The Role of Mine Action in Victim Assistance

Geneva International Centre for Humanitarian Demining
Centre International de Déminage Humanitaire - Genève

The Role of Mine Action in Victim Assistance

Geneva International Centre for Humanitarian Demining
Centre International de Déminage Humanitaire - Genève

The **Geneva International Centre for Humanitarian Demining** (GICHD) supports the efforts of the international community in reducing the impact of mines and unexploded ordnance. The Centre is active in research, provides operational assistance and supports the implementation of the Mine Ban Treaty.

For further information please contact:

Geneva International Centre for Humanitarian Demining
7bis, avenue de la Paix
P.O. Box 1300
CH-1211 Geneva 1
Switzerland
Tel. (41 22) 906 16 60
Fax (41 22) 906 16 90
www.gichd.ch
info@gichd.ch

The Role of Mine Action in Victim Assistance, GICHD, Geneva, July 2002.

The project was managed by Eric Filippino, Head, Socio-Economic Section (e.filippino@gichd.ch).

ISBN 2-88487-000-8

Contents

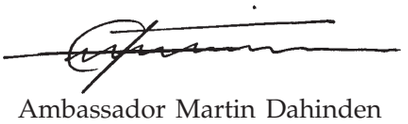
Cover photo: Mine victims are fitted and rehabilitated at the Battambang ICRC orthopaedic centre. (© ICRC/Tim Page, landmine victim, Cambodia 1996.)

Foreword

Victim assistance has sometimes sat uneasily within the conceptual framework of operational mine action. Mine action centres and mine action programmes have often been unclear as to what their operational role should be in this field. And although a number of humanitarian organisations involved in providing assistance to those injured by landmines and unexploded ordnance (UXO) also carry out humanitarian demining and mine awareness, the skills and knowledge required are typically very different. At the request of the United Nations Mine Action Service (UNMAS), the *Role of Mine Action in Victim Assistance* has sought to identify how mine action can best contribute to ensuring that mine and UXO survivors receive all necessary assistance.

The review has looked at the provision of assistance to mine and UXO victims in five disparate contexts — Cambodia, Eritrea, Ethiopia, Kosovo, and Nicaragua. Each case study had a different story to tell. It found that, in many cases, mine action has played little operational role in direct service provision, but has been able to advocate for the needs of mine victims as well as to help to mobilise resources for the specialist healthcare organisations and bodies best positioned to provide assistance to war-wounded and persons with disability.

The *Role of Mine Action in Victim Assistance* was made possible thanks to funding from the United Kingdom Department for International Development and the Italian Ministry of Foreign Affairs — their contribution is gratefully acknowledged. Additional copies of the document are available from the Geneva International Centre for Humanitarian Demining (GICHD) Socio-Economic Section.



Ambassador Martin Dahinden
Director
Geneva International Centre for
Humanitarian Demining

Summary of findings

Study finding 1

There is a widespread lack of clarity about the *operational* role of mine action in providing assistance to victims of landmines and UXO. One of the reasons for this is a lack of clarity and consistency in the use of certain terminology.

The Mine Ban Treaty does not provide a definition of operational mine action, although it provides legal, and therefore political, guidance on activities to eliminate the threat of anti-personnel mines.

Study finding 2

In most cases, field-based mine action programmes have done relatively little to promote the rehabilitation and reintegration of mine and UXO victims. Of course, primary responsibility for ensuring the provision of assistance falls to the national government, though it may need assistance in meeting its obligations. Yet, indirectly, all mine action actors can have a positive or negative impact on the survival, rehabilitation and reintegration of mine and UXO victims. The extent of mine action involvement in victim assistance must, however, depend on the local context and situation and the capacity of the actors operating in a given region — there is no "one size fits all" approach.

Study finding 3

In an emergency phase, where the national government does not have the capacity, or is unwilling, to provide assistance to mine and UXO victims, mine action programmes have, on rare occasions, assumed direct responsibility for the provision of basic healthcare services.

Study finding 4

The issue of assistance to mine victims has received significant political, diplomatic, legal and financial attention during recent years. Indeed, positive attention paid to the needs of mine victims may sometimes have acted to the detriment of other war-wounded and persons with disability.

Study finding 5

Globally, the number of new mine victims is decreasing. Although this may be attributed in part to the availability of better data, it is also an indication of the success of mine action programmes around the world.

Study finding 6

The needs of mine and UXO victims tend to be defined broadly, thereby constituting a significant challenge in programme delivery.

Chapter 1

Introduction

Problem statement

United Nations Mine Action is *"the response of the United Nations system to the global landmine and unexploded ordnance (UXO) problem"*. It includes five core components: mine clearance; mine awareness and risk reduction education; victim assistance; advocacy in support of a total ban on anti-personnel landmines; and stockpile destruction.[1] Yet, of the five components, the mine action community has not paid the same level of attention to victim assistance as it has to the others. For, although clearly part of the existing definition of mine action, few mine action organisations have much involvement in victim assistance issues and that is equally true of the coordinating entities, such as the national or United Nations (UN) mine action centres (MACs). At the same time, practitioners of mine clearance and awareness have often been unclear as to victim assistance's operational role within mine action.

There has been considerable work done at the macro level to define a strategic framework for mine victim assistance. For example, the Swiss Government — with the technical assistance of the International Committee of the Red Cross (ICRC), the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) — have sought to promote an integrated approach to strengthen health sector capacity to care for victims. This has been expressed through the Bern Manifesto, the Declaration of Kampala and the joint WHO/ICRC *Strategy on Landmine Victims Assistance*. In addition, organisations such as the Physicians for Human Rights and the United Nations Development Programme (UNDP), with the World Rehabilitation Fund (WRF), have put forward further guidelines on care, rehabilitation and capacity assessment for mine victims, and the International Campaign to Ban Landmines (ICBL) developed a booklet called *Guidelines for the Care and Rehabilitation of Survivors*.

Guidelines notwithstanding, however, action at field level within MACs, other mine action entities or mine action programmes to implement the corresponding recommendations has been relatively limited. Confusion over the nature of mine action's role in providing assistance to victims still exists within the mine action

1. See *www.mineaction.org*.

community and field level operators have requested guidance on defining and subsequently fulfilling their victim assistance responsibilities. Victim assistance falls within the stated responsibility of MACs, mine action programmes and projects, but in most mine action scenarios it is not addressed.[2]

The gaps between stated policy, quantifiable action and common practice are by no means desirable. There is, therefore, a clear need for operationally focused, field-level research that will expose the differing aspects of the problem and give guidance to mine action practitioners on their role in victim assistance initiatives.

Study terms of reference

Recognising that victim assistance must form part of an overall national and community-based public health approach to disability, the objectives of this Study are to:

- Engage in a literature review of policies, guidelines and standards for mine victim assistance in order to provide a general overview;
- Identify and analyse ways in which mine action agencies/programmes have approached victim assistance activities, including data collection;
- Identify lessons learned that will lead to the clarification of the respective roles and responsibilities of agencies involved in mine action in relation to victim assistance;
- Based on analysis and consultation with relevant experts, identify good practice in the field of victim assistance for mine action agencies and programmes.

The primary beneficiaries of the study, which was requested by the United Nations Mine Action Service (UNMAS), are MACs in general and mine action programme managers in particular, who should be enabled to develop a clearer understanding of the relationship between victim assistance activities and mine action. In turn, they will be able to plan with more accuracy and will better understand how to fulfil their responsibilities and roles with more certainty.

In addition, all other actors involved, or wishing to become involved, in providing assistance to mine and UXO survivors — including concerned governments, donors, the UN family of agencies as well as cooperating non-governmental and international organisations in the mine action field — will be provided with a frame of reference to support their strategic decision-making.

Methodology

The evidential core of this report is a set of four case studies commissioned by the Geneva International Centre for Humanitarian Demining (GICHD) in early 2001. The four contexts selected — Cambodia, Eritrea/Ethiopia, Kosovo and Nicaragua — reflect distinct mine action scenarios and developmental settings. The case studies were

2. There are a few mine action environments, notably Kosovo and Northern Iraq, where, in the absence of a stable government, mine action programmes have played a significant role in providing a framework for mine victim assistance.

conducted by independent consultants (Tim Grant in Cambodia; Christian Provoost in Eritrea and Ethiopia; Valérie Quéré in Kosovo; and Almachiara D'Angelo and Sonia Cansino in Nicaragua) and each included a review of literature and ongoing initiatives and field-work in the respective context.

Following an initial edit of the case studies, revised drafts were circulated to selected key interlocutors at field level to ensure the accuracy of information included. They were then discussed at a User Focus Group meeting held on 4 May 2001 in Geneva.[3] Following revisions and additions, the edited texts were included in a comprehensive study report, which was discussed at a Steering Group meeting held on 5 September 2001 in New York.[4] The study has also been circulated more widely for comment before its finalisation.

3. Terms of reference for, and membership of, the User Focus Group are included as Appendixes A and B to the present report.
4. Terms of reference for, and membership of, the Steering Group are included as Appendixes C and D to the present report.

Chapter 2

Study findings, analysis and recommendations

This section presents the key findings, supporting analysis and accompanying recommendations of the study based on the evidence presented in the four case studies (see Chapters 3 to 6) and additional information obtained from the literature review and discussions in the User Focus Group and Steering Group. The recommendations are addressed to the mine action community at large.

Study finding 1

There is a widespread lack of clarity about the *operational* role of mine action in providing assistance to victims of landmines and UXO. One of the reasons for this is a lack of clarity and consistency in the use of certain terminology.

The Mine Ban Treaty does not provide a definition of operational mine action, although it provides legal, and therefore political, guidance on activities to eliminate the threat of anti-personnel mines.

Analysis

A number of governments have questioned, publicly and privately, whether mine action should be actively providing assistance to mine victims, or whether this falls more to the public health sector.[5] But determining whether or not mine action does, or should have, an operational role in providing assistance to mine and UXO victims is hampered by uncertainty, disagreement or ambiguity as to the precise meaning of certain key terms, notably, *mine action*, *mine victim* and *victim assistance*.

5. Sweden's International Development Agency (SIDA), for example, has stated its opinion *"that victim assistance is a part of the public health sector, not a part of mine action. A number of actors share that opinion, but the time is not right to split up the concept of humanitarian mine action in this respect ... SIDA should foremost support mine clearance at the expense of mine awareness, survey and victim assistance ... because: regardless of other mine action activities, mine clearance is the activity that finally gets rid of the mines and creates possibilities to move freely and to use the land ..."* (ICBL, 2001).

The definition of mine action

According to the UN (1998):

> *"Mine action refers to all activities geared towards addressing the problems faced by populations as a result of landmine contamination. It is not so much about mines as it is about people and their interaction with a mine-infested environment. Its aim is not technical, that is, to survey, mark and eradicate landmines, but rather humanitarian and developmental, that is, to recreate an environment in which people can live safely, in which economic, social and health development can occur free from constraints imposed by landmine contamination, and in which the needs of victims are addressed."*

Operational assistance to mine and UXO victims clearly falls within this broad definition of mine action, but in most cases mine action professionals currently take a much narrower definition of their mandate,[6] and socio-economic theory and practice is still in the process of being incorporated into mine action operations.[7] As already noted, UN mine action includes five core components, namely:

- Mine clearance (encompassing survey and marking);
- Mine awareness and risk reduction education;
- Victim assistance;
- Advocacy in support of a total ban on anti-personnel mines; and
- Stockpile destruction.

Thus, a mine action (coordination) centre supports, or coordinates, activities that fall under one or more of these five pillars; such a centre does not constitute, in and of itself, "mine action".

International law does not furnish a satisfactory definition of operational mine action. Thus, the Mine Ban Treaty,[8] which is generally considered to be a hybrid arms control and humanitarian law treaty, does not purport to be an instrument defining *operational* mine action, nor should it be considered as such.[9]

The Treaty sets out a number of legal obligations for State Parties, with prohibitions on the use, production, stockpiling and transfer of anti-personnel mines reinforced by requirements to destroy stockpiles and clear emplaced anti-personnel mines within clearly defined time periods and to report on progress. These obligations, which may impose significant financial demands upon, especially, mine-affected developing countries, are balanced by obligations upon donor States to provide assistance for mine clearance, mine awareness and victim assistance.[10] This assistance can be provided bilaterally or multilaterally, for instance through the UN, regional bodies, the ICRC and non-governmental organisations (NGOs).[11]

6. Indeed, the terms "mine action" and "mine clearance" are sometimes used interchangeably at field level.
7. See for instance GICHD, 2001.
8. Also known as the "Ottawa Convention", although the full legal title is the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Mines and on Their Destruction.
9. This is despite an assertion to the contrary by the ICBL Working Group on Victim Assistance (1999/2000:3).
10. Thus, for example, Article 6(3) of the Convention states that *"Each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programmes"*. The relevant assistance can be technical and material as well as financial.
11. There is, however, no absolute requirement for a State Party to assist its own mine victims, although a preambular paragraph to the Convention notes that States wish *"to do their utmost"* to care for mine victims.

Since the adoption of the Treaty, however, recognition has been growing of the dangers of isolating mine victims from other war-wounded and the wider disability context.[12] Similar concern has been expressed about seeing mine clearance as wholly distinct from other community development projects. This tendency towards isolation has been reinforced by the traditional representation of mine action as a series of pillars.

Moreover, there is growing awareness of the central importance of information in effective mine action. The ICRC, for example, highlighted in 1997 the key role that information could play in improving service delivery to mine victims (Coupland, 1997). In 2001, a study for UNDP concluded that mine action was almost as much about information as it was about mines (GICHD, 2001).

The definition of a mine victim

There is also no consensus as to the scope of the term "mine victim". The International Campaign to Ban Landmines (ICBL, 1999/2000:1) defines mine victims as:

> *"those who, either individually or collectively, have suffered physical, emotional and psychological injury, economic loss or substantial impairment of their fundamental rights through acts or omissions related to mine utilisation"*.

Likewise, the Bad Honnef guidelines consider mine victims in broad terms as:

> *"human beings immediately maimed by a mine, family members and/or dependents of persons with disability or killed by mines, and all human beings affected by the existence of mines including those who, due to threat of mines, could not or cannot pursue their normal activities"* (Bad Honnef, 1997).

The significance attached to the debate was clearly illustrated in the case studies conducted for the present report. In Cambodia, a significant number of those working in the disability sector are said to feel that many people with disabilities, such as those afflicted by polio, are also mine victims, because the presence of mines in their villages resulted in them missing out on vaccinations. Some go even further and claim that all the members of a mine-affected community are landmine victims, because of the high level of impact of the weapons on their lives. Thus, while between 70 and 100 people are killed or injured each month by mines and UXO, many thousands of families have to live with the daily threat of mines.

A similar situation exists in Nicaragua where there are fewer than 5,000 direct victims of mines or UXO amid some 600,000 persons with disability across the country, whereas a sizeable rural population, already stricken by extreme poverty, is confronted by the presence or suspected presence of mines. This further impedes their ability to grow food essential for survival.

The Intersessional Standing Committee on Victim Assistance established under the framework of the Mine Ban Treaty has called for clarification in the broad definition of "landmine victim", and statistics on mine victims are generally much more narrowly focused.[13]

12. See Study Finding 4, below.
13. Thus, the Nicaragua case study criticises a tendency in that country to consider as actual victims only those who have lost one or both legs in a mine blast. See *Chapter 6. The case of Nicaragua.* Data collected and analysed by the International Committee of the Red Cross suggests that, on average, around one in three mine/UXO victims is an amputee (Coupland, 1997).

There is also strident criticism of the use of the word "victim" itself. With a view to avoid stigmatising people who have been injured in a landmine explosion and impeding their rehabilitation and reintegration, one NGO, Landmine Survivors Network (LSN), strongly prefers the term "survivor" to "victim", although as chair of the ICBL Working Group on Victim Assistance, LSN accepts the term "victim" in its work related to the Intersessional Standing Committee on Victim Assistance.

At the same time, a number of commentators have expressed their reluctance to repeat the debate about "victim" versus "survivor".[14] However, in its most recent strategy document, UNMAS refers to its vision of a world *"where mine survivors are fully integrated into their societies"*.[15]

The definition of victim assistance

In the past, there has often been a tendency to reduce the scope of mine victim assistance to the provision of an artificial limb. In addition to omitting the majority of mine and UXO survivors (only a minority have lost a leg or an arm to surgical or traumatic amputation), this fails to recognise the long-term impact of mine/UXO injuries, which have debilitating effects extending beyond the individual.

Although, as already noted, the Mine Ban Treaty should not be considered an authoritative reference for the definition of mine action and similar terms, one of its provisions, which addresses assistance to victims of mine victims,[16] refers to assistance *"for the care and rehabilitation, and social and economic reintegration, of mine victims"*.[17] These provisions were extensively debated during the Oslo Diplomatic Conference that adopted the Convention.

The ICBL defines victim assistance *"in basic terms as the care and rehabilitation provided for the immediate and long-term needs of mine victims, their families, and mine affected communities"* (ICBL, 1999/2000:1). The ICBL has published *Guidelines for the Care and Rehabilitation of Survivors*, which cover those who have suffered physical injury from landmines and other persons with disabilities. Nine issues are addressed in the guidelines:

- Emergency medical care;
- Continuing medical care;
- Physical rehabilitation, prosthesis and assistive devices;
- Psychological and social support;
- Employment and economic integration;
- Capacity-building and sustainability;
- Legislation and public awareness;
- Access to services; and
- Data collection.

A macro framework for mine victim assistance, the "Bern Manifesto", developed by the Swiss Government, ICRC, UNICEF and WHO, has sought to promote an integrated approach using the health sector. The Manifesto, which was endorsed by

14. Unattributed remarks made during the Steering Group Meeting in New York, 5 September 2001.
15. See *United Nations Mine Action: A Strategy for 2001-2005*, Section II.
16. That is, presumably, not just victims of anti-personnel mines but also of anti-vehicle/anti-tank mines.
17. Article 6(3), author's emphasis.

10 African countries in Kampala in 1997, is based on four core components: prevention, surveillance, injury management and care, and rehabilitation. It was subsequently elaborated into the "Maputo Strategy", which brings together seven principles for intervention:

- The non-discrimination of victims as recognised by international law;
- An integrated and comprehensive approach to victim assistance;
- Coparticipation and coordination of programmes of government institutions, donors, public, private and non-governmental agencies at all levels to encourage sustainable interventions;
- The importance of national ownership and institutional support;
- Transparency and efficiency using a matricial framework for planning interventions;
- A sustainable developmental approach to promote continuity in humanitarian action offered to post-war contexts; and
- The empowerment of victims and the promotion of their rights.

The issues have been further considered by the Standing Committee on Victim Assistance, which has emphasised the need to promote exchange of experiences; support wider and more integrated scope of mine victim assistance; facilitate the practical use of planning tools at a country level; share information on resource allocation at donor, country, and operational agency levels; and formulate methodology and systems for the evaluation of programmes. There are five network groups that discuss these topics.

Study recommendation 1

As part of a policy development process there is a need to develop a definition of both operational mine action[18] and operational mine and UXO victim assistance. The study proposes the following definitions for consideration.

Operational mine action

Operational mine action consists of three core mine-related activities: mine risk education, mine survey and mine clearance. These activities reflect the background, training and skills of most mine action professionals. Other mine action activities, such as mine and UXO victim assistance, advocacy, and the destruction of landmine stockpiles should be considered part of the comprehensive set of activities designed to address a national mine problem, but fall outside the narrower definition of operational mine action. All mine action-related activities demand careful management of information and coordination of effort and should be situated within broader emergency and development initiatives.[19]

Operational mine and UXO victim assistance

Operational mine action should promote the identification and satisfaction, by the appropriate healthcare actors, of the needs[20] of those injured by landmines or UXO, in particular for first aid, casualty evacuation, surgical treatment, physiotherapy and prosthetic provision. These services together with longer-term rehabilitation and reintegration should be integrated with activities targeting war-wounded and persons with disability more generally.

18. The use of the term "operational" draws a distinction between the three primary operational activities (clearance, survey and awareness) and the broader political definition that encompasses all activities.
19. For an example of a possible graphic conceptualisation of operational mine action, see Appendix F.
20. The *Guidelines for Socio-Economic Integration of Landmine Survivors*, drafted by the World Rehabilitation Fund on behalf of UNDP in 2001 and attached as Appendix G, identify the following six factors as integral to the care, rehabilitation and reintegration of those injured by landmines or UXO: national policies and institutions; medical care; rehabilitation and special education; vocational rehabilitation; economic development, and socio-cultural issues.

Study finding 2

In most cases, field-based mine action programmes have done relatively little to promote the rehabilitation and reintegration of mine and UXO victims. Of course, primary responsibility for ensuring the provision of assistance falls to the national government, though it may need assistance in meeting its obligations. Yet, indirectly, all mine action actors can have a positive or negative impact on the survival, rehabilitation and reintegration of mine and UXO victims. The extent of mine action involvement in victim assistance must, however, depend on the local context and situation and the capacity of the actors operating in a given region — there is no "one size fits all" approach.

Analysis

In areas where mine clearance teams have been operating, they have often provided "casualty evacuation" to individuals injured by mines or UXO, and in some cases their medical teams have treated patients for other ailments. Thus, in Cambodia, for instance, HALO Trust reports that in an average month, the medical teams that support its clearance operations treat *"a couple of mine victims, five pregnancies, five dengue fever sufferers and a host of other life-threatening ailments"*.[21]

Yet, once the patient has been brought to an appropriate medical facility, this normally marks the end of the role for the mine action professional. Surgeons treat as best they can the physical injuries, which in about one in three cases demand surgical amputation. Physiotherapists and prosthetists provide physical rehabilitation to the mine amputees, in the same way as they do for other amputees who have lost one or more limbs, for instance in a car accident or as the result of a bullet wound.

Later, but in rarer cases, psycho-social care, vocational retraining and education will be provided by relevant experts, sometimes in the context of programmes specifically designed for mine victims, in other circumstances, by programmes that seek to help all persons with disability. But the service providers will not be mine action professionals, they will be psychologists and psychiatrists, social and community liaison workers — individuals whose expertise originates from a different sphere.

The Mine Ban Treaty does not impose an absolute obligation upon a State Party to provide assistance to its own citizens who fall victim to landmines. The Preamble to the Convention does, though, refer to the wish *"to do the utmost in assuring assistance for the care and rehabilitation, including the social and economic reintegration, of mine victims"*.

But landmine-contaminated countries tend not to have the medical infrastructure capable of responding to the needs of landmine victims (Roberts and Williams, 1995). Harte (1999) believes that in conflict or immediate post-conflict situations, governments are dysfunctional or under severe stress, infrastructure is reduced and other priorities take over: these are unique times, with unique problems and unique strategies.

Coupland (1997) discusses some of the constraints that operate to render victim assistance difficult or impossible. These include: access; geography; lack of protection for mine victims, who are often not able to go to hospital in a government or rebel-held area; security; political and administrative constraints; poverty; a lack of educated

21. See *Chapter 3. The case of Cambodia.*

people and social infrastructure; lack of funds; inter-agency rivalry and a lack of coordination. To tackle the information constraints, in 1997 the ICRC proposed the Mines Information System — a standardised mechanism for collecting and analysing information about mine incidents. The GICHD has since made available to the UN the Information Management System for Mine Action (IMSMA) database.

Mine action programmes can and should be encouraged to set positive examples, for instance by hiring amputees within their workforce, and including positive rather than negative images of persons with disability in their literature.[22] They may, if they so wish, institute a monitoring system for the victims or participate in overall coordination of assistance, and even help to secure funds for assistance programmes, although great care must be taken to ensure that any initiatives are both integrated and sustainable. The mine action programme is invariably finite, the needs of persons with disability are not.

In Mozambique, the WRF made recommendations to UNDP and the National Demining Institute for the involvement of mine action in the socio-economic reintegration of mine survivors. Though developed specifically for the local context, their recommendations have far reaching implications for mine action in general and have been adapted as below with this wider audience in mind: [23]

Mine action should:

- Participate in the systematic collection of mine incidents involving deminers and civilians alike;
- Regularly participate in advisory, advocacy, and service committees providing support to the disabled community;
- Actively assist in the development of survivor and victim assistance policies by becoming knowledgeable of the existing laws and statutes pertaining to the disabled;
- Act as repository for survivor and victim data pertaining to the identification, and socio-economic status of groups as provided by government and civil society organisations throughout their country of operation;
- Act as a clearing-house and distribute sanctioned directories and other survivor and victim information materials as appropriate;
- Openly and regularly share data acquired on survivor and victims with all ministries and civil society organisations;
- Provide continuing education for its staff, to stay abreast of new programmes and developments concerning the disabled, by attending seminars and workshops, and inviting the community serving the disabled to mine action-sponsored meetings, working groups, etc.;
- Examine its existing policy and practices on hiring people with disabilities and recommend changes as necessary;
- Review its mine risk education materials to ensure its contents include all relevant information needed by survivors and victims.

22. According to the Bad Honnef guidelines, mine action programmes, by means of organisational development and support for collective self-help, must contribute towards overcoming the injustice suffered by the community, group or society as a whole. Efforts on the part of victims (and their dependents) to establish a reparation fund, and financial aid such as pensions, should be supported.

23. Adapted from the Executive Summary of *Mine Victim Assistance Support Visit, World Rehabilitation Fund working in partnership with United Nations Development Programme, Mozambique Country Visit 2-15 November 2001* (WRF, 2001b).

- Strengthen its linkages, communication, and participation with civil society organisations concerning mine risk education and sensibility training being conducted throughout their country of operation;
- Ccontribute to the creation and participation of mechanisms for the coordination and communication between the public, private sector, and donor community for the disabled.

Study recommendation 2

There is a need to provide detailed guidance to mine action professionals in general, and the mine action centres in particular, on the following issues:

- **The development, or distribution, of existing materials on information, awareness and education materials that respect the rights of persons with disability;**
- **The importance of hiring persons with disability;**
- **Resource mobilisation for mine and UXO victim assistance;**
- **The need to share mine victim data as widely as possible with relevant government departments and other international and local agencies and organisations (though respecting confidentiality requirements and ensuring that mine victims are not exploited by the media);**
- **The role of victim data in prioritising mine marking, mine clearance and mine awareness; and**
- **Coordination with relevant actors in the health and disability sectors, including the need to refer cases of persons with disability who have unmet needs to those able to provide assistance in country.**

In general, MACs and mine action professionals should not be required to be directly involved in the implementation of assistance to mine and UXO victims. But as part of its coordination role, a MAC should be sympathetic to the information and support needs of the healthcare providers actively engaged in the provision of assistance to mine and UXO victims.

Study finding 3

In an emergency phase, where the national government does not have the capacity, or is unwilling, to provide assistance to mine and UXO victims, mine action programmes have, on rare occasions, assumed direct responsibility for the provision of basic healthcare services.

Analysis

In — typically emergency — situations where the UN has a predominant role, and the national Ministry of Health is not functioning for whatever reason, mine action may have a role to play in ensuring coordination and funding for victim assistance:[24] this has occurred, to differing extents, both in Kosovo and, most notably, in northern Iraq.[25]

In Kosovo, since the United Nations was also the *de facto* governing authority in the

24. According to the ICBL (2000, 3), victim assistance is complex in that it involves a wide range of activities and players, positioned in the ministries dealing with health, social welfare, employment, labour, veterans. This is why a national coordinating mechanism is desirable — either the Mine Action Centre or, preferably, within a broader cross-disability coordination mechanism such as the Disability Action Councils, as exist in Cambodia and Mozambique (Harte, 1999).

25. See *Providing Victim Assistance Services for All Motor-Disabled People in North Iraq*, Report for UNOPS, March 2002. This report is annexed to the present document as Appendix E.

province, the Mine Action Coordination Centre (MACC) effectively determined that mine and UXO victim assistance would be an integral part of its mine action mandate. In these exceptional circumstances, the MACC did not benefit from the same level of either funding or technical support at the disposal of other mine action-related activities. To date, relatively few of the plethora of mine action organisations operational in Kosovo have incorporated a victim assistance component in their work, although prosthetic services generally have been actively supported by Handicap International.

In northern Iraq, however, in the absence of a "lead" organisation or agency capable of addressing the need, the United Nations Office for Project Services (UNOPS) proposed to partner organisations so that the resulting network would provide for emergency first aid, surgical treatment, provision of ortho-prosthetic devices, physical and psychosocial rehabilitation, vocational training, income-generation and advocacy. Accordingly, all services are organised and delivered by local organisations, except for the specialised surgical services delivered by an international NGO, and approximately 60 per cent of staff in the rehabilitation centres are people with disabilities.

According to UNOPS, the implementation of an integrated approach to demining in northern Iraq, which includes mine awareness, mine clearance and victim assistance, has demonstrated that an inter-disciplinary community-based approach can yield dividends that transcend the technical aspects of demining. This new approach has opened the door to many more people with disabilities, allowing them to access the network of services originally intended for landmine and UXO survivors (Dunne, 2001).

Moreover, although armed conflict may disrupt, overburden or even destroy essential health infrastructure leading to inevitable consequent suffering, researchers have sometimes stressed that this can also provide an opportunity for social change, as institutions and services have collapsed and people are looking to the outside for answers (Hastie, 1997). In Bosnia and Herzegovina, for instance, before the war, persons with disability were at the bottom of the political and social agenda, and although the breakdown of medical services left more persons with disability it also resulted in new organisations, institutions and associations being set up since the Dayton Peace Accord. This, in turn, has allowed cross-disability representation, and afforded the chance to tackle the problems faced by women with disability, which hitherto had remained hidden.

Study recommendation 3

Mine action should not completely turn its back on victim assistance. In exceptional circumstances, for instance, in an emergency situation where the national government is unwilling or unable to assist mine and UXO victims, mine action should be prepared to take an active role in the provision of services and should not assume that the technical expertise required is beyond either their abilities or mandate.

Study finding 4

The issue of assistance to mine victims has received significant political, diplomatic, legal and financial attention during recent years. Indeed, positive attention paid to the needs of mine victims may sometimes have acted to the detriment of other war-wounded and persons with disability.

Analysis

There is no doubt that the needs of mine victims, however they are defined, have received greater attention in recent years, especially as a result of the efforts of governments, the ICRC, the ICBL, and the UN. A significant number of international and national conferences and workshops have been convened to discuss ways to improve and strengthen assistance to mine victims. The Intersessional Standing Committee on Victim Assistance continues actively to discuss ways to improve the provision of assistance to mine victims.

Furthermore, the provision in Article 6(3) of the Mine Ban Treaty can itself be considered a significant success for the aspirations of mine victims in particular, and persons with disability in general. It is the first time that such aspirations have been specifically addressed in an international humanitarian and disarmament law instrument.

Accordingly, nothing in this report should be considered to run counter to the fulfilment of these aspirations. Indeed, certain funds specifically link mine clearance/awareness and victim assistance.[26] But at the same time, there is a recognition in certain corners of the disability field that funding for mine action is unlikely to be eternal, and therefore a reluctance to engage UNMAS or other mine-specific departments of the United Nations family in fundraising for fear that when funding dries up, the provision of assistance to those in need may be unsustainable.

