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My handicaps are quite visible. They can remind us of the invisible handicaps we all have—the "landmines of the heart." These landmines inside can lead us to war, to jealousy, to cruel power over others.

—Tun Channareth, Cambodian double amputee, during his acceptance speech for the 1997 Nobel Peace Prize on behalf of the International Campaign to Ban Landmines.

The Journal of Mine Action

The Mine Action Information Center at James Madison University

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Volume 3

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Defining the Pillar of Victim Assistance

by Sue Eitel, Landmine Survivors Network

In late 1995, mine victim assistance was on no one's political agenda. Today, it is recognized as one of the main pillars of mine action, which, defined by the United Nations, includes identification and clearance of mines, mine risk education and victim assistance. A topic of many international conferences and discussions, victim assistance has received global attention through the 1997 Nobel Peace Prize and the involvement of the late Diana, Princess of Wales.

Champions for the Cause

Though Landmine Survivors Network (LSN) is not the authority on landmine victims and survivor assistance, it is the only international organization created by landmine survivors for landmine survivors. Its two co-founders, Jerry White and Ken Rutherford, began their vision in 1995 as they joined together to not only promote an international ban on landmines but also raise awareness for the needs of landmine victims and include victim assistance in the Mine Ban Treaty.

“Being a survivor is a lonely business. Though there are hundreds of thousands of us worldwide, it is not a community. Suffering is not shared nor are resources pooled. Indeed, it is easy to forget that there is a face and a name behind each landmine casualty. Entire families are being blown apart each hour, in virtual isolation. Also less well understood is the personal horror that each victim experiences in the moments after an explosion. Landmines tear off limbs and shreds and strip tissue from the body. Even one’s own bones become projectiles. If the eyes are not blinded during an explosion, a victim can see his own body torn, mangled and bleeding. Most victims who die from the blast die alone. The challenge LSN took on was to unite the survivors; not to bask in their suffering, but to reveal their strength and share their testimonies about what these inhumane weapons had done to them,” said White.

As the debate continued over treaty language, much was made of “the poor victims.” One of the biggest challenges facing landmine survivors was convincing others that they were more than just poster children. As amputees, they had to remind the world that, although landmines had blown off their limbs and left them irreparably scarred, their minds, their dreams and their humanity was still intact.

Survivors around the world have come forward to speak not only of the challenges they face, but also of the actions they are taking to be involved in the process of individual and community rehabilitation. Perhaps the cause of the greatest public awareness of the need for mine victim assistance was the interest taken by the late Princess of Wales. In 1997, Diana visited two countries severely affected by landmines: Angola and Bosnia. The images of her walking through mine fields and meeting with landmine disabled were seen around the world. With her involvement, the media took notice. Landmines and the devastation they caused were now in the headlines; Diana knew that was her contribution to the cause. She realized that the media would closely follow any statement she made or action she took. It seemed mine survivors had gained a lifelong ally to help alleviate their suffering. On August 31, 1997, the world lost a lovely, glamorous woman, but mine survivors lost a true friend.

Victim Assistance and Mine Victims

The question of victim assistance is a difficult one: what is it exactly? What kind of structure is needed to coordinate such assistance? Which categories of humanitarian relief should be included? The definition of victim assistance is derived from discussions with non-governmental organizations (NGOs) active in the International Campaign to Ban Landmines (ICBL) as well as from informal discussions with government and United Nations representatives:

“Victim assistance includes, but is not limited to, emergency and medical care, access to prosthetics, wheelchairs and other assistive devices; social and economical reintegration; psychological and peer support; accident prevention programs; and legal and advisory services.”

Similarly, the definition of a mine victim is equally challenging. The ICBL Working Group on Victim Assistance developed a definition that is widely accepted:

“Mine victims include those who, either individually or collectively, have suffered physical, emotional and psychological injury, economic loss or substantial impairment of their fundamental rights through acts or omissions related to mine utilization.”

The Mine Ban Treaty

Officially, the Mine Ban Treaty is known as the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Mines and on Their Destruction. It was the first international arms control agreement that addresses the humanitarian needs of the victims of that particular weapon system. On victim assistance it states:

Preamble: “Wishing to do their utmost in providing assistance for the care and rehabilitation, including the social and economical reintegration of mine victims.”

ICBL

In February 1998, the creation of the first ICBL Working Group on Victim Assistance (WGVA) was formed, and LSN was elected by other ICBL members to chair the group (LSN was re-elected as chair at the First Meeting of States Parties in Maputo, May 1999).
The overall purpose of the WGVA is to increase the quantity, and improve the quality, appropriateness, and effectiveness of all programs that impact the victims of landmines. The five specific goals are:

1) To secure funding for victim assistance, we will press governments to commit $3 billion over the next 10 years to a broad range of long-term programs that benefit mine victims and other persons with disabilities living in mine-infested communities.

2) To promote effective and appropriate programming, we will press governments, other donors and program implementers to support a wide range of activities and programs, including emergency and continuing medical care, physical rehabilitation, prosthetics and assistive device production, psychological and social-support programs, employment and economic reintegration programs, data gathering, land tenure, legal services, vocational training and employment opportunities.

3) To share information on victim assistance, we will develop procedures to ensure open and clear communication among all members and observers of the WGVA. We will also collaborate with and serve as a resource to the ICBL national campaigns and other groups on all matters related to victim assistance.

4) To promote inclusion of landmine survivors and landmine-infested communities in all initiatives and activities which concern them. (This follows the U.N. Standard Rules on the Equalization of Opportunities for Persons with Disabilities. "Nothing about us, without us," as the saying goes in the disability rights movement.)

5) To promote the rights of landmine survivors, spurring discussion on definitions of mine victims and consideration of reparations.

To receive further information on the WGVA, please contact Becky Jordan or Jerry White at Landmine Survivors Network.

Care and Rehabilitation Guidelines

The ICBL Working Group on Victim Assistance, comprised of more than 20 international humanitarian and development organizations, has developed a set of programmatic guidelines to help shape and promote comprehensive rehabilitation for hundreds of thousands of landmine survivors worldwide.

The ICBL Guidelines for the Care and Rehabilitation of Survivors are intended to help diverse actors, including donors and program implementers, develop and fund the most effective programs to help landmine victims heal, recover and resume their roles as productive and contributing members of their societies.

The following guidelines are intended to address the care and rehabilitation of those victims who have suffered physical injury from landmines. Many of the recommendations also support other persons with disabilities.

Emergency Medical Care

Healthcare and community workers in mine-affected areas should be trained in emergency first aid to respond effectively to landmine and other traumatic injuries.

4) To share information on victim assistance, we will develop procedures to ensure open and clear communication among all members and observers of the WGVA. We will also collaborate with and serve as a resource to the ICBL national campaigns and other groups on all matters related to victim assistance.

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Access

Persons with disabilities, like all people, should have full and open access to a variety of services and assistance. Full and open access to the physical environment, rehabilitation and social and economic programs is a means of equalizing opportunities in all spheres of society. Access includes: the elimination of physical obstacles to mobility, ensuring access to buildings and public places; availability of first aid, emergency and continuing medical care; physical re-habilitation; employment opportunities; education and training; religious services; sports and recreation; safe land and tenure of land; and information and communication about available services.

Data Collection

Survey implementers must be trained and sensitized to issues of trauma and recovery experienced by mine victims and their families before engaging landmine survivors in interviews. Data collection that involves interviews with survivors must be handled sensitively so as not to heighten trauma, raise expectations or exhaust communities repeatedly interviewed by any number of organizations. The collection of information must translate quickly into humanitarian action and serve the purpose of improving services for mine victims to integrate socially and economically in their communities.

In early 1999, Landmine Survivors Network launched a paper called Preventing Landmine Survey Victims in response to the growing trend by consultants, NGOs, U.N. and government agencies to collect data from individual survivors or their families. Specialized survey teams, tools and protocols are emerging ostensibly to provide real answers to the questions, "How many survivors?" and "What are their needs?" Interviewing survivors raises expectations; specific questions raise specific expectations. The baseline principle for surveys must be "do no harm." Unnecessary raising hopes of survivors time and again without our response is harmful. It leads to mistrust, cynicism and may create barriers to future cooperation with individuals and communities.

Recommendations to reduce negative effects of surveying:

- When the survey team or a consultant is in a community for only a short time and not actively engaged in rehabilitative programs within the country, information should be collected by talking about landmine victims, rather than directly interviewing survivors.
- Survivor interviews should be conducted by organizations in place to implement programs related to survivor assistance. These organizations could utilize or adapt standard survey forms in their ongoing work and follow-up activities.
- Prior to launching or funding survey actions, one must ask:
  - How much and what kind of information is actually needed?
  - Who will use this information and how does it lead to assistance?
  - Is funding another survey the best use of available resources?

Research should be used to improve services and design better programs. Too often findings are only circulated at international conferences, surveys are conducted for their efforts and reports are shelved. Meanwhile, survivors continue to wait for promises that were made or imagined. LSNN cautioned those involved in interviewing survivors landmine victims did not survive to be counted, but to overcome their injuries and resume productive lives. Surveys invariably raise expectations. Are we prepared to meet them?

Victim Assistance Programs and Approach

Many governments, local organizations and international organizations have been active in mine-affected countries for decades, working to rehabilitate the injured. NGOs have been the primary implementers in the field, providing physical rehabilitation and other support such as training and small-enterprise development. Many of these programs continue to fund and make ongoing support for individuals injured by landmines and persons with disability from other causes.

Questions are raised regarding the best programs on the best approach in addressing the needs of landmine victims. There are concerns that positive discrimination toward landmine survivors will isolate them from the rest of the community. A public health approach has been identified as a method to address victim assistance. Some organizations work closely with governmental structures while others look toward the private sector. In looking at the approach to victim assistance, no one-size model fits all countries. We must be flexible and creative to meet the needs of persons with disabilities. The treaty was created to prevent landmine injuries and to help rehabilitate mine-injured individuals and communities. We should use this opportunity to strengthen existing programs that provide support for landmine victims (hospitals, prosthetic centers, vocational training, etc) and be prepared to create new activities to address the holistic needs of landmine survivors and other persons with disability.

The general goal should be to improve rehabilitation outcomes and to return persons with disabilities to productive lives. It may start with surgery and medical care, but that is just the life-saving beginning. The challenge and philosophy of victim assistance is to treat the whole person, no matter how many limbs are missing. Prosthetics are important, but not cure-all. How do we offer appropriate psychological and social support? In the treaty there is a clear obligation to provide for social and economic reintegration. This is not simply charity, but good development policy.

When reviewing a situation, it is important to know what programs already exist and what areas of rehabilitation are not being adequately addressed (see Section 5 for the Guidelines for the Care and Rehabilitation of Survivors). In this way effective use of resources is promoted and duplication of efforts is avoided. One initiative presented at the First Meeting of States Parties (Mozambique, May 1999) is the development of a Strategic Framework for Mine Victim Assistance. The framework offers an example of a systematic approach to the identification of intersectoral programs and resources allocated to support them. Again, it is one model available for use and the only answer in addressing this complex issue.

Future Direction

Though many donors, governments and organizations will continue to support and implement programs that directly or indirectly assist landmine victims, there is also international initiatives underway to ensure the obligations of the treaty are implemented and not forgotten.

Stemming from the First Meeting of States Parties, it was decided that working groups would be established to address five main areas related to the Mine Ban Treaty. The working groups were named Interministerial Standing Committee of Experts (ISCE). The five areas are:

- mine clearance
- victim assistance, socioeconomic reintegration and mine awareness
- stockpile destruction
- technologies for mine action
- general status and operation of the convention

The objective of the ISCE is to ensure the systematic and effective implementation of the Mine Ban Treaty. The overview offered by the ISCE should, inter alia, provide a clear picture of resources, needs and gaps. The first meeting of the ISCE was in Geneva from September 13-17, 1999 (victim assistance component was September 15-17).

Conclusion

The most recent champion to join the effort to ban landmines and promote victim assistance is Her Majesty Queen Noor of Jordan. In July 1998, Jordan hosted the first regional Conference on Landmine Injury and Rehabilitation in the Middle East. At this conference HM Queen Noor announced Jordan would sign and ratify the Ottawa Convention. She also announced her patronage of Landmine Survivors Network.

Since that time she has extended her full support for the movement to ban landmines. On victim assistance and the obligations of the treaty she said, "We would be mistaken to believe that victim assistance is charity, for it is not, it is not optional. It is a moral and legal responsibility that falls on each and every one of us."

This article was written to provide a general overview of victim assistance. Though much of this information can be found at various web sites (JMU, LSNN, ICBL), it is useful to put it all together to keep our individual initiatives in perspective. Victim assistance is being addressed at community levels, country levels and on an international level. All initiatives are important and each must be aware of the work that has already been made to avoid reinventing the wheel. At every level, landmine survivors should be participants in discussions, planning and program implementation. The phrase, "nothing about us without us" must be respected if we are to truly understand the needs of landmine victims and other persons with disabilities.
One million people have been killed and maimed by anti-personnel mines. Twenty-six thousand people a year become victims, 70 people a day, or around one person every 15 minutes. Three hundred thousand children and counting are severely disabled because of landmines. Half the people who step on an anti-personnel mine die from their injuries before they are found or taken to hospital. An even higher percentage of children die because, being smaller, their vital organs are closer to the blast. After the end of hostilities, decades afterwards, anyone who steps on a mine field is at risk. Everyone is vulnerable; women collecting water, children playing, men working the land or cattle grazing.

Most mine fields are unmapped, or have become unmarked after rains, erosion, washouts and when topographical changes have occurred. You may have no idea that you are in danger until it is too late. If the horrifying thought suddenly strikes you that the field you are in might be mined, there is not a lot you can do about it. You could painstakingly test each inch of the ground in front of you before each step, perhaps sliding a knife into the ground at 30 degrees to see if there is anything dangerous underneath. You may not discover the mine until you put your weight on it. Only 13 pounds of pressure may be necessary to activate it.

Landmines do not just kill and injure an individual. They also create long-term costs for communities, the most immediate problem being medical costs. You may have survived the blast but have to be transported to a hospital. Once there, blood transfusions, surgical time and skill, painkillers, antibiotics, artificial limbs and rehabilitation are all necessary. How is an impoverished family and community supposed to support this type of ongoing medical emergency?

Death or the disability of a parent should not only be measured in the economic toll it will take on the family, but also in the emotional scars of the widow, widower and children. Caring for the injured, financial strains, the sad sickness the living must cope with from the death or injury of a beloved; these are all factors that play into an individual’s, a family’s and a community’s well being.

To many people who live in cities and urban centers, the importance of agricultural land can not be measured. Here, in the United States, where just 2 percent of the population produces the food that we eat, the loss of agricultural land does not have the same consequence as it does in agrarian-based economies. In communities and villages where sustainable agriculture is the economy, arable land is of vital importance. The food a family eats and sells must come from the good earth. Animals can not graze, land can not be sown and villages and families slowly starve. Thirty-five percent of land in Afghanistan and Cambodia is now unusable. (Source: One World)

The Statistics of Anti-personnel Mines

It is particularly distressing to note that landmine casualties often include a large proportion of women and children (21 percent on average, and sometimes up to one-third of all cases). In other words, one mine victim in five is a woman or a child. A study carried out in Peshawar from June to December 1992 showed that, at the time they were injured by a mine explosion, 85 percent of the 528 casualties treated were engaged in non-military activities, such as agricultural work, travelling, or looking after cattle. Moreover, injuries due to mines are severe: in International Committee of the Red Cross (ICRC) hospitals 84 percent of all amputations are performed on mine victims. These dry statistics cannot portray the feelings of the surgeons, nurses, physiotherapists and prosthetists who, every year, have to treat thousands of non-combatants mutilated by these devices.

From 1985 to March 1995, ICRC hospitals and surgical teams have treated over 140,000 war-wounded, of whom about 30,000 (just under one-quarter) were victims of landmines, but even these figures represent only a very small proportion of the wounded in the conflicts concerned. The surgical office of the ICRC Medical Division has established a database carrying basic information on 23,767 war-wounded patients. There are 1,889 mine-injured patients listed up to now. This is one of the largest such databases in existence and permits a preliminary analysis of these patients, their wounds and the treatment they have received.

Statistics and information are notoriously difficult to obtain in such situations: not all victims make it to a hospital facility and their total numbers are unknown. There are other hospitals treating the wounded, even in a centralized ministry of health no longer exists. The wounded, or their family, are often afraid or suspicious of questionnaires or oral interrogations. Military authorities, in many instances, are not forthcoming with statistics, because they consider the numbers of wounded to be a secret. Volunteer medical teams are overworked, under stress, and frequently horrified by the injuries they see. The priority going to saving life and limb rather than filling out paperwork. Statistics from ICRC hospitals are consequently partial and selective, but they are nonetheless indicative of what is really happening and, when properly understood and analyzed, can give us a good picture of the extent and nature of the medical and social problems encountered.

The proportion of landmine injuries out of total wounded in any conflict varies according to the type of military activity and the nature of the terrain. In ICRC’s Khost-i-Dang hospital, 62 percent of all wounded treated there had been injured by landmines during the Cambodian war, including refugees who were placed in camps in mine-infested areas. The Quetta and Peshawar hospitals, serving heavily mined, mountainous rural areas, reported incidences ranging from 18 percent to more than 60 percent according to the period and the circumstances. The ICRC surgical team in the Jalalabad University Hospital, in Afghanistan just across the border from Peshawar, noted an increase in landmine injuries from 35 percent to 60 percent of all war-wounded in early 1993, after the repatriation of large numbers of refugees to rural areas.

Obvious non-combatants, children, women, and elderly even make up 31.5 percent of all landmine victims in the ICRC database. How many injured males between the ages of 15 and 50 years who were not members of the armed forces are a matter for conjecture, and the true figure of non-combatants higher will. Relative proportions of civilians and combatants injured by landmines also alter with changes in the political and military situations. In a study of 720 mine-injured patients admitted to the ICRC hospital in Peshawar after April 1992, when political changes in Afghanistan allowed the return of many refugees from Pakistan, the number of mine-injured admitted to the hospital rose sharply from 50 to 100 per month. Non-combatants constituted 64 percent of all mine-injured patients covered by this study, compared to 20 percent over the previous two years. Similar results were reported from the nearby Jalalabad hospital.

Eighty-five percent of the patients in the Peshawar study had been engaged in non-military activities. Of these patients, 77 percent said they had only recently returned to Afghanistan; and almost half the returns had been back for less than three months before their injury. This phenomenon is to be expected when a refugee population is repatriated to its home region where millions of anti-personnel mines have been scattered haphazardly over a period of 10 years.

A cease-fire, with consequent free movement of people for agricultural or commercial activities, will have the same result. In Mongolbori, northwest Cambodia, landmine injuries accounted for 51 percent of wounded in the four months preceding the
May 1, 1991, cease-fire, and 61 percent during the four months immediately following it. In certain re-
areas of the Caucasus, the proportion of landmine in-
juries among wounded patients has increased in 1995 from 3 percent to over 33 percent within the space of one month.

In some countries, where not only has a cease-
fire come into force but democratic elections have 
taken place as well, the same relative situation exists: In Nicaragua, almost all new amputees due to land-
mines are civilians.

Mine Injured in ICRC Hospitals:

- Potential combatants males 15-50 years old — 48.7%
- Children <15 years — 18.8%
- Women — 2.3%
- Males >50 years — 4.2%

Evacuation of Mine Victims to ICRC Hospitals:

- Only 25% arrive within six hours of injury.
- 15% travel for more than three days to reach the hospital.

Source: ICRC surgical database

The ICRC surgical database, which commenced in 1991, has more than 26,000 patients registered 
from five independently functioning ICRC hospitals. Of these, 27 percent are mine victims. From these data-
bases, and numerous testimonies from both victims and health workers, pro-
files of victims can be established which show both their injuries and 
their needs.

The 10-year-old Boy

A 10-year-old boy arrived at an ICRC first-aid post in a taxi hiked by 
his father. Ten hours earlier, he had 
stepped on a small-buried anti-per-
sonnel mine, which had shattered 
his entire left foot. The boy told the staff at 
the first-aid post that he had been 
out collecting firewood. He had in 
fact been looking for unexploded 
munitions and shells to sell in the local 
market.

In the first-aid post he had a 
dressing put on the remains of the 
foot, but had an infection put up and was given both pain-
kills and antibiotics. He was put in an ambulance 
and was taken to an ICRC hospital. The journey took 
five hours. When they arrived at the hospital, a sur-
geon examined the foot and explained via an inter-
preter that the leg would have to be amputated be-
low the knee. The father explained that this was his 
only son and that he could not possibly be of use to 
the family if he had only one leg. The surgeon and 
the hospital staff who spoke the local language 
explained that it would be very dangerous to wait 
and that the boy would be able to walk again with an ar-
tifical limb. The father refused to give permission for 
the amputation. The boy was confused and fright-
ened and began to cry again.

