CARING FOR LANDMINE VICTIMS

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CARING FOR LANDMINE VICTIMS

Every year, tens of thousands of people, mostly civilians, are killed or injured by landmines and other explosive remnants of war. Those that survive are often disabled for life, adding to the many hundreds of thousands of mine survivors around the world in need of long-term care, rehabilitation, and social and economic support. Assistance for mine victims must be an integral part of public health-care systems and must not discriminate against persons who are ill, injured or disabled for reasons other than mines. But health-care systems in mine-affected areas experience increased needs for resources to treat mine victims and consequently require particular support. In most mine-affected countries, where health facilities are disrupted by poverty and war, there is a chronic lack of resources to meet these needs.

In 1997 States recognized their collective responsibility to care for mine victims by integrating victim assistance commitments into the Convention on the Prohibition of Anti-Personnel Mines (Ottawa Convention). This was the first time that an international treaty banning a weapon required care and assistance for its victims. Today, a second weapons-related treaty, the 2003 Protocol on Explosive Remnants of War (ERW), also calls for assistance for victims. But much more needs to be done to ensure that the promises made in these treaties to victims of mines and explosive remnants of war are fulfilled.

WHAT ARE THE EFFECTS OF LANDMINES AND ERW AND WHO ARE THEIR VICTIMS?

Landmines and explosive remnants of war (ERW) continue to threaten, maim and kill indiscriminately long after hostilities have ended. Most of their victims are civilians.

"Whenever we were called in for an emergency case, we prayed that it would not be a mine injury, not another child or woman or peasant terribly mutilated."

Surgeon recalling work in an ICRC hospital on the Thai-Cambodia border in 1993.

Anti-personnel mines are designed to be detonated by the contact of a person. The suffering they cause is particularly horrific, and war surgeons consider mine injuries among the worst they ever have to treat. They inflict much more severe injuries than those caused by other conventional weapons, owing to their specific design. The kind of mine, the proximity of the victim to the explosion and where the device is in relation to the victim's body are the most important determinants of the nature and severity of the injury. When a person steps on a buried anti-personnel mine, the detonation is likely to rip off one or both of his or her legs and drives soil, grass, gravel, metal and plastic fragments of the mine casing, pieces of shoe and shattered bone up into the muscles and lower parts of the body. If it explodes while being handled, a mine can blow off fingers, hands, arms, and injure parts of the face, abdomen and chest.

The victim who survives an anti-personnel mine blast typically requires amputation, multiple operations and prolonged physical rehabilitation. Mine survivors suffer permanent disability – with serious social, psychological and economic implications. They require support for the rest of their lives. Health and social structures in mine-affected countries, already devastated by years of conflict and poverty, face major challenges in providing adequate care for mine victims.

In addition to the direct effects of mines on the persons killed or injured, the victims' families and communities also suffer, particularly if they are economically dependent on the victim. Communities suffer further impoverishment when they cannot use their lands for agriculture or other economic activities due to the presence of mines.

Anti-vehicle mines and **unexploded munitions or "explosive remnants of war"** (such as unexploded cluster bombs, shells, mortars and grenades) also cause deaths, a wide variety of severe injury and socio-economic effects similar to those of anti-personnel mines.

In countries affected by both anti-personnel mines and explosive remnants of war, it is not always possible to determine with certainty what type of weapon caused the casualty. Data collection capacities in many affected countries are poor and many casualties are not recorded properly, if at all. The term "mine victim" is therefore used in this publication to refer to persons killed or injured due to anti-personnel mines, anti-vehicle mines and explosive remnants of war.

WHAT IS THE SCALE OF THE PROBLEM?

Tens of thousands of new mine victims are recorded annually and occur in every region of the world. *The Landmine Monitor Report 2004* estimates an annual global rate of between 15,000 and 20,000 new landmine casualties in recent years, adding to the many hundreds of thousands of mine survivors in need of long-term care, rehabilitation and reintegration.