It is considered a basic principle that all persons with disability have equal right to seek and receive assistance.[27] Certainly, the express intention of those advocating greater support for mine victims is to benefit other groups.[28] Yet the corollary of the success in promoting the plight of mine victims has, in a number of instances, been a compartmentalisation of assistance to one specific category of war-wounded[29] and it has been suggested that there has been *"a disproportionate concentration of interest on assistance to victims of mine injuries at the expense of victims of other injuries"*.[30]

Furthermore, despite the *"epidemic of mine injuries"* (Coupland, 1997) and the immense political will to improve the lives of survivors and their families, those injured by mines or UXO form only a tiny percentage of the victims of violence and trauma, and in general terms face the same problems and require similar assistance to the other members of this vulnerable group.[31] In early 2001, the MACC in Kosovo claimed that

26. One such example is the Slovenian-based International Trust Fund for Mine Clearance and Victim Assistance.
27. See, for example, the Maputo Strategy referred to in the Introduction above.
28. Thus, for example, the ICBL has stated that: *"Strategies to improve services in mine-affected communities will in effect improve services for all persons injured and/or with disabilities. We recognise the advent of treaty-related processes as an opportunity to improve the situation of landmine victims, war victims, and persons with disabilities"* (ICBL, 1999/2000:1).
29. In 1995, Roberts and Williams estimated the total cost of direct medical treatment and rehabilitation of the world's landmine victims at US$750 million. The ICRC claims surgical costs of US$3,000-$4,000 per patient with an additional US$100-US$150 for the initial provision of an artificial limb (Coupland, 1997). In 1998, the ICBL Working Group on Victim Assistance, which is made up of more than 20 humanitarian and development NGOs, decided to press the international community to commit to giving US$3 billion over 10 years to promote mine victim assistance. This amount is based on their estimate that the average cost of assisting a mine "survivor" in a mine-affected region is US$9,800.
30. Swiss Agency for Development and Cooperation, undated.
31. To put the impact of mines and UXO into perspective, from figures recording injury and deaths globally for 1999, armed conflict was responsible for 10 per cent of those killed but only 0.3 per cent of these

close to 500 people had been involved in mine- or UXO-related incidents since June 1999. It recognised that the needs of Kosovo mine and UXO victims are very similar to those of the wider population with disabilities and it is generally agreed that the success of any programme in favour of mine/UXO victims must be based on this recognition. The concern generally expressed by the various actors is to meet the specific needs of mine/UXO victims without setting them apart from larger groups such as victims of trauma and people with other disabilities, in order to fully reintegrate them back into the society.

The ICBL has explicitly recognised this dilemma and although it accepts that *"conceptually, landmine victims could be 'captured' in large-scope mainstream programmes designed to assist broader categories of people who need help"*, it remarks that there are a number of risks to a purely "macro" line of thinking:

> *"First, we do not accept attitudes or policies indicating that persons with disabilities must wait until macro-level problems are solved before they begin to enjoy the same quality of life as their non-disabled compatriots.*
>
> *Second, there is a risk … that mine victims' needs as recognised in the Mine Ban Treaty may fade into the background or even disappear as the group with the highest incidence (car accident victims, AIDS victims, or whatever) receives the most attention.*
>
> *Third, assistance to mainstream communities, institutional capacity-building programmes, or public health strategies aimed at the general population do not automatically 'capture' or improve the situation of persons with disabilities. …*
>
> *The challenge is to find a 'both ... and' approach that accommodates BOTH recognised principles of humanitarian and development cooperation AND proactive inclusion of specific measures to meet the needs of landmine victims."* (ICBL, 1999/2000:2)

Indeed, the issue of integration is one that has plagued efforts to provide assistance to mine victims from the outset. Thus, at its second meeting the intersessional Standing Committee on Victim Assistance discussed ways to guarantee a long-term solution to the problems ofintegrating victim assistance into a broader context of post-conflict reconstruction and development strategies, but without losing sight of the directly affected individuals, families and communities specifically targeted by the Mine Ban Treaty (ICBL, 2000a).

As the Second Meeting of the States Parties to the Mine Ban Treaty duly noted:

> *"Currently, Victim Assistance takes place mainly within the framework of Humanitarian Mine Action. In order to guarantee a long-term sustainable solution, assistance to victims must also be integrated in a broader context of post-conflict reconstruction and development strategies. … Public health, community development, conflict and violence prevention, comprise the main contexts in which Victim Assistance should be integrated. It is crucial that both recognised principles of humanitarian and development cooperation and proactive inclusion of specific measures relevant to meeting the needs of this largely marginalised group are necessary."* (ICBL, 2000a)

fatalities were due to landmines (SDC, undated). In 2000, all injuries were believed to be responsible for around one in five of all deaths worldwide. Similarly, according to Boddington (1999), out of a global population of more than six billion, 312 million people are with moderate or severe disability; 210 million of these live in the developing world and 125 million of these are motor-disabled. On the other hand, estimates assert that no more than 300,000 of the total population with disability are surviving amputees (Boddington, 1999: 22). Roberts and Williams (1995) estimated that there were 250,000 landmine survivors with disability in the world, with adult males forming the majority.

Based on, albeit limited, evidence from the case studies, there is a suggestion that programmes targeting mine victims may be more needed in the emergency/ humanitarian phase, as State medical infrastructure is unlikely to be functioning correctly amid ongoing, or following recent, armed conflict. The number of mine victims is also likely to be proportionately higher as the conflict is ongoing or only recently ended and significant population movements increase risks of injury. As time passes, however, and national structures are rehabilitated and indigenous capacity rebuilt, humanitarian and development initiatives should seek to ensure the provision of assistance to all categories of persons with disability.

Study recommendation 4

There is a need for continuing efforts to advocate provision of the best possible assistance to mine and UXO victims, within the wider context of post-conflict reconstruction and rehabilitation. Care should, however, be taken when seeking to raise funds for assistance projects to ensure that funding is available for the long-term and that programmatic interventions are capable of being sustained.

Study finding 5

Globally, the number of new mine victims is decreasing. Although this may be attributed in part to the availability of better data, it is also an indication of the success of mine action programmes around the world.

Analysis

It is not known how many are killed and injured by mines and UXO each year, and estimates vary widely. In the past, the ICRC (Roberts and Williams, 1995:8) and the ICBL have claimed 24,000 and 26,000 annual deaths and injuries, respectively, though these are probably now overestimates. Yet casualty figures can be reduced still further, especially in emergency situations, through the reinforcement of timely and effective preventive efforts, particularly mine awareness and mine marking.

In 1999-2000 there were new victims of landmines and UXO in 71 countries, with mine accidents occurring in every region of the world. Of those, a majority (39) occurred in countries that had not experienced active armed conflict during the period. Moreover, civilian casualties in peacetime account for *"a significant proportion"* of total landmine casualties (Landmine Monitor, 2000:23). Research for Landmine Monitor shows that casualty rates increased in 1999-2000 in a number of countries and areas in the throes of conflict: however, in some mine-affected countries (e.g. Afghanistan, Bosnia and Herzegovina, Cambodia, Croatia, Mozambique, Senegal and Uganda), the casualty rate has been substantially declining.

In 2001, Landmine Monitor estimates that:

> *"there were some 15,000 to 20,000 new casualties from landmines and unexploded ordnance (UXO) in 2000, an encouraging decrease from the long-standing and commonly cited figure of 26,000 new victims per year. Important reductions in the number of new casualties were recorded in some heavily mined areas in 2000, including Afghanistan, Cambodia, Croatia, and Kosovo."* (ICBL, 2001)

Study recommendation 5

To reduce further the number of landmine and UXO victims there is a need, especially in emergency situations, to reinforce preventive efforts such as effective mine awareness education and mine marking.

Study finding 6

The needs of mine and UXO victims tend to be defined broadly, thereby constituting a significant challenge in programme delivery.

Analysis

ICRC data indicates a hospital mortality rate for mine injured of 3.7 per cent. Survey results at the household level show a death rate of 31 per cent in Cambodia, and 59 per cent in Afghanistan, in other words, most of those who die from landmine blasts do not make it to a medical facility (Roberts & Williams 1995: 9). Studies by Physicians for Human Rights (2000) have suggested that 48 per cent of landmine casualties die before receiving assistance.

Wounds from landmine incidents require extensive and specialised treatment. If the wound is left unattended for more than six hours, infection sets in. Although mine victims often suffer lifelong disability, this disability can be kept to a minimum with correct treatment (Coupland, 1997).

Mine injuries demand specific medical attention: first aid (to stop bleeding, intravenous transfusion, antibiotics); pre-operative care (register information, washings, blood tests); surgery (skin grafts, plaster or amputation (myoplastic)); anaesthesia (ketamine); nursing care; physiotherapy; specially trained personnel; hospital equipment and medical supplies; blood for transfusion; and training materials.

Despite the documented focus on medical victim assistance, ICBL (2000: 57) states that:

> *"the broad range of activities that constitute victim assistance is readily apparent in that 63 per cent of activities documented in its Victim Assistance Programme Portfolio are not medical or prosthetic care; rather, they include psycho-social support, capacity-building, economic reintegration, legislation and public awareness, and data collection".*

Physical

There are many physical rehabilitation programmes that target or include mine victims. Since 1979, the 45 ICRC rehabilitation projects in 22 countries have manufactured more than 100,000 artificial limbs for 70,000 amputees. In addition, 140,000 crutches and 7,000 wheel chairs have been made (Coupland, 1997: 9).

In Kosovo, for instance, the case study finds that an extensive network of medical support already exists across the province such that mine victims can generally reach a medical facility within a relatively short period of time. The quality of these facilities, however, varies widely and there is considerable room for improvement in efficiency in the health sector in general and hospitals in particular, Pristina Hospital being the

only one capable of dealing with major trauma cases. In addition, there remains a lack of physical rehabilitation professionals in Kosovo. Furthermore, no national capacity currently exists to fit upper limb and above-knee prostheses in Kosovo, although such cases can be referred abroad.

The situation is less promising in Eritrea and Ethiopia. Long distances between an accident and first health structure suggest that training in first aid should be organised in order to respond to traumatic injuries — and therefore increase the chance of mine victims living long enough to receive medical care. Training should first be organised at village levels to community health workers and in existing remote health structures, to medical and paramedical staff.

Psycho-social

Although the physical wounds caused by landmines or UXO can be horrific, the psychological impact is also held to be extremely significant. Individual difficulty in relationships and daily functioning is considerable, and the mine victim faces social stigmatisation, rejection and unemployment (International Physicians for the Prevention of Nuclear War, 2000). As well as coping with a permanent disability, they struggle to re-establish a place in society. Landmine survivors are often abandoned by family and friends who are unwilling or unable to provide the necessary support for successful rehabilitation and reintegration.

Beyond the provision of physical rehabilitation, however, the picture is less encouraging. Few programmes exist that include provision for the psycho-social rehabilitation of mine victims. Thus, in Kosovo, it is noted that the weakest link in the chain is in psycho-social support, vocational training and other forms of social reintegration. Indeed, Kosovo has had little tradition of psycho-social treatment or community care and support and local NGOs still have limited capabilities in this area.

Socio-economic reintegration

In 1999, UNDP contracted WRF to undertake a three-year research and action project to ensure the socio-economic reintegration of mine victims. The project aims to establish an integrated approach to dovetail the physical and psycho-social rehabilitation of landmine victims (largely the domain of other agencies, including ICRC, UNICEF, and WHO) with the need to provide alternative livelihoods and secure full participation of landmine victims in their communities, and in the process the socio-economic recovery and development of their communities.

The resulting WRF [Draft] *Guidelines for the Provision of Socio-economic Integration of Landmine Survivors*, presented to the Third Meeting of States Parties to the Mine Ban Treaty, found that:

> *"The most acute needs of landmine survivors are not the medical rehabilitation services provided, but assistance in helping the survivors become productive community members and contribute to their families. Socio-economic reintegration, therefore, has been sorely neglected as an issue to be dealt with by national governmental initiatives or by international relief organisation efforts."* (WRF, 2001)

In Eritrea and Ethiopia, for instance, the case study finds that social and economic reintegration is the intervention area where new resources should be earmarked and

local networks strengthened. Mine action organisations and agencies could play an important part in convincing donors to earmark funds (in addition to their existing mine action/mine clearance budgets) to socio-economic reintegration of mine victims. Even a limited extra investment could be disbursed effectively through local initiatives. Similarly, adherence to the Treaty may open the door to additional funding.[32]

Similarly, in Cambodia, although it is generally agreed that the prosthetic and physical rehabilitation of mine victims are adequately covered, there remain significant unmet needs for effective vocational training and employment promotion. In addition, there is a lack of qualitative data on the needs of persons with disability and insufficient input from them regarding the services and resources allocated.

Legislation and community awareness

A key issue in the process of reintegration is the prevention of discrimination against amputees. Landmine Monitor (2000) found that only 32 out of 71 countries reporting mine incidents in 1999/2000 have explicit policies and/or legislation on disability (HI, 2000).[33] Thus, Handicap International (2000:5) has highlighted the importance of making legal provision, under both international and national law, for the socio-economic reintegration of mine victims, in particular through compensation. Likewise, disability laws and policy constitute an essential framework for the establishment of equality of opportunity for mine victims.

The Eritrea and Ethiopia case study also notes that laws and policies are essential for establishing equal opportunities for persons with disability — and hence promote their social reintegration. It suggests that mine action organisations and agencies can advocate for the adoption and implementation of such legislation and policy frameworks. Draft model legislation could be prepared and then adapted to the local legislative, social and economic contexts. Further, mine awareness programmes can fairly easily incorporate positive images of persons with disability in their materials and educational initiatives in order to combat societal and community discrimination (attempts are said to be under way in Eritrea).

Study recommendation 6
Consideration should be given to developing materials for mine action professionals on the needs of mine victims. These should build on existing work carried out by the ICBL, ICRC, UNICEF and WHO.

32. Although Eritrea has now acceded to the Convention, Ethiopia is only a signatory.
33. In Africa, for instance, it is claimed only two countries (Namibia and Uganda) have a clear national policy on disability (Handicap International, 2000).

Chapter 3

The case of Cambodia

Introduction

Background to the landmine and UXO problem

Decades of bitter civil and inter-State conflict have left Cambodia with a substantial landmine and UXO problem. Hundreds of thousands, possibly millions of mines and items of UXO are littering the country, especially the border provinces with Thailand. Although a comprehensive national survey of the mine and UXO threat has not yet been completed,[34] some 3,600 mined areas have already been identified, covering an area of 2,900 square kilometres. The Programme Coordinator of the Cambodian Mine Action Centre (CMAC) has estimated that it will take at least a decade before all the high priority areas are cleared.[35]

The socio-economic context

Table 1, below, highlights a few of the basic characteristics of Cambodia. In 1998, its population was estimated by the World Bank to be nearly 11.8 million, with an average life expectancy of 54 years. About 80 per cent of the labour force is engaged in agriculture, forestry or fishing, the main crop being paddy rice. Cambodia has considerable agricultural potential, though local surveys conducted in the mid-1990s suggest that, *"although acute undernutrition (verging on starvation) is currently not widespread in Cambodia, chronic undernutrition of children ... is more widespread, and seasonal variations would appear to be significant ... Despite having substantial areas of cultivable land, the current land tenure arrangements and disputes, size of holdings, quality of particular parcels of land, and reduction of land availability in some areas because of landmines, mean that sufficient land is not available for many households that are unable to cultivate enough food for themselves by more extensive methods"* (Tickner, 1996: 12, 13-14). In 1997, a World Bank survey found that, nationally, 36.1 per cent of the population was living below the poverty line (World Bank, 2000).

34. Information provided by Ian Bullpitt, Programme Coordinator, Cambodian Mine Action Centre (CMAC), Phnom Penh, 2 February 2001.
35. *Ibid.*

Table 1. Basic statistics		
Area:		181,040 km^2
Population:		11.4 million
Male:	5.5 million	
Female:	5.9 million	
Average family:		5.2 persons
Number of villages:		13,408
Religion:		95% Buddhist
Language:		Khmer

Source: National Institute of Statistics, Ministry of Planning, 1998.

The mine action context

The impact of the conflict: The nature of the threat

Landmines and UXO

The provinces with the greatest number of mine or UXO incidents are those on the north-western borders of the country, that is Banteay Meanchey, Battambang, Oddar Meanchey, Preah Vihear, and Siem Reap. During 1998-1999, the Samlot district of Battambang recorded the highest number of casualties; this district, along with Bovel and Malai, is the site of recent repatriations.[36] Many of the returnees are not native to the areas but now have to live, send their children to school, plant their crops, and cut wood amid minefields.[37] Data collected by the Cambodian Red Cross (CRC) indicate that only 2 per cent of incident sites were reported as being marked with official minefield markings and only 4 per cent had seen any previous mine action activities. This suggests that the majority of incidents are occurring in areas not known to be mined, not surveyed, or not being classed as high priority clearance areas.

Mortality and morbidity rates

Between 1979 and 1999 a total of 41,993 landmine and UXO casualties were recorded in Cambodia.[38] The casualty rates have, in the main, been dropping steadily over the past few years.[39] In January 1997 there were 241 incidents, whereas in the corresponding month in 2000 there were only 79 incidents. Table 2 shows the average monthly casualty rate for the years 1996-2000.

36. According to information provided by the Office of the High Commissioner for Refugees (UNHCR), in the months leading up to November 2000, more than 100 people were killed or injured by mines in Samlot. Interview with Katie Grant, UNHCR, Phnom Penh, 8 February 2001.
37. Information provided by the Emergency Surgical Centre for War Victims, Battambang, 15 February 2001.
38. Statistics are taken from the CRC/Handicap International (HI) Mine Incident Data Base Project reports.
39. The decrease in mine/UXO related incidents since 1998 can be attributed to a number of factors, including the cessation of hostilities, a more stable political situation, a more settled population, an increase in knowledge of the location of mines and UXO, increased clearance, and mine awareness training. Of the landmine victims interviewed from 1998–99, 82 per cent had not received any mine awareness training. This does not mean that those who have been trained know how to avoid mines and UXO, it may only be an indication that the highest-risk groups are not being adequately reached.

Table 2. Average monthly casualty rates, 1996-2000	
Year	Average monthly casualty rate
1996	253
1997	137
1998	140
1999	84
2000	70*

*Figures available up to November 2000, CMAC.

During 2000, mine incidents (at 54 per cent of the total) were more common than UXO incidents and 67 per cent of those killed or wounded by mines were adult males,[40] with children making up 28 per cent of the victims. Tampering (at 49 per cent of the total) is the most common activity leading to an accident, followed by livelihood activities[41] at 44 per cent with military activities only responsible for 3 per cent of casualties.

Until 1996, the number of military victims usually outnumbered those of civilians. Thus, in 1996 there were more than 1,800 military casualties compared to around 1,200 civilian casualties whereas in 1999 there were 136 military casualties compared to 881 civilian casualties.

Persons with disability in society

Cambodia has an extremely high number of landmine victims in addition to many other types of disabilities.[42] The total number of persons with disabilities is, however, not known with a sufficient degree of certainty. A survey published in 1999 (National Institute of Statistics, Ministry of Planning, 1999) estimated that there were around 169,000 persons with disability in the country, which is 1.5 per cent of the population. Yet, as the Disability Action Council (DAC), a semi-autonomous coordination body working on behalf of persons with disability in Cambodia, points out, a national census in 1998 did not include information on disabilities, and the 1999 survey showed a lower number of persons with disability than a similar study conducted in 1996. It is widely assumed that the number of persons with disability in Cambodia has been greatly underestimated.

Whatever the true number, it is agreed that persons with disability are among the most disadvantaged in Cambodian society, facing widespread discrimination while enjoying only limited access to education, employment, training and social interaction. The loss of economic productivity as a result of disability affects not only individuals, but also their families, their villages and communities.

40. Adult males aged 18-40 accounted for 91 per cent of all mine and UXO injuries recorded during 1998-1999. This group, representing the heads of households, is at highest risk because men regularly have to venture into the forest to collect wood and thatch.
41. Livelihood activities include farming (22 per cent), collecting food or wood (17 per cent), fishing and herding (5 per cent).
42. Former Khmer Rouge villages in Khum Rieng commune in Battambang are said to have a particularly large disabled population, with around 60 per cent of persons with disability being mine victims.

Women with disability are particularly vulnerable for a number of reasons. One of these is that it is usually very difficult to find a partner who is willing to marry them and have a family. In Cambodia, this is vitally important because there is no social welfare system, and thus children are seen as the only guarantee that a person will be cared for in old age. Life is very difficult for an old woman who does not have the security and support of a family. Single women with disability may need additional attention and support to build up their standing in the community.

Equally, educational opportunities are not readily available for persons with disability in general, and especially for women. As a consequence, when the Cambodia Trust (an international NGO focusing on prosthetic care for mine victims) was recruiting staff, they set the criteria for selection as women with disability with basic literacy skills but found it very difficult to find even one. There are, however, some more positive experiences, such as when a distraught woman with disability turned up at the Cambodian War Amputees Rehabilitation Service (CWARS) training centre begging for a job. After they had trained her in battery recharging and repair work she became the owner of a successful business leading to her effective reintegration into society.

Existing mine action responses

Mine clearance

There is a considerable array of mine clearance actors in Cambodia: the following are some of the key organisations.

The Cambodian Mine Action Centre

The first humanitarian demining organisation began work in Cambodia in 1992. The following year the United Nations Transitional Authority in Cambodia (UNTAC) created the national mine action centre, the CMAC — at that time only the second such institution in the world. CMAC was mandated to conduct national planning, coordination of all mine action, demining, explosive ordnance disposal (EOD), survey, marking, mine awareness, technical training and research. Questions remain as to whether CMAC will be able to perform adequately the variety of tasks allocated to it.

Indeed, in 2000, it appeared that CMAC was unable to perform both its national coordination role and monitor the large number of staff. Most damaging were allegations of financial mismanagement. As a result, funding was cut and in late 2000 at least two-thirds of CMAC's staff had been laid off. Since then CMAC has reformed itself with a portion of its former tasks now being allocated to the newly-formed governmental agency, the Cambodian Mine Action Authority (CMAA). CMAC will now concentrate on demining and other scaled down activities, such as mine awareness and survey. Thus, in early 2001 CMAC re-recruited personnel to work as deminers and support staff.

NGO deminers

By 1994 there were five demining organisations working across the country, although this number has since been reduced to three, two of which are NGOs. Mines Advisory Group (MAG) began in Cambodia in October 1992 deploying one mine clearance

team in Battambang province. Today MAG runs 20 mine action teams and two EOD teams, with 300 deminers on the ground. MAG combines mine clearance capabilities with EOD, community liaison, and minefield marking and survey.

MAG's main goal is to clear small plots of land for community use, for example around pagodas, water sources, clinics, schools, agriculture and for resettlement sites. Each team comprises one supervisor, 12 deminers, one trauma care medic and a driver. Each member is primarily deployed as a deminer, however he or she is also trained with a secondary skill such as survey, marking, or mine awareness.

MAG is already involved in wider community development through its collaboration with other NGOs, notably the Church World Service, the Lutheran World Service and World Vision International. These NGOs can provide input into the process of prioritising mine clearance sites, whereas MAG does not have an active say in their workplans.[43]

HALO Trust operates in three provinces (Siem Reap, Banteay Meanchey and Oddar Meanchey). Its 850 staff includes 77 demining sections (each section made up of seven deminers), 12 mechanical units, survey teams, logistic and medical back-up. HALO Trust is currently testing new demining techniques and technology in Cambodia. Its team leaders conduct some mine awareness, although at a low level and only in remote areas where necessary and where no other services are operating.

Royal Cambodia Armed Forces

The Royal Cambodia Armed Forces (RCAF) have been engaged in clearance activities since 1994, but have always worked independently without reporting to any external authority, including CMAC. They have demined and built roads in Anglong Veng, Samlot and Veal Veng. According to RCAF data, the armed forces have cleared 26 square kilometres of land, destroying 88,000 landmines and 19,000 items of UXO in the process. RCAF may in the future play a more substantial role in mine action than they have to date. Now that Cambodia is no longer at war, soldiers are in a position to contribute positively to local communities. Although UN agencies and many donors do not directly fund military mine action, there may be a willingness to support host government funding with external technical support and training.

Commercial demining

There are now three private companies involved in mine clearance in Cambodia: Chirgwin Services Group, UXB International, and Asian Landmine Solutions. These companies have just received official permission to work in the country[44] and were to begin operations at the end of March 2001. The official sanctioning of private contract demining marks a major shift in the sector as it has been generally restricted to CMAC and NGOs.

43. Information provided by Archie Law, MAG Country Programme Director, Phnom Penh, 2 February 2001.
44. According to CMAA, Cambodia needs all the help it can get with private companies playing a valuable role in returning land to the communities. CMAA is currently working out the regulations to determine the criteria by which private companies can operate in Cambodia. CMAA will play a role in monitoring and quality assurance checks of the commercial companies while continuing to do so with the NGOs.

The private companies feel that they will offer the advantage of applying "market principles", offering cheaper and more cost-effective operations. They claim that allowing private demining concerns will see more transparent and cost-effective management methods and will help to revive CMAC's viability and integrity. The first contract to be awarded to a private company was to clear a future orphanage site, which was won against bids from humanitarian groups.

Village demining

Mine action groups acknowledge that there is a substantial amount of "village demining" going on, whereby locals are taking it on themselves to clear mines from their fields.[45] Handicap International (HI) is currently undertaking a study into the extent of this practice, although it is believed that the village deminers clear more land than the professional organisations and entities. Unofficial results suggest that although this approach is far from achieving a 100 per cent clearance rate in a given area, the injury rate seems to have been relatively low.

Mine awareness education

Cambodia saw some of the earliest mine awareness programmes, many early initiatives being adapted from earlier programmes in Afghanistan. World Vision initiated the first mine awareness programme in Cambodia in early 1993 with the Mines Awareness Training Team. Currently the main providers of mine awareness/mine risk education in Cambodia are CMAC, MAG, UNICEF/World Education, and World Vision's renamed Mine Awareness Action Team or MAT. Between 1993 and 2000 more than 1.6 million people in 4,707 villages and 136 schools are reported to have received mine awareness education (ICBL, 2000: 381).

The selection of communities to be provided with mine risk education is made depending on the mine incident rate per population, programme focus areas, location of demining sites, or upon request from the community itself. The level of community awareness is now such, however, that MAG has switched from traditional mine awareness to community liaison teams, whose task is expressly to support clearance operations at community level. It is likely that CMAC will convert to this approach.[46]

Mine ban advocacy

Since 1 January 2000, Cambodia has been a State Party to the Mine Ban Treaty. "The Law to Prohibit the Use of Anti-Personnel Mines" is the domestic legislation of the Royal Government of Cambodia to implement the Treaty. It bans the production, use, possession, transfer, trade, sale, import and export of anti-personnel mines. It also provides for the destruction of existing mine stockpiles and the creation of the National Demining Regulatory Authority to coordinate activities related to the mine problem.

45. The practice of village demining was already discussed at least eight years ago in Cambodia, with respect to whether a demining agency should equip villagers with the requisite skills and equipment. The expatriate deminers decided that it was too risky to give the village training as it might encourage more people to engage in this dangerous activity. They also felt that they would have to accept certain liability whenever a trained village deminer had an accident. Now, however, the Cambodian War Amputees Rehabilitation Service is working to try to supply training and equipment for the "village deminers". It has approached some of the demining mining agencies for assistance but with little luck so far. The majority of the village deminers are usually former Khmer Rouge soldiers who were originally responsible for mine-laying in many areas. (Interview with David Ashton, Country Representative, and Sam Oeun Pok, Programme Director, CWARS, Phnom Penh, 12 February 2001.)
46. Information provided by Sam Sotha, Director, CMAA, Phnom Penh, 1 February 2001.

Each year, a "Mine Awareness Day" is held, which is planned and coordinated by a number of mine action agencies and organisations, including CMAC and World Vision.

Mine victim assistance

On 16 November 2000, CMAC and CMAA jointly convened a mine action symposium, at which it was discussed whether formally to include victim assistance within mine action. The government, headed by Prime Minister Hun Sen, decided that victim assistance should be the ultimate responsibility of CMAA even though all the NGOs, international organisations, and UN representatives who attended argued strongly against this plan. Their concerns focused on the obvious and unnecessary overlap between the roles of CMAA and the DAC in mine victim assistance. Subsequently, the CMAA and government took heed of these concerns and decided that victim assistance should be kept under the authority of the DAC.[47] CMAA can still receive information and reports but should not have a direct role in victim assistance.[48]

Indeed, among those directly involved in mine action and disability issues it is generally agreed that victim assistance should be kept within the disability sector and not brought into mine action. The following reasons have been advanced for this stance:

- It would take away funds from the — already poorly funded — disability sector;[49]
- The disability sector already has the requisite experience, staff and infrastructure to deal with mine victims, whereas mine action does not;[50] and
- Mine victims should not be given more attention than other persons with disability[51] (which, some believe, would be tantamount to returning to the

47. Thus, Article 14 of Sub-Decree CMAA - Chapter X, Department of Victim Assistance provides that: *"The Department of Victim Assistance shall have the following responsibilities: Following up the mine victims assistance activities among relevant agencies with the Ministry of Social Affairs, Labour, Vocational Training and Rehabilitation and the Disability Action Council (DAC). DAC is required to provide strategic plan of action, updates and reports on the mine victims assistance activities; Working with the National Association of Cambodian Red Cross and the relevant expert agencies in order to register information on accident statistics rates and other relevant services; Compiling monthly, quarterly and yearly reports from the national and international organisations involved in assistance to mine victims; and Preparing monthly progress reports for the secretary-general."*

48. DAC has already received some support from the CMAA. Information provided by Ouk Sisovann, Executive Director, DAC, Geneva, 4 May 2001.

49. Mine action groups, such as the HALO Trust, themselves feel that if mine victim assistance is included as a part of mine action it will divert and dilute funding from mine clearance work, for which it is already difficult to find funding as some donors prefer activities that show quicker "returns", such as mine awareness. (Interview with Tim Porter, South-East Asia Desk Officer, HALO Trust, Phnom Penh, 13 February 2001.) Other commentators express concern that money for mine victims will eventually dry up and therefore feel that funding would be more practically devoted to all persons with disability. Thus, the DAC asks whether it is better *"to just please a donor or to really try and meet the disabled peoples ' overall needs"* (interview with Ouk Sisovann, Phnom Penh, 7 February 2001). On the other hand, most of the disability organisations initially focused on mine victims when they started in Cambodia and some people still feel it is easier to get funding for landmine victim projects than projects for other persons with disability (*ibid.).*

50. It should, though, be noted that the NGOs often bypass the governmental structures (thereby undermining them), on the basis that if they wait for the government it will take too long, and that governmental interventions are based on resources and priorities that may not always be in the best interests of communities (Interview with Katie Grant, UNHCR, Phnom Penh, 8 February 2001).

51. It has been suggested that certain donors need more awareness on the subject of funding disability-related projects. For example, the Cambodia Trust was recently offered funds by the Japan Campaign to Ban Landmines (JCBL), but JCBL stipulated that the money would have to be used for mine victim-related programmes only. The NGO refused to accept the limitations explaining that the funds could be better used with children suffering from polio. JCBL changed their demands and allowed them to go ahead. (Interview with Bill Velicky, School Director, Cambodia Trust Rehabilitation Project, Phnom Penh, 7 February 2001.)

position two or three years ago when many NGOs were entirely focused on mine victims).[52]

Thus, draft legislation on the Rights of Persons with Disabilities, proposed by the Cambodian Disabled Persons Organisation (CDPO),[53] does not support separating out (or discriminating against) any person with a particular disability. The 1996 DAC Task Force looking at the needs of persons with disability recommended that there should not be a specific focus on landmine victim assistance.[54] The DAC considers that to provide better services solely for mine victims is technically and morally wrong:[55] there should be no discrimination in favour of, or against, any specific disabilities.[56] Moreover, the number of mine victims using NGO services has levelled off, with fewer new victims of mines and UXO;[57] today, one rehabilitation centre has noted a greater need for orthotic devices than for prostheses.[58] Table 3, below, illustrates how individuals affected by polio, rather than mine survivors, have become the primary concern of Cambodia Trust.