The following morning the boy had a fever 
and a bad smell was coming from the dressing on his foot. 
The father decided to find an old uncle who lived 
about four hours away by bus and to ask his advice. 
That evening the father and his uncle arrived at 
the hospital. They had another discussion about 
the amputation with the staff in the hospital. The fol-
lowing morning, the surgeon told them that he could 
do nothing more without their permission to ampu-
tate the leg and that there was no point in the boy 
staying in hospital. The anaesthetist assured the father 
that the boy would be asleep throughout the opera-
tion. One of the locally employed nurses rolled up 
his trouser leg and showed that he too had 
stepped on a mine six years previously and that he was able 
to work with his artificial leg. The father then agreed 
to the operation.

Two hours later the boy was back on the 
ward. He had had a below-knee amputation under a 
general anaesthetic with a blood transfusion. His 
new stump was resting on two pillows and he was allowed 
to eat later that day. The following day, a physiother-
pist started to move the knee joint gently above the 
amputation. Four days later he was taken back to the 
operating room to have the skin flaps of the ampu-
tation stitched together which required another 
general anaesthetic. Five days after this, the dressing was 
taken off and the boy saw for the first time how his 
leg looked. This was a great shock to him and he began to cry once again. His father 
also cried.

Over the next two weeks he had a lot of physio-
thrapy and learned to walk on crutches. There 
were many other amputees in the hospital; some had both 
legs missing. The boy's father donated blood to 
the hospital blood bank. After a month the boy was 
transferred to the ICRC limb-fitting center where he 
received an artificial leg made out of plastic. He could 
can walk quite well with this thought it was more diffi-
cult over uneven ground. Three weeks later he was 
able to go home with his father.

Five months later he broke the limb when he was 
playing football with his friends. He and his father 
headed for the ICRC limb-fitting center again and 
he was given a new leg. A year later, walking grew 
painful and he said that he had developed an ulcer 
on his stump. Once again he returned to the limb-
fitting center and was told that maybe he would need 
an operation to remove a piece of bone that was still 
growing in the stump. The surgeon at the hospital 
examined him and the operation was done two days 
later. The stump was now a different shape and so 
he had to have yet another artificial limb fitted; his third 
in the 18 months since the mine blast.

Wife and Mother

A 32-year-old mother of three children was 
working in a rice field. A dark green object in the 
earth caught her eye. She picked it up, not knowing that it 
was a mine; it was the kind that explodes either on 
pressure or when tilted. When the mine exploded it 
blew off her right hand; her face and eyes 
received multiple small wounds from the vaporized 
mining cased. Some other people working in the rice 
field ran to her aid and tied a strip of material tightly around 
her forearm just below the elbow. She was 
unable to see and was led out of the field. 
Someone went to tell her husband.

Eight hours later she arrived at a local 
dispensary, which she had reached riding 
on the back of her husband's motorcycle. The 
mine in the dispenser put some disinfectant 
on her face and a dressing on the remains of her 
hand. There was no available bed at the 
dispensary and she and her husband slept under a tree, it being 
too dangerous to travel at night because of bandits. 
That following day he made his way to a hospital. 
A doctor there looked at her arm and told her 
that the whole forearm was dead because of the 
impregner tourniquet, and that she would have to 
have an amputation through the elbow joint.

A related problem is that 
agency might have difficulty finding the wounded 
person. In other words, geography may not allow the 
victim to encounter the agency that can provide the transport or the medical care that he or she needs.

Lack of Protection

In some countries wounded people do not go to 
hospitals for fear of their lives. Rebels and those 
among the population associated with them may not 
want to travel to government, or "enemy," held areas where the hospitals are. Any treatment they receive 
may be via an agency, which has limited access to the area. This may be the case for the majority of mine 
victims throughout the world.

Security

Many of the areas in which mine injuries occur 
are simply too dangerous for outside agencies to 
visit. Armed gangs have looted hospitals, warehouses 
and accommodations. Aircraft have been shot at.
Vehicles have been stolen at gunpoint or blown up by anti-tank mines placed on ordinary roads. Volunteer personnel have been threatened, beaten and killed.

Political and Administrative Constraints

Assistance to wounded people in one area may go against the desires of the parties of the conflict. The presence of aid agencies may be politically inconvenient. Flight plans may not be approved. Visas may not be granted. Uncooperative authorities have many tricks with which to hinder aid work.

Poverty

Free health care is not provided in many countries. In mine-affected countries there may be inadequate health-care systems for those who can afford it. Mine victims may have to rely on aid agencies or go without treatment completely.

Lack of Personnel and Social Structure

In a mine-affected country, both recoveries from the conflict and the assimilation of foreign aid are facilitated by the presence of a social structure and trained people. The cost and difficulty of delivering a service multiple times if the resource that must be imported includes trained personnel. There is little point in supplying a hospital if there are no people qualified to use these supplies correctly.

Lack of Funds

It is clear that assistance to mine victims is an extremely expensive form of aid when measured as money expended per person. All agencies are chronically short of funds to continue existing programs, let alone set up new programs.

Donor Pressure

The availability of funds may be conditional upon their use for a certain category of victim or in a particular geographical area. Thus, humanitarian priorities may be overridden by financial considerations and this is to the detriment of other victims.

Interagency Rivalry and Lack of Coordination

Lack of coordination and rivalry between organizations is, sadly, another reality, especially in new situations. It arises from different ideologies and lack of time for interagency discussion about who should do what, where and how. For example, one agency may claim it is working in and supplying a certain hospital, though this program may be inadequately funded or the agency may have difficulty recruiting qualified professionals. The agency’s claims may make other organizations reluctant to involve themselves with the hospital. The result is an aid “vacuum.” The various agencies engaged in the fitting of artificial limbs may use different, incompatible and even inappropriate technology. The technology may be determined by the wishes of the donor. Thus, amputees in a certain area may not receive adequate rehabilitation. Those agencies involved in training may give different conflicting and confusing advice; this applies in particular to programs perceived as carrying a low financial commitment such as first aid and mine awareness. The donation of medical supplies may be particularly inappropriate. Some medical items are simply dangerous, such as metallic implants for fracture surgery; in a hospital without trained surgeons, sterile or even X-rays, these implants can only make the situation worse for the victims.

It is important that the constraints listed here be put to the forefront so that we can better grasp how we can improve our aid to victims, victim assistance organizations and the organizations and politicians that promote and advocate victim assistance to victims.

It is equally important that we understand the social, economic and political environment that encompasses the village of the mine victim. It can be argued: What good is provided by an artificial limb when the person, once maimed, must now lie in the snows? We must treat the whole person—the family, the child, the wife, the father, the laborer, the mother. Victim Assistance, to be successful, must encompass more than medical treatment. It must encompass assimilation, rehabilitation, community awareness and involvement. By treating the whole person, we are treating the whole of the community. How do we begin this massive task? One victim at a time.

Sources:
ICRC
NN
UNICEF

Lantime victims have been the focus of attention since the formation of the International Campaign to Ban Landmines (ICBL), and this naturally peaked in 1997 with the signing of the Ottawa agreement. This event, while incredible, needs to be looked at as part of an ongoing process in the rehabilitation of people with mobility impairment living in low income. These are often considered as only landmine victims, but the context is wider. While the continuing work of ratification, awareness raising, advocacy planning etc. goes on, it is useful to look at the context of the ongoing work in rehab, the lessons learned and the challenges still to be faced.

The work in victim assistance (VA) is dynamic, a pillar within a wider strategy. The prosthetics industry as we know it today in the developed world is little more than 35 years old. We are learning and the countries themselves are learning. We have no need however to reinvent the wheel when it comes to planning; so much has been done already.

For the past six years I have worked in Phnom Penh, Cambodia, with a small British organization called The Cambodia Trust. Cambodia is well known today as one of the world’s most densely landmined countries. It has suffered nearly 30 years of war, as the conflict in Vietnam spilled across its borders, but is also infamous for the Pol Pot regime in the mid-70s. After that dark period the country was isolated from the international community until the late 80s, making it desperately poor and under developed. The intellectual middle class had been wiped out by the genocide leaving a largely peasant population where literacy was virtually zero. The Civil War, post-Pol Pot, lasted until the Paris peace accord in 1992, and up until earlier this year there was still sporadic fighting and displacement as the hard-liners held out in the jungles. As a result the country is extremely poor, civil society is embryonic, and education standards are low. More than 80 percent of the population are subsistence farmers with little access to a cash economy. It is against this backdrop that some 160 organizations, including Cambodia Trust, are working.

The trust has been working in Cambodia since 1992 and has developed three prosthetic service centers under the auspices of the Cambodia Trust Rehabilitation Project in Kep/Mom, Kep/Kampot and Sihanouk. It is the largest service provider in Cambodia, producing more than 1,200 prostheses and 400 orthoses in 1997-1998. The trust’s largest project, The Cambodia School of Prosthetists and Orthotists (CSPO), which includes a large rehab clinic, is based in Phnom Penh, the capital. The CSPO is the national training scheme for Prosthetists and Orthotists (PaOs) and works in collaboration with five other organizations: American Friends Service Committee (AFSC), Handicap International, Veterans International, American Red Cross and International Committee of the Red Cross, and of course with the government of Cambodia to build human resources in that country. The school has been working very closely with the International Society for Prosthetics and Orthotics (ISPO) to bring the curriculum within the guidelines set down by ISPO in October 1997, for the training of Category II Orthopedic Technologies, or prosthetist orthotists.

Status of the CSPO

The CSPO opened its doors in 1994 with an intake of six students. In subsequent years the intake has risen to 12 and as a result we have now three graduating classes with 27 new Prosthetists/Orthotists and another 43 in the pipeline. As we reach our initial estimated 1993 target of 60 graduates for the Cambodian service, we have looked more seriously at developing a regional role, and for the first time, last year, we took two students from the Lao People’s Democratic Republic. This year we have six from Laos, two from Sri Lanka and one from the Solomon Islands. The remaining three are Cambodian. One possible future for the CSPO is that we generate income by taking in fee-paying overseas students while retaining a small number of cheap or even free places for Cambodians. This would allow us to maintain the...
lead role we have taken in the development of services and would allow further postgraduate training, monitoring and evaluation.

The majority of students entering into CSPO are high school graduates or have some other third-level training. All require a competency in English. After much deliberation it was decided to teach in English and not Khmer, since this is the language of the regional economic grouping and so graduates in the future can maintain links with the international community of professionals. It must be recognized that improved language also increases the danger of students moving away from Cambodia or into other work. As we move more and more into regional training the need for a common language becomes stronger.

The Landmine Problem

Without dwelling too long on the root of our problem, or should I say the imputus for our action, we must first place this Khleang invention in its proper perspective. The anti-personnel landmine or 'body trap' is a commonly used low-cost device designed to maim, rather than kill, with the primary purpose of creating harov in the ranks of young soldiers. It is a weapon of terror, creating a sense of fear which the Khmer, since this is the language of the root of the conflict, and disabled people themselves expect to be driven out of and into creating havoc in all the training. All require a high school graduate. The root of the problem lies in the root of the issue.

In Cambodia, the vast majority of disabled people are young. Many of these young amputees are virtually all in their 20s, with up to 70 percent of them being injured military personnel.

Disability in Low-Income Countries

In mine-affected countries such as Cambodia, the vast majority of disabled people are young. Mine-victim amputees are virtually all in their 20s, with up to 70 percent of them being injured military personnel. Cambodia has a young population.

An adult life expectancy of less than 50 years, and a high post-war birth rate makes the under-18 population more than 50 percent of the total. So the requirements for the performance of a prosthetist or orthotist is very different to that of the developed world. To begin with, the standard of amputation is often low, resulting in a stump with poor distal soft tissue or adherent scar, or with generally poor skin cover. The nature of landmine injury is such that amputation is done in several stages. The initial damage to the limb may look relatively small but it is usual to find that actual sub-cutaneous damage extends much further than external inspection may indicate. The hot, high pressure gases associated with the blast will have inflated the limb prior to capture of the skin so causing what might be described as a delamination type of injury not readily observable. Dirt and foreign materials will be driven with great force into the limb, so giving great concern for infection, so the normal method of treatment is the so called "open amputation" where the stump is left unمسرط for several weeks while daily debridement is carried out. Closing the stump before all foreign objects have been removed very seriously increases the risk of infection. The procedure is not well suited to giving good results in myxedema, so resulting in poor distal end. At result, the stump is too long, too big, too thin and not usuallk able to fit a true total-contact prosthesis with any degree of limb sensation. This coupled with a young active amputee will make prosthesis fitting rather critical. It must be remembered that these disabled young people will receive little or no social service support, and may be cast out by society to fend for themselves. So prosthesis must fit and function well, the patient's ability to feel himself or his family may depend on it.

International Standards in Training of Staff

This problem has been haunting us as CSPO since the very beginning. Some agencies feel the criteria to be too broad and others to be too narrow. Some feel the time periods of training are too long and that prosthetists/orthotists should be trained in a matter of months. Some feel we are being forced to accept a first-rate economies of scale. But we have established rather clearly that cutting corners in the training of prosthetists/orthotists is often insidious in the making. The training must be of good quality. Having undergone a trauma is often insult added to injury. Low expecta tions are also a problem. In the societies in which we work, disabled people themselves expect not to work. It is clear that services cannot be focused on prosthetics and orthotics alone but need to be broader. We are currently developing services in two areas:

1. Increasing the range of skills in the rehabilitation center by employing physical therapists, medical rehabilitation doctors, social workers, psychologists and job referral agencies.

2. Changing the attitudes of society by the use of community based rehab workers. These people are very useful in patient selection and follow up but also have a massive role in empowering disabled people and in encouraging their families and communities to be inclusive.

Appropriate Prosthetic Technology

In 1995 the CSPO, with the U.S. Agency for International Development funding, held a conference in Phnom Penh to look closely at the vexed question of appropriate prosthesis technology for the developing world. This discussion had raged for several years, with various agencies adopting wildly differing views on just how we could deal with the huge numbers of limbless in the world. I first became aware of the dispute in 1993 on arrival in Cambodia, having naïvely assumed that the PiPo community would be one big happy family united by the cause. There were, at that time, seven agencies and it seemed almost as many different technologies in use.

Jaipur Limb

The Jaipur Limb was as favored by Veterans International is vigorously defended as the only appropriate technology in the world. The Jaipur Prosthetic is an aluminium comb type prosthesis, made by a technician who is trained as an artisan and not as a prosthetist. The foot is made from local rubber, quite cosmetic but heavy and rather solid. The biggest problem lies in the socket fit, which is made by one man. The opening design makes total contact or even partial distal containment very difficult.

Wood and Leather Limb

The other low technology group at that time was Handicap International, who was the fervent supporter of wood and leather technology. The prosthesis was heavy, uncosmetic and the material was quite inappropriate in wet tropical conditions. The socket fit was dubious to begin with as the heavy leather made it difficult to make an intimate fit with the cast. The fit then deteriorates further as the socket deformed in exactly the lead bearing areas.

Selection of Feet

Orthotic feet remain a subject of tremendous debate. Naturally there has been considerable work carried out to try and build a foot locally, one that is durable, light and cheap. The importation of west-
The 1995 ISPO consensus conference pointed out that all technologies in use in the Third World should be fully tested and safe. New technologies should never be tried out on the poor, who may be available and grateful for anything. They should not be field tested without proper safeguards for all. The consensus conference also noted that expensive solutions could also divert useful resources and so deprive other access with disability needs.

Who Pays and How

It is normal in the world of international development that projects like ours have a life cycle. They have a beginning, middle and end. In rural development, the beginning is a needs assessment where the communities' deficiencies are identified and a process of support planned. The middle part is the implementation of the plans, along with the donors' input. The third part is the evaluation. In this the objectives are re-examined, performance indicators applied and the project declared a success or failure. From the final reports, much is learned and the project is continued or repeated. This model is well established.

In emergency relief the needs assessment is usually foreclosed. In cases of famine, a few days are spent trying to establish the size of the problem and the amount of relief needed plus the logistics required to deliver the service. Money is raised, and the program swings into action. Lives are saved and once the emergency is passed a very short evaluation is carried out so lessons learned in logistics can be transferred to the next emergency. This model is well established and in place, and there are many expert organizations in the world who can execute such measures in a matter of days. It is sad but true, however, that emergencies happen quickly but are solved slowly, so often from emergency relief comes forth development programs. Refugees can rarely return home to wrecked countries without some sort of development assistance or infrastructure investment.

Prosthetics and orthotics should really fit into the former role model, especially in the scenario where education is involved. Indeed such was the case in Tanzania, Togo and China when the German government, through GTZ, set up training schools for P&Os. These were relatively small countries with well-established governments and infrastructure. We can say these schools have been highly successful. The planning stage was well executed, the government was a key player in this, and the graduates sloshed nearly into a well-established system of health care.

P&Os have managed to slip out of the development camp and into emergency relief, mostly due to the considerable efforts of the ICRC. By their very nature, this body is changing the paradigm. It is difficult for them to be on the front line in times of conflict. They are called upon to monitor the implementations of the Geneva Convention and aid the injured.

With the advent of landmine warfare came unreasonably high levels of amputation, and ICRC surgeons now set the world's standards in traumatology. As a result they have moved very much into a leading role in the supply of prostheses in conflict and immediate post-conflict situations. They have from that base moved into infrastructure development and P&O training. In effect they have had to move from emergency relief into development. As a result the ICRC has been involved in up to 16 countries working in P&O, and always in a development role with training components. So it can be seen just how easy it is to start a program and how difficult it is to get out.

In the conflict or immediate post-conflict situation, the difficulties are greater. Usually the governments are dysfunctional or are under severe stress. Infrastructure in general is reduced and other priorities overwhelm the emergency. In the last 10 years even greater obstacles have emerged. Not only have some countries emerged from conflict but they have seen the collapse of the whole philosophy of government. Places like Cambodia, Laos, Mozambique and Angola have embraced capitalism as a new way of life. So in many cases we will be faced with a government fully committed to the role of prevention, but unable to do so due to inexperience and the collapse of an economy. These are unique times, with unique problems that need unique strategies.

It is easy for the western countries to say that governments should be responsible, and that new programs should be handed over to governments, but when the system doesn't work, what can new programs do?

The first question is, "Who is responsible?" In answering this we should be very careful to free our minds from the constrictions placed upon them by our own experience. For those of us from the UK there is a natural tendency to try to create the beloved National Health Service. For Americans the tendency is to opt for private-sector solutions. Who is right? Naturally the tendency in post-conflict situations is to try to create a nationally run and controlled system. So what are the alternatives?

Over the past few years the debate has been taken forward in a number of forums, the most direct being the Henley Technical Workshops, a small brain-storming meeting looking at service in P&O. These roles models around the world were discussed and the diversity was quite interesting. However at the end of the day some rather important things emerged.

The role of government in a post-conflict situation is essential. The role of government in a post-conflict situation is essential. The role of government in a post-conflict situation is essential. The role of government in a post-conflict situation is essential. The role of government in a post-conflict situation is essential.

Planners and architects of post-conflict situations should be aware that the role of government is essential. The role of government is essential. The role of government is essential. The role of government is essential. The role of government is essential. The role of government is essential.

Tour guides and the other half would be planting rice, a sobering thought. It was a sure bet that the government was not planning for long term and that most of the P&O initiatives were entirely NGO driven and supported, and NGOs are very short term. So a group of interested NGOs and government staff began an effort of altering the thinking of so-called policymakers to the long-term needs of the inhabitant. To cut a long story short, we persuaded the government to set up a task force, which lasted for a year, and in that time we surveyed the country, looked at all the agencies associated with disability and began the process of national planning. Out of that has come a new body called the Disability Action Council (DMC). Since 1997, the future is at last being addressed. The DMC is a semi-government, semi-NGO group developing plans and defining problems, not just in P&O, but in reintegration of legislation, skill training, finance, the disabled and much more. It is made up of 43 agencies, large and small, along with the Ministry of Health, Ministry of Social Affairs and the Ministry of Education. Most important of all, the disabled people themselves participate as full and active members.

We are well aware of the problems, and we are well aware of the outside support, but we are also well aware of the shelf-life this outside support has. How long will it be fashionable to support disabled in the Third World once the spotlight of the landmineissue grows dim?

So What is the Point?

In a place like Cambodia, the point is simple. Put people who should be working back to work. The numbers of disabled are disproportionately high and the resources disproportionately low. With the right infrastructure and assistance we can release the potential of tens of thousands of work-aged people to contribute to the development of their own country. The technical stuff is finished, the training also, the buildings are in place and the waterworks begins. The biggest challenge is now being faced, and the objective is new and clear: the disabled are not to be helped, they are to help themselves.
Her Majesty Queen Noor visited Vietnam and Cambodia in October 1999 to see firsthand the plight of the landmine problem in these countries. As the patron of the Landmine Survivors Network (LSN), she also does fundraising activities for the organization. She recently was in the United States working in this capacity in September 1999.