States party to the Ottawa Convention reporting hundreds, thousands or tens of thousands of mine survivors to care for: Afghanistan, Albania, Angola, Bosnia-Herzegovina, Burundi, Cambodia, Chad, Colombia, Croatia, Democratic Republic of the Congo, El Salvador, Eritrea, Ethiopia, Guinea-Bissau, Mozambique, Nicaragua, Peru, Senegal, Serbia and Montenegro, Sudan, Tajikistan, Thailand, Uganda, Yemen.

Review of the Status and Operation of the Convention 1999-2004, adopted by the Convention's First Review Conference, at para. 85.

However, in countries where the Convention on the Prohibition of Anti-Personnel Mines (Ottawa Convention) is being implemented, the ICRC has observed a significant decrease in the number of new victims, as compared to levels in the early- and mid-1990s. This is due in large part to greater community awareness of the dangers posed by these weapons, increased mine clearance efforts and the less frequent use of anti-personnel mines since the Convention was adopted and other international efforts were undertaken.

Most mine victims live in the world's poorest countries, many of which are recovering from years or decades of war. **Every new casualty adds an increasing burden on health structures already strained beyond capacity by the need to support hundreds of thousands of landmine survivors injured in the 1980s and 1990s.**

WHAT ARE THE NEEDS AND CHALLENGES OF MINE VICTIMS?

People injured by mines or explosive remnants of war need immediate and intensive medical care. If they survive, victims require prolonged physical rehabilitation, psycho-social support and assistance for their economic reintegration. Like all persons with disabilities, mine survivors should be protected by laws and policies against discrimination.

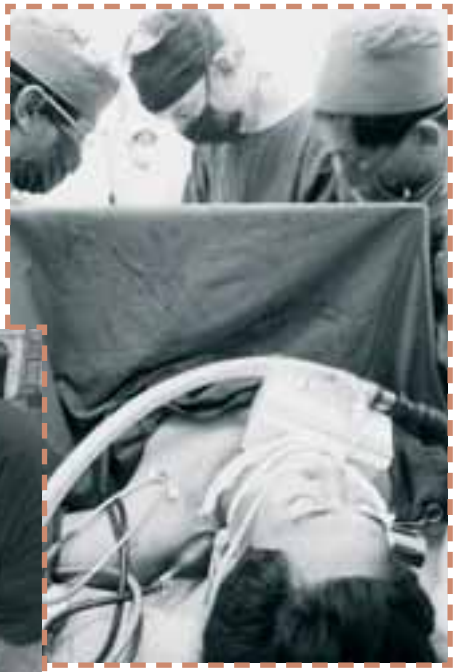
Health and social services cannot be established to deal with mine victims to the exclusion of other wounded and ill patients. **Assistance for mine victims must be carried out as an integral part of national health-care and social-services systems and embedded into larger programmes for assistance to these systems.** Nonetheless, it is acknowledged that because the treatment of mine victims typically requires much more medical resources than other types of injuries, health structures in mine-infested areas need special attention. In requiring States to assist mine victims, both the Ottawa Convention and the Protocol on ERW recognize these greater needs faced by health-care and social-services systems in affected areas. Yet improving these systems will benefit not only mine victims, but also persons wounded, injured or disabled by other means, as well as the population at large.

