights in law is a first step towards ensuring that codes of practice or victim-specific laws are in line with relevant international obligations, in particular the 1985 UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.¹⁰ In the field of reparations, examples of law making include Colombia, which passed the Law of Victims and Land Restitution in 2011, and Mexico, which passed the General Victims' Law in 2012 to compensate those affected by organized crime (Stone, 2013). European states have also established common standards in this area.¹¹

The implementation of victims' rights is often ensured through dedicated support services that are funded in a variety of ways, such as court fines, assets seized by law enforcement, general revenue allocation, or even private contributions. In El Salvador, for example, the Victim Care Unit provides legal and psychosocial support, promotes social restitution, and seeks to prevent further victimization (e.g. in revenge attacks) (Peters, 2014b, pp. 29–30). Interestingly, the Unit's services are available to victims of crime regardless of whether a criminal prosecution is under way. This is significant for individuals who lack confidence in the justice system—which is common in many violence-affected contexts—and who are not prepared to report a crime to the police. Some services are also extended to victims who are also perpetrators, which is a complicated public policy issue.

Another positive example is evident in Norway's response to the July 2011 attacks in Oslo and Utøya (Ruge, 2014, pp. 62–65). An independent commission was established to investigate all aspects of the attacks, including official responses. The upper limit for victim compensation was raised and municipal psychosocial rehabilitation services, as well as schools and universities, were asked to prioritize the survivors of the attacks. Special measures were also

taken during the trial of the perpetrator: live reporting of this case was restricted, but live transmissions to 17 courthouses around Norway made the trial accessible to survivors outside Oslo. A total of 166 assistance lawyers represented the survivors. Survivors who testified could ask that the defendant not be present during their testimony.

As noted, another difficulty is the blurred divide between victims and perpetrators. Some survivors of gun violence are indeed perpetrators of crimes, a fact that can fuel bias against all survivors who fit a certain socio-economic and/or racial/ethnic profile. This is unique to gun violence and is not a phenomenon observed with the misuse of, for example, landmines. Negative attitudes towards individuals in conflict with the law—claiming, for example, that injured gang members 'deserve their injuries'—can be a serious barrier to responsive justice, and access to rehabilitation and social support (Buchanan et al., 2014, p. 40). Lawmakers, law enforcement officers, and justice systems have to strike a delicate balance in reconciling legal punishments and the necessary care and services for survivors. This also extends to penitentiary institutions receiving survivors of armed violence.

Access to justice needs to factor in gendered realities for women and men, girls and boys. For example, female survivors of family or sexual violence may find it difficult or intimidating to deal with male-dominated law enforcement and justice system agencies, and traumatizing to repeatedly recount their ordeal in criminal justice procedures in which the perpetrator is present. Adequate training of law enforcement personnel, the appointment of sensitized female staff, and adapting procedures are all steps that can reduce secondary victimization and barriers to justice. In some contexts civil society also has a role to play as a non-threatening intermediary between survivors and the state.

Social protection

Social protection is perhaps the least understood facet of assistance to survivors of armed violence. Social protection programmes are government actions intended to mitigate vulnerabil-

Box 2 The Surviving Gun Violence Project

The Surviving Gun Violence Project (SGVP) explores the connections between gun violence, disability, human rights, and trauma. The book *Gun Violence, Disability and Recovery* (Buchanan, 2014), researched and produced as part of the SGVP, includes analysis on victims' rights, traumatic injuries, rehabilitation and recovery, social protection, as well as country studies on Canada, Guatemala, India, Somalia, and South Africa.

Thirteen policy recommendations are offered in addition to a detailed annex summarising 56 relevant international standards. Unique profiles from individual survivors are woven across the book illuminating important experiences: identity changes, poor access to sustained health care and rehabilitation, loss of faith in criminal justice processes, marginalisation, and stigma.

