



United Nations Institute for  
Disarmament Research

## Providing Appropriate Assistance to the Victims of Explosive Remnants of War

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## NOTE

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## SUMMARY

Despite a growing awareness of the devastating effects of explosive remnants of war (ERW), states continue to use weapons that, due in part to malfunctioning, produce ERW and as a consequence cause casualties among civilian populations. There is no detailed systematic research available that focuses specifically on assistance to ERW casualties, on their access to suitable facilities/services, or on whether these facilities/services have the capacity to comprehensively address their needs. For the time being, the European Union's (EU) multi-annual Mine Action strategy, *The European Roadmap Towards a Zero-Victim Target*, notes that its aim, in the longer term, is "... a world free from the *threat* of anti-personnel landmines and unexploded ordnance, in which all affected countries themselves are able to take full control of their [landmine] and [unexploded ordnance] problems and to provide victims with prompt care and ongoing assistance". Therefore, the purpose of this study is to identify the key issues that should be addressed in an EU policy on assistance to the victims of ERW.



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## PROVIDING APPROPRIATE ASSISTANCE TO THE VICTIMS OF EXPLOSIVE REMNANTS OF WAR

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### INTRODUCTION

Despite a growing awareness of the devastating effects of explosive remnants of war (ERW),<sup>1</sup> states continue to use weapons that, due in part to malfunctioning, produce ERW and as a consequence cause casualties among civilian populations. ERW contamination is reported in more than 90 countries or disputed territories and can often pose a grave danger to civilians.<sup>2</sup>

The issue of ERW is dealt with in the Convention on Prohibitions or Restrictions on the Use of Certain Conventional Weapons which may be Excessively Injurious or Have Indiscriminate Effects (CCW). However, the CCW was not regarded as being explicit enough, and an additional protocol, Protocol V on Explosive Remnants of War, was drafted. Protocol V addresses the issue of assistance to victims of ERW in Article 8.2, in the same manner as Article 6.3 of the Mine Ban Treaty.<sup>3</sup>

There is no detailed systematic research available that focuses specifically on assistance to ERW casualties, on their access to suitable facilities/services, or on whether these facilities/services have the capacity to comprehensively address their needs. For the time being, the European Union's (EU) multi-annual Mine Action strategy, *The European Roadmap Towards a Zero-Victim Target*, notes that "... for brevity this strategy refers throughout to actions against [anti-personnel landmines]. However wherever the problem of unexploded ordnance exists, the actions will be equally valid, as provided by the APL [Anti-Personnel Landmine] Regulation."<sup>4</sup> The main aim of the strategy, in the longer term, is "... a world free from the *threat* of anti-personnel landmines and unexploded ordnance, in which all affected countries themselves are able to take full control of their APL and UXO [unexploded ordnance] problems and to provide victims with prompt care and ongoing assistance".<sup>5</sup>

Therefore, the purpose of this study is to identify the key issues that should be addressed in an EU policy on assistance to the victims of ERW.<sup>6</sup>

Within that framework, victim assistance (VA) will be examined in its broadest sense, including casualty data collection, emergency and continuing medical care, physical rehabilitation, socio-economic reintegration, psychosocial support, and disability law and policy, while taking into account development strategies, cross-cutting issues and human rights. ERW survivors are part of a larger community of persons with injuries and disabilities, and victim assistance efforts should not exclude persons injured or disabled by other cause. At the same time, survivors and people with disabilities are included more and more in policy and planning to promote a rights-based approach. The direct involvement of Disabled People's Organizations, under the slogan "Nothing about us without us", is the *modus operandi*. This study takes a twin-track approach based on mainstreaming disability and survivor-assistance issues into all levels development and society, while not losing sight of certain special needs of ERW survivors.

## IDENTIFYING THE SCALE OF THE PROBLEM

Data collection and ERW injury classification are two important contextual issues for understanding the scale of the ERW problem from an assistance perspective. It is crucial to have reliable information about the extent of the problem in order to identify which programmes and services are required to meet the needs and rights of ERW survivors. The key purpose of data collection, in itself not a direct service for ERW casualties or people with disabilities, is to inform agencies funding and implementing assistance and disability programmes, so that priorities can be identified and coordinated accordingly. Similarly, the section on the type of injuries sustained by ERW survivors is intended to show planners and decision makers what kind of care will be needed. It is clear that statistics are to be collected for programme-implementation purposes. However, data can also be used for lobbying purposes by survivors and people with disabilities.

## DATA COLLECTION

There are various sources of information on casualties including media reports, surveys, assessments, government and hospital records, and databases. In principle, it is the responsibility of national governments to monitor the health and well-being of their population. However, in practice, many countries do not have the capacity to maintain a coordinated casualty data collection system. Therefore, international actors are asked to take a central role in data collection and dissemination in countries that do not have adequate “government or other organizational involvement in survivor and victim data management,” until such local capacity can be developed.<sup>7</sup> The principal collectors of casualty data, including ERW casualties, are mine action centres, the International Committee of the Red Cross (ICRC), United Nations Children’s Fund, and some non-governmental organisations (NGOs).

At present, only a limited number of ERW-affected countries use a comprehensive database,<sup>8</sup> and few of them are able to provide full-year data or data collected for all ERW-affected regions. Furthermore, even with a functioning data collection system in place, not all casualties are reported due to a lack of human and financial resources needed to employ the system effectively.<sup>9</sup>

A study conducted by James Madison University found that, “The problem is that [data] is not collected in a systematic or centralized way so that the data can be verified, aggregated and effectively analysed.”<sup>10</sup>

There are limits to the capacity of all data collection systems. Some systems do not have the capacity to cover the entire country, particularly remote areas. Other systems do not actively seek out casualties, but rather wait until an incident is reported. A comprehensive overview of all data collection systems is beyond the scope of this research; however it is useful to highlight a few initiatives, some of which are examples of best practices. Existing casualty data collection systems record some or all of the following:

- Time and place of incident;
- Personal details of casualty (name, age, sex, occupation);
- Type of device causing incident;
- Area type in which incident occurred;
- Activity at time of incident (including tampering);
- Was the area known to be mine or ERW affected?

- 
- Reason why casualty went into mined/ERW area;
  - Was mine risk education received by the casualty?
  - Was the person injured or killed?
  - Type of injury sustained;
  - Location of first medical aid;
  - Time until first aid received; and
  - Information on who collected the data.

The Geneva International Centre for Humanitarian Demining (GICHD) has developed the Information Management System for Mine Action (IMSMA). IMSMA is available in mine action programmes in 41 countries, but it is difficult to estimate how many actually use the system to its full capacity.<sup>11</sup> IMSMA was primarily designed to meet the needs of humanitarian mine action operations including mine clearance, mine surveys and mine risk education.<sup>12</sup> However, version 2 of IMSMA was expanded to collect information on casualties and includes details on types of injuries sustained and if and when the casualty reached a hospital.<sup>13</sup>

Arguably, the most comprehensive data collection mechanism is the Cambodia Mine/UXO Victim Information System (CMVIS), maintained by the Cambodian Red Cross (CRC) and Handicap International. The aim of CMVIS is to provide a sustainable national-level information system to assist the planning of all programmes concerned with mine action, victim assistance, and advocacy for mine and ERW survivors and mine- and ERW-affected communities.<sup>14</sup>

An external evaluation of CMVIS in 2002 reported that the system is “unique in the world in terms of coverage and detail”.<sup>15</sup> By interviewing the victim or their relatives, the data gatherers provide comprehensive information on mine/ERW casualties and the circumstances of the incidents. Witnesses to incidents are also interviewed to cross-check the information. In principle, a follow-up interview is conducted three to six months after the first interview to establish what disability services the survivor has received. In practice, however, the data gatherers are not always able to carry out this follow-up interview. Data gatherers also provide information to survivors on available services and provide a referral service, if necessary. Completed questionnaires are entered into a customized database in the Phnom Penh Data Management Office. Monthly reports on mine/UXO casualties are sent to an extensive list of end-users<sup>16</sup> to facilitate the planning of actions. CMVIS also has the capacity to respond to tailor-made queries in as much detail as can be extracted from the questionnaires.<sup>17</sup>

The CMVIS questionnaire is reportedly more detailed and user-friendly than the IMSMA questionnaire. A feasibility study by Handicap International on the establishment of a national surveillance network for mine and ERW incidents in Lao concluded that the CMVIS system is preferable to an adapted IMSMA, although IMSMA is already in use at UXO Lao.<sup>18</sup>

The ICRC collects mine/ERW casualty data in 15 countries. In Afghanistan, the ICRC, working together with the Afghan Red Crescent Society, is the main mine/ERW casualty data collector providing about 95% of reliable nationwide data.<sup>19</sup> The ICRC had indicated plans to gradually convert its casualty databases to IMSMA, but “has been slow to do so, apparently due to concerns about the adequacy of IMSMA to its program requirements.”<sup>20</sup>