Table 3. Cambodia Trust patients by diagnosis

1998	No.	1999	No.	2000	No.
Amputee	359	Amputee	206	Polio	177
Polio	26	Polio	145	Amputee	147
Fracture	11	Cerebral palsy	34	Cerebral palsy	71
Contracture	3	Hemiplegia	28	Hemiplegia	64
Club foot	3	Fracture	22	Fracture	50
Other	1	Club foot	20	Paraplegia	18
Leprosy	1	Other	14	Club foot	18
Cerebral palsy	1	Paraplegia	11	Meningitis	18
		Contracture	8	Congenital malformation	17
		Congenital malformation	7	Contracture	17

This does not mean, though, that mine action necessarily has no role in promoting mine and UXO victim assistance, as long as activities take place within the context of

52. Phnom Penh, 1 February 2001.
53. CDPO is a local organisation that works *"for the disabled by the disabled"*, producing newsletters, bulletins, participates in demonstrations (such as the Mine Awareness Day), lobbies for the rights of persons with disability, drafts legislation, and provides relevant training for NGOs in self-confidence and sign language. The proposed legislation on the rights of persons with disability, the first draft of which appeared in 1994, is still some way away from making it onto the Statute Book (CDPO, 2000a).
54. Thus, there is often resentment from persons without disability when they see those with disability receiving more outside attention. Ideally, therefore, all external support should be integrated into the community so as to avoid these problems. Indeed, several NGOs have seen cases where persons with disability have been ostracised by other members of the community after an international NGO focused solely on their problems. (Interview with Ky Lok, Director, Thean Thor, Battambang, 15 February 2001.)
55. Initially Cambodia had many services solely for mine victims, but this has changed and now these organizations include services for all disabilities, such as cerebral palsy and polio. Assistance to mine victims is integrated into the disability sector, which is serviced by NGOs and government departments. At the same time, it should be acknowledged that mine victims do not necessarily consider themselves as part of the wider disability community. Thus, for example, there is a village in Siem Reap where mine victims have banded together to share resources and support each other. In addition, a certain mine victim working with HI only wishes to assist fellow mine victims and not work for other persons with disability. (Opinions advanced by Steve Harknett, Rehabilitation Advisor, HI, Phnom Penh, 9 February 2001.)
56. Information provided by Ouk Sisovann, Geneva, 4 May 2001.
57. Before 1992 the work of the Ministry of Health was focused on landmine victims because of the great needs at that time. From 2001 they have broadened this focus to include all persons with disability, because otherwise, the number of beneficiaries would be very small.
58. Interview with Bill Velicky, Phnom Penh, 7 February 2001.

wider support to persons with disability. Thus, for instance, it has been suggested that the mine action community could strengthen disability awareness at community level (maybe in conjunction with their mine risk education projects), that mine action organisations could employ more persons with disability, and, of course, could contribute funds and resources to support disability work.[59] In addition, many mine action groups already have teams that visit mine-affected villages and communities, whether as part of mine awareness, mine risk education, or community liaison teams. Along with their existing tasks these teams could conduct additional activities, such as liaising with potential employers to encourage them to hire workers with disability, or collect statistics for service providers on the numbers and locations of persons with disability.

Victim assistance

Definition

In Cambodia, as in a number of other contexts, contention and concern surrounds the terminology used for "mine victim assistance". Many of the people working in the disability sector have a broad classification of the term "mine victim". They feel that many people with disabilities are also mine victims, because the presence of mines in their villages resulted in them missing out on vaccinations (as is the case for polio victims). Some people go even further and say that all the members of a mine-affected community are landmine victims, because of the high level of impact of the weapons on their lives. Thus, while between 70 and 100 people are killed or injured each month by mines and UXO, thousands of families have to live with the daily threat of mines.

For its part, the DAC strongly supports the view that the families of mine victims as well as the wider communities affected by mine pollution are also mine victims. Moreover, the DAC is actively seeking to have a national definition of persons with disability, and is currently discussing the issue with the Ministry of Health and CMAC.[60]

Mine and UXO victim needs

The basic survival needs for all people in Cambodia are centred on four areas:

- **Land** — to enable people to produce food, to provide shelter and security;
- **Food** — including access to clean drinking water;
- **Health care** — free or affordable for their whole families; and
- **Education** — basic education for children and vocational training.

However, the main problem faced by persons with disability in Cambodia is poverty.[61] An injury or debilitating disease in a family can be both very traumatic and an economic disaster with families being forced into huge debts. Thus, interviews of persons with disability conducted by Jesuit Services (JS) staff found that:

59. Interview with Mounh Sarath, Director, Cambodian Vision for Development, Battambang, 16 February 2001.
60. Information provided by Ouk Sisovann, Geneva, 4 May 2001.
61. According to a study by the World Food Programme cited by Denise Coughlan of Jesuit Services on poverty in Cambodia, returnees make up the bulk of the poor, followed by war widows. See also United Nations, 2000.

- 71 per cent do not have a house or shelter;
- 60 per cent do not have sufficient food;
- 30 per cent do not have access to water (within five minutes walk from their home);
- 47 per cent of their children do not go to school;
- 63 per cent do not have a job; and
- 49 per cent have no land (Coughlan, 2000).

Mine victims/survivors will require assistance from the time of the initial accident until they are completely integrated back into their communities. Most mine victims will require attention in the following areas:

- Transport to a hospital;
- Emergency medical treatment;
- The fitting of a prosthetic limb (assuming an amputation is their only or main injury);
- Physiotherapy;
- Support for their family while they are incapacitated (on a case-by-case basis);
- Retraining and vocational skill training;
- Micro-credit and/or tools of trade;
- Means of providing food for their family (this may require that they acquire land);
- Education for their children;
- Equal rights and access to all facilities available to all the community;
- Continuing medical care; and
- Replacement prosthetic limbs, usually every two years.

Table 4, below, depicts a variety of perceptions of the most important needs for a person with disability.

Table 4. Some perceptions of the needs of persons with disability

Landmine victims[a]	United Nations	ICBL	Basic human rights
Shelter	Accessibility	Emergency medical care	Food
Food	Education	Continuing medical care	Shelter
Access to water	Employment	Physical rehabilitation	Health
Access to school	Income	Psychological/social services	Education
Primary health services	Maintenance and social services	Employment and economic integration	
Income-generation opportunities	Family life and personal integrity	Capacity-building and sustainability	
Mine-free environment	Culture	Legislation and public awareness	
Land titles	Recreation and sports	Data collection	
Access to prosthetics	Religion	Access	
Access to roads[b]			
Social standing			
Mine awareness[c]			

a. A group of disabled people who work and study with JS, including Tun Chandarith, ICBL International Ambassador, reflected on their living conditions in mine-affected villages and came up with these needs (Jesuit Service, 2000).
b. DAC suggests that access to buildings is also of critical importance. Information provided by Ouk Sisovann, Geneva, 4 May 2001.
c. DAC suggests that disability awareness should also be added to the list. Information provided by Ouk Sisovann, Geneva, 4 May 2001.

In early 2001, one mine action NGO convened a workshop, together with village representatives, that included a discussion of the needs of mine victims. The workshop felt that there were gaps in meeting their needs in three areas:

- Financial assistance for medical treatment and rehabilitation;
- Family support for the most needy during mine-related medical treatment and rehabilitation of a household head; and
- Skills training that will facilitate employment in safe areas.

It has been claimed that needs differ for urban dwellers with disability as opposed to those in rural communities. According to this view, urban dwellers with disability tend to require income generation and loans, whereas rural dwellers with disability primarily have agricultural needs.[62] If these vulnerable people do not have land or sufficient and relevant skills they are forced into high-risk behaviour. Most will not stay at home until their families starve but will enter forest areas to collect thatch or wood, risking their lives in the process.

The existing provision of assistance

Pre-hospital care

Cambodia is a large country with only rudimentary transport infrastructure. In some instances, it may be many days before a mine victim reaches a medical facility that can treat him or her. Providing transport for mine accident victims is therefore a vital function to which all mine action groups can contribute as they are working in or close to mined areas and are required by international standards to have casualty evacuation facilities. Thus, both the HALO Trust and MAG provide transportation to hospital for people injured by mines (and other serious illnesses), even though this is not an official part of their operation. But because these groups have only small operations, more of these services are required, especially in newly accessible areas, such as Samlot.

Hospital and medical care

Landmine victims will need ongoing medical care, probably more than other members of their communities. In Cambodia, medical care is unfortunately more of a luxury than a right, and some payment is often required. Amputees, especially children, require ongoing attention and operations on the stumps as their bodies and bones grow. Further, resources are lacking, especially in heavily-mined areas, for the treatment of malaria, malnutrition, and maternity care. In an average month, the HALO Trust medical teams that support their clearance operations treat a couple of mine victims, five pregnancies, five dengue fever sufferers and a host of other life-threatening ailments.[63]

To receive medical care in rural areas often requires travel over long distances. Victims need financial support for transportation costs, their families and their medicine. Support is also needed for the provincial government hospitals and first aid clinics. The support can be in the form of technical advisors, training, medicine, equipment,

62. Information provided by George Adams, Head of Delegation, American Red Cross, Phnom Penh, 6 February 2001.
63. Information provided by HALO Trust, Phnom Penh, 13 February 2001.

or the provision of transportation. The Ministry of Social Welfare and the DAC have established a Medical and Rehabilitation Working Group, the aim of which is to improve medical facilities nationwide.

Physical rehabilitation

This is the one area which, it is generally agreed, is fairly well covered in Cambodia, with at least 80 per cent of persons with disability having access to physical rehabilitation. There are already 16 workshops across the country, operating in most of the mine-affected provinces, some of which are now being renamed as provincial rehabilitation centres. More are still needed, however, mainly to respond to needs in former Khmer Rouge areas, such as Anglong Veng and Samlot. Many of the recently injured from these areas have to be brought to Battambang, which is usually a long and difficult journey. Transport is therefore needed for patients to have their assistive devices repaired or replaced.

Physical rehabilitation facilities will always be needed and each amputee will require a new artificial limb on average every two years, and children one each year as they grow. Currently the ministry in charge of this area does not see it as a priority or have the resources to take over the operations that are currently managed by ICRC and NGOs, such as HI.

The ICRC stresses the ongoing need for professionals working in the area of prosthetics/orthotics, ideally with at least 10 years experience to ensure the correct fitting of the artificial limb.[64] If a socket doesn't fit well, the amputee can still walk but after five years may not be able to be fitted again and the stump will require further amputation. It is very difficult to fit new artificial limbs to legs that have previously been supported by homemade prosthetics, such as are common with former Khmer Rouge soldiers.

Support for the family of a person with disability is vital. If amputees cannot return to their villages because of the distance or because of the rainy season destroying roads, their families may be destitute.

Psycho-social care

Many landmine survivors need counselling and support services as they often suffer from low self-esteem. A 2000 study suggests that many of Cambodia's landmine victims are suffering from mental health problems. Of more than 1,800 people studied the preliminary results show that 46 per cent suffer from anxiety, 66 per cent from depression, and 17 per cent were diagnosed as suffering from post-traumatic stress disorder (Center for Advanced Study, 2000). They say the disability makes them "disabled in the heart"[65] and they need assistance to trust and respect themselves. When they return home they may feel they do not fit in anymore and can feel rejected, useless or an outcast in their own community. Counselling, peer group therapy and culturally appropriate interventions may be needed. Including persons with disability

64. Information provided by Dr Jean-Francis Gallay, ICRC, Phnom Penh, 8 February 2001. Cambodia Trust's school can provide Cambodia with certified trained workers through the three-year training courses they run. This prosthetics/orthotics training centre is internationally recognised and takes in students from many other countries.
65. In the words of Bishop Kike, Jesuit Services, Battambang, 14 February 2001.

in activities such as community-based rehabilitation, self-help groups, or income-generation activities can also assist their recovery.

Social and economic reintegration

Self-help groups

Most of the current development thinking and rhetoric in Cambodia tends to highlight the negative effects of war on the society, with assumptions of breakdowns in trust, solidarity and the communities ability to work together. This is not altogether true, for the fact that some associations and informal networks do exist indicates that it is still possible to bring people together on the principles of self- and mutual help. The decades of war and genocide have not completely eroded the willingness of people to work together for mutual gain.

One NGO's philosophy for self-help groups is to:

- Go to the people;
- Live among the people;
- Learn from them;
- Work with them;
- Plan with them;
- Start with what they know;
- Build on what they have.

Community networks

Traditionally in village life there has been a culture of "informal networks", which are usually shaped by family ties and friendships. In the absence of formal government initiatives these small networks foster informal information exchange, credit and shared resources, although, in the post-conflict period, it seems increasingly that market forces and economics are shaping the networks. There has been a noticeable decline since the 1990s in the concept of mutual help resulting from the emergence of the cash economy, the desire to acquire wealth, and basic day-to-day pressures.

Associations are another village initiative usually set up through the pagodas, village leaders or governments. These associations include rice banks, funeral associations, water user groups, plates and pots associations, village banks, etc., which support people during time of need. According to a 1999 study (World Bank and Social Services of Cambodia, 1999), there has been a noticeable decline in traditional associations owing to a number of factors, including corruption and inefficient management.

Vocational training, job placement and income-generation opportunities

Many NGO development schemes focus on poverty but do not include persons with disability in their activities, as it is sometimes naively believed that all persons with disability or mine victims need to be happy is a prosthesis and/or a wheelchair.[66] In fact, what a person with disability really needs is a job, as only around 20 per cent of

66. Information provided by Srey Vanthon, Programme Manager, Action on Disability and Development, Phnom Penh, 5 February 2001.

persons with disability are in a satisfactory economic situation.[67] This means long-term food security on the basis of sustainable skills such as vegetable gardening, not just handouts of rice.[68] They also need encouragement as usually they have poor education and limited employment opportunities, and without skills they have little chance of gaining employment.

There are inherent problems in setting up income generation and vocational training schemes. One of the main problems appears to be the choice of skills offered. Some NGOs have previously introduced basic and static training in areas that are not appropriate to rural life,[69] such as in carpentry to make furniture, even though Cambodian villagers rarely purchase furniture, or providing sewing skills to the women where villages can only provide a market for a limited amount of garments. People in the villages need basic farming skills or advanced techniques to improve rice or bean production. For example, chicken farming is a basic and easy technology to learn and put into place, learning how to identify, prevent and treat common chicken diseases. Persons with disability can thereby also spread their knowledge around, elevating their worth and status in the process.

A tradition exists in Cambodian society of informal shared resources and labour arrangements. It is a system for sharing and offering what one has, in exchange for something one needs, but have no other means to obtain. This system allows agricultural tasks to be completed on time when there is not enough labour or draft power available. Slowly but surely, however, this system is being replaced by hiring and cash payments because of the ease and lack of coordination required.

A study of the livelihoods and occupations in two Cambodian villages (Disability Action Council Secretariat, 2000b) showed the following results, in order of prevalence:

- Rice farming;
- Chicken raising;
- Vegetable growing;
- Pig raising;
- Small business, including grocery stores;
- Palm sugar making;
- Charcoal making;
- Government staff;
- Ice cream making;
- "Moto-taxi" drivers;
- Sandalwood gathering;
- Soldiers;
- Carpenters; and
- Doctors.

Some of the above occupations, such as ice cream- and charcoal making, are not relevant to all places and will depend on raw materials available and also village traditions. Also many activities are seasonal and require the villagers to engage in

67. Information provided by CDPO, 2 February 2001.
68. Many persons with disability are aware of this, as they have asked the Cambodian Red Cross for *"fishing equipment, rather than fish"*.
69. Information provided by Mounh Sarath, Cambodia Vision for Development, 16 February 2001.

other tasks to find food other times of the year. Some households will usually engage in more than one of the above activities in order to survive.

One NGO trained a total of 108 people in Kompong Thom province and claims a success rate of 90-100 per cent of their students being currently now gainfully employed. Their training centre in Pursat has a smaller success rate of around 80 per cent former students now working. They claim that their high success rate was because of the research they did prior to the training. They initially looked at doing craft-related activities but found that too many organisations were already involved in crafts, and what is more, the tourist trade was down at that time owing to the fighting in Phnom Penh. What they found was there was a real lack of "community needs" skills. Bicycle-repairing proved to be the most successful because many rural people rely on bicycles for transportation, and this later branched out into motorcycle repair. Results showed that there needed to be an alternative to sewing and embroidery training (as there was already a glut of seamstresses), so they started ladies hairdressing, which was very successful. They also introduced kapok mattress/ cushion-making and battery repair to add to the skills base and to supplement other seasonal trades.

In general, the outlook for farmers with disability is said to be poor, unless they have access to life education and health care services.[70] Organisations have the responsibility to promote these issues with the communities and government, to make sure that farmers with disability have access to training and information on new production techniques. The government model to date has been for their trainers to meet 30 or so farmers, run a half-day session and then leave. This does not provide sufficient training, is too expensive and quite ineffective as it does not reach the community.

The main post-training needs are credit, loans or in-kind goods. If a person with a disability does not have finance he or she cannot adequately use the skills that have been learnt. A trainee with a disability needs to set up a business, acquire tools of trade, rent a property, buy in stock and feed his or her family until the business becomes viable.

However, many pitfalls and problems confront efforts to provide credit to the rural poor. The National Centre for Disabled People (NCDP) claims that the businesses of around 70 per cent of persons with disability who received credit have failed,[71]mainly through their own mismanagement of funds, but also through NCDP's lack of follow-up and clear guidelines.[72] UNICEF has previously been involved in providing direct credit for small businesses but felt it ended up spending more time being debt collectors than working with the community. They have now worked out a new system where the target person is given one year's vocational training and counselling, then is offered a small loan. During the first period the person is encouraged to repay some of the loan and save some of the profits. Then progressively he or she is encouraged to pay back, with interest, the entire loan. This provides practical experience in a useful occupation and accustoms people to credit mechanisms.

70. Information provided by Rob Nugent, Food and Agriculture Organisation, Phnom Penh, 8 February 2001.
71. Though this should be set in the context of the rate of business failures in general, which tends to be extremely high.
72. The DAC has established a Business Advisory Council, with the express aim of assisting persons with disability in running their own business. Information provided by Ouk Sisovann, Geneva, 4 May 2001.

Another approach is to provide in-kind support, as CWARS does for its students. Once a person has completed the training he or she is entitled to receive in-kind payments of goods. This is done by maintaining a store of necessities that former students can access and not pay for until they return for further supplies the following month.

But micro-credit is not appropriate for all persons with disability. The "real poor" have to struggle every day just to survive and cannot afford to have any type of debt. Most of the CWARS credit programmes to date have not been directed towards these extremely vulnerable people but more for the "higher level poor". And many cases of credit fail because no feasibility study has been made.

Thean Thor, a Cambodian group that works with returnees and the village poor, including persons with disability, claims that it is important to monitor progress closely and to provide regular encouragement. Sometimes one explanation of how a credit system works is not enough for the rural people to understand what can be a new concept. They may have to hear it repeated up to 10 times before they completely understand it. The people who have received credit from Thean Thor have to pay the capital with four chickens as interest, rather than money. The rate of repayment will depend on each person's long-term plans.

Equal opportunity in employment

Follow-up on the people who have used NGO education and rehabilitation services found that there have been high success rates in increasing knowledge bases, but a very low success rate in employment placements. Discrimination may play a role because even if persons with disability possess the appropriate skills they are often ignored. This is despite research that has found that workers with disability are usually very good at their jobs and in many cases are a great deal more committed than those without disability.

The government claims that it does not discriminate against workers with disability: *"Don't forget that our Prime Minister is 'disabled'* [he has only one eye] and the President *of the National Committee of Disaster Management is an amputee!"*,[73] however they do not have a good track record for hiring persons with disability. The Ministry of Health has only a couple of workers with disability in its Phnom Penh office, although it claims to have "many" in the rural areas.

Ny Nhar, a polio victim and JS staff member, asserted that persons with disability still face extensive discrimination.[74]He is a university graduate in chemistry who was unable to get a job as a teacher with the government. The government official explained to him that they felt he would not be able to stand for long periods because he has to rely on a crutch and that it would be difficult for him to travel because most schools are not close to the towns. Yet he knew that he was quite capable of managing the standing and travelling required.

Mine action organisations and other NGOs can take a leading role in promoting equal opportunity in employment. Employers should make sure that persons with disability

73. Statement by Dr Khoun Eng Mony, Representative for Rehabilitation, Ministry of Health, Phnom Penh, 6 February 2001.
74. Interview with Ny Nhar, Jesuit Services, Phnom Penh, 31 January 2001.

receive the same salary as their non-disabled colleagues and also that they have the opportunities to improve their position.

Mine action groups can support mine victim assistance through employing mine victims as deminers, mine awareness staff, minefield markers, survey team members or community liaison teams.[75] MAG was the first mine action organisation actively to recruit mine victims as deminers, and it has set a quota of 20 per cent of their demining force to be made up of persons with disability. They have not found any attitude problems from within the staff, with deminers with disability being fully accepted and integrated: indeed, some are now team leaders.[76]

The role of deminers can be seen by some sectors of the communities as extremely important and possibly "heroic". This can help to raise the profile and attitudes of the general community towards mine victims and consequently all persons with disability. It may also give the mine victim an opportunity to increase his or her own personal feelings of usefulness and to be able to engage in an important community service.

Conversely, one mine action agency in Cambodia has never even had a policy on what happens to their deminers after they have been injured (usually it is just considered "bad luck", they are given some money and sent away). There may need to be external intervention in this area to address concepts of karma, fear, and ignorance of persons with disability.

Promoting equal opportunity employment with private enterprise is another important activity. This is not always an easy task as one NGO found out when they approached some of the local garment factories. Even though the NGO offered to pay a stipend they had no luck. The Chinese employers told them that persons with disability are bad luck and they refused to employ them. Likewise, many Cambodian employers, because of their belief in karma, consider that persons with disability are paying for the sins of a previous life, and say it is not good for them to intervene as it may prevent them paying back their "debt".

Some success, though, has been achieved through the efforts of the NCDP, which has set up a database of workers with disability.[77] The database is primarily for urban dwellers with disability seeking work. Yet, out of the 1,500 registered only 125 are placed per year. Another aspect of the employment issue is to rally support and jobs for mine victims. NCDP has been successful in lobbying major companies in Phnom Penh to consider employing workers with disability. As a result of their efforts one such company, Caltex, has employed a significant number of persons with disability (including many mine victims), constituting two out of three of their workforce.[78]

Sufficient land for food security

What rural poor need more than anything else is access to fertile land to enable them to produce their own food. In Cambodia there is enough land to go around but it is not divided evenly as most unused land is owned by high-ranking military. Now small landholders are starting to lose their plots to large companies.

75. Thus, for example, VVAF employs 300 Cambodian staff in four provinces of whom one half are persons with disability, including physical therapists, outreach workers, office clerks and wheelchair assemblers. Information provided by Mike Kendellen, VVAF, email correspondence, 27 July 2001.
76. Information provided by Archie Law, 2 February 2001.
77. Information provided by Kim Mom, Workshop Manager, Maryknoll, Phnom Penh, 6 February 2001.
78. Information provided by NCDP, 9 February 2001.

Cambodian Vision in Development, an indigenous NGO, has negotiated with the help of UNHCR to get land for a group of "extremely disabled"[79] people who had formed themselves into a small community. Initially they were given some non-fertile land that would have resulted in poor crop production and further suffering. Following high profile lobbying, however, more fertile land was offered to them.[80]

Some NGOs suggested that mine action groups should be more involved in the issue of land stewardship and what really happens to land after it has been demined. How the demined land will serve the community as their own resource is just as important as the clearance issue itself. There are still huge problems with the allocation of demined land because many times after it has been cleared the police or military come in and take it for themselves.

In Cambodia presently there is at least one NGO working on this issue, but considerably more follow-up and protection of rights are needed with regard to land use. HI's Land Use Planning Unit aims to work with village communities and NGOs to promote their active participation in the identification of needs and the implementation of development projects concerned with the use of demined land. They claim to have had some success to date and are waiting to restart three new land use planning units.

Education and equal access to education

In general, persons with disability have lower education levels than those without, with only 10-15 per cent reaching a minimum standard. Landmine victims usually come from the military or farming communities who have traditionally received only basic education. Taking into account the amount of time they had been out of school, their lack of confidence, certain community attitudes,[81] and lack of money, it is very difficult for many of them to progress.

There are problems with providing facilities for all the children in Cambodia, deficiencies in the overall education system in general, and a lack of classrooms and teachers. An estimated 400,000 children cannot go to school for one reason or another, usually because of lack of money to pay the teacher or excessive travelling distance. In addition, in 2000 floods destroyed 1,000 schools, and these had to be rebuilt.

The Department of Education is reviewing its present structures as it feels they may be too ambitious.[82] In 1999,[83] there were 6,449 schools in the country, although around half do not offer a complete range of classes between grades 1 and 6. The 2,447,235 children enrolled in school are taught by only 62,647 teaching staff. The Department needs financial assistance to build more schools and to train and employ at least 5,000 more teachers. Some NGO workers feel the Department should offer scholarships for persons with disability or their family members under the umbrella of helping persons with disability. Moreover, educational institutions need to make schools more "disability-friendly" with better attitudes and improved physical access.

The children of mine victims quite often cannot access education because the family has no money to pay the teachers or to buy the uniforms. One NGO, Action Nord

79. These are former Khmer Rouge soldiers who have had multiple mine injuries and are usually missing several limbs as well as having eyesight and hearing problems.
80. Information provided by Mounh Sarath, 16 February 2001.
81. A small number of people still do not want to study with persons with disability.
82. Information provided by Im Suthy, Director, Department of Education, 7 February 2001.
83. Ministry of Education and Sport and the Department of Planning, 1999.

Sud, conducted a survey in Samlot and found that 62 per cent of the children did not attend school (Sopha, 2000). As a result, the NGO set up an education project there with the objective of providing access to schools to all children. They set up the schools, built the buildings, trained the teachers[84](with the assistance of the Department of Education) and supplied the books and school uniforms. They also perform follow-up visits with the children to make sure they are actually attending school.

The question of children with disability in schools is just starting to be discussed in the Department of Education, which is planning to set up a section to deal with special education and then to set up schools for all such children, not only mine victims. They feel they need to change the attitude of people before there is more integration of children with disability in schools and a consequent increase in the enrolment numbers.

Disability legislation and community awareness

Persons with disability do not truly feel there is peace in the country as they still have to continue to "fight their own private wars". They are excluded from the wider society, the smaller communities, and even to a certain extent from their own families. Many people have no understanding of the needs of persons with disability and still refer to them not by name but by their disability.[85] Landmine victims face a lot of pressure from the community because of their situation, which can have a severe impact on their lives.[86] There is a need to break down ignorance especially towards those in the community who are "different", such as persons with disability, HIV/AIDS sufferers and those with mental health problems.

Before 1970 there were very few persons with disability visible in the streets, other than some polio victims. At that time children with disability could attend school and they were accepted in the community. Around 1984 the community's view of persons with disability worsened as gangs of ex-soldiers with disability became aggressive, threatening market stall-holders and demanding money from their customers.[87] It was not until many NGOs came to work with persons with disability that the awareness was raised to a level where persons with disability became more confident and started a slow integration into society. The CDPO has helped with this awareness-raising by holding training for government officials and provincial heads.

Today, city and rural people tend to hold different attitudes towards persons with disability. In the rural areas there is less discrimination, whereas the urban people are often faced with beggars with disabilities. Increased disability awareness campaigns need to be directed towards teachers, although in Phnom Penh it has proven difficult to include them. The CDPO and some self-help groups are preparing a national plan for disability awareness, using media, radio, TV and sporting activities, but this will require long-term commitment. A Veterans International disability awareness poster shows images of persons with disability engaging in employment and sports, with the words *"See the Ability better than the Disability"*. Continuing technical assistance is required to set up media campaigns that are innovative and interesting. Ideally, community awareness should also to be included in the national curriculum.

84. Of the 162 teachers in the district, 29 are themselves with disability.
85. Information provided by Srey Vanthon, 5 February 2001.
86. Statement by Hum Sophon, Director, Programme Department, CRC, Phnom Penh, 7 February 2001.
87. Information provided by Hing Channarith, Veterans International, Phnom Penh, 5 February 2001.

DAC's vision is for all individuals and society to recognise that everyone with disabilities has equal rights and obligations to all other citizens in Cambodia, and should therefore be given equal opportunities to participate in society, based on their abilities, enabling them to lead a life free of discrimination. Additional advocacy is clearly needed before there can be significant change. Persons with disability need to be able to articulate their problems in a non-threatening environment and to be able to mobilise themselves to deal with the issues that concern them.

Concluding remarks

Although it is generally agreed that the prosthetic and physical rehabilitation of mine victims is adequately covered in Cambodia, there remain significant unmet needs for vocational training and employment promotion. In addition, there is a lack of qualitative data on the needs of persons with disability and insufficient input from persons with disability themselves regarding services and resources allocated to them.

There is general agreement that mine victim assistance as a whole should be kept in the disability sector and not included as an operational component of mine action. Many reasons were advanced, notably issues of funding, infrastructure and expertise. Currently, however, the government is poorly able to meet its responsibilities towards persons with disability, including mine and unexploded ordnance victims. As a result, the bulk of the work is carried out by non-governmental organisations.

It is, though, felt desirable that mine action organisations should contribute, where possible, to promoting mine victim assistance by working together with the disability sector to solve problems faster. To some extent, this already occurs on an informal basis, for instance, through the provision by demining organisations of emergency medical assistance and treatment, or by the hiring of persons with disability to work for them. Mine action organisations are also in a good position to assist with one of the most difficult problems in Cambodia — the allocation and distribution of demined land. The need for safe land to cultivate crops on is a vital issue that could solve the problems of many persons with disability and significantly raise their standard of living.

Chapter 4

The case of Eritrea and Ethiopia

Introduction

In May 1998, a border dispute between Eritrea and Ethiopia in the Badme area escalated into a major military confrontation between the two countries. In May 2000, Ethiopian troops advanced deep inside Eritrea in a large-scale military offensive that uprooted an estimated 1.1 million people. On 18 June 2000, Ethiopia and Eritrea signed an Agreement on Cessation of Hostilities in Algiers to end the fighting. The agreement required Ethiopian troops to withdraw to positions held prior to 6 May 1998, while Eritrean troops were to maintain their troops at a distance of 25 kilometres from Ethiopian positions. This "no man's land" inside Eritrean territory extends 25 kilometres north of the 6 May 1998 border for the entire length of the 900-kilometre frontier with Ethiopia.

United Nations Security Council Resolution 1320 of 15 September 2000 stipulated that a UN peacekeeping force should be deployed in the Temporary Security Zones (TSZ). To date, although the TSZ have not been clearly delimited, two thirds of the 4,200-strong UN force have been deployed. In addition, by virtue of Security Council Resolutions 1312 and 1320, the United Nations Mission for Ethiopia and Eritrea (UNMEE) is mandated to monitor the demilitarisation of the TSZ and to coordinate the deployment of mine action capabilities in the TSZ and adjacent areas.