All proceeds from the sale of *Gun Violence, Disability and Recovery* are donated to the Transitions Foundation, a charity established in Guatemala by survivors and which works directly with people injured and impaired from gun violence.

Some of the photos used in this Policy Paper are taken from *Gun Violence, Disability and Recovery*.

For more information:
www.survivinggunviolence.org

ity, risk, and deprivation among citizens. For survivors of armed violence this can include unexpected and ongoing medical expenses, loss of livelihood (temporary and permanent), or adaptations to their homes. Social insurance and social security are types of social protection (ILO, 2010, pp. 13–15).

How social protection works varies enormously from state to state. Some are cash and in-kind transfer programmes; others are schemes to promote employment and community grants to disadvantaged areas. Some are contributory programmes, i.e. insurance schemes covering participants who pay into the system on a regular basis (or whose employer pays for them). Some schemes are further subsidised by the state with an additional payment. Most states have a

mixture of private obligation (e.g. personal health insurance) and public social protection in times of great need, offering a safety net.

Social protection is enshrined in the International Bill of Human Rights, the Convention on the Rights of Persons with Disabilities (CRPD), and several World Health Assembly Resolutions (WHA, 2005; 2013). However, it is most developed in International Labour Organization (ILO) conventions and recommendations.¹² Broader social inclusion principles are embedded in the CRPD, which spells out the meaning of a number of economic, social, and cultural rights for people living with disability.¹³

Many challenges remain in the area of social protection for survivors of armed violence (Mont and Treichel, 2014, pp. 117–22; see also ILO, 2010, pp. 40–43; OECD, 2003). Firstly, coverage of working-age populations who are mostly involved in the informal labour market—the situation in most low- and middle-income countries—is problematic. Many programmes are limited to people who have contributed, typically through payroll taxes, and so do not reach people who are not in formal employment. Some countries therefore combine contributory and voluntary schemes, where people in the informal market can choose—if they can afford it—to contribute to social insurance schemes. A problem remains for those who cannot afford contributions and will therefore enjoy limited benefits. In addition, such mixed systems incur higher administrative costs. Subsidizing contributions or universalizing the programmes are other possible mitigation measures.

Survivors living with impairments may have difficulty proving they qualify for benefits when eligibility criteria are based on quantifying disability and sometimes exclude partial impairments or cover only particular types of impairments—e.g. those resulting from work-related injuries. Mental-health disorders can be particularly difficult to quantify.

Sometimes social protection benefits can have perverse outcomes, such as acting as a disincentive for survivors to return to work. Many schemes only cover people who are deemed fully incapable of working. People with some capacity to

work (e.g. part time), but whose welfare amounts to more income than their salary potential, are forced to identify as ‘fully disabled’ in order to retain their welfare or insurance payments (e.g. see Stapleton et al., 2005). Some countries, however, run effective ‘return to work’ or ‘work for welfare’ (workfare) programmes for people living with disability (ISSA, 2012).

Importantly, accounting for the full cost of care remains a policy challenge, even in high-income settings. People living with disability face higher costs than able-bodied individuals. If these costs are not adequately covered through social protection programmes, survivors will enjoy fewer opportunities and be at risk of falling into poverty (WHO and

World Bank, 2011; Marriott and Gooding, 2007, p. 9).

Also, often poorly included or left out of social protection schemes is recognition of the burden of caregiving (IDS, 2013; see also Brodsky, Habib, and Hirschfeld, 2003a; 2003b; Esplen, 2009). When someone is shot and injured the burden of care often falls on women, and younger and elderly family members. Their ability to earn an income or get an education will be severely constrained as a result, but few international instruments recognize this reality. Exceptions are the 1993 UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities¹⁴ and the 2013 World Health Assembly Resolution 66.9 on Disability.¹⁵



Retired police officer James Meunier reacts to news of cuts to his disability pension. Meunier retired in 1979 after being shot in the line of duty in 1978. © Stephan Savoia/AP, 19 July 2011 (from Buchanan, 2014)



