II. Assistance to mine victims

The wounded: lifelong disabilities

Mines cause three patterns of injury. Stepping on a buried mine/UXO can result in severe injuries in which the victim's foot or leg may be literally torn off. A fragmentation mine, detonated by a tripwire, will leave victims with injuries over many parts of the body. Lastly, loss of fingers, hands or arms, eyes and parts of the face, and injuries to the chest or abdomen may result from handling mines, and victims are usually mine clearance workers, those laying mines and even curious children intrigued by the interestingly-shaped objects.

People injured by mines require evacuation, transport, first aid, surgical treatment and rehabilitation. In the long run, many will need assistance for prosthetic and orthotic fittings, and their lives may be altered for ever. Appropriate first aid and timely transfer to a health facility will help ensure survival. Surgical amputation may achieve successful physical results, and prostheses may enhance functional independence; the psychological trauma of the event itself may even ease with time, allowing the amputee to come to terms with the loss of self-image. However, social reintegration of the victim to become once again a productive member of society will depend on vocational training, family and community support, and useful employment. Often, the latter is the greatest challenge in a war-ravaged and poor society.

In 2000, the ICRC continued to provide assistance (first aid, transport, curative care, and physical rehabilitation) for war-wounded, including mine/UXO victims, in over 25 countries.

Pre-hospital care: evacuation, first aid and transport

Care for mine victims spans a broad range of services, from lifesaving measures and the evacuation of the wounded to hospital to surgical care. The ability to provide such services often reflects the condition of a country's infrastructure: roads and transport system, and the security situation.

Many mine victims are injured while they are alone and in remote places in rural settings. They may be fetching wood or water, working in fields or herding sheep. Victims may lie for hours with shattered limbs, and die before help arrives. When help does come, the rescuers must take care not to put their own lives at risk. Evacuation may involve transport without medical care, and may mean a bumpy ride in a truck or animal-drawn cart through mountains, desert or paddy fields.

It is hardly surprising that in some societies affected by conflict, many mine victims die before reaching any health facility.

The most effective way of preventing complications, disability or death is the prompt application of lifesaving first-aid measures. Tourniquets are still used far too often in many parts of the world. Applied too high on a limb or left on for too long, they may necessitate the amputation of the entire limb or lead to kidney failure. The use of a tourniquet is to be censured. Appropriate application of first aid saves lives.

Many of the hospitals assisted by the ICRC are served by first-aid posts. In some countries the ICRC provides direct support to such posts. In many countries, first-aid volunteers of National Red Cross and Red Crescent Societies are involved in the management and transfer of war-wounded, including people injured by mines/UXOs, with the support of the ICRC. Providing first-aid training to communities and military stretcher bearers is an important component of the National Societies' activities.

Curative care: hospital assistance and surgical treatment

Mine/UXO injuries require skilled surgery, large amounts of blood for transfusion, antibiotics and other drugs and dressing materials, and prolonged hospitalization. The surgeon's task is to remove dead and contaminated tissue and any foreign materials (dirt, plastic casing from the mine, bone fragments, etc.) that have been driven into the wound, and in many cases to amputate severely damaged limbs. Since few surgeons in civilian practice have experience in dealing with mine/UXO injuries, the ICRC provides local in-hospital training and organizes seminars and workshops on war surgery.

Throughout 2000, the ICRC continued to provide direct assistance to hospitals and surgical facilities for the care of the war-wounded, including many people injured by mines/UXOs. The assistance included the rehabilitation of infrastructure, water and sanitation facilities; the supply of equipment, medicines and other consumable surgical items; training of doctors and nurses in the care of war wounds and mine/UXO injuries.

In 2000, the ICRC supported some 300 hospitals treating war-wounded people in 32 countries, including those injured by mines/UXOs in twenty of them. Expatriate personnel performed surgery and provided training in twelve countries: Afghanistan, Angola, the Democratic Republic of Congo, East Timor, Eritrea, Ethiopia, Sierra Leone, Solomon Islands, Somalia, Sudan (Kenya), Tanzania (for the benefit of Burundi refugees), and Uganda.
In addition to the annual seminar on war surgery held in Geneva, the ICRC helped organize eleven seminars for civilian and military surgeons on the management of war injuries. The seminars focusing on the treatment of mine injuries were held in five countries: Eritrea, Ethiopia (four seminars), Somalia, Sudan (two seminars) and the Democratic Republic of Congo (three seminars: Kinshasa, Lubumbashi, Kisangani).

Physical rehabilitation

In 1979 the ICRC established a unit for the physical rehabilitation of war victims in order to respond to the specific needs of the war disabled. Since then 56 projects have been set up in 25 countries. Two-thirds of the projects are realized in close cooperation with government authorities, the others with local NGOs or National Red Cross/Red Crescent Societies, or by the ICRC itself.

Since the unit's inception, 145,160 individuals have been fitted with a total of 162,705 prostheses and 62,731 orthoses, while many have received assistance including 217,848 pairs of crutches, 12,259 wheelchairs and physiotherapy.