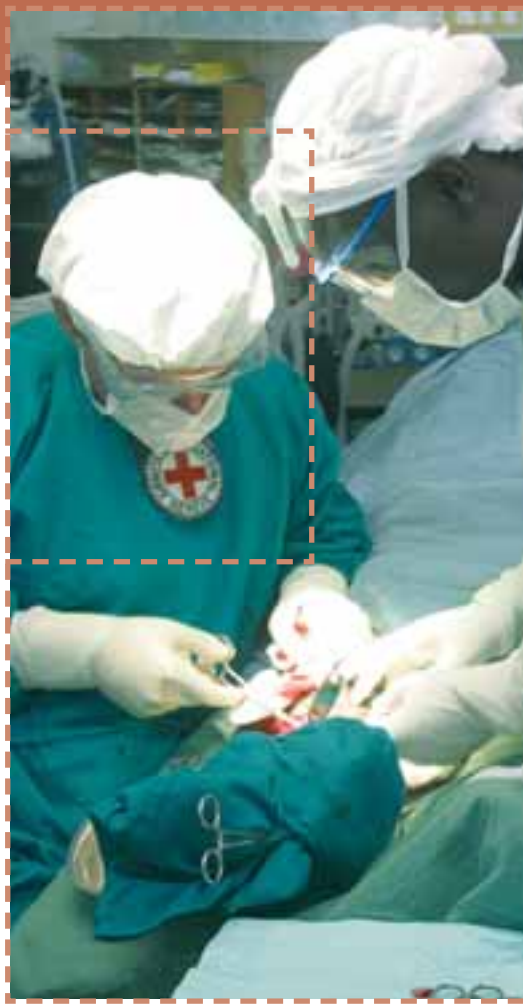
MEDICAL CARE

Medical care begins with providing first aid to the wounded and ends with his/her discharge from hospital. It consists of:

- **Emergency medical care.** The survival of a mine victim depends on the care available in the crucial hours immediately following a mine incident. The wounded person must undergo **first aid**, which involves getting him/her out of the minefield without risking other lives, stopping the bleeding and stabilizing his/her condition. This should also include administration of antibiotics to help prevent the onset of serious infection such as gangrene, especially if the contaminated wound is left untreated for more than six hours. The victim must then quickly be **evacuated** to a hospital. This implies that mine-affected areas should have first aid and transport capabilities, and sufficient medical supplies, equipment and trained staff for these purposes.

- But most mine-affected countries, which are emerging from long years of conflict, do not have appropriate services and facilities to respond to such emergencies. Hospitals are often located far away from mine-affected areas. Evacuation may mean a bumpy ride in a truck or animal-drawn cart through mountains, desert or paddy fields. Poor first aid and transportation account for high fatality rates among mine victims – up to 50% according to ICRC and medical research estimates.





- Hospital care. Due to the severity of their injuries, mine victims have specific medical needs and require prolonged hospital care. They typically undergo amputation of one or several limbs and multiple operations during which they frequently need large quantities of blood transfusions, on average more than six times as much blood as those injured by bullets or fragments. There is also a need for support services such as radiology and laboratories. Surgery is followed by a long period of hospital recovery and post-amputation physiotherapy. Appropriate and sufficient equipment, medicines and dressing materials must be available. In addition to saving lives, correct surgical intervention improves prospects for rehabilitation

- Yet in most mine-affected countries, few hospitals have the equipment, medicines, materials and trained staff needed to deal with mine injuries. Moreover, relatively few surgeons are familiar with the specific amputation techniques appropriate for mine injuries, and training in appropriate surgical techniques is rarely institutionalized.

REHABILITATION AND REINTEGRATION

After leaving the hospital, a mine survivor will need to rebuild his/her life. To do this, the mine survivor will first need to recover his/-her mobility, and then reintegrate society and the economy. **Physical rehabilitation** and **socio-economic reintegration** are closely linked needs. Enabling a person with disability to walk and move about is in itself a great achievement. But it is also an indispensable condition for the person's participation in family and community life, work and education.

- **Physical rehabilitation** involves physiotherapy and fitting with artificial limbs (prostheses) or with devices to support a malfunctioning limb (orthoses), as well as providing other orthopaedic appliances such as crutches and wheelchairs. Disabled mine survivors require physical rehabilitation for the rest of their lives. A child that steps on an anti-personnel mine today may need up to 35 prostheses in his or her lifetime.

"At the Physical Rehabilitation Centre, we are trying to help those who have been injured regain their mobility. But it is not enough just to give someone a new leg. Social reintegration is also very important. It is important to be able to carry on a life. To help people get on with their lives is not just to give them charity; it is to give them an education. The disabled can do a lot if they are given a chance."