Queen Noor has been a long time advocate in the cause to ban landmines as well as a supporter of victim and survivor assistance. She has stated that she has been a concerned activist since her days at Princeton University during the Vietnam War. Marrying King Hussein and moving to the Middle East further influenced her commitment to this cause. Witnessing firsthand the impact of war and landmines and the human, economic and environmental damages these ravages incur further strengthened her commitment.

"I appreciated more directly the horror of landmines, and the human and economic waste they cause, after I came to live in Jordan in the 1970s. On my regular trips to the Jordan Valley I had to drive past mine fields fenced off by barbed wire. The mine fields on our borders frightened and angered me, and I am still infuriated today by the ongoing loss of life and limb suffered by soldiers and civilians alike."

For over 20 years, Queen Noor has been an advocate for peace and a supporter of the International Campaign to Ban Landmines (ICBL). It was with this dedication that Queen Noor agreed in 1997 to become a patron of the LSN at the request of founders Ken Rutherford and Jerry White.

One of Queen Noor's first efforts was to host the First Regional Meeting on Landmine Injury and Rehabilitation in the Middle East in Amman, Jordan, July 1998. In cooperation with the LSN, the ICBL, the Jordan Red Crescent Society, and the Hashemite Charitable Society for Soldiers with Special needs, over 350 participants examined landmine injury and rehabilitation in the Middle East and North Africa. The conference was successful in drawing attention to the growing needs of survivors and developing plans and tools for meaningful assistance. At the conference, the LSN submitted the Bill of Rights for Landmine Survivors on behalf of Queen Noor. The Bill of Rights advocates the rights of survivors to be fully involved in all decisions affecting their own rehabilitation.

The underlying goal of victim and survivors' assistance is to continue to be working in every way possible to end the threat of landmines. Queen Noor said, "I have a particular interest in this issue because I come from one of the most mine-infected regions of the world, where mines planted since World War II and during more recent conflicts are killing innocent men, women and children daily and endangering the agricultural and economic productivity."

Queen Noor feels that the appalling suffering and waste caused by landmines far outweighs their questionable military utility.

About 10 percent of the Jordanian population live in areas that are dangerous and economically unusable because of landmines. "Scarce agricultural land and some of the most beautiful and sacred landscapes in Jordan, especially in the Jordan River Valley, remain scarred and forbidden because of the danger of landmines," said Queen Noor. The de-mining program in the Jordan Valley has cleared 146 mine fields with 64,000 mines, which has made available 3,100 acres of land that can now be used for cultivation, mineral extraction and tourism.

On a wider scale Jordan has participated in international conferences on eliminating landmines, initiated awareness programs in schools and universities, and launched a project to establish a center for the rehabilitation and training of landmine survivors. Perhaps most importantly, Jordan has signed the Ottawa Treaty and has not imported landmines since 1974.

The facts supporting landmine victims and survivors are startling, and the statistics speak eloquently. "One hundred thousand American soldiers and civilians have been injured and killed by landmines in this century alone. Thirty-four percent of American casualties in the Gulf War and 33 percent in the Vietnam War were all landmine casualties," states Queen Noor. "Some $300,000 people around the globe are living with shattered limbs and lives and the number is growing. Every month around 800 people are killed and 1,200 maimed by landmines. Anti-personnel land mines harm primarily civilians. They contravene international humanitarian law because they are designed to injure rather than kill, to maximize suffering."

One of the problems that she has often mentioned is the detailed understanding of what is required to aid survivors and help them reintegrate into their community. She wants people to see the human face of the problem. The real evil does not just encompass the unimaginable cost of prosthetics but the multiple surgeries, the trauma undergone by a young child, the psychological scars and the shattered dreams. Then there are the additional costs to the community of farmland rendered useless, livestock endangered and the economy of community and family ruined. "Landmines are generally placed in rural villages in order to shatter the morale and integrity of family, clan, tribe and village. These weapons have proliferated into a source of random terror that respects neither time nor territory and does not distinguish between hostile combatants and schoolboys playing football," said Queen Noor.

The importance of landmine awareness coupled with the issues affecting victims and survivors must be disseminated. Awareness may bring the next step action, which may result in influencing policy makers, congressmen and senators into getting the Ottawa Treaty signed and ratified. Queen Noor feels the ratification of the Ottawa Treaty will "set a moral example and honour those who have lost their lives or the families of those who have become injured by landmines in a way that ensures it won't happen to anyone in the future."
What is it worth when a life is on the line and every moment counts? Will initial first aid arrive? Is emergency surgery available? Are painkillers and antibiotics guaranteed?

In every landmine community requiring victim assistance the same inputs are required depending on what infrastructure was available pre-conflict, what still remains in the community post-conflict and how many people have been or will be injured in the future. An industry intervention approach improves the chances of longer-term infrastructure development.

Ensuring Long-lasting Solutions

There are many success stories, such as the training and broadening of responsibilities of Angolan paramedics, which if published in the academic/industry journals might initiate dis-

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Sustainability
OF PROSTHETIC AND ORTHOTIC PROGRAMS

on international resources. Such services are likely to be outside government. They will be within private nonprofit organizations: ring fenced, transparent, and capable of regular audit.

Motor-Disability in the Low-Income World

POWER was established to provide high-quality prosthetic and orthotic devices to the victims of landmines, mostly to those who had lost limbs as a result of the plague of landmines. Over the years, we have come to reassess our priorities. There is a huge global population of disabled people. Esther Helander has reported on surveys carried out in 51 countries between 1976 and 1994, suggesting that the rate of disability can vary from 0.2 percent to 21 percent. Much of the variation comes from poor definition of disability. There are problems of definition and survey method, but broadly speaking the conclusions that can be inferred from the surveys are:

- Disability increases very significantly with age.
- Rates may be lower in low-income countries because of failure to identify disability and high mortality rates among the disabled.
- Overall rates of moderate or severe disability amount to something of the order of 5 percent.

Based on a global population of 6 billion people, the total number of moderately or severely disabled people in the world amounts to 312 million. OF these, just over 100 million live in the western world and the remainder, 210 million—and our confidence— in the low-income world. It is reasonable to expect that most of these are dependent on others to one degree or another. Helander expects this figure to increase to 435 million by the year 2025—as much because of increasing age as the increasing size of the population of low-income countries.

Helander's estimates of the causes of disability are not broken down by the standard groupings employed by WHO. However, I have allocated one of his categories of disability to motor-disability and derived a percentage, which I have then applied to the figure of 210 million derived above. The result suggests a population of motor-disabled of about 125 million people in the low-income world.

Figures generally quoted for the number of landmine victims suggest that there are about 250,000 to 300,000 surviving amputees. There are thought to be 25,000 new victims every year of whom about half die and the remainder are left severely impaired. Given that a number of those who have been previously afflicted will die from various causes during any one year, the total number of landmine survivor amputees is unlikely to increase by more than about 5,000 to 10,000 per annum.

Terrible as the landmine plague is, and the plight of landmine survivors, we cannot expect to treat them in isolation. We must treat amputee landmine victims within the overall context of motor-disability.

Disabled People in Society

This paper is concerned with the problem of disability in low-income countries. My observation of people with disability is that they are marginalized. If one comes from a Darwinian stable, then the reasons for that marginalization are understandable. Survival of the fittest requires that species reject less able-bodied specimens. We can note behavioral patterns amongst other species that support this thesis. Mankind, however, lives in a different social and cultural paradigm in which life is valued for its own sake and we are able to recognize the contribution of all human lives. We also recognize and defend the rights of all humanity to certain basic norms of existence.

Despite our intellect in the low-income world, the blind, the limbless, the AIDS sufferers, those with mental impairments, the elderly, the disadvantaged young, the terminally ill, those suffering with certain types of debilitating conditions and diseases, and so forth.

The support of people with disabilities in countries such as Britain is not left entirely with government. There are sectors of society that have a strong enough conviction that the very basic services provided by the state are insufficient for the needs of these various groups and they start, run, or contribute to nonprofit organizations which will support these marginalised groups and help provide dignity in human life.

In the low-income world, the extended family has generally been seen as the fundamental alternative to the welfare society of the high-income world. But this may have been the case, and society is changing. Whatever the truth of that matter, there is neither the culture nor the economy to support a strong nonprofit sector in low-income countries.

In my submission, the high-income world must face up to the responsibility of providing care for the disabled of the low-income world, and it must treat that as a long-term commitment. It is a responsibility that goes with globalization.

In facing this commitment, the international community will wish to ensure that it gains the maximum effectiveness for the minimum amount of money.

In this regard, I would suggest that the marginalization of the low-income countries has extremely limited resources and huge demands on those resources. The provision of services for motor-disabled people is not a priority. Even where overseas funding is provided for the service, it can easily be diverted to other purposes.

The second reason is that staff salaries within government services are frequently very low: consequently, morale is low within the service, and staff eventually leave. It is tragic to spend eight or 10 years developing a service, with the provision of well-trained and competent staff, only to see that advantage whittled away as qualified personnel leave to join other industries or leave the country.

The solution to these problems is to create a body that can continue the service outside government. This body may be a local NGO, and it may be a partnership between public and private organizations. It will be a nonprofit establishment. This formula was devised by a group of international experts—many of them from the low-income world—at the 1997 Hershey on Thames Technical Workshop.

The workshop came together to attempt to define a model or models that will deliver high-quality services for the rehabilitation of disabled persons in low-income countries on a sustainable basis.

The Mozambique Experience

The International Committee for the Red Cross (ICRC) established or developed four ortho-prosthetic centers at Maputo, Beira, Quelimane, and Nampula during the 1980s. A part of the Maputo center is a manufacturing facility, making prosthetic and orthotic components, chiefly from polypropylene.
come within the POWER management, and this proved a considerable drawback. A requirement of the contract was USAID's that POWER would establish a local NGO and place the management of the four centers within this organization. In the event this did not prove possible.

Last year, POWER completely reorganized its agreement with MISAU, withdrawing from direct involvement in the four centers. Mindful of the reasons for services failing. POWER has agreed with MISAU to continue providing materials for the manufacture of limbs, both to the four centers for which it had responsibilities, as well as to those that H.I. established.

POWER is also undertaking considerable train- ing activity to strengthen management and professional capacity in the centers. Two Category II prosthetists/orthotists will attend a four year course in Strathclyde University, Glasgow, Scotland, to upgrade to Category I. Meanwhile, H.I. has arranged for three staff members to attend a course in Lyons, France, to upgrade to Category I. Thus, of the 24 Category II prosthetists/orthotists, five will be overseas training from September onward. In addition, one has been promoted to an administrative position, one has been fired, and one has moved occupation. Only 16 will be available in the upcoming year to service the requirements of the 10 centers.

Absolutely central and critical to POWER's new program is an agreement with the Associação dos Deficientes Mozambicanos (ADEMO), to strengthen its management and financial capacity, and to jointly initiate the Council for Action on Disability (CAD) which, it is hoped, will eventually take over POWER's program in Mozambique. CAD is open to any organization working for the benefit of the disabled in Mozambique to join, and five or six organizations currently attend board meetings as observers.

Also central and critical is the development of a new ortho-prosthetic center in Chimoio in Manica province. This will be within the private, nonprofit sector and will be managed by CAD. It is intended that this center will lead the way in demonstrating that high levels of productivity and quality can be achieved when staff are properly and fully incentivized.

In 1999, the Mozambique Red Cross Society (MRCS) is opening a center at Manjacaze in Gaza Province, with support from the Jaipur Limb Campaign and the Diana Princess of Wales Memorial Fund. The center is in the private, nonprofit sector and will fit Jaipur Limbs, using staff trained in the technique in India.

It is now MISAU policy to maintain one ortho-
prosthetic center in each of the 10 provinces. The center at Vilanculos in Inhambane province is to be closed down. With the opening of the POWER center in Chimoio, Manica province, and the MRCS center in Manjacaze, Gaza province, this policy will be fulfilled.

It is the responsibility of the Ministry for Coordination of Social Action (MICAS) to make patients aware of the availability of prosthetic and orthotic services and to assist their journeys to the centers. MICAS has available a number of transit centers, where patients can stay free of charge while they are receiving treatment at the centers. Currently, this system is not working well, largely as a result of an inability of MICAS to resource its responsibilities.

MICAS also undertakes a means test of all patients and makes charges appropriate to their circumstances for the services that they receive.

I believe that the service in Mozambique is now moving slowly towards the optimum. The establishment of CAD and the collaboration of organizations working for the service of disabled people are huge steps in the right direction. The development of centers in the private, nonprofit sector will give excellent opportunity to make comparisons between services delivered through the public sector and those available within the private sector.

Conclusions

• There is a huge number of motor-disabled throughout the low-income world.

• Landmine survivors represent a small proportion of this number, and their treatment must be subsumed within the broader need.

• Disabled people in general are marginalized and their needs are rarely met, either in whole or in part, by state provision.

• If the needs of the motor-disabled in the low-income world are to be met, it will tend to be as a result of financial support from the international community.

• Such financial support is likely to be required for the very long term.

• In order to minimize the demand on international financial resources, it is necessary to set up effective and competent services within the low-income world.

• Such services are not likely to be within government. The best model will be in the private, nonprofit sector wherever possible in partnership with government.

• Mozambique can provide a model for the rest of the world.

by Dr. Ernest Burgess
Founder, Prosthetics Outreach Foundation

Approximately 2 million landmines are laid globally every year. At the current rate of removal, it will take 100 years to clear the world of landmines, provided that no additional mines are planted.

V
iетnam, 1969, Uganda, 1978, Lebanon, 1986, Iraq, 1991, Rwanda, 1994, Kosovo, 1999. The world at war has greatly changed in the years that span these conflicts. Leaders and regimes rise and pass away from memory. Political objectives can and will shift. Weapons of destruction become ever more efficient. There is a constancy that can always be relied upon: the anguish, the loss of life and limb: and the starvations are the enduring legacy of warfare.

While political controversy may reign over involvement in foreign conflicts, it should have no bearing on whether to address the human suffering that accompanies it. The world must act to stem the misery of its refugees and injured, no matter the origin of hostilities. It is not enough for foreign governments and charitable organizations to simply provide food and medicine to impoverished countries. If they are to make a meaningful, substantive contribution, they must offer aid that empowers those who receive it and leads them toward self-reliance. Once the immediate threat of death is past, the daunting task of rebuilding lives presents itself. This may be a less dramatic need, but one that is just as acute.

Current events in Kosovo bring to mind another American peace-keeping effort that deeply affected the people of a foreign country. Twenty-five years after the end of the Vietnam War, approximately 20 percent of the Vietnamese population is disabled as a result of the war and its aftermath. Residual landmines continue to maim and kill the native population, many of whom are children. Political tension between the United States and Vietnam delayed foreign humanitarian efforts for 15 years, leaving a nation of amputees to cope as best they could, with little ability to make a living and survive in their ruined land.

In 1991, in partnership with the Vietnamese government, the Prosthetics Outreach Foundation (POF) of Seattle opened a medical clinic for ampu-
tees in Hanoi. Two years ago, a factory for artificial feet and legs was also created in Ba Vi, making use of POF's advanced prosthetics technology for treating injuries specific to landmines. The Vietnamese staff was trained to fabricate and fit artificial limbs, using local materials and distribution systems, thereby en-
abling the people to help themselves and contribute to their own economy. Nearly 10,000 lower limbs have been furnished by the POF Hanoi clinic to amputees in the region, allowing them to resume normal lives that include work, marriage, family, and most importantly, survival. It took money to set this in motion, but it was the technology and training imparted that made it a successful model of indepen-
dence and recovery.

The ongoing genocide in the Balkans and Africa requires an urgent response to its survivors. As America's enjoy an unprecedented era of prosper-
ity, we must stretch the parameters of our own com-
fort to include those who have lost everything but their lives. The principle of self-reliance is the cornerstone of the war-torn countries and confidence to the people. Let us look forward to peace and stand ready to share our skills and knowledge, recognizing that there is no greater humanitarian act than help-

ing people save their own lives.
to support effective assistance programs in mine-affected countries."

**State Responsibility for Survivor Assistance**

In his most recent report on the landmine crisis, the U.N. Secretary General said that a proper response to the landmine crisis includes the "rehabilitation of landmine victims and their return to productive activities in order to reintegrate them into society." State responsibility for assistance to landmine survivors can be established in international humanitarian law and international human rights law. Under such law, States have binding obligations, which they must perform in good faith to prevent landmine injuries to individuals and to make accommodations for those injured. In particular, the Landmine Ban Convention requires States to do their utmost to provide assistance and survival.

The use of landmines is inconsistent with both treaty law and customary international humanitarian law in that their use cannot guarantee civilian safety. The promotion of this body of law, he said, is an "emerging norm of international law that the use of landmines is illegal."

International human rights law imposes duties on States with respect to treatment of persons injured in their jurisdiction. Particular duties include the obligation to guarantee the rights of persons with disabilities, the right to development and the right to the highest attainable standard of health. Applying these rights, either separately or collectively, to survivors, States are obliged to ensure that survivors receive reasonable accommodations, which may necessitate special treatment, to guarantee their equal enjoyment of these rights. Such treatment includes access to proper medical treatment and comprehensive rehabilitative care.

The principle of co-responsibility in the U.N. Charter provides that, in joining the United Nations, States pledge to take "pains and separate action" to implement rights guaranteed in other States. Thus, in some circumstances, States that are not themselves mine-infected have a duty to help other States to provide landmine survivor assistance.

Under international law, States must pay reparations for breaches of international obligations. This applies when injuries are sustained as a result of illegal use of landmines, or in cases where States fail to fulfill rights guaranteed under international human rights law. Then, demands for compensation by survivors are grounds in international humanitarian or human rights law on a solid legal foundation.
A Unique Sisterhood
The African Women's Alliance for Mobilizing Action

“Landmines may take a limb or lives, but not the heart or spirit of the African Woman”—AWAMA

by Margaret S. Buce

Originally formed in 1997 as an advocate for African women's education, The African Women's Alliance for Mobilizing Action (AWAMA) quickly undertook the cause to support landmine victims and landmine removal. Working in the province of Zambezia in central Mozambique, Thelma Venichand, director of AWAMA, has no shortage of volunteers, and victims requiring assistance and integration. But, what AWAMA lacks is funding. Currently, their landmine-association programs and other support services are on hold until funding and financial aid for their project is received. They are hoping an organization and/or donor will step forward to coordinate efforts with them.

“We are very excited that we are here, and about the integration issues we hope to make progress in. When I came here and was ready to start setting up, people from the community showed up with bags of food ready to go to work and clear land for buildings. It was very heartbreaking to see them trying so hard to get money for supplies,” said Venichand.

The organization is dedicated to the community and has a grassroots campaign to keep its programs personal and community oriented, in keeping with the African culture. AWAMA also strives to be responsive to the needs of the individual. While medical care and help are prominent, the socio-economic impact on families and individuals is a paramount consideration. It needs to be addressed, say Venichand.

She also mentions that in general, people in the communities are very supportive of each other. In rural communities, women will help with the childcare and the sick of families in the community. In the African culture, women are expected to take care of the family and housekeeping, regardless of their own landmine injuries.

A woman's predominant role is to “love and support others, to cook, clean, and raise children of the children.”

—Thelma Venichand

“Landmines, while horrific for all involved, are especially worse for women. When men are injured in their community, they are taken care of by the family, cook, clean, raise children of the children.”

—Thelma Venichand

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Can We Face the Landmine Victims?

A crowd of “muladhars,” Portuguese for the mulathed ones, gathered outside the CARE office in Menengue, Angola. Among them were few with prosthetic limbs, mostly ill fitting. As for the rest of the legs, they got around on crutches that look like found objects. Several people in the crowd had lost an arm, one person was missing both.

Another man had the requisite number of arms and legs, but no hands. These were survivors of landmines. Menengue. It was a graveyard where the women, except one, a young woman, her prosthetic leg covered to the knee with a dingy white sock. As is commonly the case with women who have survived the trauma and mutilation of landmine explosions, her family still depends heavily on her. With water to fetch, meals to prepare, and children and elders to care for, she had the time to come, along with 50 men that day last month. They had heard that a stranger from America won there to talk and for their own lives and their future.

Angola is twice the size of Texas, yet within its 481,000 square miles are estimated 15 million plus landmines, about 1.5 mines for each person. Even half of that in the United States would be a crisis of staggering size. Angola’s mines are a Cold War legacy that many choose to forget. They were laid during the decades of superpower-suppressed Civil War that followed Angolans independence from Portugal. Twenty years later, nearly 77,000 of Angolans citizens are muladhars.