Programmes in 11 countries (Chad, Colombia, Eritrea, Lebanon, Mozambique, Nicaragua, Pakistan, Rwanda, Syria, Vietnam and Zimbabwe) were handed over after an average period of 10 years of full-time ICRC involvement. In some countries, the ICRC decided to resume its assistance programme because of substantial unmet needs and a persistent conflict (Ethiopia, Sudan, Myanmar, Uganda).
It is essential that projects handed over continue to provide services for the disabled, whose needs for replacements and repairs of orthopaedic appliances are lifelong. After their hand-over, most of the programmes are monitored and assisted on a smaller scale through the ICRC's Special Fund for the Disabled (SFD).

Activities in 2000

For the fourth consecutive year, the annual number of physically disabled people assisted, mainly with prostheses (16,442) and orthoses (11,005), increased. This was especially true of Afghanistan, where the production of orthoses exceeded that of prostheses. In total seven additional projects were assisted in: Ethiopia (Addis Ababa, Mekelle, Harar, Dessie), Myanmar (Yenanthar) and Uganda (Gulu, Mbarara). This increased the total number of assisted prosthetic/orthotic centres to 37 in 14 different countries. All the projects in Ethiopia, with the exception of the one in Dessie, involved the ICRC's resumption of projects previously handed over.

The increase, by 20%, in assisted projects brought about a similar increase in personnel. By the end of the year, 41 expatriate specialists and 1,049 national staff were employed in 37 field projects. During the year, three experts from the headquarters spent 176 days on field missions and visited all physical rehabilitation country programmes, except those in Georgia, Tadjikistan and Uganda.

An evaluation of the ICRC's Physical Rehabilitation Programmes, carried out by a team of external experts in 2000, made the following recommendations in its preliminary report:

- The quality of prosthetic and orthotic fittings should be the primary concern of projects implemented under the auspices of the ICRC. The production of components in individual prosthetic/orthotic projects is neither productive nor necessary.
- The current policy of free delivery of orthopaedic appliances should make way for direct payment by the patient to the producer of the appliances in order to encourage the sustainability of projects.
- Existing or planned local structures in host countries must be fully respected in ICRC programme planning.

- The image of polypropylene technology as a second-rate solution should be enhanced by demonstrating the advantages offered by this technical approach. To achieve this, better communication is needed within and beyond the ICRC.

- Proper cost calculation and data collection are essential to all workshop activities. This is mandatory if the targeted sustainability is to be achieved. A standard cost calculation mechanism should be developed and tested.

- Fitting the handicapped is not perceived as a life-saving activity Rather, this activity is associated with humanitarian objectives. Nevertheless, the projects in this sector do have a high development component which must become an integral part of the ICRC strategy through the ICRC Special Fund for the Disabled.

The evaluation's report is expected to be finalized in 2001, after which its recommendations will be taken into account in the realization of the ICRC's physical rehabilitation programmes.

ICRC prosthetic/orthotic programmes: production statistics for 2000

Countries	First-time patients (prosthetics)	Prostheses*	Prostheses for mine victims	First-time patients (orthotics)	Orthoses*	Crutches	Wheel-chairs
Afghanistan	1,926	4,600	**3,403**	3,607	6,360	10,681	865
Angola	1,187	2,366	**1,905**	13	24	3,184	0
Azerbaijan	150	477	**103**	23	51	358	0
Cambodia	577	1,295	**1,226**	284	480	4,508	0
Ethiopia	538	1,252	**617**	662	1,100	1,051	73
Georgia	238	558	**147**	320	714	470	0
Iraq	1,994	2,807	**1,487**	962	1,446	0	0
Kenya	129	348	**76**	101	160	845	0
Myanmar	906	907	**536**	0	0	0	0
D.R.Congo	229	245	**10**	21	19	91	0
Sri Lanka	35	207	**121**	15	19	66	48
Sudan	402	767	**134**	352	513	1,067	0
Tadjikistan	361	397	**38**	0	0	273	6
Uganda	202	217	**79**	93	119	0	0
Totals	8,874	16,442	**9,882**	6,475	11,005	22,594	992

* Including first-time patients

The table below sums up the ICRC's contribution to physical rehabilitation projects undertaken in 2000 by other organizations on behalf of the war-wounded, among them mine/UXO victims.

Components delivered by the ICRC to non-ICRC projects (2000)

	Knee joints	Alignment systems	Orthotic sidebars
Angola	391	2,651	0
Cambodia	1,652	6,547	1,506
Totals	**2,043**	**9,198**	**1,506**

Projects of the Special Fund for the Disabled (SFD)

The SFD was created in 1983 in response to Resolution XXVII of the International Red Cross and Red Crescent Conference recommending "that a special fund be formed for the benefit of the disabled and to promote the implementation of durable projects to aid disabled persons".

