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Life is More Than an Artificial Leg: The Luena/Angola Experience

Medico International is a German non-governmental organization (NGO) that specializes in socio-medical care and advocacy from the onset of an emergency through the rehabilitation and reintegration process.

by Sebastian Kasack, Medico International

The Mine Action Program in Luena, Mexico, Angola

Angola is one of the largest provinces of Angola, thinly populated with approximately 350,000 people, and about 100,000 who fled to Zambia during the almost 40 years of war. Angola is full of landmines and UXO. They stem from the anti-colonial warfare during Portuguese time and from the ongoing wars since Angola's independence in 1975—which involved South African and Cuban troops, and mercenaries on the sides of the belligerents, the Angolan Army and UNITA.

Humanitarian demining in Angola started in Luena, the provincial capital, in 1994 at the time of the signing of the Luanda protocol, which brought a fragile peace that lasted until 1998. Medico International and the Vietnam Veterans of America Foundation (VVAF) joined Mines Advisory Group (MAG) in 1996 on the ground in order to start a comprehensive mine action program. MAG is Medico International's partner.

The program started in 1998. It was initiated by MAG, which has extensive experience in demining in Mexico and neighbouring provinces during the fighting so they could reach Luena. In order to assist this new wave of IDPs, Medico took over the management of the mine awareness teams in 1998, including the monitoring of accidents. By the end of 2000, the management responsibility was handed back to MAG.

Mine Action Programs in Luena

1. Survey, marking, clearance and mine awareness: Community liaison is the basis used to give priorities to tasks in the interest of common people.

2. First aid and hospital care, including psychosocial care: In general, 50-70% of mine victims die before or after surgery because of distance, lack of transport or wrongly applied first aid. In the last few years, a Norwegian NGO, Trauma Care, has been training locals in first aid. Psychosocial care by social workers starts in hospital.

3. Physical rehabilitation including physiotherapy: A VVAF regional rehabilitation center has fitted over 1,000 persons with prostheses and crutches.

4. Socio-economic rehabilitation, including community development:

Because communities are traumatized by the war, repression and financial aid, social workers provide victims with psychosocial counseling, and community therapy works to improve their common perception of the healing of a shattered social fabric.

5. Campaigning and advocacy in order to gather and disseminate information: Activities include campaigning for the ban on landmines (which Angola has finally ratified in 2002), informing and mobilizing international public about landmine victims statistics in Mexico and organizing an International Day of the Disabled on the 3rd of December. Unfortunately, in 2000, activities were limited to a range of only five km because of the threat of mine. With the opening of the last Peace Accord in 2001 to mid-2002, the range expanded to about 20-30 km around Luena.

Other NGOs working with IDPs in food-aid programs and with agricultural programs are closely linked with mine awareness programs, so they can work closely together. In order to assist this new wave of IDPs, Medico took over the management of the mine awareness teams in 1998, including the monitoring of accidents. By the end of 2000, the management responsibility was handed back to MAG.

Recommendations in Regard to Victims Assistance and Economic Reintegration Through Psychosocial Care

Do:

1. Start by listening: Listen to the individual, understand the family situation, the neighbors' attitudes and the mine consciousness of the community. Facilitate a process that will help the victim find proper solutions such as participation, ownership and empowerment.

2. Start informal agriculture programs with specific emphasis on mine survivors, train community leaders and community mobilizers, run a community health post, rehabilitate schools, train teachers, run a community kitchen during emergencies, promote and teach literacy—especially for women—and teach micro-credit schemes to women.

3. If opportunities do not exist: Try to use the best resources available.

4. Network: Promote the sharing of information among those involved in the field.

Examples: Social workers need to understand how a prosthetic is made and what role psychotherapy plays in mobilizing clients for rehabilitation or to understand complaints about the prosthesis during follow-up visits. Technicians and gait trainers need to contact the local RPs.
understand how to interact with amputees in a respectful way. It is also necessary to have a basic understanding of how a traumatized person "ticks." Agricultural extensions need to have widespread knowledge of mine awareness, what should be done when an unknown device is detected or what should be done in case of an explosion. A surgeon should not only analyze the stump, but also be able to see that a woman is pregnant and anemic.

Specific care: Actively motivate clients to go for physical rehabilitation, pay specific attention to gender issues, and look for specific needs of other groups such as children, the elderly and those most vulnerable—for example, people with little or no family support.

6. Sport and culture: Life is not only about survival. Offer activities for sports, leisure and culture. Sports should include modalities in mixed groups to improve acceptance and integration.

7. Strengthen local organizations: Promote organizations for the disabled, human rights, community development, health improvement and community organizations. Include a flexible tool for funding community initiatives or the single needs of most vulnerable cases. We call this tool an "Open Fund for Community Support," which serves to support local development activities that are not an integral part of Medico, such as a mobile clinic, community theatre groups, an association of sports for the physically disabled, literacy training and more. The aim is to create a network for development-oriented activities of local initiatives.

8. Promote monitoring of the impact: Monitoring needs to cover all aspects of the mine action program. Monitoring psychosocial improvement is quite as the client approaches the client level. Indicators measuring improvement in self-confidence and self-esteem of clients needs to be agreed upon. An outcome of such monitoring is a necessary follow-up of the most vulnerable clients.