Landmine Impact Surveys (LIS), conducted mostly under the coordination of the Survey Action Centre (SAC), focus on the impact of the presence of anti-personnel mines and ERW. The full-scale surveys are community-by-community assessments of where and how known or suspected landmines and ERW compromise people’s daily lives. Information on casualties in the

two years preceding the survey is an important factor in the priority-assessment scoring system adopted by SAC. More general information is also obtained on less-recent casualties.<sup>21</sup> LIS data on recent casualties includes the number of people killed and injured, the activity at the time of the explosion, the type of injuries sustained, and the medical and rehabilitative care received. In 2004, the European Commission (EC) funded the Impact Survey in Ethiopia, which resulted in the first comprehensive casualty data set on the country.<sup>22</sup>

The existing databases do make a distinction between landmines and ERW, providing details when available; however, some caution is needed as it is not always known with certainty what type of device caused the explosion. Information is also available on whether the casualty had received risk education (addressing mines and ERW) prior to the incident, and the activity at the time of the incident. The available data is useful for the development of mine risk education programs. However, it should be noted that even when mine risk education is provided, economic necessity will often result in an individual engaging in dangerous activities. This type of information is gathered by the data collection systems and should be provided to, and used by, development programmes, not only by VA or disability projects.

Data on survivors is useful for identifying needs in particular areas and should facilitate priority setting, and adapting or introducing new programmes to meet the needs and rights of ERW survivors. The data are also a powerful lobbying and empowering tool for survivor groups and people with disabilities and should be made available to them in the appropriate format.

#### TYPES OF INJURIES CAUSED BY ERW

Data collection can also provide a useful tool to identify the types of injuries sustained and therefore the medical and rehabilitative care required. The types of injuries caused by ERW depend greatly on the type of ERW causing the explosion. ERW generally were designed to kill,<sup>23</sup> and are on or in the ground because of failure to detonate when used or because of being abandoned during or after the conflict. When being handled, ERW tend to cause more upper body injury—hand, arm, chest and facial injuries.<sup>24</sup> ERW are unpredictable and unstable. Over time, ERW become more and more unstable. ERW with large amounts of explosive can cause massive trauma and kill or injure many people in a wide radius. However, when only the fuse of an ERW explodes, this generally leads to less serious injuries, such as the loss of fingers or hands (with children) and smaller fragmentation injuries.

Usually, ERW have a metal casing; fragments are dispersed at high speed causing severe injuries. Shrapnel can cause serious external wounds and traumatic amputations, and often penetrates the body resulting in damage to internal organs and internal bleeding.<sup>25</sup> Some ERW have other mechanisms, such as an armour-piercing shaped charge or elements designed to produce a pyrotechnic or incendiary effect, which can cause severe burn injuries. The injuries are often complex to treat and require advanced surgical care and result in long, difficult and painful recoveries. Even with the passing of time, survivors often have low levels of overall physical health and experience on-going pain as a result of their injuries.<sup>26</sup>

The ICRC has developed its own system to distinguish three types of traumatic wounds identified in its surgical hospitals. The introduction of the system enhanced data collection and stimulated better-adapted surgical practices.<sup>27</sup> The system gives injuries a rating according to different criteria, such as wound size, injury of vital organs, fractures, detection of shrapnel, and entry and exit point of shrapnel. The wounds are then graded from one to three based on the level of tissue damage. For Pattern I injuries, there is usually traumatic amputation of the foot or

leg with severe injury of the other leg, genitalia and arms. Pattern II type injuries are caused by any fragmentation device; wounds can affect any part of the body. Pattern III injuries relate to accidental detonation while handling a mine or ERW; this pattern inevitably causes severe wounds to the hands and face.<sup>28</sup>

Based on interviews with trauma surgeons and information available from casualty databases, it would appear that the distinction between an anti-personnel mine injury and an ERW injury is sometimes arbitrary, and it can sometimes be impossible to differentiate the type of device simply by looking at the wounds. For example, if an anti-personnel mine is picked up or tampered with, the resulting explosion and injuries will be similar to that of ERW. Or a fragmentation mine with a trip-wire can act like any other fragmentation device (hand grenade, mortar shell).<sup>29</sup>

An analysis of CMVIS casualty data for the period 1 January 2004 to 28 February 2005 provides an indication of the type of injuries caused by various devices. Of the 1,108 people killed or injured in landmine/ERW incidents:

- 93 casualties were caused by anti-personnel mines (49 injured and 44 killed);
- 1,007 casualties were caused by ERW (antitank mines, fuses, improvised explosive devices) and UXO (844 injured and 163 killed);
- One casualty was caused by an unspecified mine; and
- The cause of seven casualties was described as other/unknown.<sup>30</sup>

**Table 1.** Type of injury sustained, reported in CMVIS by type of device  
January 2004 to February 2005<sup>31</sup>

	<b>anti-personnel mine</b>	<b>anti-tank mine</b>	<b>fuse</b>	<b>improvised explosive device/ booby trap</b>	<b>UXO</b>
Lower limb amputation	4	118	0	0	3
Upper limb amputation		15	46	4	33
Unspecified amputation			1		
Upper and lower limb amputation		9			
Amputation and other injury	2	54	17	2	26
Unspecified injury	7	32	17	4	30
Lower body injury	12	48	25	3	84
Upper body injury	9	42	47	3	86
Entire body injury	15	46	32	3	111

## VICTIM ASSISTANCE AND MEDICAL AND REHABILITATION SERVICES

Health care systems include emergency and ongoing medical care, as well as rehabilitation services. While there are many relevant policy considerations, VA should take infrastructure issues, equality of opportunity and non-discrimination in access to services, capacity-building and motivation of personnel and providers, funding strategies and sustainable development into account.

### INFRASTRUCTURE

The capacity to provide adequate medical and rehabilitative care for ERW casualties varies from country to country. In many developing countries and countries in a conflict or post-conflict situation, international agencies, such as ICRC and NGOs, support and sometimes provide health and rehabilitation services. For example in Afghanistan, only three of the 34 provinces receive government-provided healthcare services.<sup>32</sup> However, the provision of services by international actors should be seen as a temporary measure until the national infrastructure has the capacity to address the needs. The primary concern for the relevant ministries is often a lack of financial resources for health and social welfare services.

### EQUALITY OF OPPORTUNITY AND NON-DISCRIMINATION IN ACCESS TO SERVICES

ERW and landmines often afflict the poorest of the poor. In many ERW-affected countries, high levels of poverty mean that people cannot afford to access available government-run health and rehabilitation services. The care required to treat a landmine or ERW casualty can bankrupt a family. For those who cannot afford to pay, treatment sometimes does not go beyond the first aid services provided by local health centres. In general, the services of international organizations and NGOs are free or almost free and often have the capacity to provide better quality of service. To help make healthcare services more affordable for the poor, a government can put in place an equity fund; perhaps with the help of the international community and in connection with its Poverty Reduction Strategy Paper.<sup>33</sup>

### CAPACITY-BUILDING AND MOTIVATION OF PERSONNEL AND PROVIDERS

The national capacity of healthcare providers can also be an issue, in some cases due to a lack of training capacities, but also due to a lack of incentive to perform a challenging job. Often doctors, nurses and rehabilitation experts paid by the national institutions do not receive a financial reward reflecting the responsibility and the challenges of their job, nor do they receive or can afford life-long learning.<sup>34</sup>

International organizations and NGOs play an important role in the capacity-building of government officers and staff in several countries, often through employment in their programmes.<sup>35</sup> The EC development assistance programmes are able to improve the medical capacity of ERW-affected countries by providing assistance to the health services by building on national structures, or giving technical assistance to build and reinforce these structures, in close integration with development assistance programmes.<sup>36</sup>

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## FUNDING STRATEGIES FOR SUSTAINABLE DEVELOPMENT

In another intermediate step, consideration could be given to placing current NGO-run projects under national management working solely with national capacity, but with international assistance for funding. The funding could come from the “international community and local fundraising; such as income from the tourist industry or equity funds”.<sup>37</sup> However, this would require a comprehensive monitoring system and a greater emphasis on the accountability of national authorities by the international community through, for example, poverty reduction strategies and national strategies for development or mine action, to ensure that needs are being met.

## COMPONENTS OF APPROPRIATE ASSISTANCE TO VICTIMS OF ERW

An ERW explosion can cause various injuries to an individual including the loss of limbs; abdominal, chest and spinal injuries; blindness and deafness, as well as less-visible, psychological trauma not only to the person injured in the incident, but to the families of those killed or injured.