Najmuddin Najmuddin,
Director of ICRC Physical Rehabilitation Centre in Kabul, Afghanistan, and mine survivor.

- Yet few mine-affected countries have self-sufficient and sustainable physical rehabilitation facilities for persons with disabilities. Existing physical rehabilitation centres are often located in capital cities far from the areas where mine injuries occur. Travel to the centres may be too expensive or too insecure for those in need of services. In some countries, large numbers of amputees have never received rehabilitative care.

In others, when an artificial limb is broken or no longer fits, the patient can wait months or even years for its replacement. This experience can be as traumatic as losing one's leg all over again.

- Socio-economic reintegration can enable the disabled person to resume his or her life as a full member of the community. The psychological trauma and loss of self-esteem that disabled mine survivors experience can be eased through family and psycho-social support, community acceptance and employment, restoring a person's feeling of productivity and dignity. Mine survivors consistently say that their top priority is to become productive community members and contribute to supporting their families. Vocational training and the creation of employment opportunities are therefore crucial tools to help mine survivors rebuild their lives.

- Yet most mine survivors live in low-income countries that have few or no resources for employment programmes aimed at persons with disabilities, let alone for psycho-social support. In some communities, disabled persons are socially stigmatized, making their prospects for reintegration even more difficult. In too many cases, patients leave physical rehabilitation centres to become beggars and to be neglected by their families and communities.

Like all persons with disabilities, mine survivors should benefit from **legislation and public policies that protect disabled persons.**

- Legislation and public policies should protect mine survivors and other disabled from discrimination and ensure that they have equal access to public facilities, social programmes and educational and employment opportunities. Victim assistance is more than just a medical or rehabilitation issue; it is also a human rights issue.
  - But many affected States lack adequate legislation to protect the rights of mine survivors and other disabled.

Additional **challenges** to ensuring functioning health and social-services systems for war wounded and other persons with disabilities in mine-affected countries include:

- The lack of accurate data on the numbers of victims and where they are located. Victim surveillance through data collection is a useful tool to indicate the scale and nature of casualties, in order to manage assistance effectively.
- The fact that large numbers of victims live in rural areas where access to health facilities is limited or non-existent.
- The inability of assistance agencies to reach mine victims and other war-wounded due to insecurity caused by ongoing threats, conflicts or tensions.
- The lack of priority given to health care in many mine-affected countries, leaving health-care systems weak, with little or no planning or capacity building, and no systematic training of first aid and hospital staff.

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 programmes. Such assistance may be provided, inter alia, through the United Nations system, international, regional or national organizations or institutions, the International Committee of the Red Cross, national Red Cross and Red Crescent societies and their International Federation, non-governmental organizations, or on a bilateral basis.

Ottawa Convention banning anti-personnel mines (1997)
article 6, paragraph 3

Each High Contracting Party in a position to do so shall provide assistance for the care and rehabilitation and social and economic reintegration of victims of explosive remnants of war. Such assistance may be provided, inter alia, through the United Nations system, relevant international, regional or national organizations or institutions, the International Committee of the Red Cross, national Red Cross and Red Crescent societies and their International Federation, non-governmental organizations, or on a bilateral basis.

Protocol on Explosive Remnants of War (2003)
article 8, paragraph 2

WHAT DO INTERNATIONAL TREATIES REQUIRE STATES TO DO FOR MINE VICTIMS?

Each State is first and foremost responsible for the well-being of its own citizens. It follows that each mine-affected State is ultimately responsible for caring for mine victims within its territory. But most mine-affected States are developing countries where health facilities and social services have been neglected or disrupted due to poverty and war. The Convention on the Prohibition of Anti-Personnel Mines (Ottawa Convention) recognizes the difficulties faced by mine-affected countries in providing adequate care by committing all States Parties to help one another to assist mine victims (see box). This same obligation was also undertaken in the Protocol on Explosive Remnants of War.