In the Agreement on Cessation of Hostilities, the Governments of Ethiopia and Eritrea jointly requested the United Nations to provide assistance in mine action in order to enable fulfilment of their respective mine action obligations (Article 8). The Agreement calls on the parties to the conflict to conduct mine action in the contested areas, to allow the deployment of a UN peacekeeping force, and to allow the safe return of the civilian population.[88] Yet access to the minefields in the south depends on the full

88. *"Both parties shall conduct demining activities as soon as possible with a view to creating the conditions necessary for the deployment of the Peacekeeping Mission, the return of civilian administration and the return of the population as well as the delimitation and demarcation of their common border. The Peacekeeping Mission, in conjunction with the United Nations Mine Action Service, shall assist the Parties' demining efforts by providing technical advice and coordination. The Parties shall, as necessary, seek additional demining assistance from the Peacekeeping Mission."*

implementation of the Agreement, including mutual agreement on the delineation of the TSZ and the full deployment of UN peacekeepers: at the time of writing this had still to occur.

This case study reviews the existing role of mine action in assistance to mine and UXO victims in Eritrea and Ethiopia. It addresses the extent to which victims' needs are met within the wider context of assistance to war and other persons with disability and how mine action has contributed to strengthening this response. Particular consideration is given to the situation in the border areas between the two countries, although the case study also addresses the wider mine threat issue in both countries.

The mine action context

The impact of the conflict: The nature of the threat

Landmines and UXO

It appears that landmines have been used in **Ethiopia** for many decades and during a variety of conflicts, ranging from the Italian occupation of the 1930s to the Ogaden conflict in 1977-1978, the long civil war against Haile Selassie (1961-1975) and the Derg regime (1975-1991) (United Nations, 2000b). According to the United States Department of Defense, 33 different types of mines are known to have been used in Ethiopia.[89] Contaminated areas include the regions of Afar, Amhara, Beni-Shangul, Gambela, Oromiya, and Tigray.

In **Eritrea**, during the 30-year-long independence struggle (1961-1991), landmines were laid throughout the country. Since September 2000, UNMEE has confirmed 20 different types of landmines in Eritrea.[90] Mines are said to be found in rural farmlands, near water sources, and along borders, primarily in areas near former battle zones (US Department of State, 1998). This was confirmed by recent surveys and mine clearance operations being conducted by HALO Trust and the Eritrean Humanitarian Demining Project (EHDP), which suggest that these old mines (and UXO) represent a significant threat to the population, being located in some of the most productive food and income-generating areas of the country, around Asmara, Keren, Massawa, and Nakfa. Since 1996, teams from the Eritrean Historical Research Department of the Ministry of Defence have identified more than 100 minefield locations in 38 villages (*Ibid.*). Of the 11 major battle sites thought to contain mines, 10 are in provinces in the north and north-west of the country and one is in the south-east. These areas saw most of the clashes between Eritrean and Ethiopian forces during Eritrea's war for independence. Today, as a result, an estimated 5 per cent of Eritrean land is infested with mines and UXO.[91]

In addition, the Oromo Liberation Front and the Ogaden National Liberation Front are also believed to have used landmines in Ethiopia recently. Similarly, in the north-west of Eritrea, Eritrean rebel groups have been accused of using anti-personnel mines in the course of their struggle against the government in Asmara.

89. US Central Command at *www.centcom.mil/demining/ethiopia_demining_program.htm*.
90. Information provided by Phil Lewis, Programme Manager, UNMEE-MACC, e-mail correspondence, 2 April 2001.
91. Gebremedhin, 1997, cited by ICBL, 2000.

Landmines were certainly used during the most recent conflict between the two countries (1998-2000). Whereas Eritrea has never denied deploying the weapons, Ethiopia, a signatory to the Ottawa Convention, claims not to have used anti-personnel mines, although a number of international observers have privately asserted that both sides may have used landmines.

As a consequence, mines and UXO now pose a significant threat throughout the contested areas along the common border. According to HALO Trust,[92] this threat is primarily in and around "no man's land" that runs between the trenches along the various confrontation lines (May 1998 and May-June 2000) sitting astride the common border.[93]

Mines were laid in conventional patterns within well-defined successive belts, corresponding with consecutive advances and retreats of armies. The military use of landmines during the recent conflict explains the strong correlation between major battlefields and the concentration of minefields and that, to some extent and to date, relatively few civilians have fallen victim to landmines (see below).The threat from suspected mined areas includes defensive and nuisance minefields laid by military forces, cluster bomblets, and a range of other UXO left from the fighting.[94]

Box 1. Most common mines and UXO

The most common mines are believed to be:

Anti-personnel **blast mines**:	**PMN** **PMD-6**
Anti-personnel **bounding mines**:	**Type 69**
Anti-personnel **fragmentation mines**:	**POMZ, POMZ-2**
Anti-tank mines:	**TM46** **TM57** **PRB M3**

The most common **UXO** are **BL-755 cluster sub-munitions, mortars, artillery and tank munitions, and hand-grenades**.

Source: UN Mine Action Service (UNMAS)/HALO Trust.

Under UN Security Council Resolution 1320 both governments are obliged to provide maps to UNMEE. The United Nations reported on 21 March that Eritrea had submitted detailed minefield information to UNMEE, covering significant frontlines and including details of anti-tank and anti-personnel mines laid by the engineering corps of the Eritrean Defence Forces (OCHA Integrated Regional Information Network, 2001). The Ethiopian Government is reported to have told UNMEE that Ethiopian troops do not keep records of where landmines are laid, nor have they recorded their mine-lifting activities (*ibid.*).

92. Interview with HALO Trust, Ethiopia, 1 February 2001.
93. From West to East: Humera front, Badme front, Zalambesa front and Asab/Bure front.
94. Surprisingly, however, HALO Trust found no UXO during their survey conducted from October to December 2000 on the battlefields in northern Ethiopia. Interview with HALO Trust, Ethiopia, 1 February 2001.

Mortality and morbidity rates

The World Health Organization (WHO) has estimated that of 55.1 million inhabitants in Ethiopia in its 1995 National Census, 1.8 per cent were with disability, i.e. some 990,000 people. Tigray seems to be the region with the highest proportion of disabled with more than 90,000 (or 2.8 per cent). Handicap International (HI) estimates that in Ethiopia not more than 1 per cent of civilians with disability (i.e. approximately 10,000 individuals) are amputees as a result of a landmine injury.[95]

In **Eritrea**, WHO estimated in 1995 that of 3.5 million Eritreans, 4.5 per cent, or 158,000 people, were with disability. The Eritrean Department of Social Welfare[96] has claimed that 4.5 per cent, or around 7,000, of Eritrea's population with disability are mine victims, although in a 1992 study the Eritrean Ministry of Social Affairs calculated that the total number of civilian amputees (i.e. including all amputees not just those as a result of mines) was roughly 2,500. This figure can be contrasted with that provided by the Eritrean War Disabled Fighter's Association (EWDFA), which asserts that more than 18,000 soldiers were maimed during the war of independence (1961-1991).[97] The United Nations Development Programme (UNDP) estimates the number of war wounded with disability at 17,000.[98] In addition, 75 per cent of the war-injured are thought to be civilians (LSN, 2001).

In **Ethiopia**, the mine awareness programme conducted by UNICEF and the Rehabilitation and Development Organisation (RaDO) in the Tigray region gives a more accurate picture of the impact of landmines and UXO among the civilian population. Between January and October 2000, the programme registered 149 mine and UXO casualties; 55 per cent of these were in the Eastern Zone (Adi Grat - Zalembesa), with a peak in June (50) and July (35) and a progressive decrease following the cessation of hostilities (RaDO and UNICEF, 2000). Both Médecins sans Frontières (MSF) Holland[99] and ICRC[100] confirmed this perceived reduction in the number of casualties.

The overwhelming majority of civilian victims were male (91 per cent). Children under 18 made up 76 per cent of the total victims, and just under half (49 per cent) were killed or injured while carrying out agricultural activities. In addition, the Ethiopian Government claims that in the northern conflict zone, mines have killed 100 people — five to seven victims per week in 1999 — (HI, 2000) and have forced 50,000 to abandon fertile agricultural lands.

In Eritrea, the national accident report prepared by the Eritrean Police Department indicated that in 1999 10 people were registered as mine or UXO victims each week, but that the true figure could be twice as high. According to the Eritrean Humanitarian Demining Headquarters, between 1 July 1999 and 31 August 2000, 48 casualties were reported in Eritrea, including 17 deaths (State of Eritrea, 2000). Fifty-four per cent of the casualties were children under the age of 10, the victims of landmines left from the struggle for independence. The victims are believed to be mainly shepherds and wood collectors.

95. Interview with HI, Ethiopia, 15 January 2001. The number of military mine casualties is considered confidential information by the authorities.
96. Cited by Landmine Survivors Network (see LSN, 2001).
97. EWDFA, 1996, confirmed by interview on 22 January 2001.
98. Interview with UNDP Eritrea, 19 January 2001.
99. Interview with MSF-Holland, 2 February 2001.
100. Interview with the ICRC, 30 January 2001.

Despite a number of partial assessment missions conducted in both Eritrea and Ethiopia by the United Nations, the US Department of State, the Eritrean Historical Research Department, and HALO Trust, the overall level and spread of mine and UXO contamination in the two countries are not known with any degree of precision. No national landmine impact survey has yet been conducted although the UN has been formally requested by the Eritrean Government to undertake one and Ethiopia is likely to do the same;[101] therefore no clear picture exists of the full impact on human and socio-economic development. Information remains difficult to collect and it is not even possible to give a precise number of mine victims over a single year.

However, despite a seemingly low number of recent casualties among civilians compared with other affected regions of the world,[102] it is clear that in both countries mines and UXO continue to affect the repatriation of refugees and the internally displaced as well as the cultivation of arable land and pasture areas. In addition, even if a number of interlocutors[103] do not (yet) consider landmines to be a major public health issue, existing infrastructure and facilities would certainly not be in a position to respond adequately to an increased number of landmine casualties among returnees.

Existing mine action responses

Mine clearance

Since September 2000, the UNMEE Mine Action Coordination Centre (MACC) has been establishing a mine action programme to help mitigate the threat posed by landmines and unexploded ordnance. Throughout UNMEE's mandate, the MACC will coordinate mine action in the TSZ and adjacent areas. The programme will coordinate mine action in support of the operational needs of the peacekeeping force and in support of the governmental and humanitarian relief efforts, including the repatriation of refugees and the internally displaced.

The UNMEE-MACC is headquartered in Eritrea but coordinates mine action activities on both sides of the border. Its responsibilities include:[104]

- Assessment of the landmine/UXO threat;
- Mine action information management;
- Operational planning and coordination for demining, UXO clearance and mine awareness activities in the TSZ;
- Mine action quality assurance; and
- Resource mobilisation.

In addition, a system of civil-military liaison and coordination is being established, with a Civil-Military Coordination Centre (CIMIC) located in Asmara. It is envisaged that CIMIC cells would also be established at sector and regional headquarters and

101. Information provided by Phil Lewis, e-mail correspondence, 2 April 2001.
102. This is generally explained by: the "military" nature of the conflict targeting only military objectives; the conventional minefield patterns located in or around battlefields in accordance with doctrine; and the rigorous control of internally displaced and returnee population flows by the Eritrean and Ethiopian authorities.
103. For example, MSF-Holland and ICRC.
104. Interview with the UNMEE-MACC, Eritrea, 25 January 2001.

that CIMIC would ensure coordination of UNMEE activities with the humanitarian community in the TSZ.

So far, the UNMEE-MACC has focused on information gathering and activities related to the TSZ. It has also been involved in dissemination of information to, and briefing of, UN military observers and peacekeeping reconnaissance teams. Nevertheless, in January 2001, Bangladeshi, Dutch and Slovak soldiers from their national contingents started mine clearance in TSZ adjacent areas.[105] In collaboration with UNDP, the UNMEE-MACC is building capacity in the emerging national MACs in both countries.[106]

Since 1991 and the end of the Derg Regime, limited clearance has been undertaken in both Ethiopia and Eritrea, mainly by the two respective armies. A large number of mines and UXO have reportedly been removed or destroyed by both forces either during the conflict or immediately thereafter. However, the Inter-Agency Technical Mine Action Mission to Eritrea concluded that neither side has the capacity to conduct mine clearance to international humanitarian standards (United Nations, 2000a).

In **Ethiopia**, the Ethiopian Demining Project (EDP) is the only national mine action entity; it operates under the Ministry of Defence. Since 1993, the EDP has been supported financially mainly by the US Department of State. Between 1993 and 1999, EDP received US$8.8 million from the US Government for mine detection, the use of dogs, training, mine clearance and equipment.[107] The 1998-2000 conflict disrupted EDP's mine action work and forced the Department of State to pull out, leaving EDP to perform on its own. Today the EDP (limited to three 110-person companies due to personnel and material deficiencies) perseveres as a viable enterprise, achieving small yet significant humanitarian demining actions. EDP claims that it removed 40,000 landmines in 2000 in the northern conflict zone.

Prior to 1995, the army conducted most of the demining in **Eritrea**, allegedly incurring considerable injuries and deaths to deminers and civilians.[108] The EHDP was established in 1995 under the Ministry of Defence, but separate from combat units. (DanChurchAid and Action by Churches Together, 2000). Initially it was funded by the US Department of Defense, which from 1995 to 1997 deployed demining training teams and provided equipment and supplies to Eritrea to help plan, organise, train and resource its demining operations. US Special Forces trained 80 ex-combatants as deminers with additional clearance equipment provided by the German Embassy in Asmara. Between 1995 and 1998, the EHDP claims to have destroyed approximately 1,600 anti-personnel mines, 175 anti-tank mines and 4,000 items of UXO. The programme was suspended due to the outbreak of hostilities in 1998.

The EHDP has been reorganised with the executive body (the Eritrean MAC) under the Commission for Coordination with the UN Peacekeeping Mission (CCPM), and the operational component (the Eritrean Demining Agency) under the auspices of the

105. These contingents are controlled directly by Force HQ and are Force assets. Their work is reported to the UNMEE-MACC, which simply records it in the IMSMA database. Information provided by Phil Lewis, e-mail correspondence, 2 April 2001.
106. This capacity building is already conducted by the UNMEE MACC in Eritrea and by the UNDP Technical Advisory Team in Ethiopia. The Eritrean Mine Action Centre (EMAC) already exists in Eritrea. Information provided by Phil Lewis, e-mail correspondence, 2 April 2001.
107.US Department of State, *FY 00 NADR Project Status* cited by Human Rights Watch; 2000:34.
108. Source: US Central Command at *www.centcom.mil/demining/itrea_demining_program.htm*.

Eritrean Relief and Refugee Commission, with a mandate from the State of Eritrea Commission for Coordination with the UN Peacekeeping Mission. According to *Landmine Monitor*, EHDP priorities include the clearance of landmines and UXO for the resettlement of refugees, transportation, infrastructure and use of land resources (ICBL, 2000: 17). EHDP operational staff, numbering about 60 as of writing, are all military and will form the basis of the military company about to be trained by RONCO, a US commercial clearance company, under contract to the US government. About five ex-EHDP senior core staff now form the basis of the Eritrean MAC.[109]

Both EDP and EHDP will act as national coordinating bodies in the field of mine action and will certainly represent the technical component of the future national MACs. Apart from UNMEE mine clearance in the TSZ, the two national MACs believe that the international community will almost certainly confine itself to providing technical support to the strengthening of national capacity through the provision of training and equipment, rather than direct implementation of mine clearance operations at field level.[110]

Contracted by the United Kingdom Department for International Development (DFID) on behalf of UNMAS, HALO Trust is responsible for initial surveying of the TSZ from both Eritrean and Ethiopian sides to determine the scope of the landmine/UXO threat in the TSZ and adjacent areas. In Ethiopia, operating on a similar basis, HALO Trust carried out its survey from September to December 2000. Detailed survey reports were handed over to the Ethiopian authorities but to date only 17 of 30 survey reports (relating directly to the TSZ) have been handed over to the UNMEE-MACC by Ethiopia.[111] In Eritrea, with the support of the UK and the US Department of State, HALO Trust started surveying in August 2000. The survey not only concerns the TSZ, access to which has been limited from Eritrea since the Agreement on the Cessation of Hostilities was signed, but also other areas suspected to be mined. This information is stored in the IMSMA database located at the MACC and is shared with the mine action, NGO and UN agency communities.

With financial support from the Dutch Government, HALO Trust will shortly begin training of 400 national mine clearance personnel in Eritrea in medical assistance, survey techniques, mine detection dog use, mechanical and manual clearance demining. The deminers will work primarily in the TSZ and adjacent areas but will also be mandated to demine countrywide.

DanChurchAid (DCA) is a member of Action by Churches Together (ACT). Funded by Denmark's foreign aid agency, DANIDA, plus initial UN funding of US$50,000, DCA-ACT intend to provide technical support to the EHDP through the provision of equipment, training and technical expertise with a view to the creation of a national demining team of 150 national staff to be provided by the government.

Today, no governmental body in either Ethiopia or Eritrea is responsible for issuing authoritative national mine action plans, although EHDP and EDP conduct some functions associated with this task. Neither body is currently able to carry out MAC functions effectively (United Nations, 2000a).

109. Information provided by Phil Lewis, e-mail correspondence, 2 April 2001.
110. Interview with EHDP, 23 January 2001, and with EDP, 1 February 2001.
111. Interview with UNMEE-MACC, Ethiopia, 31 January 2001; supplemented by information contained in e-mail correspondence from Phil Lewis, 2 April 2001.

In **Ethiopia**, the World Bank recently approved a three-year Emergency Recovery Programme to be executed through the Ministry of External Development Assistance and Cooperation. The approved programme includes a component valued at US$30 million in the form of a low interest loan refundable after 40 years and intended to cover mine action, including mine clearance activities. This initiative has provided the Ethiopian Government with the opportunity to prepare for the establishment of the future MAC. UNDP is currently assisting relevant governmental bodies with this work. UNDP's main role will consist of ensuring that the MAC adheres to international standards for mine action, including mine clearance operations and quality assurance. The future national capacity should include a mine clearance and mine awareness component whereas the possible inclusion of a victim assistance component will be discussed later with the relevant ministries.[112]

In **Eritrea**, the MAC has been established under national Eritrean management, combining resources from EHDP and UNMEE-MACC. Support for institutional mine action capacity-building in mine clearance and mine awareness will be provided by UNDP, UNMAS and international NGOs, such as DCA, HALO Trust, and InterSos.

Ultimately, Ethiopian and Eritrean MACs should be given the means and the opportunity to coordinate all mine action in their respective countries, including in the TSZ.

In addition, the US Department of State intends to resume its support to Ethiopia and Eritrea, providing US$1.6 million to train 200 engineers in Ethiopia, and a similar amount for Eritrea. This will include approximately US$500,000 for equipment and US$400,000 for mine detecting dogs in each country.[113] Technical assistance is being provided by RONCO.

Mine awareness education

In Ethiopia, Handicap International has run mine awareness programmes in the Somali refugee camps with the support of UNHCR and the European Commission. HI has trained 18 educators, 900 "relays"[114] and approximately 200,000 refugees have been targeted by these programmes. On the government side, EDP has been running mine awareness programmes mainly through distribution of materials to communities surrounding demining sites.

Since 1999, UNICEF has been carrying out a mine awareness programme in collaboration with RaDO. Today, this programme covers the length of the border between the two countries in Tigray. Given the seemingly healthy development of the programme in 2000 in both population coverage and capacity building, RaDO and UNICEF are now expecting to extend their operations to the northern Afar region.

In Eritrea, from 1995 to 1998, EHDP carried out mine awareness with the support of the US Department of Defense. Between 1998 and 2000, however, activities were suspended. From June 2000, international organisations were allowed to resume their activities and UNHCR, with the technical support of UNICEF, implemented mine

112. Interview with EDP, 1 February 2001.
113. UNMEE-MACC Update, 22 January 2001.
114. These "relays" are made up of teachers and members of refugee associations, including youth and women. Information provided by Olivier François, HI, e-mail correspondence, 10 April 2001.

awareness education projects in returnee camps targeting schoolchildren and surrounding communities.[115]

Today UNICEF is taking the leading role in mine awareness, assisting EHDP in developing its own capacity and seconding its expertise to UNMEE for TSZ and adjacent areas. In addition, DCA plans to assist in the development of a national mine awareness capacity by training six EHDP mine awareness trainers over the course of the next six months and 20-30 within the coming three years. The UNMEE-MACC will coordinate all mine awareness training to civilians in the TSZ and will conduct impact evaluation and quality assurance of mine awareness programmes.[116]

Mine ban advocacy

Eritrea has now acceded to the Mine Ban Treaty. Ethiopia, on the other hand, has signed the Treaty (on 3 December 1997) but has not yet ratified it.

Victim assistance

Very little has been done on behalf of mine and UXO victims by mine action programmes in both Eritrea and Ethiopia. One exception to this general rule is the work of the Landmine Survivors Network (LSN), which as seen below, contributes to the socio-economic reintegration of mine victims through income-generation projects. Another important facet of LSN's work, however, is connecting mine survivors to existing rehabilitation structures, structures which are, appropriately, outside the mine action entities.

Victim assistance

Mine and UXO victim needs

Given the lack of clear and credible basic data on civilian and military landmine victims in both Eritrea and Ethiopia, it is almost impossible to give a precise picture of the victim needs in this particular post-war context. Current data collection is incomplete and does not give an accurate picture of the extent of the problem in terms of number and type of populations affected.

There is certainly no specific structure devoted to landmine victims (and probably no need, at this time and in this context) as they usually join the regular health structures devoted to persons with disability and generally benefit from the same level of assistance. Moreover, given the poor level of existing health infrastructure and facilities provided in both Ethiopia and Eritrea, landmine victims can probably receive no more specific attention than other war victims or persons with disability.

Regardless of the number of landmine victims and the uncertainty over their health, economic and social status, they clearly require the same basic assistance as any other person with disability or war victims in the two countries. This means that attention must be paid to the following needs:

115. Interview with UNICEF consultant on mine awareness, 25 January 2001.
116. Information provided by Phil Lewis, e-mail correspondence, 2 April 2001.

- Hospital care (medical care, surgery and post-operation care);
- Rehabilitation (physiotherapy, prosthetics/orthotic appliances and walking aids);
- Psychological support;
- Social and economic reintegration (skills and vocational training, income-generating projects, sports, association capacity building); and
- Representation and promotion of their rights at national, regional and community levels.

The existing provision of assistance

Pre-hospital care

More than half of the Eritrean population lives more than 20 kilometres from the nearest health centre. Although no data exists concerning the rate of landmine victims who never make it to a medical facility, it is likely that in Eritrea more than half of all injuries result in death before victims can access first aid structures. However, over the last decade, the Eritrean Government has developed first aid services within its community-based rehabilitation policy. In Ethiopia, between Badme and Adi Grat, MSF-Holland is providing first aid training sessions in health centres of three *woredas* (local administrative divisions). But these scant measures are still far from responding to the existing need, let alone the possible increase in injuries in the coming months, as most local health posts are not competent to provide emergency care to mine victims.

Hospital and medical care

Similarly, few hospitals are capable of performing emergency surgery in the mine-affected regions of Ethiopia and Eritrea. Health infrastructure is underdeveloped and medical facilities are characterised by a lack of adequate supplies and equipment. Furthermore, the endemic lack of medical staff, orthopaedic surgeons, doctors, nurses and assistants is inherent to remote mine-affected areas in both countries. When they do exist, the absence of appropriate skills to cope with emergency situations, relevant surgery and post-operation care does not permit safe and careful interventions.

Rehabilitation

Physical rehabilitation is certainly the area where foreign and national assistance have focused attention, even though efforts remain limited overall. In Eritrea, three national orthopaedic workshops exist in Asmara, Keren and Asab.[117] The orthopaedic workshop in Asmara has a production capacity of 48 prostheses per month (LSN, 2001). In Ethiopia, the ICRC has established three Prosthetic/Orthotic Centres (POCs) in Mekele, Addis Abeba and Harar.[118] Although these structures are now under the national authority of the Ministry of Labour and Social Affairs, the ICRC keeps providing raw material and free transportation to the patients. In Mekele, in the conflict zone, the POC produces 45 prostheses per month. However, according to the ICRC, hospitals in Tigray, including Adwa, Adi Grat and Axum, are not technically prepared to receive landmine victims.[119]

117. Ministry of Labour and Social Welfare, 1998, cited by LSN, 2001.
118. According to HI, there is a further workshop in Dessie to where MSF France sends mine victims that are treated in Dubti hospital. E-mail correspondence from Olivier François, 10 April 2001.
119. Interview with the ICRC, 30 January 2001.

The ICRC also provides physiotherapy assistance within the POCs because of the low number of qualified physiotherapists in Ethiopia (13 for the whole country). Since 1997, HI and RaDO have been conducting a joint project to implement rehabilitation services in the main hospitals of the country. They have opened one rehabilitation department in each of 11 hospitals to deal with basic physiotherapy training and treatment. They are also training ortho-prosthetics technicians on walking frame production. From 2001, HI's programme in Ethiopia will mainly consist of strengthening the 11 existing hospitals and bringing support to eight new hospitals. Of these 19 hospitals, only Axum and Mechem health structures are potentially concerned by assistance to mine victims.[120]

Although psychosocial assistance may not be seen as a priority by the few institutions and organisations dealing with disability in Eritrea[121] and Ethiopia,[122] the need may now be re-considered in view of the recent conflict. In Adwa transit camp for returning war prisoners, MSF-Holland has assigned two short-tem expatriates to evaluate mental health as part of a medical check-up. In addition, Care International in Eritrea (OCHA/ICC, 2001a) and MSF-Holland in Tigray and in Eritrea are now in the process of conducting research into the potential for activities addressing the psychosocial consequences of war. This research will focus on military and civilian victims of war, including landmine victims.[123] The peer support brought by LSN to landmine victims in both Eritrea and Ethiopia on an individual basis (even if still geographically limited) can also be regarded as psychosocial assistance, and the work is conducted exclusively by social workers.

Social and economic reintegration

LSN is also one of the few organisations that addresses the problem of social and economic reintegration of landmine victims in Eritrea and Ethiopia.[124] The concern to create links between survivors and existing rehabilitation structures certainly represents a first step towards social and economic reintegration. In addition, LSN contributes to socio-economic reintegration through direct assistance to landmine survivors and direct employment of mine victims in its staff. The income-generating projects it promotes (e.g. small shops, animal breeding, farming, etc.) are community-oriented and seek to relate assistance provided to the landmine victim to their familial and social environments.

The core support HI provides to Ethiopian local organisations of persons with disability, including RaDO, contributes to building or strengthening national capacity to cope with reintegration of landmine victims and persons with disability more widely.

In **Eritrea**, since the war of independence, the government has been committed to providing direct assistance to landmine victims by paying disability benefits to ex-combatants through EWDFA. The association receives strong core support from the Eritrean Government and is committed to promoting income-generating projects (e.g.

120. Interview with HI, Ethiopia, 15 January 2001. Subsequently, HI decided with RaDO to extend activities to hospitals in Adigrat, Shire and Dubti, where a number of mine victims may be treated. E-mail correspondence from Olivier François, 10 April 2001.
121. Interview with EWDFA, 22 January 2001.
122. According to MSF-Holland, strong solidarity among soldiers seems to have limited the psychosocial trauma they have suffered.
123. Interview with MSF-Holland, 2 February 2001.
124. HI works in Ethiopia only.

small shops, restaurants, bars, bee-keeping farms, etc.), special education projects (vocational training, accounting) and sports activities. It also provides health and social services and employment opportunities to its 20,000 registered members with a view to enabling the association to become independent and persons with disability more self-sufficient.[125]

Disability policy and practice

In Eritrea, there is no specific law related to disability, whereas a 1994 Proclamation from the Government of Ethiopia prohibits discrimination in employment because of disability. However, lack of adequate resources (rather than political will) means that the Proclamation is not implemented in practice.

Awareness of the needs and rights of persons with disability is therefore conducted without the requisite national legal framework, mainly by grassroots NGOs. In **Ethiopia**, the Ethiopian Federation of Persons with Disabilities and international NGOs such as LSN, promote the rights of persons with disability, mainly through articles in newspapers and social activities in collaboration with concerned NGOs. In **Eritrea**, since 1994, the Ministry of Labour and Human Welfare has been extending a community-based rehabilitation project aimed at strengthening local staff to deal with disability issues, raising awareness at village level, and counselling persons with disability and their families. The EWDFA aims to raise awareness among the public about disability through the organisation of sporting and cultural events.

Despite a lack of systematic data, recent events have unquestionably put immense pressure on existing services and structures that were already under-equipped and under-staffed. Even before the latest conflict, half of the population in Eritrea and in Ethiopia had no access to basic health services.

In **Ethiopia**, foreign assistance remains virtually the only possibility of meeting basic requirements in for coping with the needs of existing and expected landmine victims. In **Eritrea**, on the other hand, the almost complete absence of international organisations in the country over recent years, as well as the relatively low level of local associations, have resulted in low awareness of the issue by the government.

Also, as in many other countries, the majority of resources accorded to victim assistance and the war wounded with disability (even if globally already insufficient) goes towards medical and physical rehabilitation. Almost nothing is set aside for psychosocial rehabilitation or socio-economic reintegration even though the need to find a place in society remains the primary objective of action in favour of mine victims. Moreover, as in many other mine-affected countries, potential means for delivering assistance to mine victims are almost invariably in urban areas while the majority of victims are in rural areas.

Concluding remarks

Mine action programmes currently do little to assist mine and UXO victims in Eritrea and Ethiopia. With the exception of the Landmines Survivors Network, there appears

125. Interview with EWDFA, 22 January 2001.

to be an effective separation between mine action organisations and entities and those — few —working on behalf of persons with disability. It is generally acknowledged that existing health care and rehabilitation services and infrastructure in Ethiopia and in Eritrea are inadequate to respond to any increase in landmine casualties since these countries are already struggling to cope with existing demands for health care. The challenge remains how to empower local structures to sustainably handle the reintegration of landmine victims within the existing socio-economic environment and according to the resources available in each country.

One area where mine action could usefully act is in the collection and dissemination of relevant information. Without good data collection it is difficult to allocate resources properly, set priorities and measure progress. Accurate collection of data is therefore the first step in addressing the issue of assistance to landmine victims. This involves two tasks: a Landmine Impact Survey, to set a baseline for the socio-economic impact of landmines and UXO and a precise enumeration of the number of landmine victims; and an ongoing Landmine and UXO Accident Surveillance System. This assistance should be given mainly at community level in health centres and field staff should be prioritised for basic training courses on format use and regular reporting.

Long distances between an accident and first health structure frequently suggest that training in first aid should be organised in order to respond to traumatic injuries — and therefore increase the chance of mine victims living long enough to receive medical care. Training should first be organised at village levels to community health workers and in existing remote health structures, to medical and paramedical staff.

Social and economic reintegration is the intervention area where new resources should be earmarked and local networks strengthened. Mine action organisations and agencies could play an important part in convincing donors to earmark funds in addition to their existing mine action/mine clearance budgets to socio-economic reintegration of mine victims. Even a limited extra investment could be disbursed effectively through local initiatives. Similarly, adherence to the Mine Ban Treaty should open the door to additional funding.

Laws and policies are essential for establishing equal opportunities for persons with disability — and hence promote their social reintegration. Mine action organisations and agencies can advocate for the adoption and implementation of such legislation and policy frameworks. Draft model legislation could be prepared and then adapted to the local legislative, social and economic contexts. Further, mine awareness programmes can fairly easily incorporate positive images of persons with disability in their materials and educational initiatives in order to combat societal and community discrimination (attempts are said to be under way in Eritrea).[126]

As with any post-conflict emergency or development initiative, effective coordination is essential. It appears that both Eritrea and Ethiopia still lack clear definition of inter-ministerial policy related to victim assistance. Disability issues, including reintegration, inevitably involve a number of different ministries (e.g. education, employment, social welfare, health, etc.). Mine Action Centres should in due course be able to promote effective coordination through the sharing of relevant information and the establishment, where necessary, of coordinating networks. Likewise, victim assistance

126. Information provided by Phil Lewis, e-mail correspondence, 2 April 2001.

planning should be harmonised with respective national ministerial policies and plans with the objective of including mine action in the overall planning and priorities set for nationwide social and economic development.