In practice, assistance to people who fall victim to ERW is generally provided within the framework of facilities/services for people with disabilities. The review of the operation and status of the Mine Ban Treaty (MBT) and the Nairobi Action Plan provides a useful reference for developing guidelines on appropriate ERW victim assistance.<sup>38</sup> For the first time, 24 States Parties have been selected to receive special attention in the development of an adequate victim assistance programme. Some of these countries, such as Cambodia, Guinea-Bissau and Peru, note that a majority of their casualties are ERW casualties. The Implementation Support Unit of GICHD, in collaboration with the 2005 Co-Chairs of the Standing Committee on Victim Assistance (Norway and Nicaragua), have produced a Victim Assistance Questionnaire and several workshops for the 24 States Parties that discussed the components for appropriate assistance.<sup>39</sup>

The principal actors in VA generally agree that assistance includes the following components:<sup>40</sup>

- Data collection;
- Emergency and ongoing medical care;
- Physical rehabilitation;
- Psychosocial support;
- Socio-economic reintegration; and
- Laws and public policies.

Although awareness and understanding of the concept of victim assistance has increased, the services available are still far from meeting the needs of survivors. Many survivors “do not have access to the most basic needs: food security, access to water, adequate housing, roads, a way to earn an income, healthcare, and access to the lifelong rehabilitation services many require”.<sup>41</sup> This necessitates a twin-track approach focusing on the development of communities while not losing sight of the specific needs of ERW survivors. In 2004, the European Commission’s Directorate General for Humanitarian Aid (DG ECHO) provided EURO 11.45 million to assist Burmese refugees living in ten camps in Thailand, which covered basic food aid; improvements to health, water and sanitation infrastructures; mine awareness actions and assistance for 800 people handicapped in mine accidents.<sup>42</sup>

## EMERGENCY AND CONTINUING MEDICAL CARE (PRE-HOSPITAL AND HOSPITAL CARE)

### Organizational framework

Emergency and continuing medical care consists of evacuation and pre-hospital medical care, acute health facility care, referral when necessary, and definitive care (appropriate surgery), carried out by various actors. First aid centres and practitioners can be found in nearly every community. Health centres performing basic surgery are available in larger communities or towns. But severe injuries necessitating complex surgery, trained staff and modern equipment can usually only be carried out adequately in the national capital and sometimes in the regional or provincial capitals, often very far away from the location of the ERW-affected areas and thus from the site of the incident.

The provision of health care facilities for persons with disabilities, including ERW survivors, is included within general public health budgets, which focus mainly on the provision of first aid but only to a limited extent on specialized medical care.

However, within the twin-track framework, it is important to realize that ERW casualties have medical needs similar to those of other injured persons, and that adequate care for those injured by ERW means ensuring that existing systems can meet their needs and that a chain of care is in place from evacuation/pre-hospital emergency care to appropriate surgery. However, in some cases, skills not necessarily called for in other types of injuries are needed. Through the provision of aid to the health services, the EC development assistance programs are able to enhance the medical capacity of ERW-affected countries. The EC strategy will “therefore support actions which address the urgent needs of survivors by building upon existing national structures and policies, bridging (temporary) gaps and/or giving technical assistance to build and reinforce these structures, in close integration with development assistance programmes”.<sup>43</sup>

### Financial constraints

One of the most common concerns in many ERW-affected countries is the lack of resources for public health budgets, due to the economic situation. This lack of resources can result in an inability to obtain equipment and supplies, to provide and repair the physical infrastructure, and to provide adequate training of health care professionals.

In countries with limited public health resources, available funds tend to be directed towards primary health care with little left over for specialized care. As a consequence, specialized and adequate services are often far from the site of the incident and this does have an effect on the chances of survival, recovery and rehabilitation of the casualty. The United Nations Committee on Economic, Social and Cultural Rights has noted that persons with disabilities belong “to a group of people whose health care needs are worst met by the health care services.”<sup>44</sup>

### Emergency response

Specialized first aid training to respond to traumatic injuries and severe blood loss, in order to increase the chances of the victim reaching the hospital alive, is essential. The nature of ERW injuries, including severe upper body trauma, requires a rapid response at the site of the explosion including proper management of fluids and the ability to make interventions to assist the injured person to breathe more easily and increase the chances of survival. Rapid referral to the nearest

hospital is also essential. However, for many casualties there is a lack of transport for rapid evacuation. Many ERW-affected countries lack a functioning well-equipped ambulance service, particularly in remote areas. Even if the victim survives the explosion, delays in reaching the hospital can mean that they are not in the best condition to benefit from the assistance available.<sup>45</sup> The EC has seen this great need and in 2004 has, in Afghanistan, funded an ambulance service for ERW and mine casualties.<sup>46</sup>

In addition to the proper training of first aid providers, plans to address emergency medical care “should integrate a public sector and community plan of action and investment in communication and transportation systems to improve access to medical care”.<sup>47</sup>

### Continuing medical care

Medical facilities “should meet certain basic and minimal requirements, such as clean instruments and water, to be operational. Useful training tools for surgeons include a surgical theatre and manual for emergency care and follow-up, including proper amputation procedures and reconstructive surgery.”<sup>48</sup> However, in many ERW-affected countries, hospitals lack equipment, supplies, and adequately trained health care providers. As mentioned, most hospitals, and especially the best-equipped hospitals, are in large cities long distances from where most ERW incidents occur.

Incorrect medical treatment can create obstacles to the complete physical recovery and rehabilitation of ERW survivors. Often problems are created because healthcare providers do not know or do not follow the basic principles of management of war wounds. The particular nature of injury resulting from ERW also requires particular surgical techniques. Increased training in all aspects of care for weapon injuries is needed. Hospitals also need to be better equipped to address these needs.<sup>49</sup>

### In-hospital physical therapy

It would appear that in many ERW-affected countries there is a lack of recognition of the importance of physical therapy in hospitals. There are two main stages in the role of physiotherapy in the treatment of ERW survivors—the acute phase and the rehabilitation phase.<sup>50</sup>

However, in many hospitals the physical therapy sections are small and under-staffed. Often, hospital staff do not have the capacity to identify pathologies that risk leading to damaging after-effects. Additionally, doctors sometimes are not trained to know the beneficial effects of physiotherapy on physical recovery. Good surgery is made even better by good physiotherapy. Interdisciplinary cooperation is reportedly weak. In theory, good hospital physiotherapy programmes benefit everyone: ERW survivors, amputees, car accident victims, burn patients, paraplegics, people with breathing problems (asthma, obstructive lung disease and heart disease), neurology patients (polio, stroke). Better physical rehabilitation at an early stage has the potential to prevent permanent disabilities of all sorts.<sup>51</sup>

### Gender issues

Although women and girls constitute the minority of mine/ERW survivors, they can face different and often greater obstacles to obtaining appropriate medical care than males. In some countries, for cultural reasons, males are more likely than females to receive medical attention and transport. In addition, in some countries, most medical staff and prosthetic technicians are

men, and may not be able to treat women for cultural reasons. Sometimes it is not possible for a woman to leave her children while receiving treatment. Special consideration must be given to ensure that healthcare and rehabilitation services are available to men and women alike.

### PHYSICAL REHABILITATION (INCLUDING PROSTHETICS AND ORTHOTICS)

Generally, ERW-affected countries have facilities for physical rehabilitation with networks of rehabilitation centres and prosthetic workshops. However, most physical rehabilitation services are located in urban centres, while the majority of survivors live in rural areas. Access to available facilities is a problem for many survivors. The injured person might live far away from centre-based services and the availability of outreach services is limited. Obstacles to access include the high costs of transportation, an inability to leave the family behind, or fear of leaving a familiar environment.<sup>52</sup> Some service providers reimburse part of the travel costs, organize collective transport, or allow children to accompany the parent to enable the survivor to stay at the rehabilitation centre. However, in practice there are still problems, as some survivors must borrow money for transport to the centre, and reimbursement is not always 100% of costs, leaving a large debt for the survivor and their family to repay.

Ideally, facility-based rehabilitation should be supplemented with community-based rehabilitation (CBR) and outreach programmes, so that access can be maximized. CBR programmes and outreach workers can also train the survivor or family members in self-care principles.

The high cost of prostheses and assistive devices, often beyond the means of ERW survivors and their families, is another concern. Prosthetic services should produce devices that are safe, durable, and easily maintained and repaired locally. The availability of long-term services must be ensured for necessary adjustments or replacement.<sup>53</sup> Furthermore, it must be stressed that sending second-hand prostheses or poor quality components to ERW-affected countries is not an appropriate form of assistance.