I spoke with a “muladha” named Domingos Manuela. A pretty 25-year-old who looked more like 16, Manuela’s face was calm, even a little winsome, as she told me about her life. She stepped on a mine in 1992 on her way to buy cassava for her family. Abandoned by her husband after her injury and no longer able to farm her own field, she still suffers from grief and shock. Her plans to provide for her parents and children have turned upside down. Still, she tries to contribute to the household, buying oil to sell in the market. Oil is heavy, so she makes many trips on her prosthetic leg, and earns just enough to survive. The Recreation Department worked at a local hospital for 20 years before he was drafted as a military nurse. One day as he accompanied an injured soldier to find medical treatment, the car ran over a mine, killing the driver and injuring Batista’s legs. After a grueling years of treatment, he had returned to the village, where his colleagues finally got him to doctors who could amputate both legs and save his life. Batista’s desire to help others was not diminished. Once able, he returned to work in the hospital and has since become the elder of his community.

The Clinton administration said it would go to Oslo, Norway, to seek a quick ban on this terror. By seeking special status in its demands for exceptions, the United States risked alienating, even killing, the possibility of a treaty of any value. The muladhars of today and tomorrow seemed far from Clinton’s mind as his delegates pushed to accommodate Pentagon demands to exempt anti-personnel mines on the Korean Peninsula, continue the use of smart mines, and allow a loophole through which to cap out of expedient.

Talking with them, the policy arguments fade and one is left staring into wounded eyes. Batista, Manuela, and the others shared their experiences with us. The muladhars of me, understanding that I would convey their words as a testimony of the powerless to those who have the power and who share in the moral responsibility to exorcise the scourge of landmines.

Journal of Conventional Weapons Destruction, Vol. 3, Iss. 3 [1999], Art. 1

by Clarice Stylton, CARE

Landmines are multiples of misery for thousands of innocents, turning communities into theaters of war long after the combat is over.
Effect of Conventional Weapons on Civilian Injuries

Introduction

The use of weapons against people or targets containing people inevitably has a direct impact on the health of those people. This impact is related to factors dependent on the design of the weapon; wounds from bullets, fragments, and buried antipersonnel mines are distinguishable. Factors dependent on the user, such as discipline and desire to avoid or injure civilians, determine the number and kind of people injured and, in the case of bullets, determine which part of the body is injured. This century has seen an increased proportion of civilians injured during war. This is usually ascribed to military weapons passing into the hands of those with no respect for the civilian population or the Fourth Geneva Convention, which protects civilians. In parallel, there has been an extraordinary development of the military efficiency of weapons. This generates a provocative question: What is the difference between the weapon development this century linked to the increased proportion of civilians injured? This poses a further question: does increased ease with which a weapon can be used to achieve military objectives (military efficiency) increase the potential for civilian casualties?

The hallmarks of countries where most modern wars are fought are poverty, destroyed social and economic infrastructure, and availability of a variety of weapons. Disciplined armies train their soldiers in the laws of war, which include respect for the civilian population; by contrast, modern wars tend to be fought by forces that are poorly trained and may even target civilians. Another feature of these modern wars is that poor medical facilities are few or non-existent. Care of those wounded during these conflicts has fallen to international aid agencies. One of the few sources of data about casualties in these wars is the hospitals run by the International Committee of the Red Cross. We examined all the data held by the Red Cross on wound injuries treated in its hospitals from January 1991 to July 1998 to explore these two questions. We also examined data from the Kabul hospital during a period when the city of Kabul was under siege.

Analysis of data from Red Cross hospitals

by Robin M. Cooperland and Hans O. Sørensgaard

Introduction

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Patients and Methods

Database

The wound database of the International Committee of the Red Cross was installed in January 1991 and originates from a system of data collection originally designed to give the organization an indication of activities of its independent hospitals. All patients wounded in war who have been admitted to the Red Cross hospitals of Quetta (Afghan border of Paki- stan), Kabul and Kandahar (Afghanistan), Khao I Dang (Cambodian border of Thai- land), Buzare (Rwanda), Novi Aragi (Chechenia) and Lekochikio (Sudanese border of Kenya) have routinely had a data form filled out on their death or discharge from surgical wards. Age and sex, the cause of injury and the time lapsed between injury and admission are recorded for each patient. Patients are not asked whether they are combatants.

Kabul

The Red Cross hospital in Kabul, functioned independently until the fall of the communist government in mid-1992. It was the first of its kind to be in a city under siege rather than removed from the conflict over a border. Where the hospital was working was thus the same as where patients were wounded. Patients were wounded in the city itself and at the front lines surrounding the city. Those wounded among the rebel forces besieging the city had access to the first-aid posts run by the Red Cross outside the city and then were transported to the hospital by the organization's ambulances; few reached the hospital within six hours. By contrast, those wounded in the city reached a hospital usually within an hour and certainly within six hours. Pa- tients in the city were representative of victims of urbanized, modern conflict, many were clearly civilians.

Analysis

The patients' data were analyzed by age and sex and the cause of injury. As in previous studies, women and girls, boys (under 16 years of age), and men of 60 or more were considered to be civilians. In this study, bullet injuries indicate any gambrel wound, fragment indicates injury from shell, bomb, or mortar, and mine indicates injury from an anti-tank or anti-personnel mine. Differences in the proportion of people injured by bullets in comparison with mortars or mines were evaluated using the x² test. (see table at right)

Results

A total of 27,825 patients were registered between January 1991 and July 1998. Of these, 18,877 were injured by bullets, bombs, shells, mortars, or mines; the rest were admitted because of burns or blunt trauma or for reconstructive surgery. Of the 18,877 who were injured by weapons, 2,012 were ad- mitted to the Kabul hospital in less than six hours after injury.

Discussions

Limitations

These data are probably the best available means of examining the direct human impact of the use of weapons in modern conflicts. Their validity and reliability have not been ascertained by formal independent means because of the constraints imposed on collecting them under field conditions and there is obvious scope for misclassification. Some patients lie about how they were injured to gain admission to hospital or they may not know exactly what injured them, and our means of classifying patients as combatants or civilians is a potential source of error. Never- theless, any misclassification in this setting is likely to have underestimated the number of civilians. The number of men aged 16—49 who were civilians was probably greater than the combined number of women, boys and men over 49 who were combatants. Thus the proportion of civilians is almost certainly higher than the proportions given here.

Weapon type and civilian injuries

To our knowledge, the implications for civilian injuries brought by different weapons have not been fully examined before. These data show that factors relating to both the design of weapons and the discipline or intent of the user have implications for civilian injuries. The higher proportion of civilians in- jured by fragments rather than bullets is significant and may be exaggerated in a different context such as a city under siege, where at least 61 percent of those injured by fragments were civilians. Likewise, the pro- portion of injured by mines is significantly higher than that injured by bullets. These statistics must therefore be a link between the technology of weapons and who is wounded. Two points are important when consider-
Animal Casualties of the Underground War

It has become increasingly evident that animal activists need to join the fight to ban forever the use of violent, indiscriminate landmines that destroy the lives of both humans and nonhumans with their devastating force.

In some instances, landmines directly threaten both people and animals. Reuters reporter Roger Atwood wrote in 1997 that roughly 20,000 landmines are strewn across the Falkland Islands. Landmines also threaten animals, keeping the livestock from danger can be a struggle. Meanwhile, "birdwatchers, one of the biggest groups of tourists, are especially vulnerable as they walk in search of penguins, ducks and songbirds."

In Sri Lanka, as many as 20 Asian elephants are killed by mines every year, according to zoologist Charles Sarniapilau of the University of Peradeniya. Thousands of miles away, in Africa, landmines have ravaged wildlife, including threatened and highly endangered species. Mines reportedly have killed at least 100 elephants in Mozambique. Scott Nathanson, a Disarmament Campaign organizer, writes that elephants in the Gorongosa national game park "have been maimed because of anti-personnel landmines, or killed because of anti-tank mines.

In Zimbabwe, Lt. Col. Martin Rupiah, a lecturer at the Center for Defense Studies at the University of Zimbabwe, claims that "every village in Chidzui has lost at least one animal to landmines... In the Gonarezhou National Park, elephants and buffaloes have had to be killed after they were injured by landmines." In northwest Rwanda, one of the region's highly endangered mountain gorillas was killed by a landmine as a result of that country's recent Civil War. According to the field staff of the International Gorilla Conservation Program, the 20-year-old male silverback was named Mhono, which means "band" in the Kibaswali language; he had already lost a hand to a poacher's snare.

In Croatia, Professor Djuro Haber of the University of Zagreb has documented wildlife fatalities due to landmines. He reports the deaths of European brown bears, roe, deer, lynxes and foxes as a result of mines placed in the region from 1990 to 1996. The placement of landmines also poses an indirect threat to wildlife. In western Bosnia, many regions of the world, arable farmland is rendered useless when mines are placed in fields. This causes farmers to move into marginal adjoining regions otherwise inhabited by wildlife. As poverty increases because of farmland restrictions, hunting may increase to feed hungry families. Similarly, poaching wild animals may increase to fund arms purchases. In 1995, Nick Rufford reported in the London Sunday Times that the Khmer Rouge in Cambodia used tiger skins and bones to purchase anti-tank landmines and guns.

Just as wildlife habitats and farmland are put in conflict as a result of landmine placement, livestock and "village dogs" are also harmed by mine explosions. Since herds are usually large, an explosion set off by one animal may kill many others. A study of the social and economic costs of mines in Afghanistan, Bosnia, Cambodia and Mozambique concluded that more than 54,000 animals were lost to landmine detonations. Mines deployed during World War II eventually killed more than 3,000 animals per year in Libya between 1940 and 1980. A 1996 Reuters report by Jonathan Lyons in Iraq tells of a farmer named Sali Abdullah whose, "horse stepped on a mine, sending fragments, dirt and rocks tearing through (Abdullah's) face and upper body."

The animal was killed on the spot, but doctors remain hopeful they can save Abdullah's eyesight. "Such livestock/landmine encounters are not strictly accidental," Lt. Col. Bupiah noted that landmines placed in Rhodesia (now Zimbabwe) back in the early 1950s still exist and that, "Since 1980, only 10 percent of the mine fields have been cleared." He suggests that as much as farmers in their villages place 80 percent of these mines in communal areas that should have been used for crops instead of landmines. Those farmers who chose to return to their lands "pushed their cattle ahead to detonate the mines."

In western Bosnia there are unconfirmed reports that residents of Sanski have mined their own method of demining called "sheep" demining," where they simply let sheep loose into unsecured areas. Sheep were also used to clear mine fields during the 1980-1988 Iran-Iraq War. A coordinated effort is under way to use well-trained dogs for mine verification and marking. Dogs trained at the Swedish Dog Academy and used at the Cambodian Mine Action Centre are used to find and identify mines, allowing human workers to fence off the surrounding area and eliminate the mine. The United States has supported the use of this new breed of "sniffer dog," which is apparently better at mine detection than mechanical detectors because many mines are now predominantly plastic and can be unearthed by the dogs.

Unfortunately, the United States has not been an enthusiastic supporter of recent global efforts to ban these dreadful devices and ensure their removal worldwide. The United States refused to join 125 other nations in signing the historic Ottawa Treaty: the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction. The treaty establishes a schedule for all participating nations to stop using, developing, producing, acquiring, or stockpiling landmines and делеivers a commitment to ensure the destruction of anti-personnel mines.

The United States was not alone in its refusal; other nations including China, Egypt, the former Soviet Union, Israel, and Pakistan also did not sign. Unlike the United States, these nations are among the world's leading producers and exporters of anti-personnel landmines. President Clinton used the excuse that landmines along the Korean demilitarized zone are an essential deterrent to an attack by North Korea. Meanwhile, approximately 26,000 people are killed or maimed every year by a fraction of the estimated 100 million mines spread throughout the world. No one knows for sure how many animals are killed, but it is clear that landmines are indiscriminate and devastating. The 1997 treaty is an important step toward stopping the epidemic of mine casualties. However, every effort must be made to remove and destroy existing mines. A mine that costs as little as $3 to place may cost $300-$1,000 to remove. Adequate funding is vital to the successful termination of the international landmine extraction effort.

The United States has committed $60 million to the effort in 1996, but the United States must increase its efforts, and the entire effort may cost more than $30 billion to complete.

Some members of Congress are committed to the cause of eliminating landmines, particularly Leahy (D-Vt.) and Rep. Lane Evans (D-Il.). Introduced legislation to bar American armed forces from using any anti-personnel landmines for one-year beginning in January 1999. President Clinton signed the Land Mine Use Memorandum Act into law in early 1996. Leahy also introduced a bill in June 1997 with Sen. Chuck Hagel (R-Neb.) to ban deployments of anti-personnel mines after January 1, 2000. Evans has introduced a companion bill in Congress. There is now a historic opportunity to build on existing leadership in the quest for the cooperative global elimination of landmines. Animal activists need to enlist in the effort to win the coward's war for the sake of innocents being everywhere.

Your Agenda:
• To encourage greater political support for land mine elimination, write to Clinton and urge that the United States sign the Ottawa Treaty.
• Contact your senators and representatives about supporting the Leahy (S.896/Evans (H.R. 2459) Land Mine Elimination Act.
• Several web sites offer information on landmine issues. For details about animal and environmental damage caused by landmines, visit http://www.freenet.edmonton.ab.ca/~pygpydex/index.html.
• To learn about the international campaign to ban landmines, contact http://www.vvaf.org for demining projects, see http://www.mmg.org/.
by Dr. Charley F. MacKenzie
Save-The Children

On May 22, 1999, President Clinton announced a decision on anti-personnel landmines that continue the United States to sign the Ottawa Treaty by the year 2000. With this initiative, Clinton cleared the way for the United States to join the more than 120 nations that already have signed the treaty, which is an international agreement that bars the stockpiling, use, import and export of anti-personnel landmines. This is welcome news for the children, families and communities whose daily lives are affected by the scourge of landmines.

We at Save the Children urge the administration to sign the Ottawa Treaty. We believe that alternatives to anti-personnel landmines already exist and it is no longer necessary to endanger the lives of millions of the world's children through the use of landmines.

Banming landmines, however, is only one step toward solving the world's most hazardous weapons. We also must focus on the urgent need to eradicate the nearly 100 million landmines that are currently in place, and to address the long-term psychological, social and economic needs of landmine survivors. Clinton recently announced his support of the Demining 2010 Initiative, which calls upon the United States to lead a global campaign to eradicate existing landmines by 2010.

In addition to mine clearance efforts, the initiative also will address the rehabilitation and economic needs of victims whose lives have been shattered by landmine incidents. Ambassador Karl F. Enderfurth has been appointed to serve as the U.S. Special Representative to the President and the Secretary of State for Global Humanitarian Demining. The United States has expanded its own demining program with an increased funding from $68 million to $77 million in the 1998 fiscal year.

The urgency of the Demining 2010 Initiative cannot be overstated. In the last two decades alone, landmines have killed more than 1 million people, mostly civilians, many of them children. Each year an estimated 25,000 people are killed or maimed. Young children, especially, are particularly vulnerable to landmine injuries, as they are curiously, physically and socially active and adventurous. Compared with adult landmine victims, children have higher fatality rates and experience more severe physical damage and permanent disabilities as a result of their injuries.

Save the Children works with communities that are continuously exposed to the threat of anti-personnel landmines. In Afghanistan, one of the most heavily mined countries in the world, Save the Children assists children landmine victims and their families. The program uses participatory games and activities to help children recognize and avoid contact with mines. To date, this ongoing program has reached more than 100,000 children.

Save the Children also is beginning a Social Rehabilitation Program in Afghanistan that addresses the medical, psychological, social and economic needs of landmine victims and their families to assist with their recovery from trauma. Ahmed, a 15-year-old Afghan landmine victim, articulates the hopelessness so many younger feel and their challenges they face: "What will happen to my family...to my mother and father? Why couldn't I have died? It would have been better if the mine had just killed me. Now I am too weak and a burden on everyone, including myself."

The plight of children in Afghanistan has recently been documented in a report commissioned by Save the Children and UNICEF. The report, "Impact of Conflict on Children in Afghanistan," is based on extensive interviews with 500 Afghan children aged six to 18. It documents the negative consequences of civil strife on children, whose educational, social and economic needs are disrupted by conflict.

We must allow children worldwide to live in peace and play in areas free of landmines and provide them with a sense of hope for their future. As Clinton remarked, "The world's children deserve to walk the earth in safety. Let us follow through on this promise by signing the Ottawa Treaty before 2006 and continuing to strengthen our efforts for survivors of landmines, their families and their children."

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The Impact of Landmines

Yesterday and Today

by A.G. Marangione

On April 20, 1945, at about 5 a.m., still dark, I and two of my companions from Troop A 16th Cavalry were on a reconnaissance patrol on the outskirts of Dusseldorf, Germany. I was in the passenger seat of a jeep. I had a driver and one man in the rear manning a .50-caliber machine gun. His name was Clarence Brown, but because he was a huge fellow we affectionately called him "Bear." We had been together since our Cavalry-Squadron was formed in 1942 in Fort Oglethorpe, Georgia. On April 20 we were part of a very proud and successful 3rd Army and were deep in Germany. We all knew the war would be over soon and each of us, without ever talking about it, was hoping to survive, whole and healthy.

Our function as a reconnaissance unit, sometimes called a "Sniper and Peek" outfit was to gather military information by exploring enemy territory and hopefully learning the approximate strength of enemy units in men and material for our men, who were preparing to take Dusseldorf with a minimum of casualties.

Despite the fearful pounding from our artillery and aerial bombardment, the enemy, mostly young boys and old men, put up an astonishing and vigorous defense. They were short of everything soldiers need: experience, training, weapons and ammunition, but not courage.

As our jeep moved forward very slowly along a dirt road in pitch darkness, we were alert for German Rear Guard Units and even more apprehensive of what we could not see or hear, anti-tank mines. To add to our problems they also spread anti-personnel mines in the fields on either side of the roads. In this way they hoped to slow down our vehicles and our infantry. Suddenly and simultaneusly I heard a loud explosion and felt my body rising in the air. We hit a mine. Within seconds I was unconscious and remembered nothing until I awoke in a drainage ditch along the side of the road. By then the sun was coming up and it was deathly quiet. I could see the jeep badly damaged and on its side. I could feel blood on my face. I had a terrible headache and severe back pain. My nose was stuffed, making it hard to breathe. I didn't know where my driver or Bear were. I knew I was seriously hurt. I couldn't seem to move nor did I try. I was alive but by this time men despite being injured I felt I was indescribable.

My next thought was survival. Who was going to reach me first, my people or a German patrol and if the Germans got to me first would I be shot? We all know about Malmedy and the desperate circumstances the Germans were in. At that stage of the war, it was highly unlikely that the Germans would take prisoners, especially wounded ones. I took my pants off and placed it on my stomach. Fortunately, a medical jeep appeared with a doctor and two medical aids. The young lieutenant carefully examined me. Since I couldn't move my legs very much he was concerned about my back injury and took care not to make it worse by too much movement. I asked about my companions. The lieutenant told me that they only had minor injuries and that they would be taken to a field hospital. The driver's injuries were minor but Bear was dead. The doctor chose not to tell me.

I was given several injections of what I believe was morphine, which quickly put me at ease and relieved my pain. I was then put on a stretcher and driven to a makeshift field hospital which was little more than a tent where doctors and medical aids administered first aid and assessed the injuries of the wounded men. After examining me they gave me some more injections and placed a large red rag around my neck. It was a designation for priority air evacuation. I fell asleep but was soon awakened by several medics who were placing me on a metal table that opened and parted in the middle. Apparently it was decided to put a temporary cast on my back. Their attempts to put on the cast caused such intense pain that they decided instead to simply encase my back in heavy bandages. I was then returned to my original place in the tent to await ambulance removal to an airfield. There were many casualties in that tent, some dying, some dead and others moaning in pain. A number of medics seemed to by constantly coming around giving us injections of morphine that at least helped the men to cope with pain. The next thing I remember I awoke in an ambulance with three others. The ambulance was barely moving over a badly bombed out road. We were all heavily sedated so that no one made a sound. After what seemed to be an hour-long ride, the ambulance stopped in a field where we could hear the sound of airplane engines. We were quickly placed aboard a plane and told we were going to London. It was my first plane trip. We were no sooner airborne than it started to rain heavily, so much so, that the pilot landed the plane in Paris. We were then placed in ambulances and taken to a hospital in what appeared to be a very upscale part of the city. It turned out that the hospital was formerly an exclusive golf school. There I underwent a battery of X-rays and tests for my injuries.

Diagnosis was skull fracture, spine fracture, fractured both cheekbones and nose and multiple facial lacerations.

Since I hadn't washed in a week, two French nurses or aids thoroughly cleaned me, gave me a much needed shave and then placed me in a bed to await the application of a back cast. To my left was a soldier totally encased in bandages. He had been a field cook when a field stove he was using went up in flames. He died during the night. To my right was a young Southerner who was told by doctors that they could not save his leg and that they would have to amputate it the following day to save his life. He had been severely injured by anti-personnel mine a week earlier. He cried all that night. The following morning they amputated his right leg just below the knee. For days afterward he complained of "pain in my foot." I think it is called phantom pain.