Chapter 3

The case of Kosovo

Introduction

Background to the conflict

On 24 March 1999, following the breakdown of peace talks between the Federal Republic of Yugoslavia (FRY) and the Kosovo Liberation Army (KLA) regarding the situation in the province, the North Atlantic Treaty Organization (NATO) launched air strikes against the FRY and Serbian forces in Kosovo, in a conflict that lasted 78 days.[127] By the end of the conflict, significant areas of Kosovo had been contaminated with landmines and UXO (ICBL, 2000:875).

In the agreement between the FRY and NATO on 9 June 1999, all FRY forces were withdrawn from the province.[128] On 12 June 1999, following the adoption of United Nations Security Council Resolution 1244 (1999), troops from the international peacekeeping force led by NATO (KFOR) entered Kosovo and responsibility for the province's security was transferred to KFOR.

As a province of FRY, Kosovo lacked the administrative apparatus of government. UN Security Council Resolution 1244 (1999) created the UN Mission in Kosovo (UNMIK) to provide an interim administration. The ultimate status of the province remains undecided.

The socio-economic context

A study by the International Organization for Migration (IOM) found that half the total post-war population of Kosovo is under 25 years age, with 32 per cent younger than 16 years (IOM, 2000: 16). Unemployment in the province is 50 per cent, with 57 per cent of the unemployed living in rural areas. The most common sectors of activity among those employed are agriculture, education, industry and mining, public

127. For details of the conflict, see for instance Judah, 2000; Ross, 2000.
128. NATO suspended its air campaign against the FRY after 78 days of bombing raids and a total of more than 38,000 sorties, including 10,484 strike sorties. See NATO website: *www.nato.int/Kosovo*.

administration, and trade (IOM, 2000: 53). Illiteracy among those 10 years and older is 6 per cent, of which 83 per cent are women. A total of 71 per cent of persons older than 14 years have completed elementary and high school; only 9 per cent have completed higher education (IOM, 2000:16).

The mine action context

The impact of the conflict: The nature of the threat

The use of cluster bombs and landmines in Kosovo

Following the conflict between the armed forces of the FRY and the KLA, and the subsequent NATO bombing, numerous areas of Kosovo were contaminated with mines and UXO. These explosive remnants of war have posed an immediate threat to human life and an obstacle to the delivery of humanitarian assistance, the reconstruction of homes, infrastructure, essential services, and the rebuilding of civil society.

Beginning in early April 1999, NATO forces made extensive use of cluster bombs during the conflict in Kosovo, with more than 250,000 bomblets reportedly being deployed (NATO, 1999; UNMIK-MACC, 2000a). Many thousands of these bomblets failed to function correctly and require clearance, along with numerous other NATO bombs and missiles (UNMIK-MACC, 2000a). The bomblets are *"in a highly sensitive state, and can explode as a result of being moved or picked up. This volatile condition combined with their destructive power and attractiveness to children means that [cluster bomblets]... are a major part of the mine/UXO problem in Kosovo"* (*ibid*.).

Both anti-tank and anti-personnel landmines were used during the conflict in Kosovo. Mines were used by the Yugoslav Army, Serbian police forces operating in tandem with Serbian paramilitary forces under the control of the Serbian Interior Ministry, and by the KLA (ICBL, 2000:875-878). Under the terms of the Military Technical Agreement signed with KFOR, the Yugoslav Army provided 620 minefield records, (UNMIK-MACC, 2000a) accounting for some 75-80 per cent of the mines laid in Kosovo. Most of the minefields are located along the southern borders of the province and many are marked. Although the KLA has reported the clearance of mines it laid in accordance with the requirements of the Military Technical Agreement,[129] (*ibid*.) it is highly likely that mines of all types continue to be held by individuals and by unofficial ethnic Albanian and Serbian groups (ICBL, 2000:876).

Although the total number of landmines used in the conflict is not known, the MACC reported that as at 29 November 2000, a total of 11,826 anti-personnel mines and 5,437 anti-tank mines had been cleared under its auspices, as well as 6,128 cluster bomblets and 12,594 items of UXO (UNMIK-MACC, 2000a).

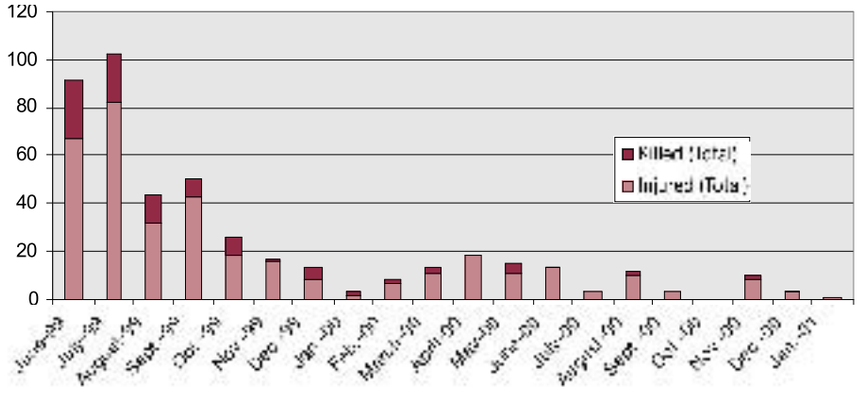
129. According to the MACC, KLA forces used anti-personnel mines sporadically during the war, mainly nuisance mining, particularly on routes travelled by the Yugoslav armed forces (UNMIK-MACC, 1999). They also laid minefields around their defensive positions, but to a much lesser degree than the Yugoslav armed forces (HALO Trust, 1999: 50). The KLA also used predominantly anti-tank mines. It is reported that most of the mines laid by the KLA were not properly recorded and the deaths of the combatants who laid them effectively erased any knowledge of their location (ICBL, 2000: 877).

Casualties

An Information Management System for Mine Action (IMSMA) has been established in Kosovo, the first time that IMSMA was used in the field. The IMSMA database stores information on minefields, cluster bomb strike sites gathered by a variety of sources, and holds casualty statistics and statistics on mine awareness education.[130] It acts as the single province-wide information system in Kosovo for both the UN and KFOR (UNMIK-MACC, 2000a).

Calculating the exact number of mine and UXO casualties has proved a difficult task as incomplete incident records were handed in during the emergency phase. Indeed, a substantial amount of data was unverified — and seemingly unedited — prior to initial entry into the IMSMA. The mine/UXO incident data depicted below in Figure 1 is a result of an information process and analysis established under the lead of ICRC in cooperation with the MACC, with WHO serving as an adviser. The vast majority of the data comes from the ICRC field staff and KFOR, with mine action organisations also providing reports.[131] Data on mine and UXO casualties are collected by ICRC both from civilian and KFOR hospitals, as well as directly from the communities, in order to determine where the accidents have occurred, who was injured or killed, and under what circumstances. The information collected on each casualty is passed on to the MACC in Pristina, which then enters it into the database.[132]

Figure 1. Casualties by month



The IMSMA database includes all information concerning people believed to have been involved in mine- or UXO-related incidents and accidents.[133] These figures include all information on incidents and accidents received before, as well as since, the end of the war, some of which has not been verified.[134] A data cleansing process has been going on at IMSMA since October 1999, with ICRC field staff doing extensive follow-up on incomplete incident records handed in during the emergency phase. This has

130. See *www.un.org/Depts/dpko/mine/macc* or *www.welcome.to/macckosovo*. The system has two component modules, a database that holds mine/UXO information and a Geographic Information System (GIS) to display and map the data.
131. Information provided by Mats Wennerstrom, IMSMA Officer, MACC, Pristina, 2 February 2001.
132. Information provided by Nora Demiri, ICRC, Pristina, 31 January 2001.
133. Victims of accidents are people injured or killed while performing demining activities.
134. According to the IMSMA database, as of 3 March 2001, some 710 people have been involved in suspected mine- or UXO-related incidents and accidents, of whom 151 have been killed and 538 injured. The remainder concern individuals who were not injured or killed, or for whom there is no further information.

enhanced the overall accuracy of the data.[135] Despite these difficulties, MACC staff have found IMSMA to have been an effective tool in planning and managing mine action in the province.

The most recent data held by the MACC indicates that close to 500 people have been involved in mine- or UXO-related incidents since June 1999.[136] The definition of "victim" retained in the following charts and tables includes a person injured or killed by a landmine, UXO or cluster bomblet. Only victims from incidents[137] that occurred after 15 June 1999 are included; the targets of deliberate and malicious attacks involving landmines are not reported in this document.[138] Figures are based on verifiable data from 16 June 1999 to 31 January 2001.[139] On the basis of these parameters, there have been 451 mine and UXO victims between 16 June 1999 and 31 January 2001, of whom 89 have died and the remainder have sustained injuries ranging from minor wounds to traumatic loss of limb.

In July 2000, the Vietnam Veterans of America Foundation (VVAF) carried out a detailed Socio-Economic Survey of Mine/UXO Survivors in Kosovo on behalf of the MACC, using grant funds provided by UNOPS. The purpose of the survey was to ascertain the exact scope of the rehabilitation, reintegration and psychosocial requirements in Kosovo. During a three-week period, eight survey teams visited 186 villages and towns and interviewed 333 survivors. The survey used the information contained in the IMSMA database as its starting point, although the survey work itself has *"greatly improved the accuracy of this information"*[140] (UNMIK-MACC, 2000b:8). Only those coming from and living in Kosovo were chosen for the survey. There were two Serb names on the list provided to VVAF by the MACC, but they were not

135. Information provided by Daniel Eriksson, Chief of Information Technology, MACC, Pristina, 2 February 2001.
136. In January 2001, the MACC reported that 496 people had been involved in mine/UXO incidents since June 1999 of whom 103 have been killed. According to information provided by the MACC, as of January 2001, statistics are counted from the end of the conflict, i.e. beginning on 15 June 1999. About 70 per cent of the victim information in the database refers to events that occurred after that date. The figures do, though, tend to change on a day-by-day basis, so an exact number cannot be given. Information provided by Daniel Eriksson, e-mail correspondence, 3 March 2001.
137. During the same time period, 20 people have been injured while clearing mines. Information provided by Mats Wennerstrom, IMSMA Officer, MACC, Pristina, 2 February 2001.
138. Information provided by Mats Wennerstrom, 2 February 2001.
139. The ICRC has confirmed about 95 per cent of these cases.
140. From the IMSMA database, the MACC selected all recorded people involved in mine- or UXO-related incidents and accidents that occurred between September 1998 and June 2000. Twice a week the VVAF Project Officer met the survey teams to monitor the progress and collect the survey forms, which were then forwarded to the MACC for data entry. The data entry and verification process continued during August and September 2000, following which the results were analysed. Discrepancies with IMSMA were double-checked and verified by both VVAF and the ICRC. VVAF found that as of 30 September 2000, an estimated 686 people in Kosovo were believed to have been involved in mine- or UXO-related incidents and accidents, of whom 537 had survived. Of these, VVAF was given a total of 460 names, the remainder not being provided because they had died, were not from Kosovo, were not entered into the database until after the survey was conducted, or there was insufficient information in their records to trace them. (A number of mine and UXO victims who had been entered twice into IMSMA were later deleted from the database.) Of the 460 names received by VVAF, the survey teams interviewed 333 individuals. The remaining 127 were not surveyed either because insufficient information had been provided, the individuals were not from Kosovo, had died, were abroad or not at home, or refused to be interviewed. In addition, the VVAF survey identified and interviewed an additional 25 people who were either completely unknown as mine or UXO victims, or whose incident forms, although completed by ICRC staff, had not yet been entered into IMSMA. Nearly all of these 25 had been injured in the spring of 1999 while fleeing the conflict. They have since been entered into IMSMA and are included among the 537 survivors reported by VVAF (VVAF, 2000a:7-10).

interviewed,[141] though VVAF did interview a number of Gorani and Roma survivors (VVAF, 2000:7,10).

In the five months following the end of the war, 800,000 refugees returned to Kosovo. During this period there were many mine casualties among the returnees, despite the fact that mine awareness programmes had been carried out by UNICEF in refugee camps prior to return (ICBL, 2000: 890). Between 7 and 14 July 1999, WHO conducted an assessment of the number of deaths and injuries due to mines and UXO in the four weeks following the end of the conflict, based on data from Kosovo's six hospitals and the MACC database. It estimated that during this short time, 150 people had been maimed or killed by landmines or UXO, corresponding to a monthly incidence rate of 10 per 10,000 (an annualised rate of 120 per 100,000). Seventy-one per cent of the survivors were younger than 24 years of age. In some areas, between 35 and 42 per cent of hospital beds in the surgical and orthopaedic wards were occupied by survivors of mine or UXO explosions.[142] WHO commented that this rate far exceeded that found in many other countries affected by landmines (WHO, 1999a).

Subsequently, the number of deaths and injuries due to mines and UXO decreased somewhat in August 1999 before once again increasing in September 1999 as people went looking for firewood and water (UNMIK-MACC, 2000c:9). The delivery of firewood by a number of organisations, including the IOM and CARE, on behalf of the Office of the UN High Commissioner for Refugees (UNHCR), may have reduced the number of casualties, even though the objective was to assist vulnerable families and not specifically to prevent mine/UXO injuries.

After a sharp decrease in mine/UXO during the winter 1999-2000, Figure 1 above shows that the number of casualties in 2000 increased *"as expected"* in early spring 2000, as communities ventured out into dangerous areas in search of food or wood, or, in the case of children, a place to play. According to the MACC, however, what was not expected was the scale of the increase — largely attributed to cluster bomblets. Less surprising was the increase in casualties in August 2000, since the majority of incidents occurred during the wood-cutting season in remote areas known to contain mines. It is said that *"the nearby villages were subjected to intensive mine awareness activities, however despite these efforts and the known dangers, people still ventured into these minefields because of economic necessity"*.[143]

As is seen in Figure 2 below, whatever their precise failure rate, cluster bomblets are, along with anti-personnel mines, the leading cause of landmine- and UXO-related death or injury in Kosovo. This led to a change in clearance strategy, which helped to stabilise the situation.[144]

Encouragingly, the rate of civilian casualties has reduced dramatically in recent months, due, at least in part, to the results of mine and UXO clearance and mine awareness activities (UNMIK-MACC, 2001c:9). The MACC believes that this will continue to be the case in the future as the remaining mines and cluster bomblets will be cleared (UNMIK-MACC, 2001b:1).

141. VVAF hoped to interview these people in the future.
142. Krug and Gjini, 1999:450, quoted by ICBL, 2000:890.
143. These areas had been deemed low priority in 2000, but were slated for clearance in 2001. See UNMIK-MACC, 2001c:10.
144. See UNMIK-MACC, 2001c:9.

Cluster bomblets have been a major threat in Kosovo, particularly to children. The data set identifies cluster bomblets as the type of ordnance whose victims have the lowest average age. As of June 2000, it was estimated that 80 children had been killed or injured by these UXO compared to about 60 child victims of anti-personnel mines.[145] The figures also show that incidents involving cluster munitions are also much more likely than mines to result in death.

Figure 2. Total casualties by type of ordnance

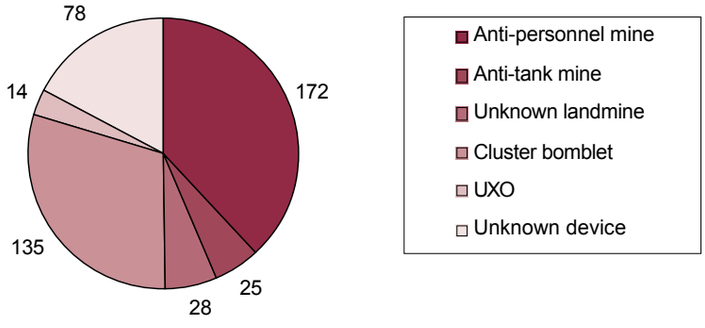
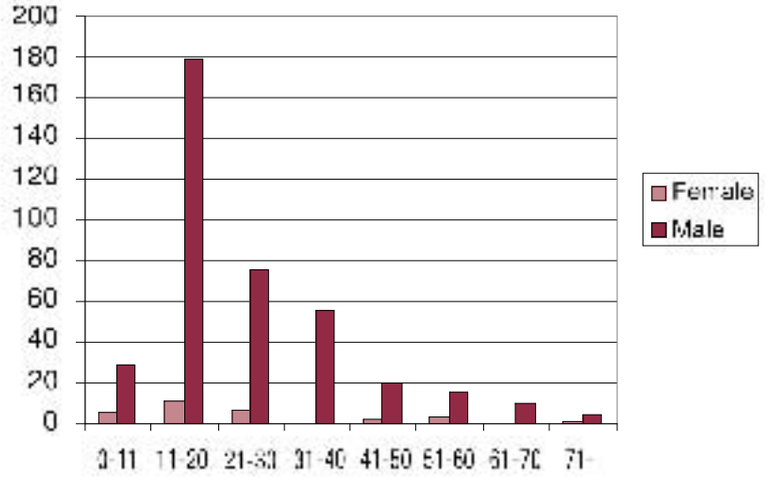


Figure 3, below, provides a breakdown of victims by age group. It shows that males, particularly those in the 11-20 age group, make up a significant proportion of mine and UXO victims. The second and third highest casualty rates occur in the 21-30 and 31-40 age groups of males, respectively. This has far-reaching consequences "*if the major breadwinner of a family is injured or killed, and means that mine incidents can have an impact that extends beyond the immediate victim*" (UNMIK-MACC, 2001c:10). As the MACC points out, it is important to take this factor into account when planning rehabilitation and reintegration support to the victims, since it must be considered a long-term issue.[146]

Figure 3. Victims by age group



145. UNMIK-MACC, extrapolated from the IMSMA database, June 2000, quoted by ICBL, 2000:891.
146. Information provided by Leonie Barnes, Chief of Public Information, MACC, Pristina, 1 February 2001.

The VVAF *Socio-Economic Survey* confirms this trend, showing that mine/UXO survivors are predominantly young, with more than three quarters of interviewees under 35 years of age, and almost half under 18. Most victims are also male (88.9 per cent of those interviewed), coming mainly from rural areas in the west and south of the province (VVAF, 2000b:10).

The MACC is reportedly *"confident that the exceptionally low incident rate during the latter quarter of 2000 can be maintained throughout 2001 until the clearance is completed"* (UNMIK-MACC, 2001c:10). This is particularly true during the current winter period. Furthermore, given the planned deployment of clearance capacity onto the remaining minefields, *"there is every likelihood that mine incidents involving civilians will become the exception rather than the rule every month. Moreover, it is believed that if the situation materialises as expected, the problem of mine victim assistance in Kosovo will become finite within a short period of time"* (*ibid*.).

Consequences: Injuries by type of ordnance

According to the VVAF *Socio-Economic Survey*, of the 333 survivors interviewed, around 45 per cent have permanent disabilities, including loss of limb, sight, or hearing as a result of their mine/UXO incident, and around 22 per cent have had an arm and/or a leg amputated. No less than 93 per cent of these survivors are male. The young are especially affected, with 64 per cent of amputees being under 36 years of age. Of the individuals who suffered traumatic or surgical amputation of a leg, 84 per cent have a below-knee amputation, 8.7 per cent have an above-knee amputation, and 7.3 per cent have a double amputation. Nine per cent of all interviewees have either lost a hand or one or more fingers, while 6.9 per cent have lost a foot; 7.5 per cent have loss of sight and 9.3 per cent have loss of hearing. Some people fall under more than one category.[147]

Between August 1999 and December 2000, Handicap International (HI), as the lead agency for physical medicine and rehabilitation programmes in Kosovo, identified a total of 788 amputees[148] in Kosovo (by no means all are amputees as a result of landmines or UXO). Of these, 602 have a lower limb amputation and 186 an upper limb amputation (HI, 2001b). Approximately 26 per cent are amputees due to war and mines.

HI has information on 456 individuals with permanent physical disability suffered as a result of the conflict (including mines and UXO). A total of 171 are mine victims, of

147. Since ICRC collects data on original injuries as part of IMSMA, the VVAF Survey did not ask mine/UXO victims about their injuries at the time of the incident, instead concentrating on their current health status and any disability they may have as a result of the injuries sustained. VVAF believes that this gives a more realistic picture of the current situation, especially for those organisations looking at longer-term physical rehabilitation needs. Since the survey was not done for medical purposes, the categorisation of disability is very similar to that used by IMSMA database. As the categories are simple and broad, there may be some room for divergent interpretation. For instance where loss of eyesight, hearing or limb was identified, it could refer to either a partial or complete loss (VVAF, 2000a:23-24).

148. Of these 788, 540 are male, 170 female and 78 children. The division of amputees by region (in descending order) is as follows: Gjakova (17 per cent), Peja (15.5 per cent), Prizren (14 per cent), Ferizaj (13.3 per cent), Mitrovica (13.2 per cent), Pristina (12.5 per cent), Kllokot (7.6 per cent) and Gjilan (6.8 per cent). The percentage of amputees due to mine/war in these regions is, respectively, 38 per cent in Prizren, 30 per cent in both Gjakova and Mitrovica, 29 per cent in Kllokot, 26 per cent in Ferizaj, 24 per cent in Peja, 18 per cent in Gjilan and 16 per cent in Pristina (HI, 2001b).

whom 131 are amputees.[149] A further 72 are war amputees from weapons other than mines (i.e. grenades, bombings, shootings) and other UXO (including cluster bomblets). Of the 131 mine amputees registered by HI, 4.6 per cent have a double amputation, 22.5 per cent have an above-knee amputation, 44.2 per cent have a below-knee amputation, 12.4 per cent have a foot amputation, and 16.2 per cent are upper limb amputees.

Box 1. A statistical summary

- As at December 2000, 788 amputees have been registered in Kosovo;
- 26% are war-related amputees;
- There were at least 451 mine victims between June 1999 and February 2001;
- 131 mine amputees have been registered by HI.

The other 253 individuals have permanent disabilities that did not result in amputation. Of these, 40 have permanent disabilities caused by mines, 140 were caused by bombing or shooting, and 73 were caused by grenades or other UXO, including cluster bomblets. Other permanent disabilities include: problems in walking and standing due to injuries to the nerves causing paresis,[150] hard contractions after fractures, hearing and ocular problems, mixed injuries, or paraplegy, etc. In addition, there are many more mine victims having injuries that did not result in permanent disability; these are not included in HI's list.[151]

There are no official figures on the number of injured and persons with disability as a result of the war. The Society of War Invalids Members of KLA estimates that there are about 4,800 war-related injured in Kosovo and that 64 per cent of its members are between 18 and 26 years of age.[152] VVAF confirms that even though no official figures exist, it can be assumed that many war wounded with disability are young given that *"Kosovo has the youngest population in Europe with roughly 65 per cent of people being under the age of 24"* (VVAF, 2000a:28).

Existing mine action responses

The mine action centre

In the absence of a recognised governmental structure in Kosovo, the United Nations was mandated by Security Council Resolution 1244 of 10 June 1999 to establish an interim administration (UNMIK), which in turn subsequently created the Mine Action Coordination Centre (MACC) under the auspices of UNMAS. UNMAS selected UNOPS to execute the project in Kosovo. Responsibility for the MACC and the overall Mine Action Programme (MAP) was initially assigned to the Office of the Deputy Special Representative of the UN Secretary-General for Humanitarian Affairs, which

149. Thus, around 76 per cent of the 171 registered mine victims are amputees.
150. Muscular weakness due to illness or disease.
151. Information provided by Iliriana Dallku, Doctor, HI, Pristina, 8 February 2001 and e-mail correspondence, 22 February 2001. Such information can be obtained from the MACC's IMSMA database.
152. Information provided by Vehbi Rafuna, President, Society of War Invalids Members of KLA, Pristina, 9 February 2001; information confirmed by Driton Ukmata, Head of Mission, HI, Pristina, 7 February 2001.

was also referred to as Pillar 1 of the four-Pillar UNMIK organisation. Following the closure of this Pillar in mid-2000, responsibility for the MAP was transferred to the Office of the UN Humanitarian Coordinator for Kosovo.[153] The MACC was set up in Pristina and became operational on 17 June 1999, five days after the entry of KFOR into the province (ICBL, 2000:882). UNMIK Headquarters approved the Outline Concept Plan for the UNMIK MAP on 24 August 1999.

The underlying principle behind the development of the MAP was to establish the MACC as a ***coordination*** body acting as a focal point for all mine action in Kosovo. As such, the MACC has not created its own operational mine action assets. In general, the organisations currently undertaking mine/UXO clearance, mine awareness, and victim assistance activities as part of the MAP have been bilaterally funded by various governments, engaged directly by humanitarian relief agencies and organisations, or contracted for a limited duration by UNOPS (UNMIK-MACC, 2000a). All organisations have to be accredited by the MACC and must meet minimum standards for training, equipment, procedures, medical cover, communications, and, in the case of mine awareness, for material that is being disseminated. The required standards are based on the *UN International Standards for Humanitarian Mine Clearance Operations* and the *International Guidelines for Landmine and Unexploded Ordnance Awareness Education*.[154] It is noteworthy that the MACC is able to assign tasks directly to accredited organisations, even though the majority of them are operating under bilateral, not UN contracts.[155]

Box 2. The Role of the Mine Action Coordination Centre

The MACC was asked to perform the following tasks:*

- Act as the focal point and coordination mechanism for all mine action activities in Kosovo;
- Coordinate with KFOR to avoid duplication of effort with military mine clearance;
- Coordinate, in the initial phase, mine action in support of humanitarian relief and the repatriation and resettlement of refugees and the internally displaced;
- Coordinate, in the longer-term, mine action support for the reconstruction and economic redevelopment of Kosovo;
- Assist local authorities in the development of a comprehensive and integrated mine action plan, minefield survey and marking, mine awareness programmes and mine/UXO clearance;
- Collect, manage and disseminate mine/UXO data;
- Develop and implement technical and safety standards, quality assurance and quality management procedures;
- Participate in resource mobilisation as required; and
- Investigate the feasibility of utilising indigenous and other mine action capabilities and retain the option for contracting for this purpose.

* See *www.un.org/Depts/dpko/mine/macc.*

153. The three remaining Pillars of UNMIK are Civil Administration (UN), Institution Building (OSCE) and Reconstruction (EU) (UNMIK-MACC, 2000a).
154. See *www.un.org/Depts/dpko/mine/macc.*
155. Information provided by the MACC, Pristina, 29 January 2001.

The MACC currently employs eight international UN staff, 10 in-kind staff and 21 local staff (UNMIK-MACC, 2001c). However, both the Mine Awareness Coordination Officer and Mine Victim Assistance Coordination Officer and Public Information Officer positions have been vacant since the start of the programme. The responsibilities and duties of all three positions are currently filled by the Chief of Public Information, who manages the Public Information Branch. Their responsibilities have either been assigned to others and undertaken *"in a somewhat more ad-hoc fashion than is ideal"*, or have not been undertaken at all[156] (UNMIK-MACC, 2001c:2).

Mine action planning for Kosovo has been based on the premise that the problem could be brought under control through a three-year programme. The Outline Concept Plan has defined three phases of activities in order to achieve this objective: preliminary, emergency and the consolidation phases. The first two have been completed (UNMIK-MACC, 2001c:1).

During the first two phases, priority was given to addressing the immediate humanitarian crisis associated with the return of hundreds of thousands of refugees, and coordinating and controlling the operational assets that were mobilised through rapid donor intervention. In close cooperation with UNICEF, WHO, ICRC and several NGOs, the MACC also started coordination of mine awareness and assisted with the establishment of a mine/UXO casualty database to support the WHO/ICRC casualty surveillance system. Close cooperation with KFOR was an important contributing factor to the speed with which mine action activities were implemented. KFOR adopted the UN's IMSMA as the database to be used by the military forces and was responsible for its management until MACC personnel arrived and developed the facilities required (UNMIK-MACC, 2001a).

The MACC has not opened regional offices within the province preferring to appoint an implementing agency from mine clearance and mine awareness organisations as "senior partner" within each of the five Multi-National Brigade (MNB) areas to act as focal point, to coordinate activities amongst the various organizations (in particular to deal with KFOR personnel on operational matters) and to represent the MACC as appropriate.[157]

The MAP is currently in its "consolidation" phase, the objectives of which are the systematic clearance of known mines and UXO, the reduction in casualties through effective mine/UXO awareness, rehabilitation and reintegration assistance to mine victims, and the development of institutional arrangements upon which medium and long-term requirements for mine action will be based. The MAP has now completed the first year of this phase (UNMIK-MACC, 2001c:1; UNMIK-MACC, 2001b:2).

Mine/UXO survey, marking and clearance

The objectives set for 2000 were to clear all high priority mined/dangerous areas and all cluster bomb sites. During the year, the MACC coordinated and tasked 16 accredited mine clearance organisations.[158] A number of organisations have trained and recruited

156. The Public Information Department, under whose responsibility fall mine awareness, public information and victim assistance, currently comprises a team composed of one international as chief of department, a national mine awareness assistant, and a public information assistant. Information provided by Leonie Barnes, 31 January 2001.
157. See *www.un.org/Depts/dpko/mine/macc*.
158. As of February 2001, accreditation for the year 2001 was ongoing.

a local mine clearance capacity, and there are now some 800 local deminers employed in the field (UNMIK-MACC, 2001b:5).

During the year 2000, priority was given to clearance efforts. A province-wide survey of dangerous areas was completed by HALO Trust in August 1999 (HALO Trust, 1999). The survey provided the MACC with a good idea of the extent of the mine/UXO threat and this information was used as part of the subsequent Mine/UXO Impact Study undertaken by the Survey Action Center (SAC)[159](SAC, 2000). The SAC Survey assisted mine action managers in setting priorities for both mine clearance and mine awareness activities, enhancing the effectiveness and efficiency of the mine action programme. According to the MACC :

> *"As a result of the Survey, each district within the province has been categorised as having High, Moderate, Low or Nil Impact as the result of mine/UXO contamination. Furthermore, each individual mined or dangerous area can be characterised in the same way, based on its affect on agricultural development, proximity to habitation or lines of communication, and impact on activities such as firewood collection ... This degree of analysis enables a clear definition of priorities for clearance, as well as identifying where other activities such as mine awareness must be placed as a minimum activity."*[160]

These priorities are intended to prevent further casualties by clearing areas around centres of population and agricultural land, and to support the rehabilitation of infrastructure and the restoration of essential services (UNMIK-MACC, 2000a).

In April 2000, the objective to clear all cluster bomb sites was modified to complete the surface clearance of strike areas. This was the result of *"the fact that [bomblets] ... lying on the surface posed a significant hazard to the population, particularly children"*. This change implies that bomblet clearance will not be completed until later in 2001, however, it proved very successful in reducing the casualty rate caused by these devices[161](UNMIK-MACC, 2001c:1,7). As of 29 November 2000, 23,640,025 square metres had been cleared, including 16,134 houses and 776 schools. Under MACC auspices, a total of 6,128 cluster bomblets, 11,826 anti-personnel mines, 5,437 anti-tank mines and 12,594 UXO had been destroyed (*ibid*.).