In addition, many countries report a lack of adequately trained rehabilitation practitioners, including prosthetic/orthotic technicians, physiotherapists and occupational therapists, together with concerns about the quality of care available. Attention must also be given to resources and training for rehabilitation personnel in the treatment of ERW injuries other than limb loss, such as loss of eyesight, deafness or paralysis.

It is reportedly very difficult to ensure the sustainability of physical rehabilitation centres without the continued support of international NGOs and agencies. Even with the training of national technicians—often survivors themselves—the majority of governments in ERW-affected countries do not have the resources to maintain the services without external support.<sup>54</sup> It is important to acknowledge that physical rehabilitation facilities do not only serve ERW/landmine survivors but all people with disability regardless of the cause, and the effects of scaling down or expanding the number of centres can only be measured in the long term, as people using these services often need life-long care, but sometimes at irregular intervals.

Special attention should also be given to the needs of children who survive an ERW explosion as the child and their family can face severe challenges in the aftermath of the accident and need support in order to re-build their lives. Children may also need additional rehabilitative care as they outgrow prosthetic devices and other aids.

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## PSYCHO-SOCIAL SUPPORT

An emotionally painful, distressing or shocking experience often has lasting psychological and physical consequences. Trauma and stress is essentially a normal response to an extreme event, “with symptoms that can include flashbacks, nightmares, insomnia, emotional detachment, avoidance behaviour, poor memory, anxiety, depression, headaches, and other pains not related to the physical injury. Psychological trauma is often externalized through behavioural change, including changes in the expression of emotion and social relations.”<sup>55</sup>

Psychological support and social reintegration includes activities that assist ERW survivors, and the families of those killed or injured, to overcome the psychological trauma of an ERW explosion and promote their social well-being. These activities include community-based peer support groups, associations for the disabled, sporting and related activities, and professional counselling. Appropriate psycho-social support has the potential to make a significant difference in the lives of ERW victims and other persons with disabilities as it can provide the support and encouragement necessary to help them to adjust to their situation. Mine/ERW survivors confirm the benefits of being able to meet and socialize with others facing similar obstacles.

A varied and multi-layered network of psychosocial support networks that goes beyond peer-to-peer support is needed. Social workers and therapists should be an integral part of hospitals and rehabilitation services. This network should include community-based and mobile teams who can provide support at the community level. ERW survivors should be included in outreach programmes and “involved in this training wherever possible so that their experiences can enhance the treatment process for others”.<sup>56</sup> Sport and related activities are recognized as a positive form of physical and social rehabilitation with activities identified in several countries.<sup>57</sup>

Local and international NGOs and agencies are working closely with mine/ERW survivors and other persons with disabilities; however, the number of people benefiting from this support appears to be small.

Psychological support and social integration is an area that has not received the attention or resources necessary to adequately address the needs of ERW survivors. Social reintegration is being hindered by the lack of understanding among the general population of the rights, needs and capacities of persons with disabilities. Increasing national and local capacity will require greater input from the relevant actors, including trauma recovery experts and agencies working with other vulnerable groups, and with ERW survivors themselves, to develop guidelines for best practices in the provision of psychological support to facilitate social reintegration. These practices should be cross-cutting and gender sensitive, and adapted to the local context.

## SOCIO-ECONOMIC REINTEGRATION

### Poverty and development context

The majority of ERW survivors, and other persons with disabilities, are generally among the poorest in affected countries and the lack of access to employment opportunities is a common concern. For many ERW/mine survivors, their most important issue is “not the medical rehabilitation services, but assistance in helping them to resume their roles as productive community members and contributors to their families’ well being”.<sup>58</sup> ERW victims and their families can experience difficulties in maintaining a reasonable standard of living after the accident.<sup>59</sup> Priorities defined by survivors were adequate shelter, enough food to eat, and water; a

job, or the possibility to generate an income; schooling for their children and a chance for adults to learn new skills.

Therefore, socio-economic reintegration needs to be an integral component of VA, to assist the survivors to return to their previous occupation or to help them or their relatives prepare for and find suitable employment. Socio-economic reintegration programmes should involve actors in responsible ministries in charge of people with disabilities and war victims, international organizations, regional bodies, religious institutions, local and international NGOs and Disabled Persons Organizations (DPOs). Socio-economic reintegration of people with disabilities should, in many cases, be integrated in a larger development framework, since survivors often live in the poorest communities, but without losing sight of the special needs of ERW survivors and people with disabilities. Inclusive comprehensive socio-economic reintegration includes education or vocational training, job placement and micro-credit schemes adapted to the local economic reality, as well as awareness-raising so that disabled people get equal chances at jobs and services. This equalization of opportunities should prevent disability from resulting in a disadvantage or 'a handicap'.

### Obstacles and social perceptions

Obstacles to economic reintegration include limited prospects for education and vocational training; limited access to transport, footpaths and buildings; and economies with few jobs and high unemployment in the general population.<sup>60</sup> The chances of socio-economic reintegration of an ERW survivor are often further diminished by negative social perceptions, discrimination and stereotyping. Often people with disabilities, including ERW survivors, are seen as unproductive members of society and a burden on society. "Disability is often perceived in a very negative way due to cultural factors, ignorance, superstitions and fear. In some places, disability is seen as a curse or punishment from God; disabled people are perceived as being sub-human and unfit to participate in society's mainstream activities."<sup>61</sup> Often the charitable model is applied to them and there is very little understanding of disability, which can lead to the tendency to hide people with disability. Sometimes ERW survivors are former combatants, and, depending on the society, they can be considered as unreliable, untrustworthy or dangerous and their expertise, such as with explosives, is not used.<sup>62</sup> "Many disabled persons develop a dependency syndrome, inferiority complex, a sense of resignation and feelings of isolation and exclusion from the society in which they are born and live."<sup>63</sup> These perceptions restrict the participation of people with disabilities, including ERW survivors, in society and therefore public awareness campaigns are needed to sensitize the society, in general, and employers, in particular, to the capacities of people with disabilities.

### Gender

The vast majority of ERW victims are male. In addition to the physical and psychological trauma experienced by survivors, their injuries invariably have far-reaching personal and social implications affecting the family's emotional and economic life, that of the immediate community, and ultimately the economic and social life of the country. Whether an ERW victim is killed or injured, the spouse faces the loss of a helper and provider. For ERW survivors there is the added cost of transportation to medical and rehabilitative care as well as other longer-term needs.

While women may not constitute the largest number of survivors, they are often the primary caregivers, or become the principal income earner or head of the household if their partner is killed or injured. For a woman with a disability, her prospects for marriage are diminished or she

may be divorced after the accident, often leaving the woman alone to support her children.<sup>64</sup> A report by Handicap International on disability in Cambodia noted “women are often the caregivers for children with disabilities and understand the needs of a person with a disability more than men”.<sup>65</sup> Women are often under-represented in the self-help groups for people with disabilities, restricting their input into meeting agendas and access to credit schemes.<sup>66</sup> Therefore, it is important to open up vocational training and income-generation opportunities to family members of the victim, in particular to wives, widows and women alone.

## Children

Children also suffer from ERW, whether they are directly injured or their parent is a casualty. The majority of child mine survivors have “little chance” of receiving an education, or receiving counselling or skills to help them adapt to their injury.<sup>67</sup> For the child of a mine/ERW casualty, the impact on the economic situation of the family often results in children losing the opportunity to gain an education, and forcing a child to look for employment to support the family.<sup>68</sup> In some cases, a mine/ERW explosion can lead to the break up of families as children are sent to live with relatives when their immediate family is no longer able to provide for them.<sup>69</sup>

For children with a disability, it is very important that they have opportunities to access education. Children or young adults with disabilities should not be excluded from normal schooling systems. Ideally, teachers should be trained to work with children who have experienced a traumatic incident.

Socio-economic reintegration programmes, including vocational training, conducted by government agencies or local and international NGOs and agencies, are operating in many ERW-affected countries. Nevertheless, the majority of programmes appear to be small and there continue to be very few opportunities for mine survivors to receive vocational training or to access employment, micro-credit or other income-generating activities.

## Vocational training

Most vocational training programmes offer courses running for a period of three months to a year, depending on the level of skill required. Many programmes provide students with lodging, food and a small stipend during the training period. The training provided includes practical or traditional skills, such as sewing, hairdressing, agriculture or the repair of motorbikes and electrical equipment. In addition, literacy and small business management skills are also taught. Graduates of programmes are often provided with basic starter kits, such as a sewing machine, tools, seeds or livestock.

Vocational training has many positive benefits in addition to teaching new skills to enable survivors to resume an active and productive life; it also has the potential to assist survivors in regaining their self-esteem and a sense of belonging through interaction with people who are in similar situations. However, it is important that vocational training programmes meet the needs expressed by survivors, are appropriate to the economic situation in the country, and that there is a commitment from service providers to the long-term sustainability of the programmes.