After a few weeks I was transferred by train to another hospital in Cherbourg and then returned to the United States by hospital ship. I then went to Rhodes General Hospital in Utica, N.Y., for treatment and convalescence. I have given little thought to the events described for nearly 40 years, until this country's involvement in Vietnam. One of the chief components of that conflict was the indiscriminate and large-scale use of anti-personnel mines. In Vietnam mines were laid, or more correctly strewn about by the tens of thousands. Landmines caused many thousands of casualties among troops, civilians and bystanders yesterday, and continue to harm the innocent today.
The Village of Many Widows

by Paul Giannone, CARE

The dusty road passed through the village with little fanfare. A few bamboo huts were scattered atop the brown dry soil. The old woman sat on a flimsy lean-to built on the side of a small stilted bamboo hut. The lean-to protected her from the unrelenting heat of Cambodia. As we approached her, we pressed our hands together as if in prayer and bowed, the traditional Cambodian greeting. Through our interpreter we asked if we could ask some questions about the village. She gestured for us to sit down on a raised bamboo mat at the back of the lean-to. Behind us sat another woman, who was probably in her late 20s but looked much older. Between her legs a small child of about five sat rested. Soon another ancient one joined us. If you could count the lines on her face like a tree, I’m sure she would have been hundreds of years old. Her face said many things to me. The lines, the dry leathery look, the sad-happy smile, all told years of hard work, poor harvests, bad weather and war. There was also strength, perseverance, dignity and the will to survive in the aura of this woman. Somewhere she had managed, either by luck or skill, to survive the cruel game of life and death that had been Cambodia for over 20 years.

Our interest was mostly the location of mine fields and we asked if there were any around or if landmines were a problem. She indicated that there used to be many mine fields out there, but the Cambodian government had come and destroyed them. "Are people still hurt by landmines?" we queried. "Not recently," she explained, but added, "we know there are mines near the river where we get water and some of the wooded and hilly areas have mines in them. We are careful where we walk." "What are your problems?" we pressed on. "Water is a problem. The river is three miles away. It's a long way for an old woman to fetch water for crops, washing and cooking. And of course you do have to be careful of the mines. Sometimes I don't have enough water to clean myself or the children," she answered.

I asked where the men were and the ancient one told me that you could call Both Non the "village of many widows." She went on to say that you might see some male children or teenagers, but most had been claimed by the wars.

For the week we spent driving around Battambang Province the pattern was almost the same. The area was former Khmer Rouge territory that was plunged from war to peace when the Khmer Rouge leadership "defected" to the government side. Displaced people, refugees and those living in towns rushed back to claim land for fear that others might homestead it. The idea of land ownership is a difficult one in the province. The Khmer Rouge destroyed all land records and deeds. Land is controlled by the government, the police, the military and people who seem to be homesteading.

Battambang Province has rich soil, precious gems and forests. The area once produced enough food to feed the entire country. Now the major harvest is landmines and unexploded munitions. The province, now at peace, does provide opportunity. Villages are springing up wherever road improvements are made. People are homesteading regardless of the risk of landmines and buried bombs or the fact that there is no infrastructure to support them. Those that can't cope, and many can't, end up back in refugee camps or destitute in the larger cities.

Everywhere we went the story was the same. Moving back onto the land was risky, but the risk had to be taken. I witnessed huts being constructed on land that was marked by the now familiar red skull and cross bones signs stating in both English and Khmer "DANGER LANDMINES." The answers to our questions became repetitive: "We need water, we need agricultural support, health care, our children need to go to school." Like any disease, mines are a part of that harsh environment influencing all the other factors. Mines and unexploded bombs prohibit the digging of wells, the improvement of irrigation systems, the expansion of agricultural land. Schools and health centers cannot be built and if they could, getting to them might be a problem. In one area where there was a school, the children could not attend full time because they needed to haul water, navigating the mine fields as they went about their task.

The specter of mines seems to be everywhere. In one village, a woman told us a man had been killed by a mine that morning while searching for firewood in the hills. As she told us the story, a procession of people came by carrying a hastily made coffin with the latest mine victim in it. In another village, I spotted an anti-tank mine sitting on the floor of a hut. The device could certainly destroy the entire hut and everyone in it. When we asked the woman why she had such a device in her home, she said she did not know why it was there, her husband had brought it in. She did not know if it had been defused. Not wanting to touch the device for fear of setting it off, we strongly cautioned her to tell local demining teams about its location to have it removed.

It is not that the Cambodian Government and other international non-governmental organizations (NGOs) working in Battambang Province do not understand the situation. The Battambang Provincial Development Plan recognizes landmines as a major impediment to development. They have also recognized the fact that in order to tackle a problem of this magnitude, everyone has to be involved in the elimination of mines. Battambang Province has many NGOs working in the demining field, including the Cambodian Mine Action Center (CMAC), Landmine and Development Action Center (LADE), and The Handicap International Cambodia Mine Action Center (HI-CMAC). However, the NGOs need funding and special attention from the government. The NGOs do not get the appropriate level of funding needed to undertake this gigantic mission.

As development agencies such as CARE wait for the needed financial support to start integrated humanitarian mine-affected programs that would not only address the safety and security issue, but deal with development and reconciliation, people in countries such as Cambodia, Angola, Bosnia and Afghanistan are being forced by external pressures to build villages on mine fields. Children do not go to school, villagers expose themselves for firewood and food and ancient widows sit in lean-tos pondering the past and worrying about the future.

Currently the worldwide strategy for the total removal of landmines centers on the development of national Mine Action Centers (MACs). The majority of U.N. and governmental funding and equipment go toward these MACs and the strategy is valid. The size of the landmine problem in most countries is so great that the national governments must take the major role for landmine removal just like they take a major role for health care, education and social services. But as the MACs are gearing up to fight the big picture war on landmine removal, the clearance of roadways, government buildings and large barrier mine fields, smaller battles are being fought at the village level for survival. The need for grass roots sup-
CARE

INTERNATIONAL

immunization of children against major diseases.
Access to family planning services.
A safe and sustainable environment.
A role in the decisions that affect their families, communities and nations.

Over the years, CARE has adapted to meet changing human needs. In the 1960s, it expanded into emerging nations and used U.S. surplus food to feed the hungry. In the 1960s, they pioneered primary health care programs. In the 1970s, CARE responded to massive famines in Africa and helped prevent them with an innovation called agroforestry, which integrated environmentally sound tree and land management practices with farming programs. Today, CARE has expanded its efforts to also respond to the landmine crisis and to the crises for help of the victims.

Landmines, A Human Rights Issue
Each year, 60,000 people are killed by anti-personnel landmines. That translates into 70 people every day, most of them in- nong women, men and children. Landmines don't just kill; they maim and inflict terror. They are inhuman. Even when the war is over, landmines continue to inflict horror on innocents for years to come. Landmines also have a paralyzing ef- fect in poor communities in many places around the world. They cut off access to markets, schools, water and farmland. CARE works in 30 of the 70 countries riddled with landmines, including Angola, Afghanistan, Cambodia and Bosnia.

The Landmine Epidemic
Once-terrible fields lie abandoned, haunted by the specter of death and disfig-urements. Roads are deathtraps, even for re- lief workers in armored vehicles. Land where children once played sit empty, the deadly areas sometimes marked, sometimes not. For the men, women and children who contend every day with landmines, the sheer numbers of the weapons make prospects bleak.

Angola is only one of many countries suffering from this global epidemic. 110 million landmines cover 64 countries, with 2 million more added each year. The weapons, inexpensive to produce or buy and easy to distribute, are extremely difficult to detect and costly to remove. In some places, mines seem to multiply faster than people do. As a 1994 U.N. report stated, "Cancut has more mines than children; two for every child."

CARE's Stand Against Landmines
In June of 1995, CARE joined the Inter- national Campaign to Ban Landmines (ICBL). This coalition of more than 400 non-governmental organizations (NGOs) takes a clear and unequivocal stand against the proliferation of these weapons. CARE will address the landmine problem directly through its new Systematic Landmine Re- moval Program. This program, the first at- tempted at the global level by an NGO, will clear areas for the end of landmines and habi- tations on mine avoidance and injury pre- vention. The program will begin in Angola, a country facing the prospect of 15 million landmines, two-thirds cleared.

The strategy in Afghanistan
The CARE staff radioed to another mine action team, which immediately proceeded to the area, blocked off the trench, and disposed of the remaining 19 fences before they could cause further tragedy. The 8-year-old boy fled to death from a severe head injury caused by a direct hit from the mortar fuse. Even the best care would not have saved his life.

This type of incident is precisely what the European Union-funded CARE Mine Related Interventions (CAMRI) Project is working to prevent. "This was a very bad day," observed Willy Williscroft, CARE's technical advisor for the CAMRI Project, "and unfortunately, this type of incident is not an unusual occurrence here; but you can't let it affect your ability to carry on. There is so much work to be done."

CARE's 21-person mine action team frequently works seven days a week to keep up with the demand for their skills. All staff are trained to clear and dispose of mines and explosives safely, and can be deployed in small groups. Removing all the mines and explosions in Angola would be a monumental undertaking; there are an estimated 15 million landmines in Angola. The CAMRI Project is coordinating its activities with other CARE relief and rehabilitation activi- ties to clear critical areas; pathways to roads to water sources and health posts, agri- cultural land, and in and around where people live. CARE also provides mine awareness training to parents and children, so that they have the information and skills necessary to identify a potential problem and seek help before disaster strikes.

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Comprehensive Disabled Afghans' Program

History
The Comprehensive Disabled Afghans' Program (CDAP) was established in 1995 as a UNDP/UNOPS interagency initiative in Afghanistan. CDAP targets beneficiaries including primarily disabled persons, but also vulnerable women and children. The organization uses NGOs to implement a common Community Based Rehabilitation (CRB) project model for disabled and other vulnerable people in both rural and urban areas of Afghanistan. Thorough National Disability Workshops, which bring together all international and national agencies working in this field, CDAP takes a lead role in formulating disability policy and strategy in Afghanistan.

Disability as a Development Issue
Although no national survey has been done, local surveys indicate that about 3 percent of the population of Afghanistan are disabled. A population of 20 million this means about 700,000 children, women and men. War has disabled thousands, creating amputees, blindness and paralysis and, while people disabled by the war a highly visible proportion of the disabled popula- tion, an equally significant but much less visible group are those with sensory and multiple impairments. Many disabled people are hidden from view, especially dis- abled women and children; trapped by their culture and lack of services within very nar- row confines at home.

While 3 percent are directly disabled, if the disabled person was the main breadwinner in the family, the whole family is adversely affected. Thus the actual propor- tion of the population affected by the dis-abled is probably higher than 10 percent.

Community Based Rehabilitation
"Community Based Rehabilitation (CBR) is a practical approach to achieving the rights of disabled people through, for example, prevention and rehabilitation in primary health care activities, main- streaming of disabled children in ordinary schools and provision of economic activities for disabled adults. Disabled people, their families and communities, and the appro- priate health, education, vocational and so- cial services all combine to implement CBR."
CDAP encourages the formation of local committees who take responsibility for disability and related issues in their own area. These committees are typically composed of health workers, schoolteachers, parents of disabled children, disabled people themselves, as well as local shura members. Both field workers and local committees recruit volunteers at the village level who raise local consciousness, provide one-to-one skill training and home-based training. In addition, disabled people's organizations (DPOs) are encouraged and supported at the national, regional and district level. There are currently more than 800 volunteers in the program, 270 local committees and 100 DPOs at the local level.

CDAP and Women's Participation
CDAP is committed to ensuring the full participation of women in the program, as beneficiaries, as workers and as decision-makers. In 1998 approximately one-third of the beneficiaries were women, and one-quarter of the field workers were also women, and female CBR committees exist in all geographical regions of the program. Home-based training by both male and female field workers and volunteers provides an ideal opportunity to reach women who are confined to the home by culture and by disability. Being trained as a field worker or physiotherapist provides women with valuable opportunities for adult education, which are rare in rural areas.

Within the framework of the UNDP PEA.C.E. Initiative, CDAP has responsibility for vulnerable groups other than disabled people, especially women and children. Its main objective is the full integration in community life for marginalized women and children, through advocacy of their needs and rights. Local communities set up to focus on disabled people seek a wider role in addressing the needs of all vulnerable people in their communities. Disability is therefore used as an entry point for concerned discussion and action around marginalized people at the village level within the context of a community development approach.

Who Does CDAP Work With?
• The Swedish Committee for Afghanistan (SCA)
• Coordination for Humanitarian Assistance (CHA)
• Guardians
• Radda Barnen supplies training and advice for CDAP staff in CBR and the needs and rights of disabled children
• Sandy Gall's Association for Afghanistan (SGAA) and International Assistance Mission (IAM) provide training for physiotherapists
• SERVE provides resources and training for work with deaf and blind people
• Inclusive Education (UNESCO)
• Employment Support, vulnerable women and children (ILO)
• CBR, Physiotherapy and Orthopedics (WHO)

CDAP's current program is funded by UNDP, the donor governments, including Sweden, Norway and Canada.

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Doctors Without Borders
Médecins Sans Frontières

When a natural or a man-made disaster strikes a developing country, death and disease is often compounded by a lack of adequate medical care. In many war-torn countries, animosity is so great between warring factions that medical care is often denied to those in need because of their religion, ethnic identity, or political affiliations. In such cases, who will help the helpless?

In 1971, a group of concerned physicians established Doctors Without Borders. Médecins Sans Frontières (MSF), to provide emergency assistance wherever wars and man-made disasters occur. Since then, MSF has grown into the world's largest independent international medical relief agency, aiding victims of epidemics, armed conflict, and natural and man-made disasters in more than 80 countries through the efforts of more than 2,000 volunteers representing over 45 nationalities. Additionally, MSF is often called upon to provide assistance to individuals who lack health care due to graphic remoteness or ethnic marginalization.

The MSF Charter
MSF dispenses relief efforts in strict accordance with the principles outlined in the organization's charter:

• Doctors Without Borders offers assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict, without discrimination and irrespective of race, religion, creed or political affiliation.

• The doctors and nurses of Doctors Without Borders observe strict neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance, and demands full and unhindered freedom in the exercise of its functions.

• Doctors Without Borders' volunteers undertake to respect their professional code of ethics and to maintain complete independence from all political, economic and religious powers.

• As volunteers, members are aware of the risks and dangers of the missions they undertake and have no right to compensation for themselves or their beneficiaries other than that which Doctors Without Borders is able to afford them.

Additionally, MSF asserts its identity as a completely independent, international humanitarian organization. The organization is able to maintain flexibility and independence in its choice of operations thanks to its reliance on private donors. While MSF remains neutral in all conflicts, the organization states, "When medical assistance is not enough to save lives, Doctors Without Borders will speak out against human rights abuses and violations of humanitarian law that its teams witness in the course of providing medical relief."

The MSF Procedure
The primary goal of the MSF is to provide aid promptly and efficiently, following a proven method and well-defined objectives. To accomplish this, the MSF continually seeks information about countries facing emergency situations or potential conflicts. Media reports and close cooperation with other organizations on local, national, and international levels help the MSF assess potential situations. An exploratory team is dispatched to the region in question to consult with local experts and to witness the situation first-hand. The exploratory team then reports to the MSF headquarters as to whether the situation merits action.

MSF maintains strict mission criteria, which it briefly outlines on the organization website:

• The situation must involve the provision of medical emergency aid for victims of war, epidemic, or natural or man-made disaster.

• The aid offered by local medical services and other organizations in the area must be deemed inadequate in relation to existing needs.

• An area must be accessible.

• The safety of the staff must be guaranteed.

• The organization must have enough qualified personnel at its disposal to carry out the work.

• Preferably, there are local organizations or authorities with which to collaborate.

If the MSF decides that it can be of assistance in a situation, the organization can be on the scene of the disaster within 24 hours with planeloads of supplies. This is due in large part to the maintenance of four logistical centers in Europe, East Africa, and stocks of emergency equipment in Central America and East Asia. MSF has even developed pre-packaged disaster kits complete with portable surgical theatres and obstetrics kits that can be ready for transport to the disaster site within hours. Quick and effective response is what MSF does best, and when the disaster is stabilized, MSF leaves to make room for long-term relief organizations and free its own personnel for response to new disasters. As a side benefit to its 26 years of experience in the field of humanitarian relief, MSF has developed handbooks covering many aspects of relief work that have been translated into several languages for the benefit of other relief organizations. The organization also publishes a book series "Populations in Danger," an annual report on the world's most acute humanitarian crises, in order to increase global public awareness.

MSF Assistance to Landmine Survivors
With its highly developed disaster response procedures, it should come as no surprise that MSF is well suited to respond to victims of landmines. The organization voices its opinion in no uncertain terms, "Doctors Without Borders wished to add its voice, in the strongest way possible to the international movement aimed at banning landmines." To this end, MSF has developed a detailed report on the problem of landmines in Afghanistan. Living in a Minefield. In the report, MSF calls for an international ban to help prevent the horrors its staff has witnessed in Afghanistan from ever happening elsewhere. MSF does its part by ensuring that all landmine victims treated by its staff in Kabul, Afghanistan are systematically registered. Between mid-March 1995 and the end of 1996, MSF treated 108 mine victims, and reports that one-in-three were children. In addition, MSF has analyzed the types of injuries most commonly received from landmines, and makes recommendations for emergency treatment and follow-up treatments that the organization would like to see implemented as standards.

The Continuing Role of MSF
MSF plays a vital role in the humanitarian relief cycle, providing rapid response to populations in need, rushing emergency supplies and trained medical personnel to the scene of any of the world's worst humanitarian disasters. Once on the scene, MSF takes life-saving action, providing much-needed services such as massive vaccination campaigns, water and sanitation, feeding and patient care. Perhaps most im-
Handicap International

Presence World Wide

Officially started August 3, 1982, Handicap International (HI) works to provide rapid intervention on behalf of the handicapped and the most vulnerable populations when armed conflict upsets existing systems of assistance and solidarity. In countries where the economic problem is severe or where their expertise in prevention and socioeconomic development is requested, HI also steps in to assist. Technicians in the association offer expertise in prostheses, physical therapy, pneumothorax therapy, psychology, and landmine action. HI presently conducts over 160 projects in rehabilitation, prevention, rural development and emergency programs in 52 countries.

Work in Europe

Because many countries western solutions are not appropriate, Handicap International focuses on developing simple techniques for the fabrication of prostheses for the most destitute of the handicapped. HI's socioeconomic programs enable the construction of survival strategies which Third World and former Eastern Bloc countries, who are affected by famine, underdevelopment and war, can implement for themselves.

HI's work in Europe seeks to integrate handicapped children into the social fabric. To bring about this integration HI facilitates their acceptance into non-specialized schools already in place, such as schools, leisure and vacation, training, modern communication and by encouraging an active role of their families.

Treatment, Prevention, Integration

HI describes its three-pronged approach as "multi-disciplinary programs designed to improve the living conditions of individuals faced with handicap or vulnerability." Real solutions will happen when the communities of the Third World derive technical support from local opportunities and then put those into practice in close cooperation with the handicapped community. The work for HI integrates all of these preventive measures that work according to the shape of the local economic and social conditions.

More specifically described, HI's three priorities are the reinforcement of local capabilities, support for development and integration initiatives and the prevention of handicap-inflicting conditions. Overseas workers for HI integrate all of these principles and have specifically tackled the following:

• Creation of re-adaptation units that provide simple orthopedic devices made from locally available materials.
• Intensive training of local technicians from the handicapped population if possible, and the insertion of those technicians and their services into the community network.

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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 in internal violence and to provide them with assistance. It directs and coordinates the international relief activities in situations of conflict. It also endeavors to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863 on the principles of Henry Dunant and the meeting of the Geneva Conventions, the ICRC has also originated the International Red Cross and Red Crescent Movement, and plays a significant role in providing aid to landmine victims.

ICRC Work with Landmine Victims

The systematic use of violence to resolve human conflicts is as old as humanity and shows no sign of going out of fashion. The phenomenon of landmines, devices that make life in present day warfare, however, go far beyond purely military activity. Their use affects the physical and psychological health of people, in its social and economic development. In some countries, landmines have been killed or injured by mines than by nuclear weapons. The doctors, nurses and orthopedic technicians of the ICRC have witnessed and recorded the human face behind the cries of pain, and the inhuman consequences of what can only be described as a man made public health catastrophe.