The requirement that mine victims be provided assistance is one of the unique features of the Ottawa Convention and the Protocol on ERW that distinguishes them from traditional arms control treaties. However, in the context of the Ottawa Convention, the fulfilment of this requirement has so far been the most difficult to implement and the most difficult on which to measure progress.

Since the entry into force of the Ottawa Convention in 1999, the practical experience of governments, international agencies and non-governmental organizations at field level has led to a better awareness and understanding of the needs of mine victims and more broadly of the needs of persons with disabilities in low-income countries.

At the First Review Conference of the Ottawa Convention in December 2004, States Parties recognized that implementing their victim assistance obligations **"calls for ensuring that existing health-care and social-services systems, rehabilitation programmes and legislative and policy frameworks are adequate to meet the needs of all citizens – including landmine victims"**, but also requires that **"a certain priority be accorded to health and rehabilitation systems in areas where landmine victims are prevalent"** (Review of the Status and Operation of the Convention 1999-2004, adopted by the Convention's First Review Conference, at para. 65).

TURNING PROMISES INTO ACTION

In the *Nairobi Action Plan 2005-2009*, the States Party to the Ottawa Convention made eleven specific commitments aimed at fulfilling their victim assistance obligations and increasing efforts to meet the needs of mine victims (see Annex).

As a step towards fulfilling their promises, States Parties have agreed to include health, rehabilitation and social services professionals in the work of the Convention at the levels closest to the victims (i.e. at national and regional levels), as well as in the work of the Convention's Standing Committee on Victim Assistance – the body created by the States Parties to monitor the implementation of the Convention's victim assistance requirements. Health and social services professionals are best placed to identify, advocate for and respond to the specific needs for victim assistance in their respective countries.

In addition, mine survivors themselves must continue to play as active a role in advocating for victim assistance as they have in the past. When mine victims and other persons with disabilities are included in the planning and implementation of assistance programmes, needs are better understood, and programmes are made more effective.

In addition to making sufficient human, material and financial resources available to meet the needs of mine victims and disabled, States should take the following actions, consistent with the Nairobi Action Plan:

- Both donor and mine-affected States need to make health care and services for the disabled a higher priority, notably in national development plans.

- Victim assistance programmes should focus on capacity building and sustainability, including ensuring the continuity of training programmes.
- States with many mine survivors to care for need to develop long-term national plans for their health-care and social-services systems, establishing clear objectives and priorities and making their needs known to other States and international agencies.
- States Party to the Ottawa Convention with large numbers of mine survivors to care for should continue to report their "problems, plans, progress and priorities for assistance to mine victims" to the Standing Committee on Victim Assistance and report on their achievements, challenges and needs in "Form J" of the annual reports required by Article 7 of the Convention. This can help channel resources to priority sectors.
- Closer cooperation should be fostered among health and development authorities of mine-affected States and donor countries, international agencies and specialized NGOs at national, regional and international levels to ensure that the commitments made by governments to mine victims are known and implemented.

The preventable suffering caused by landmines and explosive remnants of war is the result of decades of their proliferation and use in countless armed conflicts. Public conscience finds it difficult to accept that the killing and maiming caused by weapons of war should continue even after hostilities have ended. In adopting the Convention on the Prohibition of Anti-Personnel Mines and the Protocol on Explosive Remnants of War, governments have made a solemn commitment to the victims of these weapons, promising that they will receive the life-time assistance they need to rebuild their lives in dignity. A measurable improvement in the situation of victims will only be possible through the long-term commitment of all.

WHAT DO THE ICRC AND THE INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT DO TO ASSIST MINE VICTIMS?

ICRC mine victim assistance is one of three pillars of ICRC mine action activities. The others two focus on prevention in the field through incident data gathering, risk reduction and mine risk education, and on prevention at national and international levels through the promotion of the norms contained in the Ottawa Convention and the Protocol on Explosive Remnants of War.