## Employment

In some situations, the newly disabled person does not need vocational training but rather needs assistance in finding employment or a loan to set up a business. Micro-credit and micro-

enterprise schemes, job placement schemes, or advice on how to deal with banks can provide a solution.<sup>70</sup>

However, the report of the Director-General to the International Labour Organization's 91<sup>st</sup> Session in 2003, noted that "[t]he most common form of discrimination is the denial of opportunities to persons with disabilities either to work altogether or to build on their abilities and potential;"<sup>71</sup> and that "vocational training alone does not automatically ensure access to the labour market for people with disabilities".<sup>72</sup> Studies support the view that often the best solution for the economic reintegration of ERW/mine survivors is to establish small business ventures. "Entrepreneurship can be the most direct route to social and economic independence for disenfranchised groups. Self-employment offers unmatched flexibility to work around a disabling condition."<sup>73</sup>

## MAINSTREAMING VICTIM ASSISTANCE INTO DEVELOPMENT

Disability is a crosscutting issue that affects sectors such as health, education, transport, agriculture, social services, labour, foreign affairs, finance, and even defence. Disability is not limited to social protection schemes or medical rehabilitation work. Disabled people have rights to education, employment, poverty reduction and environmental programmes, and have positive contributions to make. Disabled people are also affected by developments in all sectors.

The issue of rehabilitation and reintegration of ERW survivors cannot be separated from the broader context of development in the affected country; however, implementing sustainable activities in ERW-affected areas will benefit not only ERW survivors but also their families and their communities.

Projects envisioning sustainable development should enhance the capacity of all people to participate in this development. Development efforts should, therefore, include the empowerment of poor and vulnerable people, such as ERW survivors or people with disabilities, to take part in mainstream social, economic, cultural and political activities. "This is done through supporting activities that enable the poor and marginalized people to gain better command of their lives."<sup>74</sup> This includes better access of the vulnerable and marginalized people "to the structures, processes and resources of their societies".<sup>75</sup>

The European Union is committed to the Millennium Development Goals (MDGs),<sup>76</sup> such as universal health care, universal primary education and the fight against HIV/AIDS. "These goals cannot be met without considering the needs of disabled people; yet disabled people are still not sufficiently included in international development work funded by the EU."<sup>77</sup>

ERW survivors are often the poorest of the poor in remote communities where people suffer from the obstacles of poverty, including lack of access to housing, water, food, an income, or health and rehabilitation services. Sustainability is the key to reach the ultimate goal of victim assistance programmes—the complete rehabilitation of ERW survivors and their reintegration into the wider community. To ensure sustainability and to avoid unnecessary segregation of survivors, assistance to ERW survivors should be viewed as a part of a country's overall public health and social services system. At the same time, within those general systems, deliberate care must be built in to ensure that ERW survivors and other persons with disability receive the same opportunities in life as every other sector of a society. Sometimes, levelling the playing field requires services or systems particular to people with disabilities. These two approaches—special

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services when obviously necessary and mainstreaming whenever possible—constitute the “twin-track” toward disability.

Disability should be mainstreamed into general development policies on issues such as health, education and labour. At the same time, there should also be specific disability policies including empowering persons with disabilities through strengthening organizations of disabled people, and ensuring access to appropriate rehabilitation facilities and aids. The issue of gender must also be addressed. It is also essential that mainstreaming be supported by appropriate levels of funding, for example through earmarking a certain percentage of every mainstream budget to disability issues.

A more integrated approach, aimed at the general development of the poorest areas could also reduce the number of new victims as people may resist going into known ERW-contaminated areas for economic necessity, such as agriculture, gathering of wood, or scrap metal collection.<sup>78</sup>

## DISABILITY POLICY AND PRACTICE

ERW survivor assistance, as with assistance for all persons with disabilities, is more than just a medical and rehabilitation issue; it is also a human rights issue. Until this is recognized and addressed people with a disability will continue to face significant barriers to their social and economic reintegration. Other mechanisms, such as a legal framework or awareness-raising campaigns on the rights and needs of persons with disabilities are needed.

The majority of ERW affected countries have legislation to protect the rights of mine survivors and other persons with disabilities and to provide social assistance. However, due to the economic situation in many countries it would appear that there are insufficient resources to fully implement the provisions of the legislation. Pensions are often inadequate to maintain a reasonable standard of living.

On the international level, the draft Convention on the Rights of Persons with Disabilities has the potential to strengthen the right-based approach to ERW survivor assistance. In December 2001, the United Nations General Assembly agreed to establish an Ad Hoc Committee to consider proposals for an international convention to “promote and protect the rights and dignity of persons with disabilities”. The Ad Hoc Committee first met from 29 July to 9 August 2002 and again from 16–27 June 2003, where it agreed to establish a Working Group to prepare and present a draft text for a “Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities”.<sup>79</sup> The draft text addresses issues such as general State obligations, international cooperation, the need to achieve equality and non-discrimination, and various rights of disabled persons under the law, including the rights to life, equal recognition and freedom of expression, as well as respect for privacy, home and family and being included in the community.<sup>80</sup>

The Final Report of the Nairobi Summit on a Mine-Free World<sup>81</sup> provides a clear framework on which to develop a victim assistance component for future programmes, and is equally relevant to ERW victims: “... the call to assist landmine victims should not lead to victim assistance efforts being undertaken in such a manner as to exclude any person injured or disabled in another manner.”<sup>82</sup>

However, caution is needed to ensure that funding for ERW survivors, and other victims of war, is focused on the identified needs and that states do not avoid their obligations under treaties by untargeted support of disability issues in general. At the same time, it is fully acknowledged that survivor assistance services should benefit all people with disabilities. The holistic approach to survivor assistance in the field, ideally, works on a rights-based and capacity-building basis to rehabilitate and reintegrate all people that make use of services. The longer-term vision of expanding existing services—such as expanding casualty data collection systems into disability data collection systems—are good examples of this. Furthermore, organizations of disabled persons have the potential to enhance survivor assistance as DPOs have a broader base, more variety and different movements, which focus on a larger framework than just medical and physical aspects.<sup>83</sup>

## CONCLUSION AND RECOMMENDATIONS

Victims of ERW need a wide variety of assistance and facilities to ensure complete rehabilitation, reintegration, inclusion and respect of their human rights. A long-term and holistic approach is needed to guarantee that all aspects of the survivor's recovery and reintegration are addressed. However, in practice, it is not possible to separate the issue of assistance to victims of ERW, or of landmines, or victims of war and people with disabilities in general.

A comprehensive casualty data collection system is essential to effectively match resources with needs. However, many ERW-affected countries do not have the capacity to establish and maintain a functioning data collection system. Existing databases are not uniform and in some cases are neither detailed enough nor used efficiently. Casualty data collection systems should be adapted to suit local conditions and be a proactive tool that not only records data but facilitates analysis and planning of survivor assistance needs and other mine action activities such as clearance and mine risk education. In the longer term, the prospect of turning ERW and landmine casualty databases into more general disability or injury databases would be beneficial to better understand the disability situation and needs in a country.<sup>84</sup>

The initial response in the immediate aftermath of an ERW explosion can have long-term implications for the recovery and rehabilitation of survivors. Considerable attention is needed to build national capacity and infrastructures for emergency and continuing medical care. Expertise in trauma care and an effective evacuation system is essential to ensure the survival of an ERW casualty. At the hospital level, there is a need for additional trauma surgery training, equipment, supplies and physiotherapy, and an adequate salary to ensure the motivation of practitioners. Infrastructures must be improved and, ideally, there should be more medical centres at all levels, country-wide, with a fast referral system, outreach teams and ambulances. In addition, medical care must be affordable and accessible even to those who without the resources to pay.

Most attention and resources appear to be directed towards physical rehabilitation. In many countries, services are provided or supported by international agencies and NGOs. There is a need for capacity-building within the relevant ministries in ERW-affected countries. Ongoing training and capacity-building of national prosthetic/orthotic technicians, physiotherapists and occupational therapists is also essential. In addition, access to rehabilitation services and assistive devices even for the poorest people in remote areas must be facilitated through outreach services and transport to services.

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Appropriate psycho-social support has the potential to make a significant difference in the lives of ERW victims and other persons with disabilities as it can provide the support and encouragement necessary to adjust to their situation. Activities include community-based peer support groups, associations for the disabled, sporting and related activities, and professional counselling. ERW survivors provide an essential resource in the planning of appropriate programmes.

In order to resume their role as productive members of their communities, ERW survivors or their families must be able to earn an income to provide for their daily needs. Vocational training, access to micro-credit schemes, or employment referral systems all provide possible solutions. Children must also have access to an education. It is essential that activities be in place to raise awareness among the community and employers of the rights, needs and capacities of persons with disabilities.