Landmines are indiscriminate and pernicious weapons; they kill and injure more people, women, children and agricultural workers after a cease-fire than during the actual fighting. Many mines contain just enough explosives to maim and horrendously mangle. Caring for the victims of anti-personnel mines challenges every part of a public health care system at every stage of its development, and the problem is most acute in countries least able to bear the burden. Landmines render whole regions useless for human habitation and activity, they displace populations and create demographic pressures which destabilize neighboring regions. The surgical activities of the ICRC stem from the institution's general mandate to protect and assist the victims of armed conflict. The war wounded are only one category of the victims included in the ICRC's terms of reference. The ICRC's main role in relation to the war wounded is not to treat them, for this responsibility is the governments involved in the conflict and hence their army medical services. The task of the ICRC is first and foremost to ensure that all involved are familiar with the provisions of the Geneva Conventions and apply them, meaning they also encourage the enemy forces as well as their own and afford medical establishments and personnel the protection to which all are entitled.

Nevertheless, basic medical services are often completely overwhelmed in conflict situations and the ICRC is then compelled to step in to help the war wounded. When supplying hospitals with medical equipment and medicines is not possible, the ICRC must set up its own surgical facilities to offer the wounded the care that the authorities cannot provide.

Some countries simply lack the surgical infrastructure necessary to care for war wounded; in others, access to existing hospitals is denied to certain victims for political reasons, or is simply not available because of geographical factors and the ICRC means of transportation. The ICRC first attempts to solve such problems by either providing medicines, dressing materials and surgical equipment to local structures or by negotiating with the authorities to obtain access to surgical care for all the wounded, in accordance with the principles of the Geneva Conventions. When these approaches are insufficient, the ICRC helps to set up first-aid posts and transportation facilities where possible, send surgical teams to work within existing structures, or open new ICRC administrated facilities for surgical care and rehabilitation. Special consideration is given to establishing safe blood transfusion services and prosthesis workshops to manufacture artificial limbs, which are both in high demand for landmine victims.

In the last 15 years, the ICRC has organized over a dozen of its own surgical units in conflict zones. Most of them have had to treat large numbers of landmine victims, attesting to the fact that the use of this low technology weapon is becoming more widespread, especially in internal conflicts.

Current Activities

In June 1999 the ICRC launched an appeal for 105 million Swiss francs (U.S. $90 million) to fund its activities for mine victims over the next five years. The financial appeal covers all the ICRC's activities relating to mine victims.

Goals

• To promote universal adherence to and full implementation of the Ottawa Treaty and amended Protocol II to the 1980 U.N. Convention on Certain Conventional Weapons.
• To reduce the risk of mine-related incidents through mine awareness programs currently being conducted by the ICRC in six countries.
• To provide mine victims with treatment and physical rehabilitation in 23 limbitating centers that the ICRC is running in 11 countries, and to continue its support for similar centers run by ministries of health.

Publication date 1999, 32 pages, in English, French, German, Spanish, Italian, Russian, Chinese, Arabic and Hindi.
Landmine Survivors Network

Landmine Survivors Network (LSN) works to help mine victims and their families recover through an integrated program of peer counseling, sports, social and economic re-integration into their communities. In countries in the developing world where landmines are prevalent, survivors lose more than a leg or arm; they often lose their place as a valued and respected member of their society. LSN works with survivors and their families to support their efforts to retrace their place and become productive members of their communities. For example, landmine survivors play a crucial role in landmine education, particularly for children within communities at risk.

Since its inception, LSN has been building a worldwide network to link landmine survivors with the resources available to help them. LSN is developing the first comprehensive database designed to track the rehabilitation needs of mine victims and the organizations that can channel urgently needed assistance to the impoverished survivors who need it most.

Today, the network is concentrating its efforts on the mine-polluted countries where most survivors live, including Afghanistan, Angola, Bosnia, Cambodia and Mozambique. In each country, we are working to bring medical supplies, education and employment opportunities to thousands of survivors. LSN is on the steering committee of the International Campaign to Ban Landmines (ICBL), a coalition of more than 1,000 humanitarian, religious and development groups, that was a co-recipient of the 1997 Nobel Peace Prize.

Jerry White
Jerry White, co-founder and director of LSN, stepped on a mine in Iowa in 1984 while hiking with friends. He has 10 years experience tracking the spread of weapons of mass destruction. A graduate of Brown University, White worked at the Brookings Institution prior to becoming assistant director of the Wisconsin Project on Nuclear Arms Control in Washington, D.C. He has testified before Congress and published numerous articles in the New York Times, though many continue to receive financial and technical support from the ICRC. In a number of countries, the National Red Cross and Red Crescent Societies, supported by their International Federation, care for mine-injured people through health, rehabilitation and social welfare programs.

In addition to these activities, the ICRC and national societies are conducting mine awareness programs in several countries in order to reduce the number of landmine incidents in mine-affected areas.

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White's injury in a mine field in Iraq belies the arguments of those who believe the mine problem can be solved by better signs and fences. White spent five months in a hospital in Tel Aviv, where he underwent five operations and learned to walk with a prostheses. "I was only four years old when Syrian soldiers, retreating during the 1967 Arab-Israeli War, laid Soviet-supplied mines in the Golan Heights. The soldiers no doubt hoped the mines would maim or kill Israeli troops. Instead, my mine waited silently in the ground for nearly 17 years until it exploded under my foot and blew off my right leg.

"I was 20 years old. I had taken time from my university studies in the United States to explore the Middle East. I wanted a soldier. I was motivated with only a backpack and an Arabic and Hebrew dictionary. Two friends and I had decided to explore northern Israel on a hiking trip. We were looking for a place to camp and had no idea that we had entered a mine field. There was no fence and no sign to keep us out. The next morning, on a beautiful spring day, I stepped on a mine. I can still remember the deafening blast and the smell of blood, burnt flesh and metal. Only when my friends rolled me over did they see the extent of my wounds. The explosion had ripped off my right foot, shrapnel had lacerated my skin and my left leg. Fortunately, I had a home sticking out of my calf. We screamed for help but it seemed that no one but God could hear. Either I would bleed to death, or my friends would have to carry me out of the mine field. Luckily, we made it out without further loss.

"All the talk about fencing and marking mine fields is a distraction from the real challenge: to stop the proliferation of landmines. I was injured in a country that takes pride in how well it has fenced and marked its mines. But even in a small, security-conscious state like Israel, fences break down, signs fade, fall, or are stolen and mines shift with changes in weather and soil erosion."

Ken Rutherford
Ken Rutherford, co-founder of LSN, holds masters' degrees in international affairs and business administration and has extensive international experience, including work as a U.S. Peace Corps trainer in Mauritania and for the U.N. High Commission for refugees in Senegal. Rutherford was a training officer in Somalia for the International Rescue Committee when he was injured by a landmine in December 1993. Rutherford undertook 11 operations including the amputation of both his legs below the knee. Since his accident, he has traveled worldwide to speak on behalf of a ban and to raise awareness of the mass suffering caused by these weapons. Rutherford currently holds a teaching fellowship at Georgetown University, where he is pursuing doctoral studies in government.

"In December 1993, I was working as a training officer for the International Rescue Committee in Somalia, where my job was to help Somali applying for loans so they could rebuild their country. My project was funded by USAID. On December 16, as I was inspecting a project site near the border with Ethiopia, my car hit a landmine.

I suddenly became something new: an American; a landmine victim. It was to change my life forever.

"After the explosion, I first remember seeing a foot lying on the floorboard of the car. I remember thinking: Is it mine? It was. I was my right foot. I remember that I kept trying to put it back on, but it kept falling off. Then I looked at my left foot. The top part was ripped off and I could see the bone going to my toes, one of which was missing. I dragged myself out of the car and called for help on my radio. It seemed like a lifetime before help arrived. While I was waiting, I prayed to God. I wanted to live. I wanted to be able to walk again."

"I am here today because of the resources that have been provided. I had a radio to call for help and airplanes to evacuate me. Most landmine victims are too lucky. The United Nations estimates that the average lifetime care of a landmine victim costs from $5,000 to $7,000. My medical costs have already exceeded a quarter of a million dollars."

The statistics are staggering. Roughly every 20 minutes someone is killed or maimed by a landmine. That amounts to over 26,000 men, women and children each year injured through no fault of their own. The number of victims has been portrayed in terms of shocking ratios: one in every 230 Cambodians is an amputee; from a landmine injury; one in every 350 Angolans. In truth, no one knows the exact numbers. Most mine victims die without anyone documenting the tragedy.

Today, there are hundreds of thousands of landmine survivors worldwide, including thousands of children, with no access to proper and affordable medical care and rehabilitation. Moreover, the number of victims is on the rise with assistance programs unable to keep up with the demand.

LSN Achievements
- Recognition by the Norwegian Nobel Committee of LSN's contribution to the ICBL co-recipient of the 1997 Nobel Peace Prize.
- A global ban treaty signed by 124 governments, including language recommended by LSN urging signatories to rehabilitate mine victims, the first time humanitarian assistance for victims to be included in an arms control treaty.
- High profile tour of Bosnia in August by White, Rutherford and Diana, Princess of Wales, attracting global attention to the landmine issue just prior to the September
1997 treaty negotiations in Oslo, Norway.
- Establishment of working relationships with survivors in Africa, Asia, and Europe willing to promote cooperation on landmine issues, including better rehabilitation services.
- Development of an easy-to-use database to link landmine survivors with the resources available to help them.
- Over 35 public presentations and speeches, and well over 300 media interviews to build support for a ban treaty and victim assistance.

Since its inception, the Landmine Survivors Network has been building a worldwide network to link landmine survivors with the resources available to help them. LSN is developing the first comprehensive database designed to track the rehabilitation needs of mine victims and the organizations that can channel urgently needed assistance to the impoverished survivors who need it most.

Profile:
Norwegian People’s Aid

Founded in 1939, Norwegian People’s Aid (NPA) is one of Norway’s largest nongovernmental organizations (NGOs). Although NPA is currently involved in more than 300 projects in thirty countries, the organization still adheres to the basic principles set forth by its labor union founders: solidarity, human dignity, peace, and freedom. The range of NPA’s projects is diverse, from extensive outreach programs for the people of Palestine, to short-term emergency relief programs and long-term development cooperation in over twelve countries in Africa, and more. One of NPA’s most notable efforts is its humanitarian demining activities, centered in Asia and Africa.

A History of Excellence

It should come as no surprise that the founding principles of the NPA should have guided it to take a place as a driving force behind the world-wide humanitarian demining effort. Starting in 1992 with mine work in Cambodia, NPA has expanded their operations into several other countries, especially Mozambique, Angola, and Iraq. In accordance with the spirit of its founding principles, NPA not only tackles the physical problem of landmines, but the social and political factors that make mines such a deterrent to the development process of these recovering countries. The Landmine must be addressed not only as a physical threat, but also as a symbolic anchor on the efforts to rehabilitate and rebuild a country.

With this in mind, NPA has developed a multi-faceted mine program that is easily adaptable to individual local needs, but always contains the following elements:

- Mapping of mine fields—NPA is quick to point out that the mapping of mine fields is nothing new, but the social angle which the organization impacts to the activity. To NPA, mapping is not only an aid to the operation of demining, but an important psychological step to empowering the local population by limiting their paralyzing fear of the mines.
- Training—NPA has developed a three-step program for training deminers, and a two-step program for training accompanying medical personnel. The eventual goal of both programs is to make the local population self-sufficient; and eliminate the need for Norwegian presence within five years.
- Demining—NPA’s demining operations are based on tools used by the Norwegian Army, adapted to peace time goals.

NPA points out that it has set the official UN standards for demining in many areas. One of the most successful elements of the organization’s demining programs is the dog-sniffing project, started in October 1994. The dogs make a vital contribution to the demining effort by sniffing out mines and helping to determine the borders of mine fields, so miners do not waste time and resources clearing areas where there are no mines in the first place.

- Mine Awareness—NPA realizes that the extent of the landmine problem is so great, that even with the best of clearance efforts, the local populations of seriously affected countries will have to live with the daily threat of mines for at least the next thirty years. The organization’s mine awareness program consists of instructor training and day-long courses for the local population. The secret of the program lies in the choice of instructors. NPA points out, “It is not enough for the person to be a good instructor, he or she must also be an important resource person that most of the local people will trust. In this way we ensure that the projects will continue for a long time without our presence.”

- Methodology—NPA is actively involved in the development of new demining equipment, with experienced project workers collaborating with organizations such as the Norwegian Armed Forces, the Norwegian Institute for Industrial Design, and The Foundation for Scientific and Industrial Research at the Norwegian Institute of Technology (SINTEF).

Some Individual Successes

Employing 350 deminers, 18 dogs and 2 demining machines, NPA is the largest operator in the mapping and clearance of mines in Angola. Recent efforts include the use of new, time-saving technology to collect and analyze air samples to check for the presence of mines along roads. The samples are collected by mine proofing vehicles, and then given to specially trained dogs to sniff out the presence of mines.

In Mozambique, 1997 was a milestone year for NPA’s demining efforts. Control of the demining program was handed over to Mozambican personnel. NPA continues to support its Mozambican partners in their quest to achieve the use of new, time-saving technology through measures for regional development, mine clearance, and organizational and institutional development. So far, almost 2 million square meters of land have been cleared of landmines, 39 percent more land than NPA originally planned.

The Future of NPA’s Mine Program

One of the only truly new organizations that specializes in mine warfare, NPA continues its efforts in accordance with the organization’s founding principles of solidarity, unity, human dignity, peace, and freedom. To NPA, it is not enough to address only the physical problem of landmines, the political and social implications of the mine problem must also be addressed as an integral part of an affected country’s redevelopment and rebuilding process. And for as long as the mine problem exists, NPA will be there to guide part of the solution.

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Patrick J. Leahy War Victims Fund

Leahy Amendment Moratorium on Use of Anti-personnel Landmines

In 1989, Sen. Patrick Leahy started a fund to get medical aid to victims of landmines. There are an estimated 100 million unexploded landmines in over 60 countries, where they kill or maim an estimated 26,000 people each year. Varieties of countries like Cambodia, Bosnia and Angola have become death traps.

In 1992, Leahy sponsored an amendment to stop U.S. exports of anti-personnel landmines: the first law of its kind anywhere in the world. In 1993, the amendment to extend the export ban passed the Senate 100-0, and in 1997, President Clinton adopted it as permanent U.S. policy. The senator sponsored a 1995 amendment to ban U.S. use of anti-personnel mines for one year, beginning in 1999. That amendment was passed in the Senate 67-27, and was signed into law by Clinton on February 12, 1996. The law reads as follows:

Title I: Moratorium on Use of Anti-personnel Landmines
Sec. 563 (a) UNITED STATES MORATORIUM: For a period of one year beginning thirteen years after the date of enactment of this Act, the United States shall not use anti-personnel landmines except along internationally recognized national borders or in demilitarized zones within a perimeter marked area that is monitored by military personnel and protected by adequate means to ensure the exclusion of civilians.

(b) DEFINITION AND EXEMPTIONS: For the purposes of this section:
(1) ANTI-PERSONNEL LAND-MINE: The term "anti-personnel landmine" means any munitions placed under, on, or near the ground or other surface area, delivered by artillery, rocket, mortar, or similar means, or dropped from an aircraft and which is designed, constructed or adapted to be detonated or exploded by the presence, proximity or contact of a person.


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Prosthetics Outreach Foundation

Prosthetics Outreach Foundation (POF) is a non-profit medical service organization that provides urgently needed high-quality prostheses (artificial limbs) to amputees in developing countries and in the United States. Since 1988, the staff and volunteers have fitted over 10,000 children and adults with new prostheses, enabling each amputee to walk again with dignity. POF helps communities to meet the needs of their own amputees by establishing clinics to create and fit artificial limbs and workshops to manufacture prosthetic components with local materials.

The Ongoing Mission of POF
- POF provides humanitarian relief and modern prosthetic care to amputees in developing countries.
- POF employs the use of computer-aided design and manufacturing technology for high quality automated prosthetic treatment.
- POF provides regular clinical outreach services to amputees living in remote regions.
- POF conducts ongoing research into prosthetic components which are durable enough to withstand the harsh physical and climatic conditions typical to tropical regions.
- POF assists communities in becoming self-reliant by establishing clinics and workshops to manufacture prosthetic components with local materials.
- POF serves as a clinical and technical resource for amputees, government institutions and humanitarian organizations.

Dr. Ernest Burgess

Burgess pioneered hip replacement surgery, new techniques in amputation surgery and became the mentor to generations of orthopedic surgery residents. He introduced the long posterior flap amputation technique to the United States following an academic exchange tour of Poland. This technique dramatically improved circulation in the residual limb and allowed many amputees to enjoy a more active lifestyle.

In 1964, the United States Veterans Administration asked Burgess to establish Prosthetics Research Study (PRS). PRS has become one of the leading centers in the world for developing postoperative care that directly improves the rehabilitation of the amputee.

Technology and Innovations Developed at PRS
- Immediate post-operative fitting (IPOF) of a prosthesis improved healing and rehabilitation time considerably.
- The Seattle Foot®, which has an in-shoe spring, opened the door for amputees seeking an active lifestyle. "Compliant feet" based on this model have also improved comfort for amputees of all ages.
- Always the visionary, Burgess foresaw the impact that the computer could have on the prosthetics profession. Seattle ShapeMaker® software and the AFMA techniques have improved accuracy, efficiency and consistency in the design and production of prostheses.

In 1994, an Endowed Burgess Chair was established at the University of Washington Medical School to fund orthopedic research.

American veteran amputees who had returned to Vietnam and were aware of the horrible inadequacies of medical services and prosthetics there, asked Burgess to help the thousands of Vietnamese men, women and children in need of such care. In 1988, with the assistance of volunteers, POF began the planning for a demonstration clinic in Vietnam. The Prosthetics Outreach Center (POC) opened in 1991 to provide free limbs to amputees in desperate need of prostheses. To date, thousands of amputees have received a new prosthesis free of charge.

International Outreach

The essence of POF service to amputees is providing mobile prosthetic treatment to rural areas where many of the amputees live. POF also provides clinical and technical consultation to international organizations and health ministries of developing countries who seek effective solutions to amputee treatment.

Vietnam

The Vietnamese team coordinates monthly visits to the rural provinces from the Chinese border to as far south as Da Nang. It requires two visits to each rural site to complete a prosthetic fitting. On the first visit, the medical staff evaluates, documents, and then takes a plaster bandage case of the patient’s residual limb. The team then returns to the Hanoi clinic and begins making the prosthesis using the AFMA system. Upon completion of the prosthesis the team returns to fit the limb to the patient. Any custom adjustments can be made on site using portable workshop tools transported by the team. POF has also begun to assist small provincial workshops with training, tools and supplies so that they are able to maintain the prosthesis and ensure it continues to be functional for the amputee.

Philippines

The Philippines has assisted Our Lady of Victory Training Center on Mindanao Island in the Philippines since 1997. Dr. Cecelia Wood has created a unique surgical and rehabilitation center to care for abandoned children in need of surgery and rehabilitation care. POF assisted with the design of their new prosthetics clinic and has supplied equipment and prosthetics supplies. David Mathews, from our foundation, has also conducted AFMA training for the staff. This new center will act as a catalyst for improved prosthetic care for all of the Philippines.

Nicaragua

POF assisted the Mercy Ships organization with the creation of their mobile prosthetics workshop, including design, installation and staff training. This unique self-contained workshop is housed in a 20-foot-long standard shipping container. The workshop was transported to Leon, Nicaragua, where it provided prosthetic services for the surrounding region. Mathews provided the Mercy Ships’ staff with training in AFMA techniques and in the fabrication of the Monolimb. Only two staff members were needed to complete more than 200 limbs in this very efficient facility. Following the Hurricane Mitch disaster, POF donated a shipment of prosthetic feet to the National Rehabilitation Center in Managua. Nicaragua continues to need outreach services to the many remote communities where amputee services are unavailable. Your donation can help POF to fund a prosthetic outreach clinic in Central America.

1999 Milestones

POF Sends Hope to Kosovo Amputees
POF announced plans in June 1999 to send 250 prosthetic feet to landmine victims in Albania and Kosovo. Two hundred adult and 50 child-sized artificial limbs will be distributed in 1999 to help sustain survivors in this war torn region during the transition to peace.

Little Footprints
POF announced in July 1999 a goal to provide artificial limbs to 500 Vietnamese woman and children in need during the year 2000. The estimated cost to complete this project is $100,000. Beginning in 1996, Prosthetics Outreach Foundation began a series of development projects with the goal of improving the quality of the prosthetic service in Vietnam and enabling the Vietnamese people to become self-sufficient in prosthetic technology and clinical services. The staff at POF welcomes the opportunity to share this clinical technology and we look forward to a dialogue with colleagues who have suggestions for improvement.

Bi-Vi Orthopedic Technology Center

This center, located 50 kilometers west of Hanoi, is the national manufacturing center for rehabilitation products in Vietnam. The building and machines are old, but the staff has the energy and enthusiasm to design and manufacture new products of improved quality and function. This collaborative project could serve as a model of self-reliance for other countries.