The objective of clearing all high priority areas in 2000 was met. The majority of work remaining in 2001 will be conducted on minefields that were previously rated as "low" or «nil» priority. Thus, *"although these areas are generally in heavily forested locations, or on land that is used for raising stock in the summer months, they still pose a hazard to the local population, particularly woodcutter and farmers"* (UNMIK-MACC, 2001c:7). The MACC is currently targeting all 620 mined areas for which the Yugoslav army provided records[162] (UNMIK-MACC, 2001b:5). In addition, as a number of known mined areas

159. The survey combined information from a wide variety of sources such as UNMIK, UNHCR, the Food and Agriculture Organisation (FAO), the World Food Programme (WFP), IMG, WHO, ICRC, and the HALO Trust Assessment. The SAC, which is managed by VVAF, seconded an expert to the MACC to produce the Kosovo survey. The expert created a socio-economic index of the impact of landmines and UXO and aggregated the information at the level of 320 districts within the Province. In cooperation with the GICHD, this data has been integrated in IMSMA. (See VVAF website *www.vvaf.org*)
160. UNMIK-MACC, 2000d:5, quoted by ICBL, 2000: 885.
161. In total, 617 strike areas have been identified of which 162 have been completed to sub-surface standard, 217 sites have been surface cleared, and 219 sites remain to be cleared in 2001.
162. Of the 620 recorded areas, 453 have been cleared to date. Work will resume on the remaining 167 minefields in 2001 (UNMIK-MACC, 2001c:6).

were laid particularly by the Serbian Police and paramilitary forces and for which records were not provided, the MACC tasked specific organisations to search for new mined areas and to confirm the existence of the recorded minefields (UNMIK-MACC, 2001b: 5). Subject to resource availability, the MACC plans systematically to complete the clearance of all known minefields and NATO cluster bomb strikes areas and suspected areas by December 2001 (*ibid*.).

The MACC also comprises a Quality Assurance (QA) Cell for mine and UXO clearance, which comprises five inspection teams. During operations, the QA process consists of a series of evaluations at critical stages of the clearance activities. Completed minefields are subjected to a final QA inspection before being signed off by the MACC (UNMIK-MACC, 2000b:2).

Since the inhabitants of Kosovo will continue to find items of ordnance for many years, an appropriately trained and equipped capacity must be able to respond to the situation. Currently, the MACC is in the process of defining the institutional arrangements to meet long-term mine action requirements. This role will be assigned to the Kosovo Protection Corps (KPC), to which, with assistance from KFOR, will be transferred the responsibilities assumed by the MACC as part of its detailed exit strategy.[163]

Overall, the powers and responsibilities given to the MACC have been used effectively to minimise duplication of effort, a major risk with so many actors involved. Indeed, although no system is ever perfect, the level of coordination of mine clearance in Kosovo has probably been among the best in the world.

Mine awareness education

The MACC, in cooperation with UNICEF, coordinates all mine awareness activities in Kosovo. The mine awareness education component falls under the Public Information Department, which is responsible for identifying needs and priorities for mine/UXO awareness education activities, providing guidance and standards to implementing agencies, facilitating coordination of activities, and monitoring and developing appropriate responses.[164]

In 2000, the MACC coordinated and tasked 13 organisations implementing mine awareness education activities throughout the Province. In addition, four KFOR contingents have also been accredited and have developed a support programme of mine awareness education for schoolchildren designed to bridge the gaps until the training provided in the school curriculum comes fully into effect in 2001 (UNMIK-MACC, 2001c:3).

The main mine awareness programmes implemented are "*community-based"* activities which include the Safer Village concept and the Child-to-Child programme. The Safer Village concept examines the specific needs of a village and tries to provide an alternative solution to risk-taking behaviour. As analysis of mine victim data shows

163. Information provided by John Flanagan, Programme Manager, MACC, Pristina, 29 January 2001; see also UNMIK-MACC, 2001b:5-7. UNMIK Regulation No. 2000/61, of 9 November 2000, tasked the Department of Civil Security and Emergency Preparedness to *"plan and develop the long term arrangements for mine clearance in cooperation with the UNMIK Mine Action Coordination Centre"*. See the proposed future mine action structure for Kosovo in Appendix 5.
164. See *www.un.org/Depts/dpko/mine/macc*

that males between the ages of 15 and 25 are the highest risk group, awareness initiatives have targeted this group. The Child-to-Child programme focuses on the child as a trainer of other children and parents in the home, using traditional games and activities. It is claimed that it *"allows for the reinforcement of positive messages over a longer period of time and already there have been occasions when children have used the information passed to them during the Child-to-Child training to report cluster bombs and UXO to a responsible adult/community member or KFOR representatives"*.[165]

Mine awareness messages were also incorporated into other activities, such as soccer matches, summer camps, religious prayer and theatre. Linkages have also been made with other outreach programmes, for example, through youth and health centres.[166]

Mine awareness continued to play a vital role in the MAP in 2000. In close cooperation with partners such as UNICEF, ICRC, KFOR, NGOs and mine clearance organisations, the MACC implemented a "holistic" mine awareness education campaign designed to target all sectors of the population in accordance with the associated level of risk.[167]

The MACC Public Information Department is said to have been instrumental in improving the integration between mine awareness and mine clearance organisations. Since many mine clearance organisations did not have their own integrated community liaison teams to support their daily activities, the MACC identified mine awareness organisations to provide direct support to clearance teams.[168] To fill the gap, Mine Awareness Support Teams (MAST) were then created, guidelines were written and a MAST for each mine and battle area clearance (BAC) organisation was identified. A mine awareness component was included as part of the quality assurance and certification process of completed mine/BAC clearance tasks. MASTs were tasked to support mine/BAC clearance before, during, and at the completion of, a clearance operation. Doing so, teams members act both *"as educators and facilitators"* (UNMIK-MACC, 2001c:13). Through this process *"information on the mine threat is continuously gathered and can be validated against the priority list to ensure that the most urgent needs are being addressed"* (UNMIK-MACC, 2000a).

A reporting system has been developed for mine awareness that provides a means to monitor each organisation. The accompanying database has many benefits, giving visibility to activities carried out within Kosovo, assisting in planning future programmes, and investigating incidents involving the civilian population. It has proven to be a very effective coordination tool, and has been adopted as the model for future development of the IMSMA Mine Awareness Module (UNMIK-MACC, 2001c:11).

A series of guidelines for the quality assurance of mine awareness training activities was developed and implemented in 2000. The MACC also coordinated monthly centralised mine awareness meetings and weekly regional mine action meetings. In

165. See *www.un.org/Depts/dpko/mine/macc*
166. *Ibid*.
167. For instance, during the school summer break, there was a risk of the incident rate increasing as children were out and about. To prevent this happening, a number of mine awareness organisations teamed up with various KFOR contingents to ensure that a high level of awareness was maintained throughout this period. (See UNMIK-MACC, 2001c:11.)
168. Community liaison was not the area of expertise for some mine awareness organisations and the Public Information Department developed guidelines to assist with the implementation of this initiative. The results were reportedly positive in the majority of instances, and the effectiveness of the clearance activities increased as a result (UNMIK-MACC, 2001c:3).

addition, a series of seminars and training activities were carried out to provide mine awareness organisations with a greater understanding of their role within the overall mine action programme (UNMIK-MACC, 2001c:12).

Mine awareness is a key part of the long-term strategy to keep the population safe from mines and UXO. Even though the MACC envisages that the immediate hazard caused by known minefields and cluster bomb strikes areas will be removed, and that the residual threat remaining will be low, it is expected that individual mines and UXO will still be found for many years. The focus for the MACC in 2001 will be to ensure adequate coverage of other mine awareness target groups throughout the province, (UNMIK-MACC, 2000e:9) including by introducing mine awareness education into the school curriculum. UNICEF, as the UN focal point for mine awareness education, is about to implement this plan in cooperation with the Department of Education and with support from the MACC. This will mean that school-age children will receive regular messages about safe behaviour, which is considered an important component of the long-term strategy. It is expected that full implementation into all schools will occur throughout the 2001 school year (UNMIK-MACC, 2001b:9). In this way, *"the message that must be passed on through successive generations is that if people see a suspicious object, they must report it, and should not under any circumstances touch it"* (UNMIK-MACC, 2000a).

In addition, the MACC is currently working on the process for transferring responsibility for the MAP to the UNMIK Joint Interim Administrative Structures (JIAS) Departments. The overall objective is *"to put the necessary systems and processes in place as early as possible in 2001, to ensure that an effective system is fully operational prior to the end of the year"*. Accordingly the local institutions will require development of capacity and some external financing and assistance in the initial period (UNMIK-MACC, 2001c:14). As part of the exit strategy, it is seen as essential that a single department be given responsibility for managing the IMSMA database and to act as the central depository for all mine information. A number of different options are currently under consideration (UNMIK-MACC, 2001b:7-8).

Working under the auspices of the UN Humanitarian Coordinator has enabled the MACC to deal effectively with UN agencies and other organisations involved in mine action such as FAO, UNDP, UNHCR, UNICEF, WFP, WHO, ICRC, and the NGO community. Moreover, this has not prevented the MACC from working closely with UNMIK Departments as well as other key actors, notably KFOR. The position of the MACC accordingly enhances its ability to support all components of UNMIK and to provide inputs into the policy-making process (UNMIK-MACC, 2001b:4). However, the MACC has no seat in JIAS and no real authority to operate within UNMIK Departments providing the basis of the future government. It is recognised that the MACC lacks visibility within these Departments.[169]

According to the MACC, much of the success that has been achieved is due to the continued support from donors both through bilateral arrangements, and financial contributions to the Voluntary Trust Fund for Assistance in Mine Action that have enabled core assets to be contracted and MACC operational costs to be met. It is, though, essential that the process continues to be managed and coordinated, and, as of writing, the MACC still requires funding support in order to undertake effective operations through to the end of 2001 (UNMIK-MACC, 2001c:13,16).

169. Information provided by Leonie Barnes, 1 February 2001.

Mine victim assistance

UNMIK Mine Action Coordination Centre

Although initially a post of Victim Assistance Coordination Officer was planned in the MACC organigram, the position has remained vacant since the start of the programme. Thus, the responsibility that would normally be assumed by the Victim Assistance Coordination Officer has been assigned to the Chief of Public Information and a Public Information Assistant — in addition to the many other activities that these individuals have had to do.[170]

According to the MACC's Chief of Public Information, in the implementation of its mine action programme it is essential for the MACC to be fully aware that victim assistance is an integral part of mine action, although at the same time, it is clearly recognised that it does not have the necessary resources to provide the range of support that mine and UXO survivors need. Thus, the Public Information Department's primary role is to ensure adequate and accurate reporting of mine/UXO victims, a comprehensive assessment of the victims' needs, and a link with pertinent organisations for provision of assistance.[171]

The MACC takes care to point out, though, that the success of any specific programme for mine/UXO survivors under its auspices (UNMIK-MACC, 2001a:1) will also depend on the acknowledgement that the needs and concerns of mine/UXO survivors are, in general, no different to the needs and concerns of other persons with disability in Kosovo. Victim assistance is therefore an area that requires the full collaboration and coordination of as many stakeholders as possible so as to ensure wide consultation, raise awareness, and gain consensus for programme implementation. This implies the involvement not only of the MACC and mine action organisations, but also many other national and international NGOs working in health sector and on disability issues and UNMIK departments dealing with public health, emergency health, rehabilitation systems, social welfare, education and other public services. The full participation of mine/UXO survivors in the entire process is also a prerequisite to its successful implementation.[172]

Thus, in 2000, the victim assistance objectives of the MACC as a whole were to support the existing prosthetic and rehabilitation capability and the development of psychosocial and vocational training services to assist with the reintegration of mine/UXO victims.[173] In order to achieve these objectives, a number of activities were identified by the MACC and these would continue to be implemented in 2001. The main objectives for the programme in 2001 were to continue both to support the ICRC mine victim surveillance system and, in conjunction with the Department of Health and Social Welfare, to promote the implementation of a comprehensive range of victim assistance activities (UNMIK-MACC, 2001c:14).

First, the MACC Victim Assistance Programme aims *"to provide visibility of deaths and injuries suffered throughout the region from mine/UXO related incidents"* (UNMIK-MACC, 2001a:1). (The vast majority of data comes from ICRC field staff, generally its mine awareness officers, who have completed face-to-face interviews at hospital or at

170. Discussion with John Flanagan, Programme Manager, MACC, Pristina, 29 January 2001.
171. Information provided by Leonie Barnes, 31 January 2001.
172. Discussion with Leonie Barnes, 1 February 2001.
173. *www.un.org/Depts/dpko/mine/macc/*; UNMIK-MACC, 2000a.

home. KFOR and mine action organisations also provided a number of reports.) The objective was to establish and maintain an efficient individual mine/UXO victim data collection system that accurately reflects the personal details, location and circumstances surrounding each incident. The second objective was to monitor trends in injuries based on locations and age and to use the resulting analysis to make meaningful adjustments to mine awareness education programmes, as and where necessary. The third objective was to provide the necessary information to allow analysis and guidance of primary health care needs in emergency medical treatment of mine/UXO related incidents. Finally, the MACC sought to produce a monthly information summary of mine/UXO related incidents to all interested parties (UNMIK-MACC, 2000a). According to the Chief of Public Information, all the requirements of this activity were met despite the difficulties encountered in data gathering.[174]

The MACC has been allowed to pass on the information collected when requested by organisations presenting a project and explaining their need for it. However, the identity of the victims remains confidential. According to the MACC, despite certain initial problems concerning the sharing of confidential data about the victims with other parties,[175] the activity of data gathering and sharing has worked well. With regard to data gathering, however, it is felt that improvements could be made by increasing the standard and accuracy of reporting, including an initial assessment of the cause of the incident. Thus, for instance, *"at times reports are not comprehensive, or staff lack experience to make the linkage between injury, activity at time of injury and possible implications for mine action"*[176] (UNMIK-MACC, 2001a:3). In this regard, discussion is ongoing with ICRC concerning data gathering and the possibility to support ICRC officers on the need for accurate reporting by further developing the ICRC questionnaire form. Changes to the data collection form and a system for technical incident investigation have been implemented with Senior Demining Partners in the region.[177]

The MACC has also developed a new incident investigation report, which analyses in depth the injury, cause, activities and possible mine action implications. The report is aimed to develop more in-depth analysis providing better feedback and ensuring better linkages between injury causes and activities at that time and how, if relevant, mine awareness and clearance programmes could be improved. The report also includes questions on victim assistance issues to follow up, psychosocial support to children in the area, and further monitoring requirements.[178] It will be distributed to mine awareness organisations to be used for new incidents and to re-visit victims if it appears from IMSMA database that the victim had previously received mine

174. Information provided by Leonie Barnes, 31 January 2001.
175. VVAF notes that one of the greatest difficulties encountered at the beginning of their Assistance to Persons with War-Related Disabilities project was the identification of persons with war-related disabilities, as VVAF was not allowed to access confidential information contained in the MACC's IMSMA database during the first few months. This was due to conflicts arising within the ICRC data collection management system, and a reluctance by ICRC to share relevant information, although the situation was later resolved. Discussion with Sarah Warren, Pristina, 29 January 2001.
176. Initially, there were several problems regarding the gathering of information. For instance, sometimes the name of the victim was wrong, or the person who answered the question was not the victim but a member of his/her family, the information regarding the injury and its cause was inaccurate, and there was little information regarding the activity at time of the incident. As a result, the IMSMA database had to be checked several times. (Information provided by Leonie Barnes, 1 February 2001; view supported by Daniel Eriksson, Chief of Information Technology, MACC, Pristina, 2 February 2001.)
177. Information provided by Leonie Barnes, 21 January 2001.
178. See *Civilian Incident Investigation Format Relating to MAE Information/Feedback* in UNMIK-MACC, 20011:7.

awareness, in order to understand what really happened, and assess the reason of the failure of the impact of the mine awareness message given.[179] The report may be relevant to other countries and might be further developed in other programmes (UNMIK-MACC, 2001a:4). In the course of March 2001, there were plans to include more information about mine/UXO victims in the IMSMA database.[180] In addition, a stocktaking of the information would be made with the number of victims expected to change by up to around 20 per cent.[181]

During 2000, the MACC Victim Assistance Programme also sought to provide a monitoring facility for the progress of survivors through the various stages of the assistance cycle and assist the individual where possible to contact the necessary support agencies or government programmes where required (UNMIK-MACC, 2001a:2). Even though the IMSMA database contains names, addresses, causes of incidents, and types of injuries, there was no socio-economic and psychosocial data on persons involved in mine incidents. Little, if anything, was known about what happened to the individual victim and his or her family following the incident, even though this information was essential for programme implementation and monitoring purposes. Accordingly, VVAF was asked by the MACC to carry out a survey of mine/UXO survivors in order to validate the existing information and to obtain a better understanding of their needs.[182] Given the quantity of information provided by the VVAF Survey, plus the fact that any new victims should now be easily identified, the MACC considers *"it will be possible to track all victims through the various stages of rehabilitation and eventual reintegration back into society"* (UNMIK-MACC, 2001c:10). The MACC wants to make sure that, as far as it is possible, no one will be forgotten.

According to the Chief of Public Information, the result achieved did not totally correspond to the initial objective, the survey giving a good global picture of the circumstances surrounding the mine/UXO victim as a group and of the scope of activities needed for future victim support, but not managing to place the individual in the various phases of the victim assistance cycle (rather just a percentage of the whole). This did not enable the MACC to refer victims to pertinent NGOs and agencies or other social services that could provide the necessary and appropriate support.[183] In order to achieve its initial objective, the MACC decided to conduct an analysis of the current information based on its own database and the VVAF Survey to identify and place the victims into the appropriate phase of victim assistance cycle on an individual basis.

In addition, the MACC was in the process of analysing records from IOM,[184] HI, and Handikos of people with disabilities resulting from a mine/UXO incident.[185] This data is being cross-checked with the mine/UXO survivors registered in the IMSMA database in order to establish a complete individual tracking system to identify who is and who is not receiving treatment, to assess the needs, define a list of priorities, and allocate resources in support of the needs (VVAF, 2000b:3). From these records the MACC would establish referral lists or recommendations for follow-up addressed

179. Discussion with Leonie Barnes, 1 February 2001.
180. Thus, for instance, the IMSMA database does not contain information regarding the services available in Kosovo.
181. Information provided by Daniel Eriksson, 2 February 2001 and e-mail correspondence, 3 March 2001.
182. Information provided by Leonie Barnes, 1 February 2001.
183. Discussion with Leonie Barnes, 1 February 2001; see also UNMIK-MACC, 2001a:4.
184. IOM is responsible for the coordination of medical treatment provided abroad.
185.This plan was presented to the concerned organisations attending the last Mine/UXO Victims Interagency Meeting organised by the MACC on 2 February 2001.

to various agencies, such as Handikos, HI, IOM, and VVAF. The MACC stressed that the lists would include Serbs and minority groups.

The MACC Victim Assistance Plan for 2001 foresees that VVAF will be in charge of providing psychosocial and socio-economic support to persons who have already been identified and surveyed by VVAF teams, i.e. to the 333 victims interviewed in its *Socio-Economic Survey*. VVAF will have to report to the MACC each month on progress. The MACC points out that given current funding constraints, the solution whereby needs are prioritised represents the best that could be done, but is far from ideal.

The third objective of the MACC in 2000 is to facilitate discussion on disability issues at a policy level during provincial planning and to maintain an advocacy role for mine/UXO victim related issues both in Kosovo and in the wider context of mine action throughout the world (UNMIK-MACC, 2001a:1). In order to complete this task, the MACC seeks *"to take a leading role in advocacy on disability issues particularly those relating to disabilities caused by mine/UXO injuries"* (UNMIK-MACC, 2001a:3).

The MACC freely acknowledges that the needs of Kosovo mine/UXO victims are very similar to those of the general population, and much the same as those of persons with disability as a whole (UNMIK-MACC, 2001a:5; VVAF, 2000b:32). However, the MACC has sought to play a role in commissioning information about disability issues and reporting them within the NGO community through the coordination of Mine/UXO Victim Assistance Inter-Agency meetings. In the past, meetings with health actors have not always succeeded in bringing together many organisations. At this level, there is said to have been a lack of sustained cooperation and coordination with the health sector and other NGOs.[186] Apparently, there was a "lack of interest" on their part, mainly due to the fact that they did not know or understand the role and aim of the MACC regarding victim assistance.[187]

For this reason, the MACC has abandoned the concept of monthly Mine/UXO Victim Assistance meetings, and focused on taking part in other disability and health related meetings *"so as to ensure a wide coverage of all disability issues and a good overall awareness of facilities and support services available"* (UNMIK-MACC, 2001a:3). A major success within this general disability forum has been that UNMIK is now considering disability access issues in all new building constructions. While it is acknowledged that this awareness process is rather late given the amount of reconstruction that has already taken place in Kosovo, including the rebuilding of schools without access for persons with disability, the MACC strongly believes that it will have an impact on new works engaged and have a positive effect in the future.[188] The MACC also lobbies UNMIK through the Department of Health and Social Welfare to take into account disability issues.[189]

The MACC's objective for 2001 is to continue to participate actively in general disability coordination meetings, and to direct coordination of input into a register of accessibility for schools, parks and public buildings (UNMIK-MACC, 2001a:5). The MACC will also seek opportunities to advance disability-related issues in general, highlighting mine/UXO victim needs, through an integrated Mine Action Public Information

186. Discussion with Leonie Barnes, 1 February 2001; and with Sarah Warren, 29 January 2001.
187. Discussions with Driton Ukmata, 7 February 2001, and with Halit Ferizi, 8 February 2001.
188. Discussion with Leonie Barnes, 1 February 2001; see also UNMIK-MACC, 2001a:5.
189. Information provided by Leonie Barnes, 1 February 2001; see also section on UNMIK Department of Health and Social Welfare.

Campaign. In order to reach this objective, the MACC is currently coordinating the organisation of a local charity concert in September 2001 with the aim of raising awareness and maintaining advocacy both on the landmine ban campaign and disability issues, and to collect funds for mine/UXO victims in Kosovo, particularly for sporting programmes for youth with disability.[190] The MACC is also coordinating a series of "Fun Runs" to highlight safe area accessibility by the community and to present positive mine action results throughout the Kosovo region (UNMIK-MACC, 2001a:5).

Given the success that has been achieved in reducing the casualty rate, and the belief that mine incidents will be a rare occurrence from now on, the MACC is confident that mine victim assistance will be a "finite" activity that will belong under the mandate of the UNMIK Department of Health and Social Welfare. Despite the collaboration between the MACC and the Department of Health and Social Welfare, the MACC recognised that this cooperation really needs to be further developed. One of the outstanding issues the MACC will address this year is to find out what is effectively being done by the Department of Health and Social Welfare with respect to the victim assistance cycle, and to identify how the MACC can assist them.[191]

Both the MACC Programme Manager and the Chief of Public Information regretted the lack of specific expertise in mine victim assistance within the MACC. They felt that such a body should treat the issue in the same way as it treats mine clearance and mine awareness, working in collaboration with other mine actions teams, developing strategic programmes, analysing data and coordinating the broad range of activities to be carried out and the various actors concerned. (Lack of staff and time and also of sufficient funding explain why this branch of mine action has been too often neglected up to now.) [192] Practically, a victim assistance officer should have two main roles: one operational and the other related to policy.

At the operational level, the victim assistance officer would have been in charge of gathering all information concerning the victims and also working in close cooperation with mine awareness and mine clearance officers. The officer would not only have been expected to provide an accurate picture of deaths and injuries from mine/UXO incidents throughout Kosovo, but also a careful assessment of the short- and longer-term needs of mine victims. In a sense, a needs assessment would have been done much sooner. In addition, the officer would also have ensured better coordination of the activities of the various actors able to support the victims, and perhaps even been able to allocate them tasks as necessary.[193] He or she would have been able to organise regular inter-agency meetings and participate actively in all the meetings organised by the health and social welfare sector with a view to monitoring relevant programmes and projects.

At the policy level, the victim assistance officer's main role would be to ensure a good visibility of mine/UXO victim-related needs within discussion on health and disability issues and to provide guidelines when necessary.

190. Information provided by Leonie Barnes, 1 February 2001; see also section on UNMIK Department of Health and Social Welfare:5; MACC Victim Assistance Plan for 2001 presented by Leonie Barnes, 7 February 2001.
191. MACC Victim Assistance Plan for 2001 presented by Leonie Barnes, 7 February 2001.
192. Discussion with John Flanagan, 29 January 2001; view confirmed by Leonie Barnes, 2 February 2001.
193. Discussion with Leonie Barnes, 2 February 2001.

In sum, all the activities that the MACC is planning to carry out and to oversee in 2001 in cooperation with VVAF and other organisations and agencies could have been done more effectively with the help of a mine victim assistance officer. As a consequence, the Chief of Public Information firmly believes that such technical support remains necessary. Furthermore, after the completion of various activities planned by the MACC, external evaluators should come and assess the effectiveness of what has been done. [194]

Regarding the lack of funds attributed to mine victim assistance, the MACC points out that mine action organisations are generally funded on a bilateral basis and that they are the ones who decide to allocate money to a given programme. Once they are accredited, the MACC can assign tasks to these organisations in order to fulfil the objectives of the programme, but cannot decide where to direct the money. As far as mine victim assistance is concerned, however, the situation has been rather different. Although the Socio-Economic Survey was carried out on behalf of the MACC (and mostly funded by it), this is the only case where the MACC assigned a mine victim assistance task.[195]

Other actors in Kosovo have expressed their views on what should have been, and should be, the MACC's role in victim assistance. HI, for instance, acknowledges that to date it has not cooperated a great deal with the MACC because it was not really aware of its role and objectives with regard to mine victim assistance, and did not see the interest to do so. The organisation claims that the MACC should have the duty to protect the rights of landmine victims, to serve as a coordination body, to assess the immediate needs of the victims, to decide on the evacuation of victims in cooperation with UNMIK, to allocate funds and assign duties to the various NGOs willing to be engaged in favour of mine victim support, as was done for mine awareness and mine clearance operations. Accordingly, HI has agreed to cooperate with the referral system to be initiated by the MACC in the course of 2001. At the same time, however, HI warns against creating a special status for mine victims: instead it recommends the promotion of their reintegration within the community structures in the same way as for the other persons with disability. In addition, HI recommends that the MACC work with Handikos in order to elaborate a long-term disability strategy within UNMIK's Department of Health and Social Welfare.[196] VVAF, for its part, feels that the MACC should focus on data gathering and coordination, and not more.[197]

Oxfam's main recommendation is shared with VVAF, namely to create a database including information contained by the MACC, Oxfam, HI, VVAF, Handikos, and other partners which could be used by all actors. It also recommends that the MACC cooperate with UNMIK's Department of Health and Social Welfare so as to integrate the needs of mine victims in future policy and to give some inputs in the elaboration of such policies.[198]

UNICEF believes that victim assistance has not been effectively coordinated since the end of the war and points out that it was difficult to obtain information about mine victims. The role of the MACC should be to coordinate all actors involved in mine victim assistance as it did for mine awareness and mine clearance organisations.[199]

194. Discussion with Leonie Barnes, 2 February 2001.
195. Discussion with Leonie Barnes, 7 February 2001.
196. Discussion with Driton Ukmata, 7 February 2001.
197. Discussion with Sarah Warren, 29 January 2001.
198. Discussion with Dukagjin Kelmendi, 6 February 2001.
199. Discussion with Véronique Heckmann, Pristina, 8 February 2001.

Victim assistance

Health and rehabilitation facilities

Health care capacity

The health care system in Kosovo was based on the socialist model, and was therefore *"dominated by large institutions, depended on vertical organisation of services, and was criticised for being excessively bureaucratic, inefficient, and centralised"*. The system relied on financing through a combination of social insurance, tax revenues and, to a limited degree, out-of-pocket payments (UN Interim Administration Department of Health and Social Welfare, 2000a:8).

Although relatively autonomous before 1990, between 1990 and 1999 health care and services were run by the Ministry of Health in Belgrade. Although appointed independently by the institutions, the directors and boards of health institutions reported directly to the Ministry, which took all major decisions, including the types and numbers of health institutions and the right to use health services. The directors of health institutions had the power to manage their human resources — i.e. hiring and discharging of workers — and financing was centralised.

During this period, many ethnic Albanians, both health care professionals and patients, were excluded from the organised health system. As a consequence, they were forced to pay for medical treatment, rely on humanitarian service provision (mostly organised through the network of the Mother Theresa charity organisation), (UN Interim Administration Department of Health and Social Welfare, 2000b:1) or simply go without. Indeed, during the decade of Albanian exclusion from the health care system, a truly parallel system of service delivery developed, in tandem with a parallel educational system, which led to the qualification of some 700 doctors and 1,200 nurses. These professionals *"are felt to have received a solid theoretical background, but practical experience is probably less than desired"*.[200] In addition, during State violence and the war, much of the health infrastructure was destroyed (UN Interim Administration Department of Health and Social Welfare, 2000a:8).

Persons with disability and rehabilitation capacity

According to Handicap International , which has been present in Kosovo since 1994, in the past Kosovo has had a relatively low rate of disability, with only around 2 per cent of the population suffering from some form of disability.[201] Before the crisis, a HI survey conducted in collaboration with its local partner, Handikos,[202] the only local association for persons with disability, had identified around 6,000 people with disabilities, mainly of a physical nature (HI, 2001a:3).

200. WHO, 2000:7,46. According to this report, some of the Albanian staff worked in the hospitals ten years ago, but others have never seen a patient in a hospital bed. Young doctors and nurses have been educated and trained in "the parallel system" without ever meeting patients in a hospital environment. As a result, knowledge of hospital management and the care and treatment of hospital patients is often limited. See also VVAF, 1999:6.
201. HI, 2001a: 3. One survey carried out by Handikos suggests that 1 in 40 of the population has some type of physical disability. See UN Interim Administration Department of Health and Social Welfare, 2000b:1.
202. Handikos was formerly the Association of Paraplegic and Paralysed Children from Kosovo (APEK).

Today the number of persons with disability is estimated around 15,000, and includes cases that have remained untreated for more than 10 years.[203] Based on a survey performed through Handikos' network, it appears that the main causes of disability in Kosovo are poor or inadequate prenatal care, birth delivery conditions, primary health care, community consulting services for young parents, as well as the prevalence of war injuries. The Handikos survey noted the following problems with the rehabilitation capacity in the province:

- A lack of rehabilitation professionals in the primary health care system to recognise and treat disabilities in a timely manner to reduce the impact of the impairment;
- The absence of proper referral services between services linked to disability issues;
- Underdeveloped specialist institutions and proper psychiatric wards;
- Poor education about disability among persons with disability themselves, their parents, family members and members of their communities;
- Social bias and discrimination against people with disabilities resulting in a lack of integration and employment opportunities;
- Poor community services for persons with disability;
- The absence of disability-related topics throughout the education system;
- The lack of educational programmes for rehabilitation professionals, especially physiotherapists and occupational therapists;
- No recognition in policy or support funding for the role of rehabilitation professionals at community level.(UN Civil Administration, Health and Social Services, 1999:26-27; HI, 2001a:3-4).

Before the conflict, persons with disability tended to be ignored by public health, social and educational services and were dependent on their families.[204] At the beginning of 1995, having previously provided emergency support to institutions and specialised centres hosting people with physical and mental disabilities, HI reoriented its activities towards persons with disability living outside these institutions, who were otherwise generally ignored by the existing social structures. Working in cooperation with Handikos, HI developed a network of community-based rehabilitation centres throughout the province to register persons with disability and provide them with access to physical rehabilitation care and basic medical follow-up.[205] This network was composed of "communal groups", which involved persons with disability themselves, volunteers and a variety of local professionals, and community rehabilitation centres, where physiotherapy and psychosocial activities were targeted mainly at children with disability; training of local volunteers and counsellors also took place in the centres. From March 1998, the programme had to be reduced *"because of unfavourable political and security conditions, taking into account that the association was run by Albanian-Kosovar people within the parallel system implemented in response to the governmental policy"*. Moreover, physical rehabilitation facilities and the community-based rehabilitation network were unable to meet the needs already existing *"due to the lack of professionals in this field and an absence of clear policy as well as funding resources for this task"* (HI, 2001a:16-17). The war put an end to this work.