ERW survivor assistance, as with assistance for all persons with disabilities, is more than just a medical and rehabilitation issue—it is also a human rights issue. People with disabilities face significant barriers to their social and economic reintegration. Other mechanisms, such as effective legal frameworks or awareness-raising campaigns on the rights and needs of persons with disabilities, are needed.

To ensure sustainability and to avoid unnecessary segregation of survivors, assistance to ERW survivors should be mainstreamed into the country's general development planning. However, at the same time attention must be given to the special services needed to facilitate the rehabilitation and reintegration of survivors.

In summary, most ERW-affected countries experience similar problems in addressing the needs of ERW victims, though to varying degrees. There are several key issues/challenges that should be addressed to ensure that ERW victims and their families receive adequate and appropriate assistance. These include:

- Creating a comprehensive mechanism to record ERW casualties to ensure that resources are used most effectively where the needs are greatest;
- Facilitating access to appropriate healthcare and rehabilitation facilities;
- Affordability of appropriate healthcare and rehabilitation;
- Improving and upgrading facilities for physical rehabilitation;
- Increasing availability of psycho-social support, including peer support groups and opportunities to participate in sport and recreation;
- Creating opportunities for employment and income generation, including special attention for the spouses of ERW victims;
- Capacity-building and ongoing training of health care practitioners, including doctors, trauma surgeons, nurses, physiotherapists and orthopedic technicians;
- Capacity-building of government officials in the relevant ministries;
- Gender balance among healthcare and rehabilitation practitioners to ensure that the specific needs of men, women, boys and girls are met;
- Raising awareness on the rights and needs of persons with disabilities;
- Inclusion of ERW victims in policy-making decisions;
- Establishing an effective social welfare system and legislation to protect the rights of all persons with disabilities, including ERW victims; and

- Mainstreaming ERW victim assistance projects into development programmes as part of poverty reduction strategies but with special attention to the particular needs of ERW survivors and other persons with disabilities.

## Notes

<sup>1</sup> For the purposes of this study, Explosive Remnants of War (ERW) is “a broad term for explosive ordnance (such as mortar bombs, grenades, cluster sub-munitions and air-dropped bombs) which have not exploded and are left as a hazard in the post-conflict environment. This results from ordnance being fired but failing to explode (unexploded ordnance—UXO) or from ordnance stores being abandoned during the fighting (abandoned explosive ordnance—AXO)” and to anti-vehicle landmines. See *Explosive Remnants of War and Mines other than Anti-personnel Mines: Global Survey 2003–2004*, Landmine Action UK, March 2005, p. 2. [hereinafter Global Survey].

<sup>2</sup> Ibid., p. 6.

<sup>3</sup> Article 8.2 of Protocol V requires that “Each High Contracting Party in a position to do so shall provide assistance for the care and rehabilitation and social and economic reintegration of victims of explosive remnants of war.” Article 6.3 of the MBT states that “Each State in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims ... .”

<sup>4</sup> European Commission, *The European Roadmap towards a Zero Victim Target. The EC Mine Action Strategy & Multi-annual Indicative Programming 2005–2007*, Brussels, 2004, p. 7. [Hereinafter *The European Roadmap*].

<sup>5</sup> Ibid., p. 12.

<sup>6</sup> When relevant, reference will be made to initiatives for landmine survivor victim assistance, as these initiatives, in practice, already deal with ERW casualties and people with disabilities, often without making a distinction. The *European Roadmap* is a case in point.

<sup>7</sup> United Nations Mine Action Service, *Mine Action and Effective Coordination: the United Nations Policy; Sectoral Policy: The Scope of Action of Mine Action Centers and Organizations in Victim Assistance*, May 2003, This statement of United Nations policy is a subcomponent of “Mine action and effective coordination: the United Nations Policy” (UN document A/56/448/Add2, dated September 1998).

<sup>8</sup> At the moment, there are no databases specifically designed to record ERW incidents, the current systems collect both mine and ERW casualty information, even if in some cases, such as Guinea-Bissau, most casualties are caused by ERW.

<sup>9</sup> International Campaign to Ban Landmines, *Landmine Monitor Report 2004*, Human Rights Watch, New York, October 2004, p. 51 [Hereinafter *Landmine Monitor Report 2004*].

<sup>10</sup> Suzanne Fiederlein, Mine Action Information Centre, *Enhancement of Casualty Data Collection & Management, A Report on the Analysis of Landmine Casualty Data Collection & Management Procedures and Recommendations for Improvements*, James Madison University Grant Task 1.4.4, 2003–2004, submitted to US Department of State, 30 June 2004, p. 13. [hereinafter *Enhancement of Casualty Data Collection*] The study concluded that, as an intermediary step, data collection efforts focused on known contaminated areas are more effective in capturing data on casualties than relying on a national injury surveillance system [*Enhancement of Casualty Data Collection & Management*, p. 16.]

<sup>11</sup> IMSMA is provided free of charge to mine- and ERW-affected countries and to the governments of countries actively involved in peacekeeping and mine action support operations.

<sup>12</sup> E-mail from Alan Arnold, Programme Manager, Mine Action Information Systems, Geneva International Centre for Humanitarian Demining, 13 April 2005. For more information on IMSMA visit <<http://www.gichd.ch/imsma>>.

<sup>13</sup> IMSMA utilizes three different types of casualty data collection forms: the *Mine Accident Report*, which records the information on the general circumstances of a mine accident; the *Victim* form records the personal details and circumstances of the accident; and the *Casualty* form records specific information on an accident during mine clearance activities.

- <sup>14</sup> CMVIS utilizes 18 full-time data gatherers and three part-time data gatherers in 17 provinces of Cambodia. In addition, six CRC and 75 other volunteers cover the remaining seven provinces. On average, it takes two to three days until the data gatherers are informed of an incident in the region under their supervision.
- <sup>15</sup> Steven Mellor, "External Evaluation of the CMVIS Database, Data-entry and reporting systems," Evaluation conducted on behalf of Handicap International and the Cambodian Red Cross, September 2002, p. 1.
- <sup>16</sup> These include government authorities, mine action agencies, NGOs, and other service providers.
- <sup>17</sup> Interview with CMVIS team in Phnom Penh, Cambodia, 22 March 2005; interview CMVIS data gatherer, Cambodian Red Cross, Battambang, Cambodia, 30 March 2005; Cambodia Mine/UXO Victim Information System, Handicap International & Cambodian Red Cross, *Towards Zero Victims, National Census of the Victims and Survivors of Landmines and Unexploded Ordnance in Cambodia 2003*, Phnom Penh, Cambodia, August 2004, pp. 9–10.
- <sup>18</sup> It was judged to be "more flexible, more adapted to the needs of the end-users (queries and reports) and much quicker than the whole IMSMA software." Handicap International, *Feasibility Study into a National Network for UXO Accidents in Lao PDR*, funded by UNDP and implemented by Handicap International Belgium, January–February 2004, p. 20. It should be noted that data from the CMVIS database can be easily transferred to IMSMA.
- <sup>19</sup> Information on mine and ERW casualties is collected from over 490 health facilities in 24 provinces.
- <sup>20</sup> Suzanne Fiederlein, Mine Action Information Centre, *Enhancement of Casualty Data Collection & Management, A Report on the Analysis of Landmine Casualty Data Collection & Management Procedures and Recommendations for Improvements*, James Madison University Grant Task 1.4.4, 2003–2004, submitted to US Department of State, 30 June 2004, p. 14.
- <sup>21</sup> Generally, all the information is linked and cross-referenced to IMSMA. In other cases, the LIS also links to other data collection systems. For example, in Cambodia, the survey teams used certain parts of CMVIS. This cooperation on the specific needs of the two systems resulted in a mutual reinforcement. According to the Survey Action Centre, *Cambodia National Level 1 Survey, 7.3 Cambodia Mine Victims Information System (CMVIS)*, "The main objective of the completed Level One survey is to facilitate planning and priority setting for humanitarian demining in terms of socio-economic impact, requiring the location of contaminated areas to be of the highest importance; whereas CMVIS strives to provide comprehensive ongoing information on the nature and situation of mine and UXO casualties in Cambodia to facilitate planning and monitoring of mine action and victim assistance in terms of casualty reduction and survivor assistance, requiring casualty information to be of the highest importance." The full report is available at <<http://www.sac-na.org/>>.
- <sup>22</sup> Between 2002 and 2004, the EC supported nine Impact Surveys.
- <sup>23</sup> This is different from anti-personnel mines, which are not designed to kill, but rather to injure.
- <sup>24</sup> E-mail from Dr. Robin Coupland, ICRC–Science for Humanity, 10 March 2005; he added that "buried antipersonnel mines, by design, target the lower limb."
- <sup>25</sup> Hospitals sometimes lack surgical experience and specialized equipment and are often reluctant to remove shrapnel due to the risks involved.
- <sup>26</sup> Handicap International, *Life after the Bomb: A Psychosocial Study of Child Survivors of UXO accidents in Lao PDR*, final draft, December 2004, pp. 8–9.
- <sup>27</sup> The distinct advantage of the ICRC wound classification system is that it looks at wounds as surgical injuries rather than as effects of certain weapons.
- <sup>28</sup> Robin Coupland, *Assistance for Victims of Anti-personnel Mines: Needs, Constraints and Strategy*, International Committee of the Red Cross, Geneva, 1997. The full text of the document is available at <<http://www.icrc.org/>>. An analysis of data on 720 people treated in ICRC hospitals found the following incidence of injury type:
- Pattern I: 30 %;
  - Pattern II: 50 %;
  - Pattern III: 5 %; and
  - Unclassifiable: 15 %.