While the ICRC recognizes that all areas of mine victim assistance are important, its assistance focuses mainly on **emergency and hospital care** and on **physical rehabilitation**. In countries where the ICRC is providing such assistance, it normally collaborates with other organizations to ensure that mine victims and other disabled have access to other types of assistance, notably to ensure their **socio-economic reintegration** into society. The ICRC directly contributes to this by striving to employ disabled persons, including mine victims, in its rehabilitation centres. In Afghanistan it has also established educational, vocational and micro-credit programmes to enable the disabled, with excellent results.

Providing **emergency and hospital care** for the war-wounded has traditionally been one of the ICRC's main activities. In particular, the ICRC assists **pre-hospital care** in the form of training and material support to local first aid capacities and ambulance services, usually through National Red Cross and Red Crescent Societies. This helps ensure that injured persons can quickly obtain first aid and be evacuated to hospital. ICRC **hospital assistance** involves direct support to local capacities by repairing hospital infrastructure, providing hospital management assistance, supplying materials, equipment and medicines, and providing training in war surgery. In the past two

decades hospitals supported or run by the ICRC have treated hundreds of thousands of people wounded as a result of armed conflict. From 1999 to 2004, some 10% of war-wounded receiving treatments in ICRC-supported hospitals were mine victims.

For 25 years (1979-2004), the ICRC has supported (through training and technical and financial assistance) or directly managed 93 **physical rehabilitation** centres in 37 countries, including all of the world's most heavily mined areas. Most of the centres supported by the ICRC are run by relevant government ministries, while others are managed by National Red Cross or Red Crescent Societies or NGOs. Within these centres, mine victims and other disabled have access to orthopaedic devices such as artificial limbs, wheelchairs and walking aids, as well as physiotherapy services. During these 25 years, **approximately 60% of the amputees fitted with prostheses in ICRC-supported centres have been mine/ERW victims**. In some countries such as Cambodia, where many disabled persons are living far from physical rehabilitation centres, the ICRC supports schemes to improve accessibility of care, including mobile outreach programmes which bring the needed services to remote areas.

The ICRC has developed physical rehabilitation techniques and international standards for the physical rehabilitation of disabled and has a leadership role in this area of assistance. In 2004, the ICRC was awarded the Brian Blatchford Memorial Prize from the International Society for Prosthetics and Orthotics (ISPO) in recognition of its efforts over the past 25 years to assist war-amputees and other physically disabled, in particular by designing and developing the polypropylene prosthetic system as an alternative to other, more costly, technologies. The **ICRC-developed polypropylene technology** is now widely used, not only by the ICRC but also by most organizations working in the field of physical rehabilitation.

Given the life-long needs of the physically disabled (including mine victims), the continuous functioning of physical rehabilitation centres is essential. This requires long-term planning and resource commitments. To help ensure the continuity of support for physical rehabilitation, the ICRC established the **Special Fund for the Disabled (SFD)** in 1983. The SFD provides technical training and material and financial assistance to rehabilitation centres formerly supported by the ICRC, helping them to maintain the quality and quantity of services needed. It also assists centres in other developing countries. It is estimated that some 30-40% of all patients assisted through SFD- sponsored programmes are mine or ERW victims.

Assistance to mine and ERW victims is a key component of the International Red Cross and Red Crescent Movement's *Strategy on Landmines*. The ICRC is given the lead role to implement this strategy, which it does in close cooperation with National Red Cross and Red Crescent Societies.