Do Not:
1. Do not exclusively help mine survivors: This only leads to more isolation. Houses built by the government for disabled only, kindergartens for disabled only, and agriculture for amputees only address the physically disabled discrimination. Options for inclusion approaches to community development with a focus on persons with disabilities. The aim of programs for the general community with a special focus on mine survivors is twofold: to improve living conditions for clients and to fight prejudice and stigmatization by creating a better understanding within the community of persons with disabilities.
2. Do not rely on professionals from only one field: At a glance, it seems obvious: demining is a job for military experts, psychology is for psychiatrists, and orthopedics is for traumatized persons. Medical care is provided by doctors; rehabilitation centers are run by certified prosthetists and orthopedists. Traumatized persons need to see a psychiatrist. However, this is only a part of the picture. As the Luena experience exemplifies, different expertise is used to offer the best services in each field of mine action. But if we put people first, then we need a proper understanding of the people and their culture; we need to be able to use participatory tools in order to reach them — with respect. For this, social workers, community liaison persons and community mobilizers are a prerequisite in any field.

In regards to the traumatized person who needs to see a psychiatrist, we do not think this is to be appropriate for the conditions of Luena and the cultural context. We did not bring in psychologists with clinical training (only once, and with little impact). We do, however, know that the psychosocial approach outlined above has helped the severely traumatized (direct) landmine survivors tremendously, others to a lesser extent, and led to a higher awareness and acceptance of survivors as community and neighborhood level.

Instead of a Summary: A Best Case
Let me finish with one of our best examples: Mr. Lino is a man in his early 40s. He made his living by driving minibuses as public transport. One day, he drove over a mine 30 km outside Luena, and it exploded right between his legs. He received help and made it to the hospital but both legs had to be amputated, one upper the knee and one below the knee. Mr. Lino did not want to live any more. He did not know how he would support his wife and children ever again. The family of his wife advised him to leave this man since he had become "useless." Our social workers intervened; they listened and talked to everyone involved, and eventually the family stayed intact. After both limbs healed, Mr. Lino received prostheses and bravely learned to walk again. He was able to buy a tricycle. Now he could go long distances with the tricycle and walk the shorter distances. But survival! With some help he got a plot of land and started to cultivate his field. Nowadays, his neighbors, "complete" ones, envy him for the good crop he yields.

References
1. To promote this comprehensive development-oriented approach the ban horrific" framework was drafted by Medico in conjunction with the Standing Mine Action (SMA) in 1997. The framework can be retrieved in German, English, French, Portuguese, Spanish, Russian, Chinese and Arabic under: www.landmine.org.
2. Medico received funds for the first three years from the German Government; in 1999 and in 2000 very little funding could be secured, only from OCT. 2001 for three years from the Diana, Princess of Wales Foundation (DHF) aimed to fund in U.S $150.000. MAC has received funding to launch its activities from the German Federal Office via Medico since October 2000.

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Building Sustainable Local Capacities for the Assistance of Landmine Victims in Southern Africa: A Concept from the Minefields of the Zambezi Basin Escarpment

After various intense conflicts in the region, southern Africa is plagued by landmines and UXO. The author describes the concept and implementation of Minefield Reaction Sticks to help alleviate the problem.

by Dr. Martin Chitsama, SADSA

Landmine Burden in Southern Africa—Situation Analysis

Over the past three to four decades, theaters of war and bitter conflict involving various militant parties across southern Africa have left the regions soils buried with millions of mines and UXO. Exact per-country landmine contamination figures are difficult to obtain, but useful gross citations are available that help define the regional landmine victims problem. At the June 2002 Luanda Landmines Conference, heads of the region’s Mine Action Centres (MACs) estimated that southern Africa’s soils still harbor in excess of 20 million mines and that at an approximate cost of $150 million (U.S.) obtained through a 20-arm donor conduit, it took 35 demining operators some five to six years (1995–2001) to remove close to 600,000 landmines from the region’s soils. Extrapolating the mathematics shows that at the current pace of mine clearance, it will take over 200 years and a cost exceeding $5.9 billion to clear the currently known minefields of southern Africa. Thus, the landmine victims register of southern Africa shall continue to admit new arrivals for the next two centuries.

Landmines have affected communities of southern Africa in various ways. The death of 116 people and injury of 56 others when a truck struck a mine on 16 August 2001 in Cuanza Norte province (Angola) and the instant killing of eight children who were collecting scrap metal to sell on 5 December 1995 in a village in Maputo (Mozambique) are only two of the thousands of such incidents that communities who live trapped in areas littered with landmines have to endure in southern Africa. The Southern African Development Community (SADC) Trade, Industry and Investment Review 2001 notes that before the outbreak of civil war, Angola was the fourth largest producer of coffee with an annual output of 200,000 tonnes and that recovery in the agricultural sector will be possible once peace is secured and a mine clearance programme is successfully carried out. In numerous mined pockets of southern Africa, such as the upper reaches of Carabba Bassa Dam in Mozambique, access to roads, agricultural land, safe drinking water, public health outreach programmes (such as HIV/AIDS awareness campaigns and malaria/cholera control) and land for collecting and gathering firewood has been hampered by the presence of minefields.

A mushroom of parties has done sterling work in removing the plight of mine victims in southern Africa as both individual and community levels, which includes assisting states in landmine clearance programmes. This pool includes the European Union (EU), United Nations Agencies and non-governmental organizations (NGOs) such as Handicap International, the International Committee of the Red Cross (ICRC), Mines Advisory Group (MAG), People Against Landmines (MAGM), the Vietnam Veterans of America Foundation (VVAF), the Jatpur Limb Campaign, HALO Trust, Norwegian Peoples Aid (NPA) and the Jesuit Refugee Service. They, among others, have worked in cooperation with national governments in establishing prosthetics centres and victim rehabilitation programmes such as the Victim in Luanda, Angola.

The June 2002 Luanda Landmines Conference, held under the auspices of Mine victims Assistance reported that the process of formulating and implementing mine victim assistance programmes in southern Africa has been slow and poorly coordinated due to: 

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18

19