- <sup>29</sup> Interview with Dr. Cino Bendinelli, Medical Coordinator, Emergency Hospital, Battambang, Cambodia, 29 March 2005; e-mail from Dr. Chris Giannou, Head Surgeon, International Committee of the Red Cross, 8 April 2005.
- <sup>30</sup> Analysis of casualty data provided by CMVIS.
- <sup>31</sup> Analysis of casualty data provided by CMVIS. It should be noted that these figures do not match the total number of injured because some individuals suffered more than one type of injury.
- <sup>32</sup> Interview with Sarah Dyer, Programme Manager, National Programme for Action on Disabled (Afghanistan), United Nations Development Programme, Kabul, 5 May 2005.
- <sup>33</sup> Poverty Reduction Strategy Papers (PRSPs) aim to present a coherent strategy that helps poor countries achieving sustainable growth and a substantial reduction in poverty leading to better national coordination and more resources of which the health sector is expected to benefit. World Health Organization research shows that PRSPs recognize the need to make health investments as part of an overall development strategy by extending health services and making them more efficient and responsive. As people with disabilities are among the poorest of the poor, they should benefit from these strategies. In Cambodia, the poorest in the community are eligible for health cards that give the right to free medical care and sometimes transport, paid for by an equity fund that grows proportionally with the revenues of the hospital and is also used to supplement staff salaries. In Calmette Hospital in Phnom Penh, a similar system is in place to accommodate patients who cannot afford the services. There is however a formal division between paying and non-paying patients. The same services are available but non-paying patients must wait longer for services. Interview with Dr. Chhor Nareth, Head of Emergency Department, Calmette Hospital, Phnom Penh, Cambodia, 1 April 2005.
- <sup>34</sup> In Cambodia, for example, the salary of a government-employed doctor averages around US\$ 20–30 a month, whereas a woman employed in a textile factory earns around US\$ 40. Doctors and physical and occupational therapists working for international NGOs can earn significantly more. For example, the Handicap International-supported Spinal Cord Injury Unit in Battambang supplements the government salary by up to US\$ 300 a month. Calmette Hospital also supplements the government salary with up to US\$ 90 a month with fees from patients. Interviews with Dr. Chan Sokhom, Director, Spinal Cord Injury Unit, Battambang, Cambodia, 30 March 2005 and Dr. Chhor Nareth, Head of Emergency Department, Calmette Hospital, Phnom Penh, Cambodia, 1 April 2005.
- <sup>35</sup> For example, the ICRC provides war surgery seminars and trains prosthetists and orthotists; Handicap International provides training for physiotherapists and prosthetic technicians; Trauma Care Foundation, working together with the Ministry of Health, provides first aid and emergency care training at three levels for local health workers; the Italian NGO Emergency trains national staff and government officers in their hospitals; and in Afghanistan UNDP is building the capacity of relevant ministries to address the needs of persons with disabilities.
- <sup>36</sup> European Commission, *The European Roadmap towards a Zero Victim Target. The EC Mine Action Strategy & Multi-annual Indicative Programming 2005–2007*, Brussels, 2004, p. 15.
- <sup>37</sup> Interview with Edith van den Wijngaard, Coordinator, Rehabilitation Department, Handicap International, Phnom Penh, Cambodia, 21 March 2005.
- <sup>38</sup> The first review conference of the MBT was held in Nairobi in November/December 2004. At the conference the Nairobi Action Plan 2005–2009 was approved. The Plan includes concrete actions to reinforce the victim assistance provisions of the MBT. For more information see United Nations, “Final Report of the First Review Conference of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, Nairobi, 29 November–3 December 2004,” UN document APLC/CONF/2004/5, 9 February 2005, pp. 26–33 and 99–101. [Hereinafter, *Final Report of the First Review Conference*].
- <sup>39</sup> However, whereas the definition of the problem was done reasonably adequate by the actors, the objectives were not always SMART (SMART: Specific, Measurable, Achievable, Relevant and Time-based) and it was recognized that concrete plans and means to achieve these objectives and implement the plans were not identified or dealt with sufficiently by the States Parties in the questionnaires. Mostly, lack of funding was called upon as a major obstacle. GICHD, *Efforts to Assure that the 24 States Parties to the Convention which have Reported Significant Numbers of Landmine*

*Survivors Develop 2009 Victim Assistance Objectives in Time for the 2005 Sixth Meeting of the Status Parties*, September 2005.

40 For further information, see ICBL Working Group on Victim Assistance, *Guidelines for the Care and Rehabilitation of Survivors*, <<http://www.icbl.org/problem/solution/survivors/guidelines>>; see also, *Providing Assistance to Landmine Victims: A Collection of Guidelines, Best Practices and Methodologies*, compiled by the Co-Chairs of the Standing Committee on Victim Assistance, Socio-Economic Reintegration and Mine Awareness, May 2001.

41 International Campaign to Ban Landmines, *Landmine Monitor Report 2004*, Human Rights Watch, New York, October 2004, p. 54.

42 DG ECHO, *When Disaster Strikes, 2004 Annual review*, p. 19. <[http://europa.eu.int/comm/echo/pdf\\_files/annual\\_reviews/2004\\_en.pdf](http://europa.eu.int/comm/echo/pdf_files/annual_reviews/2004_en.pdf)>.

43 European Commission, *The European Roadmap towards a Zero Victim Target. The EC Mine Action Strategy & Multi-annual Indicative Programming 2005–2007*, Brussels, 2004, p. 15.

44 Aart Hendriks, *The Rights to Health*, 1 *European Journal of Health Law*, No. 2 187 (1994) (reporting on the General Day of Discussion on the Right to Health held at the United Nations in Geneva in 1993).

45 Telephone interview with Dr. François Boillot, Surgeon, Médecins sans Frontières, 14 March 2005; and interview with Dr. Cino Bendinelli, Medical Coordinator, Emergency Hospital, Battambang, Cambodia, 29 March 2005.

46 According to an analysis of data collected in Afghanistan on the location of the first medical care received by mine/ERW casualties, it took on average 1.2 hours for the victim to reach a dispensary, 2.2 hours to reach a health centre, and 3.2 hours before reaching a hospital. In some parts of the south and east of the country it can take four days to reach the nearest hospital, interview with Michael O'Brien and Zamanuddin Noori, International Committee of the Red Cross, Kabul, 9 May 2005 and ICRC analysis.

In Cambodia, an analysis of data on 869 mine/ERW casualties indicated that for 40 casualties it took more than two hours before the first care was received, for 205 it took between one and two hours, and for 624 it took more than 30 minutes. Analysis of casualty data provided by CMVIS.

47 ICBL Working Group on Victim Assistance, *Guidelines for the Care and Rehabilitation of Survivors*, <<http://www.icbl.org/problem/solution/survivors/guidelines>>.

48 Ibid.

49 E-mail from Dr. Robin Coupland, ICRC–Science for Humanity, 10 March 2005; e-mail from Dr. Chris Giannou, Head Surgeon, International Committee of the Red Cross, 8 April 2005; telephone interview with Dr. François Boillot, Surgeon, Médecins sans Frontières, 14 March 2005.

50 The acute phase (post injury/surgery) includes:

- prevention of contractures/deformities which prepares the amputated limb for prosthetic fitting;
- treatment of associated injuries, for example chest trauma, fractured ribs, or pneumothorax. By treating chest trauma this in turn improves oxygenation and increases the overall healing rate;
- treatment of burns with exercises and splinting to prevent contractures;
- commencement of strengthening exercises and early rehabilitation in preparation for prosthetic training; and maintenance of strength and function to prevent debility and deconditioning which in turn will shorten the rehabilitation time.