“Jerry”, graffiti artist in Haiti. © Surviving Gun Violence Project/Fiona Stephenson (from Buchanan, 2014)

Policy suggestions

This paper has noted a number of key policy challenges related to health, justice, and social protection responses for survivors of armed violence. These responses, as well as interventions in other sectors (e.g. urban planning, gender, and social inclusion) could form the backbone of a Geneva Declaration agenda for action on survivors of armed violence. Such an agenda could be informed by consultations at the forthcoming regional review conferences and confirmed as part of an overall affirmation by Geneva Declaration states of their commitment to undertake policy action in the areas of development, armed violence, disability, and trauma. It could include the following:

- **On health.** The WHO Executive Board decided at its January 2014 meeting to prepare a resolution on interpersonal violence prevention to be tabled at the May 2014 World Health Assembly. This resolution would reiterate the commitment of member states to improving the health-care sector’s response to all forms of

violence. This is an important opportunity to spell out in more detail what this entails. Health interventions start with first responders and emergency services, then progress through rehabilitation and psychological support, and eventually to post-discharge support. They can be improved through audits of health institutions and related private sector or civil society service providers, noting the role professional associations can play in audits and standard setting. Audits should pay particular attention to the possible negative attitudes of health-care personnel (secondary victimization) and to the detection and treatment of psychological trauma, because these are less obvious gaps.

- **On justice.** The 1985 UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power is a key international standard on victims’ rights. States should review their national legislation and develop or update codes of practice in line with these and other relevant standards. The substantive right to

compensation is often particularly weak and could be supported by setting aside additional resources at the national and international levels. A global fund for assistance to survivors would be a practical step forward. Beyond legislation and resources, possible negative attitudes by criminal justice institutions (primarily police and justice departments) must be detected and addressed. In post-conflict situations peace agreements and disarmament, demobilization, and reintegration programmes are opportunities to include commitments on assistance to survivors as a feature of post-war recovery.

- **On social protection.** A number of ILO conventions and recommendations spell out principles for social protection, but they are not always widely ratified. These standards must be reaffirmed and developed. Current gaps include standards for people not employed in the formal sector and recognition of the burden of caregiving, particularly on women and girls. The inclusion of a ‘carer’s pension’ in social protection

schemes could go a long way to compensate for this hidden cost of armed violence.

■ **On research.** Little information is available on many aspects of surviving armed violence, which undermines the effectiveness of policy responses. Some of these research gaps include quantitative studies of the ratio between people killed and injured by armed violence; longitudinal studies tracking trends in experiences, impacts, and outcomes; caregiving; measuring/quantifying mental-health impacts; exploring the victim/perpetrator nexus; or exploring the links between quality rehabilitation and disconnection from gang life. Supporting such research remains a priority.

■ **On inclusion.** Article 4.3 of the CRPD calls for the active consultation and involvement of people living with disability in processes relevant to them. This is an essential ethical principle applying equally to policy development, programming, and research. Engaging and including survivors of armed violence has to be meaningful—i.e. survivors should not be merely asked to recount their stories, but be consulted in negotiations at the global level or involved in the design and rollout of interventions and research projects. Adopting a statement or code of conduct on survivor inclusion could advance respect for this principle.

Endnotes

- 1 These Policy Papers deal with issues such as ‘controlling the instruments of violence’, ‘victims and survivors of armed violence’, ‘accessing security providers’, and ‘the role of the private sector in armed violence and prevention’.
- 2 The discussion in this paper is largely based on Buchanan (2014). See <<http://www.survivinggunviolence.org>> for more information.
- 3 Further recommendations are captured in WHO (2004), particularly pp. 75–78, and WHA (2007).
- 4 Slightly adapted from the definition of victims in the 1985 UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. It was proposed by Cate Buchanan in 2010 and further refined in Buchanan (2014, p. 16).
- 5 Strategies for raising the standards of