203. Information provided by Driton H. Ukmata, Head of Mission, HI, Pristina, 7 February 2001, and Halit Ferizi, Director of Handikos, Pristina, 8 February 2001.
204. Information provided by Halit Ferizi, 8 February 2001.
205. HI, 2001a:3-4, and information provided by Halit Ferizi, 8 February 2001.

The assessment of medical and public health facilities undertaken by HI after its return to Kosovo in June 1999 revealed more starkly the absence of medical staff trained in disability care, such as ortho-prosthetics and physiotherapy.[206] No operational capacity for ortho-prosthetic manufacture and fitting existed to deal with the existing and ongoing caseload, let alone the new emergency cases resulting from the war, including mine and UXO injuries. Appliance manufacture and fitting capacity were formerly provided by the national ortho-prosthetic workshop, a semi-private company prior to March 1999, which was located in Pristina's central hospital. (HI, 2001a:12) It seems that the workshop was able to provide a variety of prostheses, ranging from conventional wood and leather to polypropylene. However, on the basis of old prostheses returned for repair, it was apparent that the main production was the conventional prosthesis — a leather socket with a metal joint for an above-knee amputee, fixed into shaped wood with a resin cover (VVAF, 1999:9). After the war, the centre was no longer operational, lacking material and funds and benefiting from only a basic staff presence (HI, 2001a:12).

Two specialised rehabilitation centres operated in Kosovo prior to the war, one in Kllokot, the other in Peja. The Kllokot rehabilitation centre was built close to mineral water spring in 1981. Before the recent conflict only about 10 per cent of its orthopaedic patients had been with disability as a result of trauma but in November 1999, due to an influx of war victims, that percentage had increased to about 60 per cent. The treatments offered are mainly physiotherapy, electrotherapy and hydrotherapy. The Peja rehabilitation centre is older and is also built around a thermal spring. In the 1980s, when it was fully functional, it could receive up to 600 patients with its staff of 250. As with Kllokot, it offered physiotherapy, electrotherapy and hydrotherapy (VVAF, 1999:12-13). A rapid assessment made after HI's return to Kosovo found that specialised institutions for persons with disability were in need of equipment, material, refurbishment, and experienced staff[207] (HI, 2001a:10).

According to Oxfam, persons with disability in Kosovo are among "*the poorest of the poor*", both in economic terms and in the failure to respect their fundamental rights. Moreover, it is said that *"it is a traditional attitude prevalent in Kosovo to consider disability as a punishment from God"*, this shame being exacerbated by a lack of information about disability issues, resulting in considerable limits being placed on what persons with disability are allowed to achieve.[208] In Kosovo, for centuries persons with disability have been excluded from the mainstream of the society and are often hidden from sight. Those of the population with disability have been viewed *"as passive, weak, helpless, and unable to make decisions or take responsibility for themselves"*.[209]

Existing social welfare services

A number of Centres for Social Work (CSW) were established in Kosovo during the

206. The issue of needs is treated in greater detail below.
207. In addition to these two rehabilitation centres, other existing specialised and educational centres that care for persons with disability have been identified, specifically: an old people's home in Pristina, the special institution with the department for child and youth mental disabilities in Shtimje, the school centre for rehabilitation of deaf and mute children Spiro Mojsic in Prizren, the centre for education of children and youth with slight mental disabilities of Prizren, and the special school for the education of blind children in Peja. These centres fall under the responsibility of three ministries according to the tasks performed: the Ministry of Health, the Ministry of Education, and the Ministry of Social Welfare.
208. Information provided by Dukagjin Kelmendi, Oxfam, Pristina, 6 February 2001.
209. Information provided by Karen Reiff, Danish Council of Organisations of Disabled People (DSI), Pristina, 8 February 2001.

1960s, and especially the 1970s, as a main service through which the Government would provide special attention to vulnerable categories of people. Their purpose was to provide social protection through a variety of allowances, and to offer professional counselling services. Although the idea looked good in theory, in practice the plans to create multi-disciplinary teams including specialists in social work, psychology, law, pedagogy, and special education, never came to fruition because Pristina University was not able to generate the requisite expertise. As a result, there was a shortage of trained professionals with posts being filled by under-qualified staff (UNMIK Department of Health and Social Welfare, 2000:1) with a reputation for bureaucracy and inefficiency (International Catholic Migration Commission, 2000:2).

CSWs predominantly operated at municipal level and, in accordance with the 1976 Law of Social Protection, were allocated broad responsibilities, including the provision of assistance and services to persons with disability.[210] In a similar situation to the hospitals, most of the CSWs went through radical changes in staffing over the course of the previous decade, with Albanian staff being expelled from their posts. It is reported that during 1998 and the first part of 1999, activities in the centres had come to an almost complete standstill (UNMIK Department of Health and Social Welfare, 2000:2).

Victim needs

Physical needs

Based on data available up to September 1999, WHO prepared an initial series of recommendations regarding assistance to victims of mine injuries based on a global picture of the needs at that time (WHO, 1999b). It was claimed that the care of the injured population was *"being hampered by a slow and inadequate recovery service which is often unable to provide the immediate care necessary to a victim at the scene of the injury"*. It recommended support for first aid services and for a province-wide, centrally-controlled and appropriately-equipped ambulance service, with trained personnel able to deliver the requisite immediate care.

The report also noted a lack of relevant equipment and experience in dealing with mine injuries in hospitals in the worst affected areas. There were particular shortages of staff able to provide suitable physical therapies and nursing care. To redress the situation, it recommended funding for appropriate equipment and training to local staff. It further noted that although the most important aspect of the treatment of mine victims is the provision of appropriate rehabilitation after they leave hospital, this aspect had been somewhat neglected in the province. The HI-run prosthetic service was said to be *"under pressure"*. Accordingly, increased funding for prosthetics was recommended.

210. In accordance with the Law of Social Protection of 1976, Centres for Social Welfare are required to provide assistance and services concerning, among others, the following: social assistance and disability allowance; emergency material support (financial or in kind); allowance for "carers" (e.g. those looking after persons with disability); adults and children with disability (support to the families and individuals); guardianship responsibilities for children, young people and all persons unable to protect their own rights; psycho-social counselling; admission of children and adults to specialised institutions; assessment of the needs of children and adults; assessment of social insurance requirements; assessment of the educational needs of children; health protection for social cases; legal services; and referrals to other organisations.

Medical care still remains an unresolved issue for many mine survivors. As previously noted, of the 333 survivors interviewed in the Socio-Economic Survey, close to half have permanent disabilities, and an overwhelming three quarters of all interviewees reported that they continued to suffer from one or more outstanding health problems. Among the most common problems are ongoing pain, remaining shrapnel, difficulty in moving an arm or leg, and problems with sight or hearing. Less than half of these individuals said they were receiving any treatment for these problems. The most common reason — related by half of those not receiving treatment – was said to be financial; a further quarter said that they had no need of treatment.[211]Lack of transport to relevant facilities was also mentioned.[212] Also of note, more than half of interviewees claimed that they had not received any physiotherapy (VVAF, 2000a:25). Accordingly there appears to be a significant need for physiotherapy and ortho-prosthetics in Kosovo.[213]

A number of people indicated several places where they were receiving medical treatment. More than a half received medical treatment in hospitals, including Pristina and regional hospitals. Others received medical treatment in *ambulantas*,[214] rehabilitation centres, or at a KFOR-run hospital. Yet, it appears *"that people know where they can go for treatment but ... they are less aware of what can and cannot be done for them"* (VVAF, 2000a:25,30). Furthermore, a number of people do not seem to be aware that, in certain circumstances, patients do not have to pay for medical treatment. For example, those families who are part of the social assistance scheme ("Category 1" families) are exempt from any fees[215] (VVAF, 2000a:17-19,30).

On a more positive note, most of the people requiring mobility equipment (prostheses, wheelchairs, crutches, etc.) already have what they need (VVAF, 2000a:2). This equipment is distributed at different places throughout Kosovo.[216] However, of those without such equipment, some have lost upper limbs and cannot be provided with a prosthesis, because such equipment is currently not available in the province. There are, though, a number of lower-limb amputees waiting for a new prosthesis,[217] and a few with partial or complicated foot amputations and people with difficulties walking due to shrapnel wounds, broken bones, and so on, who were still in need of equipment at the time of completing the survey (VVAF, 2000a:2,26,31). Of those who did not have mobility equipment, more than a half said they did not need it.[218] On the other hand, more than three quarters of those who do have mobility equipment claimed to

211. These are usually people with shrapnel still inside their bodies who have been told it will come out by itself and who think nothing can be done for them. Staff from VVAF's outreach project for persons with war-related disabilities have reported that on many occasions they have met mine/UXO victims with shrapnel, loss of movement in the limbs and other injuries who simply do not know their diagnosis or what treatment they need, or who were told by a doctor that they need to go abroad to be cured. Even where the loss of movement or other condition is likely to be permanent, no one had made it clear to the patient who continues to look and pay for medical treatment (VVAF, 2000a:24,30.).
212. For many people living in rural areas it is not just the cost of medical treatment but also the cost of transportation that is prohibitive.
213. Information provided by Driton Ukmata, 7 February 2001.
214. *Ambulantas* are smaller outpatient health facilities.
215. Category 1 covers especially poor families, notably where no member is capable of working; such families are exempt from payment for medical treatment and receive some financial help. This may include adults with a permanent disability or even families with children with disability, where the parent is needed for the care of the child.
216. Mostly in hospitals, by humanitarian organisations and in rehabilitation centres.
217. These were mainly people with recent injuries and those needing to switch from a temporary to a permanent prosthesis.
218. Though VVAF thinks that there was some confusion with the question in the survey instrument (VVAF, 2000a:26).

use it. For those not using the equipment, the most common reason cited for this is that it is not useful or is no longer needed. According to VVAF this is particularly true among people with crutches and wheelchairs, who may have only needed this equipment during the early stages of rehabilitation. More of concern, however, is that some people also stated they were not using their prostheses because wearing them hurts or is uncomfortable.[219] Furthermore, around 22 per cent of those who have been fitted with a prosthesis received it abroad. Most are young and will therefore have significant future needs. *"Whether or not they will be assisted to travel abroad again for a similar prosthesis, when it is time to change, remains to be seen"* (VVAF, 2000b:32).

In sum, medical care remains an unresolved issue for many people. And though the number of mine incidents is decreasing every month, a number of individuals will need rehabilitation services, and possibly medical treatment, for many years to come.

Psychosocial needs

According to WHO's needs analysis of September 1999, mental health services and psychosocial services in Kosovo were *"severely underdeveloped"*. Its main recommendation regarding reintegration was to target services for the vocational training and psychosocial support of victims (WHO, 1999b). To date, however, relatively little emphasis has been placed upon psychosocial support to mine/UXO victims.[220]

Socio-economic, vocational and educational needs

In 1999, VVAF started a pilot psychosocial assistance project in Kosovo, helping 45 war wounded with disability and their families in the process of their rehabilitation and social reintegration. Combined with the knowledge gained during the development of the pilot project, the Socio-Economic Survey has provided a detailed understanding of the physical, social and emotional well-being of the familial situation, education, employment and economic status of survivors in Kosovo. The results *"reinforce experience in the field, demonstrating that mine/UXO survivors have a wide variety of needs and greatly varied living conditions"*. The data serves as a baseline upon which the MACC and other organisations can build future programme strategies (VVAF, 2000a:2-3).

The living conditions of mine/UXO survivors and their families appear to vary greatly, mirroring the situation of the general population. While some families are living in very difficult circumstances, others live in average or even good conditions. Almost every family initially received some form of assistance (food, housing or financial), and some are still receiving help as part of the social assistance scheme that began in June 2000 (VVAF, 2000a:17-19,28).

According to VVAF, the general housing situation in Kosovo, and for mine/UXO survivors in particular, is far from being fully resolved. The rate of housing destruction in Kosovo has been calculated at about 60 per cent, with some rural areas attaining 95 per cent. Even though a very high number of families had their home either partially

219. The number of those reporting such problems represent 8.7 per cent of all those interviewed who had a prosthesis (VVAF, 2000a: 27,31).
220. Information provided by Leonie Barnes, 1 February 2001 and view expressed by Sarah Warren, former Programme Manager, VVAF, Pristina, 29 January 2001.

or totally destroyed during the conflict,[221] more than half are now living in homes that have been at least partially rehabilitated. Another 20 per cent are on a waiting list to have their homes rebuilt and can expect to be soon living in new houses, while the remaining 21 per cent still do not know whether or not they are included in such a list. This seems to be the case in several municipalities, although it is particularly common in the centre and north of the province (VVAF, 2000a:14,28-29).

More than three quarters of the families surveyed own their own land, and 96 per cent of these use it for subsistence farming. Around 22 per cent, however, do not use their land, often because they believe it is mined or unsafe. This seems to be especially true for persons living near the borders with Macedonia and Albania, such as Prizren, Kacanik and Gjakove, all areas that known to have been heavily mined. Thus, *"considering that this is a largely agrarian society, this number, however small, is important"* (VVAF, 2000a:16,29).

In addition, *"employment and lack of income are among the most critical issues facing mine and UXO survivors, although to some extent their conditions are similar to that of the general population"*. Four out of five of those interviewed who were of an employable age do not have jobs and this finding matches the 80 per cent unemployment rate for the overall population in Kosovo.[222] A large number of the survivors interviewed expressed their wish to work but cannot due to disabilities and medical problems. Some specifically mentioned that they were no longer able to perform hard physical work.

Almost half of mine/UXO victims who are currently unemployed claimed to have worked in the past, most in a company or in the public sector. It is believed that these continue to be the most common places of employment today. Others claimed to have been self-employed or working in agriculture sector in the past. These two sectors employed more people before the war than they do now. Thus, *"the fact that there are many persons with work experience and specific job skills could be important for organisations looking into future job creation opportunities in Kosovo"* (VVAF, 2000a:3,14-16,29-30).

Also of note is the fact that 60 per cent of the mine/UXO survivors interviewed stated that their financial situation has deteriorated since they were injured. The most common reasons cited for such a change are medical expenses and the inability to work (VVAF, 2000a:17).

The Socio-Economic Survey looked at both the level of education of adult mine/UXO survivors and school attendance among young mine/UXO victims interviewed. Findings as to child education were more positive than expected,[223] as only six of the 147 children between the ages of 6 and 18 surveyed were not in school due to medical problems or transportation difficulties. All six have a disability, the majority being loss of limb. Many other children interviewed cannot attend school because of their parents' financial situation (VVAF, 2000a:3,20). A total of 182 mine/UXO survivors over 18 years of age were interviewed, and the findings show that the majority (34.1 per cent) had finished secondary school, while 33.5 per cent had finished primary school (VVAF, 2000a:21).

221. More than 80 per cent of those interviewed suffered partial or full destruction of their houses.
222. Only one in five mine/UXO victims in the 19-65 age-group is currently employed. Unemployment among mine/UXO victims is lowest (about one in five) in Pec, Podujeva and Mitrovica, while much higher in areas such as Lipjan, Suva Reka, Decan and Gjakove.
223. In total, 36 out of 147 were not attending school. 88.4 per cent of these 147 children surveyed are male.

Nearly 70 per cent of the mine/UXO survivors surveyed believe that their ability to participate in training, attend school, or go to work has been impaired because of their injuries. When asked what they cannot do now but wish they could, although a significant minority answered that they can do almost everything, the majority answered they would like to be able to work and to play sports (VVAF, 2000a:22).

Encouragingly, despite the unmet needs detailed above, available social and "emotional" data suggests that 65 per cent of survivors are generally happy people (VVAF, 2000a:3,21).

Community awareness

In Kosovo, persons with disability appear generally to be pitied. VVAF remarked that there is no equivalent word for handicapped in Albanian, only a word meaning "unable".[224] In addition, the Socio-Economic Survey indicates that the — roughly — half of mine/UXO survivors who are with disability *"lack the proper information on their rights and role models that could demonstrate the capabilities of disabled persons"*.[225] About 20 per cent of the mine/UXO survivors surveyed feel others treat them differently as a result of their injuries (VVAF, 2000a:22). VVAF claims that, *"it is clear from the survey that a majority of mine/UXO victims believe that their lives have changed forever, and that their inability to work and play sports, for example, is a permanent condition"* (VVAF, 2000a:31).

It is unanimously agreed that attitudes towards persons with disability in Kosovo must be transformed so that they can enjoy the same dignity and rights as the rest of the population.[226] Further, a great deal of work needs to be done to build the self-confidence of persons with disability and change their own beliefs and attitudes about their disability. Thus, for example, mine/UXO victims and other persons with disability need to see more positive role models of persons with disability who have gone on to lead normal productive lives.[227] General awareness of disability issues must also be raised among the public and health and social welfare professionals.

More than a half of the survivors interviewed claimed to know of other mine/UXO victims and/or persons with disability in their community and around 95 per cent of them acknowledged to interact with them, often on a regular basis. A number of persons with disability also live together and/or are members of the same family. It is said that younger mine/UXO victims usually talk and play together (VVAF, 2000a:22).

Legislation

Persons with disability must be assured of an acceptable level of care and full and open access to a variety of appropriate services and assistance. Appropriate legislation should be adopted promoting effective first aid, emergency and continuing medical care, physical rehabilitation, psychosocial support, education and vocational training, employment opportunities, religious practice and recreational activities, and protection

224. Information provided by VVAF, Pristina, 29 January 2001.
225. For instance, VVAF's outreach team has met lower-limb amputees who could not imagine being able to hold down a job, ride a bicycle or play sport.
226. A view expressed by all case study interlocutors from the MACC and concerned NGOs as well as UNMIK's Department of Health and Social Welfare.
227. VVAF, 2000b:10; discussion with Sarah Warren, 29 January 2001.

for all citizens with disability, including landmine survivors. Access for persons with disability means not only eliminating all physical barriers to mobility — i.e. by ensuring appropriate access to buildings and public places — but also the availability of basic services and awareness of their existence. In addition, persons with disability need to be legally protected against all forms of discrimination (ICBL, 1997).

As things stand, opportunities for persons with disability to participate in society are limited, owing to a variety of physical, social, economic, normative, and cultural obstacles.[228] Accordingly, there exists *"a unique opportunity to develop an accessible environment for disabled people at this phase of the reconstruction process"*.[229] This demands, though, the elaboration of a comprehensive disability policy. Currently, coverage of disability issues depends on the individual efforts of officials and persons (often with disabilities themselves), because no guidelines or policies exist. Such a province-wide policy, as well as plans for its effective implementation, need to be developed as soon as possible to combat the social exclusion of persons with disability. As part of this, it is essential *"that all levels and sectors of society learn to consider people with disabilities as a resource that can and is willing to contribute to the community"*.[230] Or, in the words of the Director of Handikos, *"it is time to erase the **disability** of handicapped people and to highlight their **ability**"*. [231]

The existing provision of assistance

According to the MACC, resources available to deal with the immediate and long-term specialised treatment of mine victims remain inadequate. Development of the necessary facilities will take some considerable time, as much of the public health system and services have deteriorated over a number of years and will require significant efforts at repair and upgrading (UNMIK-MACC, 2000a). A central issue to the objective of meeting the specific needs of landmines victims, though, is how to achieve this without setting them apart from larger groups such as the victims of violence and trauma, as well as the other persons with disability.

UNMIK/Governmental

The crisis leading up to the war in Kosovo resulted in the total disorganisation of all administrative structures in the province. UNMIK, along with a JIAS, is responsible for the setting up of a new administration for Kosovo, including the planning, regulation and coordination of health care services. As part of the JIAS, 20 interim administrative departments have been established.

The JIAS Department of Health and Social Welfare, co-headed by one international and one local staff, was established by Regulation No. 2000/10 of March 2000.[232] The Department of Health and Social Welfare covers all range of health and social welfare issues, including health policy, health care, mental health, social work, social services, social assistance, social security, and community shelter. Under Regulation 2000/10, the Department of Health and Social Welfare was authorised to develop policies to guide the development of Kosovo's health care and social welfare system.[233]

228. Information provided by Karen Reiff, DSI, Pristina, 8 February 2001. See also DSI, 2001:1-2.
229. Information provided by Karen Reiff, DSI, Pristina, 8 February 2001. See also DSI, undated:1.
230. *Ibid.*
231. Discussion with Halit Ferizi, 8 February 2001.
232. Regulation No. 2000/10 on the Establishment of the Administrative Department of Health and Social Welfare, 3 March 2000.
233. Discussion with Evelyn Arnold, Deputy Co-Director, Social Welfare Section, UNMIK Department of Health and Social Welfare, Pristina, 5 February 2001.

The UN focal point for mine victim assistance is WHO, which has been given responsibility for ensuring coordination and the appropriate development of health services, both in the immediate emergency situation and for the longer term, and is to assist the Department of Health and Social Welfare to rehabilitate the public heath system in Kosovo. The main role of the MACC in this regard is to collate the data collected by ICRC field teams and to provide this information to WHO in order to enhance their understanding of the overall situation (WHO, 2000; UNMIK-MACC, 2001b:10). UNMIK and WHO have brought in a third party, Handicap International, to be responsible for providing the direct technical assistance for the implementation of Physical Medicine and Rehabilitation programmes in Kosovo (HI, 2001a:8).

The UNMIK Department of Health and Social Welfare has not responded specifically to mine victim assistance needs as such, but rather addresses them in the context of wider medical and social welfare efforts and policy design on disability issues in the post-conflict arena.[234] The Department itself is financed from the Kosovo Consolidated Budget, a combination of donor funds and locally collected revenue. In the fiscal year 2000, health care expenditure was about DM40 (approx. US$20) per capita, i.e. DM75 million (approx. US$35 million) in total. The Consolidated Budget is not likely to grow rapidly in the foreseeable future (UN Interim Administration Department of Health and Social Welfare, 2000b:3; 2000a:11). UNMIK's major problem is that it does not have the necessary budget to carry out its responsibilities.[235]

The Department of Health and Social Welfare has, however, developed Health Policy Guidelines after consultations with a variety of stakeholders throughout the province. These policy guidelines, submitted in November 2000, are the follow-up to the *Interim Health Policy Guidelines* issued by the UN Civil Administration in September 1999 and will guide the development of health services in Kosovo during the period of interim administration (UN Interim Administration Department of Health and Social Welfare, 2000b).

The current health care and rehabilitation system

Primary care has traditionally been organised around specialist polyclinics (or health houses) located at municipal headquarters and *ambulantas*. General practice was seemingly neither comprehensive nor well developed (WHO, 2000:7). According to an assessment of the current health care system, access to primary care is variable depending on location. In urban areas, there may be several health houses and *ambulantas* within an easy distance, while in rural areas facilities are sparser and the level of care also varies. Many *ambulantas* are reportedly quite small with only a nurse or doctor and therefore provide minimal services. Emergency transport to health care exists in only a few locations, mainly in urban areas, and many patients depend on the availability of car, tractor or cart transport provided by family or friends (UN Interim Administration Department of Health and Social Welfare, 2000b:2). Outpatient secondary care (and also considerable amounts of primary care) have largely been delivered by specialists located in "health houses".

234. View expressed by Bengt Stalhandske, Deputy Co-Director of Health section, and by Evelyn Arnold, Deputy Co-Director of Social Welfare section, UNMIK Department of Health and Social Welfare, Pristina, 5 February 2001.
235. View expressed by Evelyn Arnold and Bengt Stalhandske, 5 February 2001; discussion with Driton Ukmata, 7 February 2001.

Hospital care has been provided at one tertiary hospital (in Pristina) and five regional or district hospitals. The basic infrastructure of the buildings is generally sound, though most are in a state of poor repair with a low standard of sanitation. Buildings are likewise poorly adapted for persons with disability. Each hospital comprises a number of separate "clinic" buildings, each providing inpatient, outpatient and emergency care in one or two special fields. Clinics sometimes have their own laboratory, intensive care and operating theatres, rather than shared services (UN Interim Administration Department of Health and Social Welfare, 2000a:10; 2000b:2).

There is said to be considerable room for improvements in efficiency in the health sector in general, and hospitals in particular. Hospital capacity is low compared to regional and European averages, and considered relatively inefficient with a low level of use but a long length of average stay. In total, Kosovo has about 5,500 hospital beds, with occupancy rates of 75 per cent or less and average length of stay of 12.5 days, and probably more staff than necessary (WHO, 2000:7). Over the past decade the progressive decrease in the province's economic status has led to a decrease in funding for the health sector and the subsequent deterioration of infrastructure (UN Interim Administration Department of Health and Social Welfare, 2000a:8). In addition, during the war, much of the existing health infrastructure was destroyed. The rapid assessment of medical and public health facilities undertaken by the international community in June 1999 revealed a general lack of equipment and first aid material in the different hospitals.

The majority of the population, including health workers, returned to Kosovo during the early months of the interim administration. Health workers returned in large numbers to the existing health institutions, many of them after almost 10 years of being excluded from the government health care system (UN Interim Administration Department of Health and Social Welfare, 2000a:8). This prompted staff distribution between regions, sectors of care, and health care institutions, to become unbalanced. (UN Interim Administration Department of Health and Social Welfare, 2000b:2) The efforts of Kosovo's health workers were supplemented by the work of humanitarian organisations and KFOR, both of which provided much-needed inputs and resources. This has helped to meet immediate needs and contributed to the longer-term development of health services. Coordination efforts included meetings, promulgation of guidelines, and the registration of external organisations, but these efforts are considered to have been only partially successful. Accordingly, *"improved coordination, clearer policy guidelines, and better project planning will make their contribution even more useful in the future"* (UN Interim Administration Department of Health and Social Welfare, 2000b:2).

In addition to the relatively extensive network of medical support already existing across the province, KFOR units are also providing an evacuation capability as well as immediate medical attention, particularly for serious cases. In some areas, KFOR rescue teams practise recovery drills designed to extract people from mined areas. (UNMIK-MACC, 2001b:10) The MACC therefore believes that mine victims can generally reach some form of medical facility within a relatively short period of time. However, the facilities that exist can vary widely depending on the location, with only Pristina Hospital capable of handling major trauma cases (*ibid*.). During the initial phase of mine incidents after the end of the war, surgeons in the district hospitals coped as best as they could. Often inappropriately-qualified surgeons were carrying out amputations, and even those who were orthopaedic surgeons did not have the necessary experience, as such wounds were not commonly seen before the war. This

has resulted in some poor quality stumps, which render difficult the fitting of a prosthesis (VVAF, 1999:8).

Multiple initiatives to improve the quality and quantity of health services have been initiated, based on the principles outlined in the *Interim Health Policy Guidelines*[236] (UN Interim Administration Department of Health and Social Welfare, 2000b:5-20; WHO, 2000:10-77). As far as mine and UXO victims are concerned, as their number is now decreasing, the lack of appropriate emergency transport facilities and the need to improve secondary health care capacities is a less urgent problem than it was at the outset. It is also claimed that hospital care for mine injured is now of an adequate standard.[237] Capacities could still be improved, however, for example by the purchase of equipment, such as a fluoroscope X-ray, which is able to locate shrapnel in the body, and which costs about DM100,000. In terms of human resources, it is said that there are not enough anaesthetists.[238]

According to the *Interim Health Policy Guidelines*, improving and strengthening secondary and tertiary health care, and ensuring that everyone in Kosovo has access to appropriate transport health care facilities in an emergency, remain priorities. It is planned to equip every hospital with at least two ambulances (UN Interim Administration Department of Health and Social Welfare, 2000b:8-9,14). The emergency services of the Department of Health and Social Welfare are coordinating the plans, though seemingly with uneven results. In addition, KFOR's British Royal Marines medical squadron has just completed a six-week training course for 22 ambulance paramedics (16 Albanians and six Serbs).[239]

By February 2001, according to WHO, general and basic orthopaedic surgery were available in all regional hospitals, though expertise is limited in the regions and therefore complex cases are referred to Pristina Hospital.[240]

Supporting the redevelopment of the pharmaceutical sector in order to ensure equitable and sustainable access to drugs and medical supplies required for the treatment of disease and relief of suffering is also a major objective (UN Interim Administration Department of Health and Social Welfare, 2000b:15-16). In early 2000, supplies were still largely dependent on humanitarian contributions (WHO, 2000:24). Today, drug and medical supplies are officially within the remit of the new Kosovo Drug Regulatory Agency, with support of EU, and distribution is organised by the Kosovo Pharmaceutical Cooperative, which was created by UNMIK's Department of Health. Accordingly, all essential drugs needed to meet health needs of the people in Kosovo, approved by the UNMIK Department of Health, are available in sufficient quantities within Kosovo, but health facilities, and particularly some hospitals, have yet to adjust to the ordering system. There have also been problems with distribution to minority areas, but KFOR is helping in several places.[241]

236. The guidelines include initiatives aiming to strengthen primary, secondary and tertiary health care, maternity care, mental health, public and environmental health, oral health, prevention and rehabilitation of disability, services for those with learning disabilities, emergency transport, occupational health, drugs and medical supplies, and other key aspects such as infrastructure and equipment, human resources, financing, and a management system for the health services in Kosovo.
237. Discussion with Bengt Stalhandske, 5 February 2001.
238. Information provided by Driton Ukmata, 7 February 2001.
239. E-mail correspondence with Edward Poultney, Public Information Officer, WHO, Pristina, 21 February 2001.
240. *Ibid*., 25 February 2001.
241. E-mail correspondence with Edward Poultney, 21 February 2001.

One of the remaining major problems in Kosovo is to ensure physiotherapy. According to VVAF's December 1999 study, in the post-operative stage patients were not being referred for physiotherapy on the wards. Initially, the orthopaedic surgeons would very often refer patients straight to the orthopaedic workshop in the National Ortho-Prosthetic Centre (NOPC) without any physiotherapy at all.[242] The presence of physiotherapists and the availability of post-operative treatment in Kosovo varied in quality and extent, the best being at Pristina Hospital. HI confirms that there is a huge need for physiotherapists and ortho-prosthetic staff. Indeed, according to research by HI, Kosovo's medical institutions need more than 500 new physiotherapists, while, as of November 2000, only 49 physiotherapists and physiotherapy technicians were available in the province.[243] HI concludes that the coverage of physiotherapy needs in Kosovo should be considered a priority, implying above all an improvement in the status of physiotherapy and ortho-prosthetics in Kosovo. In addition, there is a need to rejuvenate and/or upgrade existing rehabilitation facilities. So far, premises and equipment have been upgraded only in Kllokot rehabilitation centre and the NOPC — by HI— and in Peja hospital by an Italian NGO[244] (HI, 2000a:44). Peja's rehabilitation centre is still partly occupied by Italian KFOR.

The prevention and rehabilitation of disability is one of the priority areas of the Interim Health Policy Guidelines. A rehabilitation programme catering to the needs of persons with physical disability will address the following issues:

- Prevention of disabilities, including awareness and public education in mine awareness, accident and injury prevention, traffic safety, and antenatal care;
- Strengthening the ortho-prosthetic centre in Pristina;
- Creating and improving rehabilitation facilities in family health centres and in each hospitals;
- Improving existing rehabilitation centres and possibly establishing a new one (intended particularly for war wounded with disability);
- Upgrading the training of physiotherapists to post-secondary level and improving the training of other key professionals in rehabilitation; and
- Strengthening a community-based rehabilitation network, including local non-governmental organisations and international organisations, and improving its integration with communal primary health care (UN Interim Administration Department of Health and Social Welfare, 2000b:13).