51 Email from Dr. Chris Giannou, Head Surgeon, International Committee of the Red Cross, 13 April 2005; Interview with Bernard Franck, Technical Advisor, Handicap International, Siem Reap, 26 March 2005; Robin Coupland, *Assistance for Victims of Anti-personnel Mines: Needs, Constraints and Strategy*, International Committee of the Red Cross, 1997.

52 Interview with Joel Ninninger, Head Prosthetist-Orthotist, ICRC Regional Physical Rehabilitation Centre, Battambang, Cambodia, 30 March 2005.

53 ICBL Working Group on Victim Assistance, *Guidelines for the Care and Rehabilitation of Survivors*, <<http://www.icbl.org/problem/solution/survivors/guidelines>>.

54 In Cambodia, for example, the physical rehabilitation sector is entirely supported by international agencies and NGOs as the Ministry of Social Action and Veteran Affairs does not have a budget to implement programmes. In the past few years, the number of physical rehabilitation centres covering

the 24 provinces reduced from 16 to eleven in 2004. According to service providers, the principal reason for the decrease in the number of centres is decreased funding; also due to issues of cost, quality control, and sustainability. Improved infrastructure throughout Cambodia reportedly allows amputees from areas near closed centers to travel to the closest remaining centre. International Campaign to Ban Landmines, *Landmine Monitor Report 2004*, Human Rights Watch, New York, October 2004, p. 266. However, in reality access is problematic for some survivors, and there are calls to reopen certain centres or to expand the outreach services in remote areas that are not adequately covered.

55 Handicap International, *Life after the Bomb: A Psychosocial Study of Child Survivors of UXO accidents in Lao PDR*, final draft, December 2004, p. 12.

56 World Rehabilitation Fund, *Guidelines for the Socio-economic Reintegration of Landmine Survivors*, New York, August 2003, p. 14.

57 Not only does sport have the potential to increase the physical strength and condition of a person with a disability, it promotes social interaction, self-esteem and a feeling of belonging.

58 World Rehabilitation Fund, *Guidelines for the Socio-economic Reintegration of Landmine Survivors*, New York, August 2003, p. 1.

59 Data collected by Jesuit Service Cambodia as part of its outreach program in 1999 and 2000 revealed that of 1,663 survivors interviewed: 71% did not have adequate housing; 7% had no house at all; 45% had to travel more than five minutes to get water for drinking and washing; 89% reported food insecurity; 32% had no land for housing or cultivation; 28% received a government pension; 50% had a "job" (including rice farming); and the children of at least 46% did not go to school. As a result of the survey, mine/ERW survivors developed a 12-point plan to address their needs, including priorities for socio-economic reintegration. International Campaign to Ban Landmines, *Landmine Monitor Report 2004*, Human Rights Watch, New York, October 2004, p. 271. For more details of the 12-Point Plan visit <[http://www.jrscambodia.org/proj\\_12pp.html](http://www.jrscambodia.org/proj_12pp.html)>.

60 "Job Opportunities Remain a Huge Hurdle for Survivors," Rights for All, Landmine Survivors Network, 3 March 2004, available at <<http://www.rightsforall.org/article.php?id=255>>.

61 European Commission DG Development, *Guidance Note on Disability and Development for EU Delegations and Services*, I/Disability/ Guidance note on disability 030304 – Final D1256, March 2003. [Hereinafter *Guidance Note on Disability*].

62 This is not always the case, for example in Afghanistan former combatants are regarded as having made a sacrifice for the country and treated with respect.

63 European Commission DG Development, *Guidance Note on Disability and Development for EU Delegations and Services*, I/Disability/ Guidance note on disability 030304 – Final D1256, March 2003.

64 "Interviews with women with physical disabilities in Afghanistan revealed that their disabilities are used against them to keep them from finding employment, from continuing their education and sometimes from being visible. Interestingly enough, these women have begun to adhere to the disability stereotype about themselves and articulated statements such as 'we can't go to school because we are disabled' or 'we have nothing to offer as disabled women'. In addition, women with either acquired or congenital disability, barring blind and hearing impaired women, have no chance of marriage." Interaction in Health, *Disability in Afghanistan, An Assessment for Caritas Germany*, Amsterdam, 5 May 2004, p. 17.

65 Handicap International Belgium, "Capacity Building of People with Disability in Community (CABDIC) in Cambodia: Evaluation," 2 October–3 November 2000, p. 14.

66 Ibid.

67 United Nations Children's Fund, "Impact of Landmines on Children in the East Asia and Pacific Region", East Asia and Pacific Regional Office, September 2003, p. 10.

68 Ibid., p. 11.

69 "Action for Victim Assistance: Cambodia 2003," Disability Action Council, Cambodia, September 2003, p. 8.

70 For example, in Cambodia, there is a well-developed network of coordinating bodies for disability issues. On the policy and coordination level, the Disability Action Council takes the leading role and the National Centre for Disabled Persons (NCDP) is the service provider. NCDP's Information and

Referral Service (IRS) includes a database which is cross-referenced with job opportunities, vocational training and job-seeking skills. In collaboration with NGO partners in the rehabilitation sector and with private companies, the Business Advisory Council (BAC) was established to increase the number of employment opportunities for people with disabilities and to provide advice on employment issues to companies. Interview with Yi Veasna, Executive Director, NCDP, Phnom Penh, 23 March 2005.

For more information on the BAC, see World Rehabilitation Fund and United Nations Development Program, *The Socio-Economic Reintegration of Landmine Survivors, Designed to Establish an Integrated Approach to Victim Assistance for the Social and Economic Independence of Landmine Survivors and Their Families*, New York, 2003, pp. 5–6.

71 *Time for Equality at Work: Global Report under the Follow-up to the ILO Declaration on Fundamental Principles and Rights at Work*, Report of the Director-General, International Labour Conference, 91<sup>st</sup> Session 2003, Report I (B), Part 1, para. 114, p. 34.

72 Ibid, para. 297, p. 97.

73 “Job Opportunities Remain a Huge Hurdle for Survivors,” Rights for All, Landmine Survivors Network, 3 March 2004, available at <<http://www.rightsforall.org/article.php?id=255>>.

74 STAKES, the National Research and Development Centre for Welfare and Health in Finland, *The Disability Dimension in Development Action*, Revised online version 2003, p. 13.

75 Ibid., p. 13.

76 However, disability and disabled people are not mentioned in the MDG indicators.

77 European Commission DG Development, *Guidance Note on Disability and Development for EU Delegations and Services*, I/Disability/ Guidance note on disability 030304 – Final D1256, March 2003.

78 In Afghanistan, for example, 350 out of 1,026 casualties were collecting wood or water, farming or tending animals at the time of the mine/ERW explosion; 242 were tampering with a device. In Cambodia, 294 casualties out of 1,107 were collecting food, herding or farming at the time of the explosion; 409 were hurt while tampering with the device.

79 In total, there have been six ad hoc sessions and the seventh will take place in New York in August 2005.

80 The Working Group is comprised of 27 governmental representatives and 12 NGO representatives, particularly organizations of, and for, persons with disabilities. The Working Group has prepared the draft text, which has been discussed at subsequent Sessions of the Ad Hoc Committee. International Campaign to Ban Landmines, *Landmine Monitor Report 2004*, Human Rights Watch, New York, October 2004, p. 48. For more information see UN General Assembly Resolution 56/168; <<http://www.un.org/esa/socdev/enable/rights/>>; see also <<http://www.rightsforall.com/>>.

81 “Final Report of the First Review Conference of the States Parties to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, Nairobi, 29 November–3 December 2004,” UN document APLC/CONF/2004/5, 9 February 2005, pp. 26–33.

82 Ibid., p. 27.

83 Telephone interview with Kirsten Young, European Regional Coordinator and Legal Counsel, Landmine Survivors Network, Geneva, 9 March 2005.

84 Within the framework of the UN Economic and Social Commission for Western Asia, workshops on disability statistics have already been organized.

## ACRONYMS

APL	anti-personnel landmine
CBR	community-based rehabilitation
CCW	Convention on Certain Conventional Weapons
CMVIS	Cambodia Mine/UXO Victim Information System
CRC	Cambodian Red Cross
DG ECHO	Directorate General for Humanitarian Aid
DPO	Disabled Persons Organization
EC	European Commission
ERW	explosive remnants of war
EU	European Union
GICHD	Geneva International Centre for Humanitarian Demining
ICRC	International Committee of the Red Cross
IMSMA	Information Management System for Mine Action
LIS	Landmine Impact Survey
MBT	Mine Ban Treaty
MDGs	Millennium Development Goals
SAC	Survey Action Centre
NGO	non-governmental organisation
UXO	unexploded ordnance
VA	victim assistance