- 6 For example, training programmes developed by the American College of Surgeons and the International Association for Trauma and Surgical Intensive Care are now implemented by national bodies such as the Trauma Society of South Africa. See Hardcastle et al. (2014, p. 72).
- 7 According to WHO (2001, p. 9), ‘firearms have been reported to be one of the most common causes of brain injury in the United States. Similarly, in Brazil, a study conducted in seven state capitals found that over a quarter of all spinal cord injuries were caused by firearms, and a study in Soweto, South Africa reported a high prevalence of spinal cord injuries due to shootings’.
- 8 Depending on the context, CBR initiatives may include interventions in the fields of health, education, livelihoods, social rehabilitation, and empowerment. Its principles are based on the Convention on the Rights of Persons with Disabilities. Essentially, CBR programmes link people with disabilities and development initiatives (WHO, 2010).
- 9 UNGA (2005) distinguishes among restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition. Where possible, restitution aims to restore the individual to his/her original situation before violations were committed, addressing mainly personal, but also material suffering (e.g. a return of property). Compensation is for damage that can be economically assessed and provided to the claimant/s. Rehabilitation involves wide-ranging health and psychological care. Measures include the cessation of violations, truth seeking, a search for the disappeared, the recovery and reburial of remains, public apologies, judicial and administrative sanctions and commemoration, and human rights training. Non-repetition involves structural policy changes to strengthen human rights, the rule of law, security system transformation, judicial independence, etc.
- 10 Waller (2011) provides a model law for policy-makers.
- 11 See in particular European Parliament and Council (2012), which establishes minimum standards for the rights, support, and protection of victims of crime.
- 12 1952 Convention No. 102 on Social Security; 1955 Recommendation No. 99 on Vocational Rehabilitation (Disabled); 1964 Convention No. 121 on Employment Injury Benefits; 1967 Convention No. 128 on Invalidity, Old-Age and Survivors’ Benefits; 1969 Convention No. 130 on Medical Care and Sickness Benefits; and 1983 Convention No. 159 on Vocational Rehabilitation and Employment (Disabled Persons) and its namesake Recommendation No. 168.
- 13 These include access to the physical environment and transportation (art. 9); freedom from exploitation, violence, and

abuse (art. 16); independent living and inclusion in the community (art. 19); personal mobility (art. 20); education (art. 24); habilitation and rehabilitation (art. 26); work and employment (art. 27); and participation in political and cultural life (arts. 29 and 30).

- 14 UNGA (1994, Rule 8.3): ‘States should also ensure the provision of income support and social security protection to individuals who undertake the care of a person with a disability.’
- 15 WHA (2013, para. 5): [The World Health Assembly urges States] ‘to promote the receipt by informal caregivers of appropriate support in supplementing the services provided by health authorities.’

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List of abbreviations

CBR	Community-based rehabilitation
CRPD	Convention on the Rights of Persons with Disabilities
ILO	International Labour Organization

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The Geneva Declaration on Armed Violence and Development



The Geneva Declaration on Armed Violence and Development, endorsed by more than 100 countries, commits signatories to supporting initiatives intended to measure the human, social, and economic costs of armed violence, to assess risks and vulnerabilities, to evaluate the effectiveness of armed violence reduction programmes, and to disseminate knowledge of best practices.

The Declaration calls upon states to achieve measurable reductions in the global burden of armed violence and tangible improvements in human security by 2015.

Affiliated organizations include the Bureau of Crisis Prevention and Recovery (BCPR) and the United Nations Development Programme (UNDP), the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), and the Quaker United Nations Office (QUNO).

The Small Arms Survey hosts the Geneva Declaration Secretariat and provides research to enhance knowledge about the distribution, causes, and consequences of armed violence.

For more information about the Geneva Declaration, related activities, and publications, please visit www.genevadeclaration.org