Technical Updates
- EB1 Foot: The EB1 component of prosthetics history that has been a design challenge in regard to the durability of the prosthetic. A team of engineers and prosthetists both in Hanoi and Seattle set about to design, test and manufacture a durable, locally manufactured foot named the EB1.
- Modular Components: In addition to the foot manufacturing, a system of modular above-knee and below-knee components has also been manufactured. These include a knee joint, 30mm poly, and alignment adapter with mounting plate, Monolimb bushings and suspension studs. Local suppliers have also been located for 6mm, 8mm and 10mm bolts, cotton stump socks, leather suspension belts, pelite and copolymer plastic materials.

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Prosthetics Outreach Clinic (POC)
POC is both a central fabrication workshop for the mobile prosthetic outreach service and a research facility to improve the quality of the prostheses. All prototype component designs are tested on a small group of patients affiliated with the clinic.

- POF Monolimb: Many amputees in Vietnam have long residual limbs, which are typical of landmine injuries. As a practical prosthetic solution, the Monolimb (or extended below-knee socket) was fabricated. POF refined the components and fabrication techniques to make the monolimb a very affordable, durable, and high-quality prosthetic.

- ShapeMaker Alignment: Although a Monolimb can be fabricated using manual methods, POF is dedicated to designing the Monolimb using the AFMA techniques. This new alignment screen now featured in version 4.3 of Seattle Shapemaker allows a complete prosthesis to be designed and fabricated.

- Quality Assurance: The process of quality improvement and quality control in manufacturing has required the training and monitoring of specialized staff. POF began the component development projects by first establishing a basic laboratory to test prototype designs. The static and cyclic testing machines were manufactured at Bi-Vi.
Save The Children

Save the Children's unique self-help approach to relief, recovery, and ongoing development has nurtured the seeds of hope for millions of people. Save the Children of the United States is a non-profit, non-political, nonsectarian organization working in more than 35 nations around the globe. More than 60 years of experience working hand-in-hand, shoulder-to-shoulder with families and communities at home and abroad has taught us that poverty need not be a life sentence.

One Child, Global Problems

In nations around the world, Save the Children programs recognize that a child's health begins even before birth. Health care activities that target women and other caregivers, such as nutrition education, have the greatest success at the lowest cost. Today, 128 million children in the world have no school to attend. Education systems throughout the world and in the United States are generally ad hoc and thinly funded. While their mothers work, millions of children are either left unattended or are in situations of low-quality childcare. Save the Children supports new approaches in child development and basic education around the world.

Poverty undermines the physical, social, intellectual and emotional development of children. A root cause is the lack of adequate economic opportunities, which would enable parents to provide for their children. Children are typically the first and most vulnerable victims in emergencies. Save the Children is committed to helping victims cope with crisis and begin the process of recovery. Around the world, we coordinate our relief activities with other international agencies, in addition to strengthening the national institutions that can carry out this work.

History

Across the United States and around the world, Save the Children has helped to
https://commons.lib.mu.edu/journal-vol-3/vol3-31

UNICEF

Many children are at risk for landmine injury just by performing everyday chores such as gathering wood, tending livestock, and collecting water for their families. International Save the Children Alliance members also urge international policy makers to ratify The Convention on the Prohibition, Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, also known as The Ottawa Treaty, by the year 2000. Endorsed by 122 countries, in December 1997, this treaty not only bans the production, use, and export of landmines and mandates the destruction of stockpiles, it also requires countries to participate in mine clearance and victim-assistance programs.

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UNICEF

United Nations Children's Fund

Principles for Action, The Convention on the Rights of the Child: UNICEF's deep commitment to eliminating landmines is guided and legitimized by many of the articles of the Convention on the Rights of the Child, in particular the following:

• Article 6 requires States Parties to ensure "to the maximum extent possible the survival and development of the child.

In addition to enormous pain and suffering, landmines bring lingering economic and social costs. They render agricultural land unusable, endanger the safe return of refugees and impede post-conflict reconstruction and development. The indiscriminate use of anti-personnel landmines is a flagrant violation of both international human rights law, including the Convention on the Rights of the Child, and of international humanitarian law. Eliminating all anti-personnel landmines is a humanitarian imperative.

Landmines, The Deadly Threat

"Landmines have inflicted death and enormous pain and suffering on hundreds of thousands of children over the last several decades. We must do everything in our power to protect them from these deadly weapons," said Carol Bellamy, UNICEF executive director. Of all the weapons that have accumulated over years of war, few are more persistent and more lethal to children than landmines. Hundreds of thousands of children, while herding animals, planting crops or just playing, have been killed or maimed by these deadly weapons. In 68 countries around the world there are an estimated 115 million landmines still lodged in the ground waiting to explode. Once planted, they remain active for decades. Another 100 million are believed to be stockpiled and ready for use.

In addition to enormous pain and suffering, landmines bring lingering economic and social costs. They render agricultural land unusable, endanger the safe return of refugees and impede post-conflict reconstruction and development. The indiscriminate use of anti-personnel landmines is a flagrant violation of both international human rights law, including the Convention on the Rights of the Child, and of international humanitarian law. Eliminating all anti-personnel landmines is a humanitarian imperative.

Landmine Facts

Of the more than 2,000 people killed or injured by landmines every month, 30 to 46 percent are children. There is one mine for every 12 children in the world, Mines cost about $3 each to manufacture but up to $1,000 each to clear. Medical care, prosthetics and rehabilitation for each person injured by a landmine cost $3,500 to $5,000.

An Integrated Strategy

Recognizing the need for both curative and preventive action, UNICEF supports the following integrated strategy:

Promoting a Ban on Landmines

UNICEF supports the International Campaign to Ban Landmines (ICBL),
coalition of over 1,000 NGOs calling for a total ban on anti-personnel landmines, and for global funds for mine clearance and vic-
tim assistance. UNICEF urges that national legislation be enacted towards the ban and encourages governments to report progress to the Committee on the Rights of the Child. UNICEF supports the development of regional mine-free zones and has made a commitment to phase out these products from
companies that sell or manufacture anti-
personnel mines or their components.

Reducing Injuries through Awareness
Programs to help communities and
families reduce the risk of mine injuries in their daily lives are critical. Mine dema-
cration, mine surveys, mine clearance and vic-
tim rehabilitation should always accompany mine awareness education. Supporting fo-
cused demining programs; programs to clear mines from essential community infrastruc-
ture, such as schools, water points and medi-
care centers, are also essential. UNICEF is not
able to mandate to do the actual clearance of landmines. It does, however, try to
persuade countries to allocate greater re-
sources to these clearance operations.

Rehabilitating Children
In addition to physical suffering, landmines inflict sustained injury on the psychological and social well-being of their victims, especially children. Children with disabilities are often prevented from attend-
ing school and friends and families may shun them. UNICEF supports community-
based rehabilitation programs that address the physical, psychosocial and vocational rehabilitation of child landmine survivors.

Call for a Greater Effort
Although the treaty to ban anti-person-
nel landmines became binding on its ratifiers March 1,1999, UNICEF said that a widely expanded effort is needed to help the treaty bear fruit. The children's agency called for universal implementation of the treaty and an international commitment to see
that every child in a mine-affected area knows proper safety procedures.

"A giant step has been taken, which
shows that the world is more and more re-

ticent to use these hidden killers," Bellamy
said. "But the real test lies in seeing that
the treaty is fully implemented, that stockpiles are destroyed and that demining proceeds rapidly. Children will only be safe when they know
the dangers of the millions of landmines still in the ground. Universal rat-
ification of the treaty is crucial to ensure that the production and use of landmines are

truly abolished. The treaty obliges states
ratifying it "never under any circumstances
... to use anti-personnel mines; [to] de-
develop, produce, otherwise acquire [or] stock-
pile them" and "to destroy or ensure the
destruction of all anti-personnel mines."

Bellamy praised the 133 nations that
have signed and the 65 nations among them
der now have ratified the treaty. Bellamy said the anti-mine movement has already had
remarkable effects, and noted recent reduc-
tions in the use of anti-personnel mines and
figures from the International Campaign to
Ban Landmines that indicate 18-15 million
mines have been destroyed from stockpiles.
She also noted that the number of countries involved in producing landmines has dropped from 50 to 15.

Mine Awareness and Education
UNICEF has been designated within
the UN family as the lead agency to edu-
cate and advocate nations on the landmine
issue. Educational campaigns have centered
on teaching children about the danger
of landmines and about safety procedures to
follow in mine areas. Almost all mine-damaged countries served by UNICEF have an ed-
cational program in place, Bellamy noted, but she added that these are dependent on continued donor commitment.

In Afghanistan, educational materials have been distributed to almost a half mil-
lion persons. In Angola, UNICEF, with Norwegian Peoples Aid, government agen-
cies and other partners, alerted over 600,000
people last year to the danger of mines. In

Bosnia and Herzegovina, UNICEF has
reached all children enrolled in primary
schools with mine awareness messages. In
Iraq, approximately one million mine aware-
ness exercise books have been distrib-
uted, mainly to primary school children.
In addition, 4,000 Iraqi teachers have been
trained in mine-safety procedures.

Mine awareness is an essential activ-
ity," Bellamy said. "We have worked and
will continue to work with many partners to
make sure that no child in a mine area is
without a clear warning about the danger
and how to avoid it. But the true victory will
come when such awareness is not needed be-
cause there are no more mines in the
ground. That day is not here yet and it will
not be until the whole world acts to gar-
antise the right of children and all inno-
cents to survive in a world free of these
dreadful murders."

Other Positive Developments
• Last December's urging by the Inter-
national Committee of the Red Cross
(ICRC) that all states sign and/or ratify
the landmine convention.

• China's announcement that it will
release some 800,000 landmines from the
Sino-Vietnamese border by the end of the
year, along with the recent clearing of more
than 280,000 mines and unexploded bombs
from areas in Vietnam.

• The British army's recent destruction
of some 2 million anti-personnel landmines.

"Nations that have not yet signed or
ratified the landmine treaty should take note of
these actions," Bellamy said. "Much of
the world is already on the move to elimi-
nate these killers, but only universal ratifi-
cation and a commitment to full global
compliance will stop landmines from destroy-
ing the lives and health of an estimated
26,000 people a year; half of them children
and women.

Among the countries that have not yet
signed the treaty; which prohibits the use,
production, development, acquisition, sale, stockpiling and transfer of landmines are

the United States, China, Russia, Yugosla-
via, Saudi Arabia, Iraq and Iran. UNICEF
has been appointed as the Focal Point for
mine awareness education. The Office of
Emergency Programs, UNICEF, New York has
underaken the task of developing the follow-
ing International Guidelines in order to
promote the effective planning, imple-
mentation, monitoring, and evaluation of
mine awareness programs. It is to be hoped
that these guidelines, with the collective
experience of individuals with recognized
expertise, can serve as a reliable point of ref-
cence for people involved in mine aware-
ness programs.

Landmines are horrific weapons of mass murder. So often used indiscrimi-
nately, mines kill and mummify 9,000-
10,000 children a year, and severely impede
the healthy development of millions more.
Even when mines have been used in accor-
dance with the rules of international law,
their ability to remain active and deadly for
decades makes their effects indiscriminate.
For children living in a mine-affected area,
the simple act of going outside the home
may become a matter of life and death, sur-
vival or disaster.

MINES

Mines Protocol

Landmines are horrific weapons of mass murder. So often used indiscriminately, mines kill and mummify 9,000-10,000 children a year, and severely impede the healthy development of millions more. Even when mines have been used in accordance with the rules of international law, their ability to remain active and deadly for decades makes their effects indiscriminate. For children living in a mine-affected area, the simple act of going outside the home may become a matter of life and death, survival or disaster.

Mines Protocol

Mines Protocol

History
Vietnam Assistance for the Handicapped

Vietnam Assistance for the Handicapped (VNAH) is dedicated to assisting the disabled in Vietnam on an equal access basis without regard to social or political status. They operate exclusively for hu-
manitarian, charitable purposes. Through their support for rehabilitation clinics in Vietnam, they are enabling the disabled to get on their feet, regain their dignity and

help them survive and develop in accord-
ance with their inalienable rights under the

This "Child Rights Guide to the 1996 Mines Protocol" is intended as a straightforward
guidebook for those who wish to know more about the legal protection of children from landmines. In particular, it discusses how far we can expect the Protocol, a hu-
manitarian law instrument, to cause that children will enjoy their fundamental rights to life and physical integrity amid the armed conflicts of tomorrow.

Under the Convention on the Rights of the Child, States Parties undertake to re-
spect and to ensure respect for international humanitarian law relevant to children. Al-
though UNICEF has been disappointed by the results of the review process of the 1980 Mines Protocol, which fell far short of the
oral ban that we sought, UNICEF calls upon all governments, at the minimum, to ad-
here to and respect its provisions at the earliest possible moment. Children not only
deserve our protection; they have a right to it. (From the foreword by Carol Bellamy, Ex-

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Chronology of Activities
In 1990 Ca Van Tran made his first visit to Vietnam after nearly 15 years in America.
He was greatly disturbed by the conditions he encountered. His reaction was swift.

Upon his return, he determined to find-

a way to bring help to the disabled. In 1991, he established VNAH with the help of a small group of supporters.

During 1992, Disabled American Veterans participated in a visit to Can Tho: The Prosthetics and Rehabilitation Center. A private group donated eight prefabricated artificial limbs and VNAH purchased several more at a cost of $800 per limb. Noted during this visit were several major considerations: Not only was there a huge disabled population waiting to be served, but also the quality of wheelchairs and prosthetic devices needed improvement. Later in the year, Disabled American Veterans made the first large donation of $30,000, which launched a pilot project to manufacture prosthetics onsite in Vietnam with available raw materials and supplies. This enabled VNAH to reduce the cost to $25 and custom fit each limb to the amputee.

In 1994, VNAH hosted several U.S. government delegation visits to the Thu Duc and Can Tho locations to improve the quality of the prosthetics and rehabilitation equipment, which included representatives from the departments of Defense, State, and Veterans Affairs as well as prominent members of Congress. VNAH secured $250,000 from the United States Agency for International Development (USAID), among the first humanitarian assistance programs funded in Vietnam when the country opened its doors to the outside world.

The first training programs were designed and conducted at the Thu Duc and Can Tho centers to improve the knowledge and skills of the technicians and production staff, which resulted in higher quality prosthetic and orthotic prosthetics and wheelchairs. VNAH organized its first lifetime of donated pharmaceuticals and medical supplies, in conjunction with other relief organizations, in response to a major flood by the Mekong River.

During 1995 VNAH secured a $25,000 grant from the Nippon Foundation of Japan to expand the rehabilitation and vocational training facility at the Thu Duc center. The foundation also supported water systems and a temporary patient-boarding-facility reconstruction project. Vietnam’s Ministry of Labor, Invalids and Social Affairs (MOLISA) made its first $200,000 grant to support these efforts, bringing life back to a center that had been neglected. Improved facilities enabled VNAH to expand its efforts and to develop a training component allowing the disabled to work in the manufacturing facility where they gained vocational skill. VNAH initiated outreach missions to bring services to remote surrounding areas. VNAH participated in two moreirth of nearly $7.5 million of donated pharmaceuticals and medical supplies.

In 1996, VNAH hosted a delegation of Vietnamese officials to visit the U.S. President’s Committee on Employment of Persons with Disabilities (PCEPD), Tapty Veterans of America (IPOA) and others to exchange information on barrier-free access and employment of the disabled. VNAH expanded renovation efforts at Thu Duc center that resulted in improved space for housing and vocational training. VNAH organized and delivered donations of computer equipment, instructional tools, medical equipment and supplies, and clothing.

During 1995 VNAH secured two major grants from the U.S. Agency for International Development that will allow their technical assistance programs to greatly expand. The first grant, the Prosthetics and Rehabilitation Project, will support primary mission to provide wheelchairs and prosthetics to the disabled, as well as train medical and educational personnel, manufacturing technicians and other volunteers at the three main centers at Can Tho, Thu Duc and Ho Chi Minh City. The second grant, the Barrier Free Access Project, will support their expanded mission to establish a full time technical advisors in Hanoi who will coordinate disability programs and policy on the national level. Both grants are for a 27-month period, which will provide funding through the year 2000.

In 1999, VNAH and the PCEPD jointly announced the opening of a new Office of Disability Technical Assistance in Hanoi. This new office will help lead an effort to advance the full social and economic integration of Vietnamese with disabilities into all aspects of life. It is unique in Vietnam to have a U.S.-based nonprofit voluntary organization, VNAH, with the PCEPD and the USAID, both public organizations. The project will focus on the design and implementation of policies and programs that benefit the disabled. The project will work closely with the MOLISA, the Ministry of Construction and other Vietnamese entities.

Disability Policy & Program Project

The Disability Policy and Program Project (DPPP) is an unprecedented cooperative effort to advance the full social and economic integration of Vietnamese with disabilities into all aspects of life. It is a unique Vietnamese public-private partnership that brings together U.S.-based, non-profit voluntary organizations—VNAH, with the PCEPD and the USAID—and Vietnamese organizations. The project will work closely with the MOLISA, the Ministry of Construction and other Vietnamese entities.

Disability Laws Adopted

The Standing Committee of the Vietnamese National Assembly recently adopted a new comprehensive ordinance to assist the disabled. In a landmark decision the assembly approved the Law for Disabled People, which contains eight chapters and 35 articles concerning, among other important issues, barrier-free access, allowances, preferential policies for education and employment. MOLISA and the Committee on Social Affairs of the National Assembly are among key government agencies coordinating this effort.

Massive post-war construction and new infrastructure development offers an unprecedented opportunity to provide barrier-free access to new facilities. This law will assure Vietnamese with disabilities equal access to buildings and transportation as they assimilate into productive society. Over the past several years, VNAH has worked closely with the PCEPD and others, to share with Vietnamese officials the Vietnamese experience of formulating and implementing disability policy. Several provisions of the 1990 Americans with Disabilities Act are important components in the Vietnamese comprehensive ordinance.

VNAH coordinated several exchange missions and a National Conference on Disability in October 1997, in Hanoi, resulting in high-level meetings, educational workshops and site visits in order to promote viable policies to address and implement disability programs in Vietnam.

Since 1995, VNAH and the president’s committee have jointly facilitated exchange visits, conferences and workshops for Vietnamese disability experts and government officials as they crafted a framework for disability legislation. The Vietnamese National Assembly adopted the Disability Ordinance in November 1998; Vietnam joins other nations to formally recognize the humanist and economic importance of supporting the rights and opportunities of people with disabilities.

Since 1992, VNAH has provided over 25,000 artificial limbs and wheelchairs to disabled children and adults in Vietnam. In cooperation with MOLISA and its regional prosthetics and rehabilitation centers, VNAH has donated custom-fitted prosthetics and wheelchairs to victims of polio, landmines and accidents. Rehabilitation and vocational training services have helped the disabled regain their dignity and become productive members of society.

PCEPD is one of the U.S. premier disability policy organizations. As an independent U.S. government agency, it promotes private-public partnerships among national and state organizations as well as individuals working together to improve the lives of people with disabilities by increasing their opportunities for employment.

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Profiles

Vietnam Veterans of America Foundation

"Most international humanitarian aid organizations pride themselves on remaining above the fray: non-partisan, objective and silent on issues affecting the people for whom they provide vital assistance. We don’t," said Bobby Muller, president of the Vietnam Veterans of America Foundation (VVAF).

"VVAF finds it impossible to avoid embracing an advocacy role when human tragedy cries out not only for help in overcoming the aftermath of a crisis, but in addressing the root causes. The worldwide scourge of landmines is an example of an issue, which necessitated our active intervention and advocacy."

"Throughout our anti-landmine campaigns, we were cautioned that we could be jeopardizing our funding for our all-important work in providing prosthetics and rehabilitation for victims of war. Combining effective and well managed humanitarian programs with strong and effective advocacy has now become a part of who we are as an organization."

Helping Victims

Founded by a group of Vietnamese veterans in 1980, the VVAF seeks to transform the experience of war suffered by America’s Vietnam veterans into programs of aid to others who have suffered the horrors of national and international conflict. VVAF programs concentrate on helping heal war-torn societies and providing assistance to the innocent victims of the conflict.
VFAF Aid Programs

The VFAF started their first aid program for landmine survivors in Cambodia in 1991. Since then, programs have grown to include Vietnam in 1993, El Salvador in 1994, and Angola in 1997. Each program is tailored to meet the special needs of each locality, but all four programs share common goals:

- Rehabilitation—In each country, VFAF has helped to open a rehabilitation facility that provides artificial limbs and wheelchairs to disabled survivors. VFAF also provides physical therapy and follow-up services to help ensure the proper use of the hardware distributed to victims, and to ease the transition back into society.

- Training—In addition to rehabilitative services, VFAF facilities offer job training, and in some cases workshops, for disabled victims to enable them to support themselves and reclaim dignified places in their society and family.

- Program continuity—VFAF takes great pains to ensure that all programs have strong potential for continuity by hiring and training local staff, many of whom are disabled, and by using many locally available materials as possible.