Annex

Extract from the Nairobi Action Plan 2005-2009

IV. ASSISTING THE VICTIMS

5. Article 6 (3) of the Convention calls for States Parties to provide assistance for the care, rehabilitation and reintegration of mine victims. This constitutes a vital promise for hundreds of thousands of mine victims around the world, as well as for their families and communities. Keeping this promise is a crucial responsibility of all States Parties, though first and foremost of those whose citizens suffer the tragedy of mine incidents. This is especially the case for those 23 States Parties where there are vast numbers of victims. These States Parties have the greatest responsibility to act, but also the greatest needs and expectations for assistance. Recognizing the obligation of all States Parties to assist mine victims and the crucial role played by international and regional organizations, the ICRC, non-governmental and other organizations, **the States Parties will enhance the care, rehabilitation and reintegration efforts during the period 2005-2009 by undertaking the following actions:**

States Parties, particularly those 23 with the greatest numbers of mine victims, will do their utmost to:

Action #29: Establish and enhance health-care services needed to respond to immediate and ongoing medical needs of mine victims, increasing the number of health-care workers and other service providers in mine-affected areas trained for emergency response to landmine and other traumatic injuries, ensuring an adequate number of trained trauma surgeons and nurses to meet the need, improving heath-care infrastructure and ensuring that facilities have the equipment, supplies and medicines necessary to meet basic standards.

Action #30: Increase national physical rehabilitation capacity to ensure effective provision of physical rehabilitation services that are preconditions to full recovery and reintegration of mine victims by: developing and pursuing the goals of a multi-sector rehabilitation plan; providing access to services in mine-affected communities; increasing the number of trained rehabilitation specialists most needed by mine victims and victims of other traumatic injuries; engaging all relevant actors to ensure effective coordination in advancing the quality of care and increasing the numbers of individuals assisted; and further encouraging specialized organizations to continue to develop guidelines for the implementation of prosthetics and orthopaedic programmes.

Action #31: Develop capacities to meet the psychological and social support needs of mine victims, sharing best practices with a view to achieving high standards of treatment and support on a par with those for physical rehabilitation, and engaging and empowering all relevant actors – including mine victims and their families and communities.

Action #32: Actively support the socio-economic reintegration of mine victims, including providing education and vocational training and developing sustainable economic activities and employment opportunities in mine-affected communities, integrating such

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efforts in the broader context of economic development, and striving to ensure significant increases of economically reintegrated mine victims.

Action #33: Ensure that national legal and policy frameworks effectively address the needs and fundamental human rights of mine victims, establishing as soon as possible, such legislation and policies and assuring effective rehabilitation and socio-economic reintegration services for all persons with disabilities.

Action #34: Develop or enhance national mine victim data collection capacities to ensure better understanding of the breadth of the victim assistance challenge they face and progress in overcoming it, seeking as soon as possible to integrate such capacities into existing health information systems and ensuring full access to information to support the needs of programme planners and resource mobilization.

Action #35: Ensure that, in all victim assistance efforts, emphasis is given to age and gender considerations and to mine victims who are subject to multiple forms of discrimination in all victim assistance efforts.

States Parties in a position to do so will:

Action #36: Act upon their obligation under Article 6 (3) to promptly assist those States Parties with clearly demonstrated needs for external support for care, rehabilitation and reintegration of mine victims, responding to priorities for assistance as articulated by those States Parties in need and ensuring continuity and sustainability of resource commitments.

All States Parties, working together in the framework of the Convention's Intersessional Work Programme, relevant regional meetings and national contexts, will:

Action #37: Monitor and promote progress in the achievement of victim assistance goals in the 2005-2009 period, affording concerned States Parties the opportunity to present their problems, plans, progress and priorities for assistance and encouraging States Parties in a position to do so to report through existing data collection systems on how they are responding to such needs.

Action #38: Ensure effective integration of mine victims in the work of the Convention, inter alia, by encouraging States Parties and organizations to include victims on their delegations.

Action #39: Ensure an effective contribution in all relevant deliberations by health, rehabilitation and social services professionals and officials, inter alia, by encouraging States Parties – particularly those with the greatest number of mine victims – and relevant organizations to include such individuals on their delegations.

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MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance. It directs and coordinates the international relief activities conducted by the Movement in situations of conflict. It also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the International Red Cross and Red Crescent Movement.

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