One noteworthy event of 2000 was the resolution by the ICRC Assembly in June to transform the SFD into an official foundation under Swiss law, independent of the ICRC, and to open the SFD's Board to non-ICRC members. By virtue of its new status, the SFD has two main objectives:

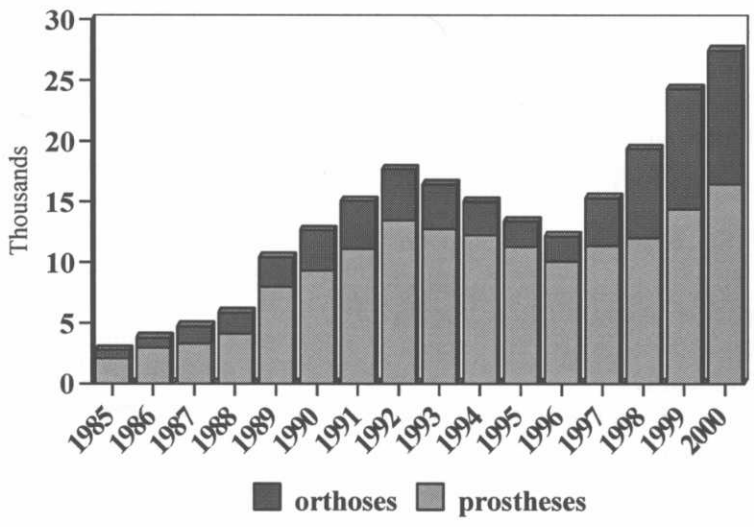
1. *" ... to assist the physically disabled by ensuring the continuity of ICRC projects in this domain"*, and
2. *" ... to assist physically disabled people through non-ICRC projects ..."*

In 2000, through its three regional projects in Addis Ababa (Ethiopia), Ho Chi Minh City (Vietnam) and Managua (Nicaragua), the SFD extended technical, training, material and financial assistance to projects in 34 countries.

Countries where the SFD supports projects

Africa		Asia	Latin America	Europe	Middle East & North Africa
Angola	Malawi	India	Colombia	Albania	Lebanon
Burundi	Mali	Vietnam	El Salvador		Mauretania
Cameroon	Mozambique		Honduras		Morocco
Chad	Nigeria		Nicaragua		Syria
Congo (DRC)	Somalia		Peru		
Côte d'Ivoire	Sudan				
Djibouti	Tanzania				
Eritrea	Uganda				
Ethiopia	Zambia				
Kenya	Zimbabwe				
Liberia					

Patients assisted with appliances



III. Cooperation within the Movement

The International Red Cross and Red Crescent Movement's global network, its experience in the field and contacts with communities give it a comparative edge in assisting civilian populations protect themselves against some of the dangers that threaten their lives.

Mine-related projects count among the activities undertaken by the ICRC, in partnership with National Societies, in most of the countries where the institution is operational. Examples of such activities include mine/UXO-awareness projects in the Democratic Republic of Congo, Eritrea, Ethiopia, Afghanistan, Nicaragua, Costa Rica, Albania, Bosnia and Herzegovina, Croatia, Yugoslavia (Kosovo), Iraq and Lebanon, details of which are provided in the chapter "Assistance and preventive action by country" of the present report.

Such partnership with National Societies is realized within the ambit of the five-year Movement Strategy on Land mines, adopted by the Council of Delegates, a statutory body of the Movement, in October 1999. The Strategy urges the ICRC to spearhead the Movement's mine action and encourages National Societies to contribute to specific activities such as promotion of the Ottawa treaty, mine awareness and assistance to mine victims.

The Strategy acknowledges the National Societies' role as vital advocates of the Red Cross/Red Crescent, at the country level, and calls on the ICRC and the International Federation to assist them in acquiring the requisite skills and resources to play their advocacy role and carry out long-term mine action effectively. It offers general guidelines for the promotion of international norms, mine awareness, the protection of civilian populations, care and assistance to mine/UXO victims, and ways of taking concerted action in the future.

The main objectives of the Movement Strategy on Land mines are to:

- achieve universal adherence to and effective implementation of the norms established by the Ottawa treaty and amended Protocol II ;
- reduce civilian casualties in mine-contaminated areas through community-based education programmes about mine/UXO risks;
- remind parties to armed conflicts of their obligation to comply with humanitarian law with reference to land mines, and of the humanitarian consequences of the use of mines;
- ensure that mine victims have equal and impartial access to proper care and assistance;
- assist the National Societies of the most affected countries in incorporating mine-related activities and services into their regular programmes, and to support National Society endeavours on mine issues;
- cooperate with mine-clearance organizations according to humanitarian priorities, by developing mine-awareness activities and providing medical assistance to clearance teams.

The ICRC Special Appeal Mine Action 1999-2003 allocates Sfr 2,5 million to special, small-scale projects run by National Societies. This sum is intended to offer National Societies the flexibility to initiate activities that are consistent with the Movement Strategy, but which are not necessarily anticipated and planned for within the scope of the ICRC annual objectives and budget. A note was sent to all National Societies, stating the procedures to be followed to in order to qualify for this special allocation, and several projects planned for implementation in 2001 were submitted for approval. National Societies which applied for the allocation include the Mozambican, Colombian, Cambodian, Zambian, Zimbabwean and Nicaraguan Red Cross Societies.

The role of National Societies, with their branch networks on the ground and extensive knowledge of local needs and environment, is crucial to the operational effectiveness of the Movement in mine-related activities.