- Teamwork—VFAF programs team with other humanitarian organizations and local government to ensure that they are able to provide a full range of rehabilitative services.

Raising Public Awareness

Recognizing that all of their aid can not prevent new landmine victims, the VFAF takes a strong and outspoken position in the fight to ban landmines worldwide. In 1991, the VFAF founded the International Campaign to Ban Landmines, a campaign which compelled over 120 countries to sign the international treaty to ban landmines. The organization also serves as coordinator to the United States Campaign to Ban Landmines, a coalition of more than 300 organizations dedicated to building U.S. support for the international treaty to ban landmines.

The VFAF is currently using their access to landmine areas to coordinate a global mine survey to establish the scope and depth of the landmine problem in most of the twelve most heavily mined countries. The survey, which the VFAF hopes to have completed in two to three years, will also gather data on landmine victims and the impact of mines on agriculture, commerce, and public health.

To further raise public awareness, the VFAF has published two books dealing with the horror of landmines. The first, After the Gone Full Silent: The Eroding Legacy of Landmines, details not only the physical damage caused by landmines, but examines the social and economic impact of landmine problems on affected societies. The second, In Its Own Words: The U.S. Army Against Personnel Mines in the Korean and Vietnam Wars, examines the impact of landmines on American personnel, and how the United States made landmines were used to devastate U.S. fighting forces during the Korean and Vietnam Wars.

The Future of the VFAF

With the 1998 ratification of the international treaty to ban landmines, the VFAF started the Campaign for a Landmine Free World. The new campaign will allow the VFAF to provide vital leadership in the area of victims' assistance, demining, and public education. As part of this leadership role, the VFAF hopes to expand and improve its existing aid programs. And as the best leadership example of all, the VFAF vows, "As long as landmine victims require new or replacement limbs, VFAF will be there to help them."

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War Child

In the desolate heights of Afghanistan, in the lush African savannahs and steep Bosnian valleys, in cities and villages, tens of millions of landmines lie hidden to be discovered, to be discussed, to be defused—put in the "one limb at a time." Anti-personnel mines primarily target civilians. Victims are invariably the poorest and most vulnerable members of society. It is the subsistence farmers, nomads, children at play, fleeing refugees and those returning home after the war to heavily mined vil-

lages and farm that are the most affected.

Effects on Children

Children's size and natural curiosity make them particularly vulnerable to anti-personnel mines. They are often too little to see mines that are clearly visible to adults. Unable to keep up with older members of the family when travelling by foot, children will often be left off safe routes into minefields. They may not be able to recognize or read warning signs. Also, in many cultures, young children are required to perform jobs that are critical to the economic survival of the family, such as tending livestock, scavenging, gathering firewood and collecting water. In heavily mined regions these simple tasks become fraught with danger. It has also become common practice in some areas for small children to be paid a few pence to retrieve landmines for resale.

Even if arms manufacturers deny allegations that landmines are designed to look like toys, they surely cannot be unaware of the appeal and attraction that their lethal products have for children. Brightly colored, oddly shaped, easy to pick up or kick, children will seldom resist the temptation to play with these "new toys."

In many heavily mined areas children have now become so used to landmines they forget that they are lethal weapons. In northern Iraq, rural children commonly use mines as wheels for toy trucks and go-carts and in Cambodia they play bocce with B40 anti-personnel mines. Even when children understand the dangers, the risk element can prove a fatal attraction. For instance, in Afghanistan, a favorite game is to throw stones at "Bunny" mines; the winner being the one whose stones cause the mine to detonate.

For children who survive mine accidents, the physical injuries are usually far greater, the emotional trauma much deeper, and the economic prospects significantly bleaker than for an adult victim. The majority of child mine victims have few prospects of going to school, of receiving counseling, of learning skills which could help them adapt to their new condition, or marrying when they grow up.

For all mine victims who live outside the provincial capitals, the journey to a rehabilitation clinic can be prohibitively ex-

pensive and extremely difficult, often involving a several day trek. Consequently, poorer children seldom receive the long-term care they need. Children require frequent medical checkups and new prostheses need to be fitted regularly because of a child's growth rate. Also, as a child amputee develops, the bone of the amputation site grows more quickly than the surrounding tissue, which may require reamputation, sometimes repeatedly.

Economically, child victims are a drain on limited resources, and the fact that they may be unable to contribute to the family can have a profound psychological effect on the child and on the family as a whole. Landmines can also have far-reaching effects on children when their parents are the victims. Loss of employment and the deprivation that can follow directly affect children. They may have to leave school to look after injured parents and supplement the family income.

Economic Cost

Landmines are indiscriminate weapons and their destructive capacity does not end with the signing of a peace treaty. In fact peace in a mine-affected area cannot be established until millions of landmines continue to kill and mutilate civilians and thwart reconstruction efforts. The long-term economic and social costs are considerable and are overwhelming as mines vastly outweigh any immediate military usefulness.

The presence of huge numbers of unexploded mines, renders vast areas of land inaccessible, prevents refugees who have displaced their people returning home, precludes farmers and shepherds from working their fields, hampers humanitarian aid and hinders development and rebuilding following the end of the war.

As well as the disruption to agriculture and farming, the mining of dams and electrical installations affects the ability of a country to produce the power necessary for reconstruction. When transportation systems have been mined, it interrupts the movement of people and the flow of goods and services. This disrupts market systems, which in turn has a direct impact on employment and contributes to inflation.

Many landmines are designed to disable their victims rather than killing them. The kinds of wounds they inflict often require extensive treatment over long periods of time. The medical costs stemming from landmine casualties result in a significant economic burden both to the nation and to the mine victims and their families. The countries most contaminated by mines are often also among the poorest nations in the world. Their fragile economies are easily devastated, the basic requirements for self-sufficiency denied them, and they quickly become an economic burden on the international community.

These countries seldom have the ability to fund the extensive demining programs that are essential if their economies are ever to recover. Only when these lethal toxins have been removed will the war be finally over, and will it be possible to talk of peace in a substantive sense, only then will the long process of reconstruction and healing begin.

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MINE ACTION'S CRACKED PILLAR

by Joe Lokey, Deputy Director, Mine Action Information Center

JUST ABOUT ANYONE doing anything regarding landmines knows the four pillars of mine action. We routinely acknowledge that mine awareness, mine clearance, victim assistance and advocacy must all proceed in concert. The four pillar metaphor is a convenient and useful one, but if the world is to be safe of mines, we must understand each one. To break one part of the cycle with a purpose (giving landmine survivors aid that others equally in need can't receive) would somehow isolate them from the rest of the community. The landmines that have harmed them are also the threat to the rest of us. The armaments companies and governments that stockpiled and sold these weapons are equally at fault.

The articles in this issue of the "Journal of Mine Action" focus on victim and survivor assistance as a crucial and critical pillar of that four-cornered approach. This crucial pillar, however, may be cracking. On the horizon, there are continuing questions about maintaining an adequate source of funding to ensure that resources needed get to victims, families, and communities and to ensure that the focus does not dissipate with waning interest in landmines as an "issue." The routinely short political attention spans now supporting action could quickly move on to the next emotional hot-button de jour and the funding needed is huge. The landmine victims Network estimates over $3 billion will be needed over the next 10 years to adequately address victim and survivor issues. Mention dollar figures in billions and watch people cringe—crack one.

The in-country Mine Action Centers (MACs) being set up by either the United Nations or others are ill-defined, ill-equipped and insufficiently staffed to deal with the needs of this long suffering group. Most host countries feel that their Ministry of Health, or equivalent, is the sole party responsible for helping victims and any survivors. The countries that have landmine victims are those who can least afford to do anything about it. The drain on national health systems is enormous and outside aid and assistance is usually the only source of additional resources. Though there are some success stories, it is not clear that this assistance is coming in any significant quantity. Poor internal direction and distribution is not easy to fix—crack two.

Without the organization and direction needed to give involved governments and industry partners a clear picture of how they need to help, the victim assistance pillar will be a weak one among the four. While the mine clearance area now focuses on specifically recommended technologies and programs that will make the biggest impact on mine reduction, the victim assistance area has yet to formulate specific strategic objectives on an international scale that guide resource managers to the most effective use of their contributions. The Guidelines for the Care & Rehabilitation of Survivors is an enormously valuable first step. It does a superb job of laying out principles and the foundation upon which national policies may be built. The clarity of these guidelines, however, may also be their biggest liability.

The fear within the survivor community that "positive discrimination" (giving landmine survivors aid that others equally in need can't receive) would somehow isolate them from the rest of the community has led to an approach that groups survivors with other disabled. While there is certainly no moral objection to this view it may be bringing unintended consequences. Pragmatically it: (1) cloaks survivor issues in a timidity that doesn't necessarily rise above other voices of need and (2) has emmeshed survivors within the larger social disability picture many donors consider unsolvable and too expensive to redress in the short term. Donors who passionately want to do something to help put a prosthetic on a victim will not be as enthusiastic if they understand their funding will be used to build wheelchair accessible ramps in downtown Cairo or lobby parliaments for greater disability benefits. Both of these possibilities lead to less funding for victim assistance initiatives—crack three.

The international community has had little co-ordinated response to these and other concerns. There is some optimism that the Intersessional Standing Committee of Experts (SCE) on Victim Assistance that met in Geneva in September 1999 would have come to the same conclusion and produce more than the customary moral outrage that has characterized many victim assistance conferences. The results of the Geneva meeting and its impact are just beginning to emerge. The main problem with the SCE is that it is inexorably tied to the Ottawa Treaty and all the baggage that entails. While the treaty is remarkable for the awareness and consensus it built, it is much less an actionable document and does not necessarily compel the transfer of resources to support mine action. There are those, however, who want to change that without changing the treaty.

Signatory States to the Ottawa Treaty may have unwittingly obligated themselves to raise on their national treasury under Article 6, Paragraph 5, when they agreed that 'Each State Party in a position to do so shall provide assistance for the care and rehabilitation and social and economic reintegration of mine victims ...' Under this terminology, outside groups determine whether or not a State is in a position to do so and if, in their opinion, adequate resources are not forthcoming, then maintain that the States has abrogated its obligations and is in non-compliance with the treaty. The word 'shall' instead of 'shall' would have left a true measure of internal authority whereas use of the latter forces the States to open their checkbooks to aid organizations and activists. This is not a small point to countries with limited GDP growth and internal problems of their own. The solution to victim assistance long-term funding, in this contentious view, is to legally compel states that signed the treaty to contribute. To attempt to "compel" aid via a treaty is a knife at the throat of the donor—crack four.

In the coming year, we expect to see a few more meetings and conferences at which very specific and tightly focused efforts will be made to inject some actionable programs and initiatives into the victim assistance areas. The victim assistance pillar of mine action may be cracked but is nowhere near crumbling. The articles in this issue of the "Journal" are written by some of the very best and leaders in global initiatives to strengthen this aspect. I would encourage all who read this to contact them and either get involved or coordinate your activity with theirs. Partnerships, teamwork, and collaborative efforts are one of the best ways to strengthen victim assistance and add stability, balance, and a significant dose of humanity to global mine action programs.
by Dennis Bardos
Director, Mine Action Information Center

FROM SEPTEMBER 15-17, 1999, victim assistance experts met in Geneva to provide input to the Standing Committee of Experts on Victim Assistance (VA), Socioeconomic Reintegration and Mine Awareness, one of several committees called into being as a result of meetings in Maputo dealing with mine action aspects of the Ottawa Treaty. The following observations are made in the context of that meeting, which was hosted by the Geneva International Center for Humanitarian Demining.

The Scope of Landmine Victim Assistance

For me, the quintessential question of the meeting was posed by Mark Albon (Mission of South Africa), when he asked, "How do we determine the costs of providing care and rehabilitation support for landmine victims?"

This simple question goes right to the heart of the challenges, which we face as we try to determine the elusive, yet critical, role of "Victim Assistance" in the context of Mine Action Programs. The need for the answer to such a question may at first seem as obvious as it is important. Donors, countries-at-risk, operators, and health practitioners need to know how much money is needed to plan and conduct a "Victim Assistance" activity.

But the question was not meant as a simplistic query. At the risk of being prescriptive, I think what Mark was asking was "How do we go about measuring costs—political, social and financial; and how do we determine what kinds of 'care' are appropriate and affordable?" In trying to answer this omnibus question, we trust mission and project planners to understand the assumptions behind any estimates, and in so doing, come to the very heart of the discussions and debates in Geneva, which were so fruitful.

For the most part discussions in Geneva revolved around the two categories of discussion: 1) what kinds of levels of care should be provided, e.g., Does it include retraining? Does it include psychological support? Does it include loans to reestablish a business or to purchase livelihoods? Does it include prosthetic re-fittings? Does it include management and coordination mechanisms? 2) What kinds of costs are associated with providing such care? e.g., What are the financial costs of operating prosthetics operations? Will demining organizations be willing to pay the institutional "cost" of sharing information? Will victim assistance organizations and other health and mine action groups be willing to pay the political "cost" involved in coordinating and scheduling their activities?

Mr. Albon's question then, provided an excellent backdrop against which experts were able to discuss in a structured yet stimulating and interactive way, the requirements and constraints of the Victim Assistance—and perhaps health care, write large—component of Mine Action programs.

The Level of Care for Landmine Victims

Two facts hung in the air like twin swords of Damocles as services for victims were discussed. One was that the kinds of support identified are not typically getting to landmine survivors today. The other was to make accessible the kinds and levels of care desired would carry an enormous cost—in political as well as financial capital.

A suggested list of requirements, was presented by the International Campaign to Ban Landmines (ICBL), which listed the following types of victim assistance:

- emergency medical care
- continuing medical care
- physical rehabilitation, prostheses and assistive devices
- psychological and social support
- employment

Jerry White reported a cost-analysis, done a year ago, which attempted to identify required needs and accompanying costs for a typical landmine victim in a developing country. His list of needs included: first aid, medicine, hospitalization, psychological and social support, therapy, sports involvement, retraining, and small loans. The total amount was calculated at a modest $9,820 per person annually. The estimated cost, therefore, of providing that level of care to 300,000 survivors over ten years was $3 billion.

There were several interventions, which suggested additional services, such as:
- legal aid
- gender-specific support
- child-specific support services
- family support services
- availability of loans
- legislative initiatives

One central theme was that many of the activities need to be applied in an "integrated" fashion to achieve the most effective and lasting results. Dr. William K. Smith (UNICEF), referred to the "bio-psycho-social" approach, and Evliseul Vleebbeck of the U.N. Mine Action Service (UNMAS), referred to this method of integrating activities as a good example of "sustainable thinking." That could be seen as being championed by White, who noted that little attention is being given currently to the psycho-social needs of landmine victims.

Jack Victor, President of the World Rehabilitation Foundation, also pointed out a note of caution over the growing list of perceived needs of landmine victims. While he presented a very progressive list himself, he cautioned that to support landmine victims to such a great extent may have a negative impact on the affected society. Landmine victims, receiving a number of liberal support packages, may receive more aid—and resultant ennui—than other citizens with health problems just as, or perhaps more, severe. This thought while not the most popular of the day, necessarily reflects reality and will have to be revisited before this entire subject is dealt with and guidelines are promulgated.

The Mine Action Continuum

One of the most difficult questions debated—indeed the one which began and ended the VA segment of the conference—was the question of how it is that the best of activities, should relate to the other two major legs of the mine action operational triad: landmine clearance and mine awareness.

While clearance and mine awareness activities are specifically germane to mine action programs, many of the activities associated with VA have parallels with direct applications in other health care areas. For instance, prosthetics, trauma treatment, psychological support and other landmine related care activities are also a necessary application to car accident victims, people with certain illnesses and those who are injured by unexploded ordnance.

Several interventions made by attending national representatives (the U.S., Cambodia, and Sweden) encouraged a more comprehensive view of the victim care needs within the context of an improved health care capacity of the host nation.

After much discussion, the group consensus seemed to be that VA as a mine action topic needs to be considered more as a "stand alone" set of capabilities, less coordinated with landmine clearance than Mine Awareness, and more in tune with capacity building within the larger sphere of health care.

One of the most thought-provoking interventions in this regard came from Michael Boddington (POWER) who asserted that governments whose citizens are at-risk to landmines are often incapable of providing the infrastructure to provide the most effective help. He suggested that often the best organization to help build such a capability could be a private organization.

Taking note that VA is less concerned with demining as a set of activities than health care as an over-arching rubric, several representatives (the ICBL, the Geneva International Center for Humanitarian Demining (GIC), and the International Committee of the Red Cross (ICRC)) at the conference suggested that Mine Awareness and VA should be considered under the purview of different standing committees. Ambassador Hofer took note of this suggestion.

The Integration of Victim Assistance Activities

The greatest sense of "need" was for integration, and of course, nearly everyone was in favor of it. But as the discussions developed I realized that there was confusion owing to the term, "integration." Some representatives meant it as a way of transitioning a landmine victim back into the mainstream of life. Others were using it to mean the integration of victim assistance activities into an overarching mine action plan, while still others were suggesting that the various organizations involved in the global problem of landmine victims should coordinate their efforts into a more synergistic international effort. I, however, believe that most of the delegates were espousing a desire for a coordinated victim assistance campaign, which would synchronize—and ostensibly manage—the social, medical, legal, legislative, informational, psychological and other components of a national plan.

As examples of the kinds of "integration" called for, there were recommendations for:

- donors to "pool" their funds—or at least to coordinate procedures
- information and data to be shared
- bringing bio-psycho-social elements together
- consolidating (and de-conflicting) donor support mechanisms
- using the overall development plan as the "roof" for VA activities
- having UNMAS coordinate the component activities of a VA campaign

[Edited by Dennis Bardos]
It soon became apparent that like the numerous kinds and levels of care, there are also numerous types and degrees of integration. This is another concept that will require further discussion and development.

**Donors**

Donors were the most frequently discussed group at the meeting; yet there was very little concluded about this all-important group. Indeed, about halfway through the conference, one brave delegate admitted to some confusion over the term and opined that it is a concept "not commonly understood or easily simplified." Even when the donor is a nation, he observed, it often goes through other organizations and in the last analysis must be looked upon as a sort of alliance.

Donors were encouraged to pool funds, coordinate activities with other donors and to make their funding procedures more transparent. They were also asked to budget to allow multiyear funding and for funds not to be earmarked for specific activities. It was also noted that there exists a need to make donors more aware of the nature and challenges of VA activities and programs, so that the foregoing can occur.

**Information**

One way in which the VA participants paralleled the views of the other standing committees was in their desire for better and more coordinated information sharing and gathering.

The ICBL has listed data collection as one of its needs for VA and even asserted that there is a lack of information about the groups that are involved in performing landmine victims assistance work. UNMAS voiced its desire to have VA data managed and integrated more systemically, and Mr. Chiba of Japan stressed that the sharing of such information must be emphasized.

While the call for more and better information sharing was supportive of the ability to plan and implement programs, several organizations stressed its importance in allowing proper monitoring, analysis, and evaluations of on-going and completed activities. It was noted by Mark Albon, for instance that a more "hands-on" and "eyes-on" approach is needed to properly analyze and evaluate programs properly.

The need to gather more information was not universal, however. Jerry White struck a common chord with many delegates when he observed that there is sometimes an "... over emphasis on data matrices and surveys." He suggested that more operational [informational] support is needed.

**Sustainment**

A very useful dialog grew out of a discussion about "ownership" and sustainability. While most delegates felt very strongly about the necessity of the host country and locality owning and directing the program, there were strongly argued counterpoints.

It was noted, for instance, that health care skills, perhaps unlike mine clearance or awareness skills, are more complex. Oftentimes a nation-at-risk does not have the capability to manage a complex health care campaign; and it may not be able to sustain one after the practicing NGOs or other firms and organizations move on.

An example could be prosthetic services. It may be that a country could serve by having an indigenous organization formed to create and fit prostheses, but it may be that such assistive devices made in a more advanced factory outside the host country may offer a superior product. Does one opt for the inferior yet homegrown product, or the more advanced, imported one? The answer involves many other factors.

**Next Steps for the Standing Committee**

Ambassador Hofer announced of the conclusion of the gathering that the committee intended to begin preparations for the next set of meetings (March and September, 1999) by addressing initially five major issues (or themes) which arose from discussions and interventions. Both Victim Assistance and Mine Awareness will be discussed by this committee and will address the following topics:

- Information and Data—Facilitated by the Geneva International Center for Humanitarian Demining (GIC)
- The Victim Assistance Reporting Structure—Facilitated by Handicap International and the ICBL
- The Portfolio (overview) of Programs—Facilitated by the ICBL
- Guidelines—Facilitated by Mexico and Nicaragua
- Victim Assistance as a Development/Public Health Issue—Facilitated by Sweden and Norway

I encourage you, as you or your organization are stimuliuated or activated by these issues, to monitor or participate in the discussion which these committees and subcommittees will be holding. The rapports are for the Standing Committee are staff members of the GIC who can help you learn more about the work of these important committee functions.