No special attention has been paid to mine victims, but the need to build up rehabilitation facilities in general has been addressed through HI's work. A main concern is felt to be the challenge of ensuring long-term capacities for the rehabilitation especially of children, and long-term social services in general, as the mine survivors with disability, as with the other persons with disability, will become social cases that

242. This has reportedly changed in Pristina as the NOPC refuses to take any referrals straight from the orthopaedic surgeons – the rehabilitation doctors and physiotherapy unit must assess them first and give treatment as needed (see VVAF, 1999:8).
243. Information provided by Driton Ukmata, 7 February 2001; see also HI, 2000a :34. In addition, the current geographic distribution of the existing physiotherapists is very unequal, with more than two-thirds of human resources being concentrated in Pristina and Peja (HI, 2000b:8-12; 2000a:24-34).
244. According to WHO, Peja regional hospital has a new orthopaedic department which can also produce prostheses (e-mail correspondence with Edward Poultney, 25 February 2001). The MACC reported that little information exists at this stage regarding its capacity. It is further claimed, though, that Peja hospital has a basic prosthesis capability only for lower limbs and it has been asserted that the quality of the prostheses remains poor and that the hospital requires further training and better equipment (Mines Awareness Trust, 2001:8).

Kosovo society will have to deal with.[245] HI, along with other NGOs, has drawn up plans to upgrade physiotherapy services in Kosovo.[246]

Psychological support

The strengthening of mental health services is also considered as a high priority for Kosovo where there is little tradition of psychosocial treatment and thus little capacity to deal with psychiatric and psychosocial problems, with very few local mental health specialists and no involvement in community-based care and support strategies. Learning disability services rely on institutions providing only custodial care. It is, however, estimated that 4 per cent of the population will have psycho-pathological reactions because of the severe emotional trauma due to the recent events (UN Interim Administration Department of Health and Social Welfare, 2000b:2; WHO, 2000:12, 40). To date, according to information provided by the WHO, there are only 22 psychiatrists and one psychotherapist available in Kosovo.[247]

Even though several agencies, individuals and donors have become involved in mental health issues, there remains a substantial need for treatment and psychological support for people who are traumatised and whose capacity to cope has been impaired.[248] The Department of Health and Social Welfare considers community-based services to be the cornerstone of mental health care and it will support the construction of appropriate facilities and the training of mental health teams (UN Interim Administration Department of Health and Social Welfare, 2000b:9-10). The priority will be to improve the capacity of family medicine teams to deal with mental health problems in the community with a longer-term objective to develop a community-based mental health system. Such transition is highly desirable, but *"may take years to complete"* (UN Interim Administration Department of Health and Social Welfare, 2000a:18; 2000b; WHO, 2000:12).

According to information recently provided by WHO, a great deal of effort is currently being directed towards general training in the context of community-based mental health and mental health care within the primary health care family medicine programmes. To this end, the WHO Mental Health Unit is being strongly supported by collaborating centres in Birmingham, Trieste and Asturias.[249] However, the programme still requires technical assistance from international experts to train and educate mental health professionals in cooperation with UNMIK.

Disability issues and policy

In order to achieve the other objectives outlined in the *Interim Health Policy Guidelines* with regard to disability, the Department of Health and Social Welfare has undertaken

245. Discussion with Bengt Stalhandske, 5 February 2001.
246. According to Article 2(4) of the Memorandum of Understanding between UNMIK and HI, HI is responsible for *"development and implementation of education and training requirements for people of Kosovo in the field of physical medicine and rehabilitation according to the most urgent needs"* (UN Interim Administration, Department of Health and Social Welfare, 2000c). The creation of an Albanian language high-level post-secondary physiotherapy school has been defined as a priority for HI. The three-year training curriculum has been elaborated in cooperation with Pristina Medical University with direct support from HI, the International Canadian Agency for Community Based Rehabilitation and Limoges physiotherapy school in France. Training should start in October 2001(HI, 2001a:9; 2000a:34).
247. Information provided by Edward Poultney, e-mail correspondence, 10 March 2001.
248. Discussion with Bengt Stalhandske, 5 February 2001.
249. Information provided by Edward Poultney, e-mail correspondence, 21 February 2001.

a number of other initiatives, such as cooperation with other public sectors (e.g. education, housing, transport, etc.), civil society and disabled people's organisations in order to develop and coordinate services for persons with disability[250] (UN Interim Administration Department of Health and Social Welfare, 2000b:13). The Guidelines also stress the importance of access for persons with disability[251] (UN Interim Administration Department of Health and Social Welfare, 2000b:13).

In accordance with these objectives, as a first step, a "Task Group on Disability" has been created to develop a Comprehensive Disability Strategy that will become the framework of more specific policies and legislation on disability. The Board of this Task Group includes UNMIK Departments, Handikos, HI (as leading agency for Physical Medicine and Rehabilitation), other organisations of persons with disability, and the heads of Special Institutes. The Task Group is to be composed of organisations representing a range of physical and mental disabilities, and will design policies on disability giving a voice to persons with disability themselves. Up to now, however, few organisations have taken part in the Task Group; there is, therefore, a need for much greater involvement from organisations for persons with disability to ensure the representation of all disabilities.[252]

It has been claimed that, *"the recognition of the Task Group on Disability at this stage in the reconstruction process leaves the UNMIK administration, the municipalities and the local government, the OSCE as well as the disability sector a unique opportunity to develop a comprehensive Disability Strategy together"* (DSI, undated:2). The appointment of the Task Group is in fact the first step towards the recognition of the advisory role of the disability sector in Kosovo and the acceptance of their representatives' participation in the decision-making process.[253] It is recommended that the *UN Standard Rules for the Equalisation of Opportunities for Persons with Disabilities* (United Nations, 1993) and the *World Programme of Action Concerning Disabled People (1982)* should be guiding documents for the Task Group on Disability in the elaboration of a Comprehensive Disability Strategy for Kosovo (DSI, undated:2).

As of writing, the policy-making process of the Task Group is still in its preparation phase. The Task Group is currently doing an assessment of existing legislation on disability,[254] and identifying key policy areas such as education, social welfare, accessibility, rehabilitation, democratisation, and participation of persons with disability in the decision-making process. The first step in the creation of a Disability Strategy will be to draft a Green Paper on Disability, which should be done by March

250. The *Interim Health Policy Guidelines* draft document of August 2000 planned that an office in the Department of Health and Social Welfare should be responsible for issues concerning disability. Such an office would cooperate with civil society and organisations for persons with disability, coordinate services for persons with disability in the health sector, and be part of any standing governmental committees which are responsible for multi-sectoral approaches to disability issues (UN Interim Administration Department of Health and Social Welfare, 2000a:22).
251. The draft document of August 2000 referred to the need for legal reform to ensure that all new buildings include ramps or other means of access for persons with disability. Over time, as resources allow, providing access for persons with disability to existing buildings should also be a priority (UN Interim Administration Department of Health and Social Welfare, 2000a:22).
252. Information provided by Pascal Giron Lanctuit, Advisor in charge of reorganisation of Handikos Headquarters, HI, Pristina, 5 February 2001.
253. Discussion with Evelyn Arnold, Pristina, 5 February 2001.
254. According to information provided on 9 February 2001, UNMIK had no information about existing legislation on disability. HI's Coordinator on Disability Policy, in collaboration with UNMIK, was currently working to identify laws that were believed to exist. Discussion with Majid Turmani, Coordinator on Disability Policy, HI, Pristina, 9 February 2001.

2001.[255] The Green Paper should reflect both the thinking about how the government and other authorities can contribute to an improvement in the situation of persons with disability and the promotion of their rights as well as an intensive process of consultation within the disability sector. It should raise awareness on disability issues not only among the public, but also in the different UNMIK departments, the municipalities and the local government. Before becoming a White Paper, the Green Paper should outline the strategy for a Comprehensive Disability Policy and should be discussed with administrative, judicial and non-judicial bodies interested in establishing a common agenda for persons with disability in Kosovo (DSI, undated:3). The White Paper on Disability is planned for September 2001.[256] It should introduce a framework facilitating the development of an integrated and coherent policy addressing the needs of persons with disability, and be the start of a further process involving persons with disability in the development of specific legislation and policies on disability (DSI, undated:3).

As part of the process, two working groups of the Task Group were created in December 2000, one dealing with accessibility issues and the other with education. Additional working groups on transport, employment, rehabilitation and training issues will be created later. Cost is often cited as the reason for failure to provide proper regulations or legislation on disability, especially when accessibility questions are addressed. *"However, when accessibility is incorporated in the original design, the additional cost does not generally exceed more than 0.2-0.3 per cent of the overall cost development."* (DSI, undated:3)

Despite these encouraging first steps, it is clear that the Department of Health and Social Welfare must strive further to include effectively disability issues as a real priority both within its policy and strategy planning, and within its budget, and to sustain the efforts already undertaken.[257]

Current social services

As far as social welfare services are concerned, the main concern expressed is that they should be made effective throughout the province by building the capacity of Centres for Social Work.[258] The situation of former staff is similar to that of health workers as most of the premises were looted and damaged. Most of the Serbian staff fled in mid-1999, leaving many of the CSWs without experienced staff. Staff members gradually returned from exile and came back to work. However, during the summer months of 1999, the CSWs were not yet completely functional and, to a large extent, were not recognised either by the UNMIK or by international NGOs providing emergency social services (UNMIK Department of Health and Social Welfare, 2000:2-3; International Catholic Migration Commission, 2000:2).

CSWs have legal responsibility for two major areas: social protection and social work services. Social protection usually refers to financial assistance to those in need, while social work services are broadly defined to include the provision of protection to, and legal representation of, those not able to protect themselves. The CSWs are considered

255. Discussion with Majid Turmani, 9 February 2001; discussion with Halit Ferizi, 8 February 2001.
256. Information provided by Majid Turmani, 9 February 2001.
257. Discussion with Driton Ukmata, 7 February 2001; also with Halit Ferizi, 8 February 2001.
258. Discussion with Evelyn Arnold, 5 February 2001; also with Halit Ferizi, 8 February 2001; and with Véronique Heckmann, Project Officer, Children in Need of Special Protection Unit, UNICEF, Pristina, 8 February 2001.

to be of fundamental importance to the development of a modern social welfare system in Kosovo. There are currently 27 CSWs across Kosovo; staffing typically consists of a director, social workers, pedagogues, a legal advisor, a psychologist, a sociologist, and administrative and finance staff.[259]

But the events of the previous years and recent recruitment have meant that many centres have a substantial proportion of staff with little experience or who need training in modern social welfare practice. In terms of disability issues, for instance, awareness needs to be raised in order to change attitudes towards persons with disability among these professionals, who otherwise generally consider that the solution is to place them into institutions.[260] In addition, CSWs must be provided with the necessary financial resources in order to function properly. Funding is currently an urgent concern (International Catholic Migration Commission, 2000:4).

Capacity building of most CSWs took place in 2000, UNMIK having heavily relied on NGOs to provide equipment and/or repair buildings and to train old and newly employed CSW staff,[261] with further contributions from UNHCR and UNICEF. Training for the implementation of Social Assistance Scheme has been directly provided by UNMIK, with help notably from WFP and the food distribution agencies. UNMIK took a lead role in coordinating training activities since January 2000 and through regular meetings has maintained working relationships with NGOs interested in training activities in the Centres (UNMIK Department of Health and Social Welfare, 2000:4-7).

After municipal elections and especially during 2001, the Department of Health and Social Welfare will be responsible for the regulatory framework for social welfare, including the setting of standards, prevention, and the monitoring of service delivery both in terms of quality and target groups to be reached. Policymaking and the setting of standards and procedures have reportedly been recognised as the necessary next step. After the elections, municipalities will assume responsibility for the provision of social services in their communities. This will include the CSWs, NGOs and the coordination of their services. How this model will operate in practice, though, remains to be seen (UNMIK Department of Health and Social Welfare, 2000:5).

At present, disability issues are not a priority for the CSWs but should be seriously addressed in the near future. There is a real need to raise awareness among the public and social work professionals regarding the needs and rights of persons with disability. It is hoped that in 2001 Oxfam will deliver such disability awareness and training to social workers to give them a better understanding of the needs of persons with disability.[262]

It is clear that CSWs alone will not be able to cover all the needs and provide all the social assistance required. They can and should play a key role, but additionally, a range of social services in the government and non-government sectors must be

259. International Catholic Migration Commission, 2000: 1-2; view also expressed by Véronique Heckmann, 8 February 2001.
260. Discussion with Evelyn Arnold, 5 February 2001 and Véronique Heckmann, 8 February 2001.
261. ADRA, CARE Caritas Spain, CRS, ECT, ICMC and Save the Children have worked to address some of the most pressing training and to provide material assistance. A few other NGOs also contributed in particular ways and to a smaller numbers of CSWs or one isolated Centre.
262. Discussion with Evelyn Arnold, 5 February 2001; and Dukagjin Kelmendi, Oxfam, Pristina, 6 February 2001.

developed in Kosovo.[263] Coordination and cooperation with local NGOs is absolutely necessary regarding information sharing, so that CSWs know which services are available in the country to provide assistance and be able to refer to the appropriate organisation. The Department of Health and Social Welfare encourages collaboration between CSWs and Handikos in order to map out those social services that should be delivered by CSWs and those that will be developed through NGOs, avoiding both duplication and gaps in the provision of social services to persons with disability.[264]

In 2001, primary responsibility for mine victim assistance will be progressively transferred from the MACC to the Department of Health and Social Welfare. For its part, the Department of Health and Social Welfare acknowledges that it has not so far collaborated greatly with the MACC, mainly due to lack of time and to the fact that mine victim assistance as such was not a priority. It has, though, recognised the need for more cooperation in the future and increased information sharing to evaluate what has been done by the MACC. Thus, the Department had received the VVAF Socio-Economic Survey, but as of February 2001, had not yet had time to study it.[265] As noted by the MACC, the results of the survey provide a good basis for identifying long-term requirements and developing appropriate programmes, although *"it is already recognised that rehabilitation and reintegration initiatives will need greater emphasis"*. These requirements are linked to the overall rehabilitation of the public health and social welfare system and therefore the Department of Health and Social Welfare has the lead for this task (UNMIK-MACC, 2001b:1; 2001c:14).

Non-governmental organisations

The Kosovo emergency saw a large influx of humanitarian aid and humanitarian organisations in the health and social welfare sector. Their contribution has been extensive and in most cases it helped meet immediate demands and contributed to the longer-term development of services in the province, although some difficulties with coordination did occur. Coordination efforts included meetings, promulgation of guidelines, and registration of external organisations.[266]

Handicap International

HI evacuated its team from Kosovo the day before NATO bombing started and assets were transferred to Albania and Macedonia where a range of activities were initiated in support of the refugees. The organisation returned to Kosovo two days after the arrival of NATO ground troops and restarted its activities. As noted above, HI was then mandated by UNMIK and WHO as the leading agency for the Physical Medicine Rehabilitation programme in Kosovo,[267] including responsibility for developing strategy, policy, planning and interim administration and ensuring coordination in the sector, and as such has played an extremely active role.

HI sees its role of lead agency:

> *"as a good opportunity to develop rehabilitation services for physically and intellectually disabled children and adults, in continuity collaboration with the*

263. View expressed by Evelyn Arnold, 5 February 2001. See also International Catholic Migration, 2000:6.
264. Discussion with Evelyn Arnold, 5 February 2001.
265. Discussion with Evelyn Arnold and Bengt Stalhandske, 5 February 2001.
266. View expressed by Evelyn Arnold and Bengt Stalhandske, 5 February 2001; see also UN Interim Administration Department of Health and Social Welfare, 2000b:2.
267. See UN Interim Administration Department of Health and Social Welfare, 2000c.

> *communities (based on this tradition of solidarity), with local partners such as Handikos association, continuing through specifics inputs in an overall education system and finally through development and integration of the specialised institutions. The integration of such an approach in the health policy of the future government of Kosovo is also the objective of Handicap International, in order to ensure the long term sustainability of this policy"* (HI, 2001a:5).

In the initial emergency phase, as the APEK (Handikos) network was not able to respond immediately due to lack of premises and staff, HI opened a temporary network of nine sub-offices to carry out the necessary work at regional level. The main objectives were to offer a rapid response to persons with disability by providing them a medical diagnosis and material, and to adapt the assessment to integrate new war victims and persons with disability in order to create an updated database usable by all agencies interested in helping this population. The main duties of the sub-offices were the identification of the patients in the field or in the hospitals, the distribution of walking aids, hygiene kits, other specific material, the organisation of consultations with physiatrists and physiotherapists from the reference hospital to confirm diagnosis and obtain prescriptions when necessary, the organisation of reference to NOPC or to the closer physiotherapy unit when necessary, and providing information to patients on how to prevent complications (HI, 2000c:9).

Accordingly, work mainly concentrated on first visits to new patients with disabilities, distributing if necessary orthopaedic devices and ensuring follow-up. Responsibility for the distribution of other material has been passed on gradually to the Handikos network. The sub-offices were gradually reduced as Handikos' local structures developed and by June 2000, all sub-offices had been closed. Instead, visits have been made by a central medical mobile team in order to support Handikos structures in complicated cases. Handikos' medical staff have been trained on the proper use of material through "training of trainers" by daily contact and through home visits by the mobile team (HI, 2001a:16).

HI mobile teams and the Handikos network regularly visit hospitals in order to identify new persons with disability and to assess their health treatment and specific problems. HI believes that, in cooperation with Handikos, they have identified around 90 per cent of disability cases, covering 90 per cent of Kosovo. Most mine victims have been identified through these visits and questionnaires completed, with the information transmitted to ICRC and the MACC. HI does not have special teams to identify new mine victims, but they expect them all to end up in Pristina Hospital or in the National Ortho-Prosthetics Centre. If, however, there is information regarding a new mine incident, and the survivor does not come to Pristina Hospital, HI teams go and check.[268]

As there existed no operational capacity for ortho-prosthetic appliance manufacture and fitting following the end of the conflict, one of HI's primary tasks has been to work with local staff to reactivate and develop the ortho-prosthetic workshop (ex-RUDO) situated in the compound of Pristina University Hospital.[269] The main objective was to provide an operational ortho-prosthetic workshop facility to respond to the emergency needs of victims of war, mine and munitions injuries, but also for all kinds of amputations and malformations needing the provision of adapted appliances and physical rehabilitation sessions.

268. Discussion with Driton Ukmata, 7 February 2001; also with Iliriana Dallku, Medical Doctor, HI, 8 February 2001.
269. Discussion with Driton Ukmata, 7 February 2991.

In the emergency phase, HI provided material in kit form to cover the initial fitting needs of 150 adults and children with below-knee amputations, and 100 adults and children with above-knee amputations. They claim that the system was *"fast and simple, requiring no additional machinery or equipment and the existing staff could be rapidly trained"*. This solution enabled the post-operative waiting list to be treated rapidly and provided the necessary intermediate fitting while the patient's stump adapted to the stage where it could be fitted with a permanent appliance (HI, 2000a:50). In parallel, activities such as technical reorganisation, administrative management, recruiting and training of ortho-prosthetic and physiotherapy staff, the fitting of permanent appliances, and physical rehabilitation sessions and patient follow-up, have been carried out in coordination with Handikos and their CBR network (HI, 2001a:12).

While the quality of prosthesis produced by NOPC is good it could be improved. At present NOPC is also working on increasing the quality of permanent prosthesis. Currently in the development phase, machinery has been refurbished and basic materials (such as resin, glass fibre, polypropylene laminates, etc.) supplied in order to shift to the resin technology needed to produce permanent appliances, so as to meet the needs of patients who have been treated in the emergency phase and to treat new patients. [270]

The NOPC is the only such facility in Kosovo. According to the MACC, the NOPC has sufficient capacity to deal with the number of cases it receives. However, there appears to be considerable difficulty for some patients to access the facility on a regular basis, particularly those in rural areas who do not have support from family or friends in Pristina. The NOPC has no accommodation facilities.[271]

NOPC is now administratively fully integrated in the Pristina University Hospital, but still gets technical, financial and logistic support from HI (HI, 2000a:50). Many problems still have to be faced in order to ensure the NOPC's full autonomy, in particular concerning administrative and management aspects. But as the centre moves from the emergency and post-emergency phases to a capacity-building stage, these problems are being solved (HI, 2001a:14).

HI and the Pristina University Hospital instituted a prescription system for NOPC. The patients are referred by physicians or even by the Handikos network to the workshop. Twice a week, a team composed of a physiatrist or an orthopaedist, the HI prosthetist/orthotist, the three orthopaedic technologist students and the physiotherapy technician, gather in the NOPC for patient consultations. Assessment is made of the type of appliance needed by the patient (HI, 2000a:52). The work has been carried out by two professional ortho-prosthesisists from HI, along with local staff of the NOPC (HI, 2001a:13).

HI is financing the studies of one orthopaedic technologist in France who should finish training in 2003 while another should join in September 2001. Since June 2000, HI has been training three students in the NOPC to become prosthetic or orthotic assistants, and, if conditions are good enough, to be graduated as orthopaedic technologists. It is expected that by 2004, NOPC will have 13 prosthetic and orthotic staff (HI, 2001a:13).

270. Information provided by Driton Ukmata, 7 February 2001. See also HI, 2000a:50.
271. Visit to NOPC, Pristina, 8 February 2001.

It is reported that between September and December 1999, 98 patients were fitted with a prosthesis, (HI, 2000a:51) while 194 people were fitted either with a temporary prosthesis (132) or a permanent prosthesis (62) in 2000. By September 2000, 95 patients with a temporary prosthesis had received treatment and follow-up with physiotherapy (HI, 2001a:13; 2000a:51). It is not clear, though, how long patients have to wait for an appointment for prostheses and it may depend on how many patients come to the workshop at any one time.[272]

The physiotherapy technician working in the NOPC provides physiotherapy to patients in Pristina Hospital during the morning and in the NOPC in the afternoon. HI believes the NOPC needs another physiotherapist, a permanent physiatrist and doctor, and also a social worker. There is no psychosocial support provided to victims while they are in hospitals or receiving treatment at the NOPC, despite the need for such assistance, especially, in the case of amputees, at the beginning in order to prepare them for their new prosthesis.[273]

When a patient has received a temporary prosthesis and initial rehabilitation care in NOPC, he or she goes to Kllokot rehabilitation centre to receive further rehabilitation sessions to prepare for the fitting of a permanent prosthesis. It is not clear how long patients have to wait before receiving their permanent prosthesis. Once it has been fitted, however, if there is any problem afterwards, the NOPC can ensure the necessary follow-up. HI itself does not have outreach teams for this purpose. This is addressed through the Handikos network referring the patient to NOPC.[274]

Treatment at the NOPC centre is supposed to be free for war and mine injured and it has been claimed that free long-term assistance will also be provided.[275] The management of the Kllokot rehabilitation centre has agreed to offer 10 days of rehabilitation free for each person sent by HI; HI already finances an average of 20 days rehabilitation for each patient (HI, 2000c:14).

The NOPC, however, only has the capacity to fit lower-limb prostheses: accordingly upper-limb and above-knee amputations cannot be fitted in Kosovo. The possibility exists to refer serious cases to the Slovenian International Trust Fund, which has a specialist rehabilitation centre in Ljubljana for mine victims, and this applies in particular to the fitting of upper-limb prostheses and complicated cases.[276] However, sending people abroad has proved a rather contentious issue. HI stresses that it is not against sending people abroad to receive treatment who cannot be treated in Kosovo. However, the concerns expressed regarding people sent abroad, especially with regard to children, is that they are fitted with sophisticated prostheses which will have to be replaced or repaired afterwards in Kosovo while there is no national capacity to ensure the necessary follow-up. The risk is that people, particularly children, will not be satisfied and disappointed with their new prosthesis having lower quality level, and

272. According to a VVAF assessment in December 1999, some patients could be assessed and measured for prostheses very quickly while others needed to wait up to two weeks for an appointment (VVAF, 2000b:10).
273.Information provided by Iliriana Dallku, Medical Doctor, HI, visit to NOPC, Pristina, 8 Fenbruary 2001.
274. *Ibid*.
275. *Ibid*. However, it was reported by VVAF in December 1999 that although currently all appliances are free, HI was envisaging that in the future patients would have to pay for their prostheses. No confirmation of this was obtained (VVAF, 2000b:10).
276. Information provided by Leonie Barnes, Chief of Public Information, MACC, Pristina, 2 Fenruary 2001.

will refuse to wear it which in turn will decrease their ability. HI strongly recommends that UNMIK coordinate appropriately the evacuations and also asks the institutions providing treatment abroad, either to ensure the long-term follow-up of the patients, or to provide technical support in order to train people and raise national capacity in Kosovo.[277]

Sadly, due to the prevailing political climate, it did not appear that amputees from ethnic minorities in Kosovo, particularly Serbs, were able to receive prostheses at the NOPC. In February 2001, however, it was asserted that Serb and Roma people *"have the same right to receive services in NOPC"*.[278] Due to the difficult situation of minorities, mostly Serbs, living in so-called enclaves without any access to the health and social welfare facilities, HI reports having provided emergency support since June 1999 and distribution of material through close collaboration with medical NGOs. In September 2000, one expatriate started an assessment of the needs of this population in order to supply them with the necessary material. However, as reported in January 2001, this activity was delayed because of security reasons but should be re-started soon (HI, 2001a:9).

HI considers Handikos as the key actor for the future of disability issues in Kosovo and works with its partner to build its capacity. Thus, *"it is very important to help it to move from a parallel system to an official structure in order to be integrated in the public health and social welfare sector as a key and confirmed interlocutor for the rights of the disabled people"* (HI, 2001a:17). HI has supported Handikos through the provision of services, equipment and technical advises on community-based rehabilitation management and logistics.[279]

Both Handikos and HI do not approve of treating mine victims separately, believing that they should be treated in the same way as other persons with disability. HI strongly recommends that disability issues become an effective priority for UNMIK Department of Health and Social Welfare,[280] noting that the priority is to find an alternative to the work done by itself and other NGOs, by handing over to local structures.[281]

Handikos

At community level, the principal association for persons with disability, which has existed since 1983, is Handikos. Formerly the Association of Paraplegics and Paralysed Children of Kosovo (APEK), it was renamed Handikos after the war. Before the war, volunteers ran the APEK network, but since then its community-based network also includes paid staff.

Handikos considers mine victims as a sub-group or "sample" of persons with disability in Kosovo and their needs are addressed according to their disabilities through integration into work in favour of disability issues in general.[282] To date, the total number of persons with disabilities registered by Handikos in the province is around 15,000.[283]

277. View expressed by Driton Ukmata, Pristina, 7 February 2001.
278. Discussion with Dr. Iliriana Dallku, HI, Pristina, 8 February 2001.
279. Discussion with Driton Ukmata, 7 February 2001; and with Halit Ferizi, 8 February 2001.
280. Discussion with Driton Ukmata, 7 February 2001.
281. *Ibid.*
282. Discussion with Halit Ferizi, 8 February 2001.
283. *Ibid.*

Handikos actions are based on a community-based rehabilitation programme relying on 25 communal groups and 10 community centres with community-based rehabilitation workers specialised on rehabilitation or in social affairs. The global objective of the organisation is to improve the rights and living standards of persons with disability and to provide help to their families. Handikos's network across Kosovo aims to cover among others the following functions:

- Identifying persons with disability and their families;
- Making home visits;
- Distributing specific material, such as crutches, wheelchairs, incontinence kits, hygiene kits, etc;
- Implementing community-based rehabilitation projects;
- Providing physical rehabilitation (prevention, follow up, advice) and psychomotor activities;
- Providing psychosocial activities;
- Supporting social reintegration;
- Lobbying on disability issues;
- Developing a database system; and
- Developing communication material and sensitisation campaigns.[284]

However, practically speaking the network is still not fully in a position to provide support for the effective reintegration of mine victims, as it lacks both resources and capacity.[285] To date, visits, distribution of medical, orthopaedic and hygienic material, and reference activities have been the main activities carried out. It is still needed to develop vocational, educational, income generating project, cultural and recreational opportunities.[286] Furthermore, the Handikos community-based rehabilitation centres currently only provide rehabilitation and psycho-social support to children up to 15 years of age.[287]

At present, Handikos is working on its restructuring and revising its organisational structure to become a sort of "umbrella organisation" for all disability associations. It is currently in a transitory phase between emergency and development work. HI has hired one expatriate administrative adviser who is in charge of reorganisation of the Handikos headquarters.[288] Reportedly the work has been done in phases, starting with the general administrative issues and continuing with logistics and program coordination. HI recommends that the network must be still strengthened through some financial support (objectives, premises, transport), material support (orthopaedic, medical etc.), technical support (training) and administrative support (registration procedure, status of the association, legal aspects, etc.). In parallel the professional capacity of physiotherapists in the CBR still need to be strengthened to improve the quality of physical rehabilitation services provided to the population.(HI, 2001a:17).

284. HI, 2000a: 47-48; discussion with Halit Ferizi, 8 February 2001.
285. Information provided by Leonie Barnes, 2 February 2001. Handikos also recognises that in practice the work in some areas is passive and that there is generally a great need for capacity building in all areas. Discussion with Halit Ferizi, 8 February 2001.
286. Information provided by Halit Ferizi, 8 February 2001; discussion with Pascale Giron Lanctuit, Adviser in charge of reorganisation of the Handikos network, HI, Pristina, 9 February 2001.
287. Visit to Gjakova Community Centre, 9 February 2001 with a mobile team from Handicap International. Like other centres, this one provides psychosocial support to children. A local Special Educator working for HI trains the play activity workers, while a local physical rehabilitation worker trains physical rehabilitation assistants in the 10 community centres.
288. Discussion with Pascale Giron Lanctuit, 9 February 2001; see also HI, 2001:18.

Cooperation between Handikos and UNMIK Departments of Health and Social Welfare and Education has also been initiated, but is still in its initial stages. The objective is to define how to rationalise and sustain in the long term an operational network for persons with disability involving both governmental authorities and the associations of persons with disability themselves.[289] The position of UNMIK Department of Health and Social Welfare regarding the future role attributed to Handikos and to the Department itself is still unclear. It is acknowledged that the Department will not be able to take all disability issues under its charge, so a clear distribution of the roles and tasks between the Department and Handikos will have to be established.[290] The future role of Handikos will also depend on what will be decided regarding the development of activities and role attributed to the Centres for Social Work referred to above.

Vietnam Veterans of America Foundation

In August 1999, VVAF established its first office in Pristina to evaluate the needs for mine/UXO awareness and victim assistance. In November of the same year, VVAF conducted a two-week assessment of rehabilitation services in Kosovo.[291] Since then, VVAF has undertaken a pilot programme called the Assistance to Persons with War-Related Disabilities. Partly funded by the MACC, this 10-month psychosocial outreach programme has already provided help to 45 war-wounded with disability and their families. VVAF stressed out that raising funds to carry out this pilot assistance project has been difficult as all the efforts were concentrated on mine clearance and mine awareness operations.[292]

The second phase of this project is aimed to reach a further 400 war-related disability cases. These persons will be identified and prioritised from VVAF's survey forms, records kept by ICRC and HI and other sources. VVAF notes that its assistance programme is mostly *"designed to support MACC work and exit strategy by addressing one of the key tasks still uncompleted"*, i.e. assistance to mine and UXO victims.

Although organisations such as HI and Handikos provide services to the war wounded with disability, VVAF is the only organisation specifically advocating on behalf of the vulnerable group of mine and UXO victims. VVAF affirms its complete agreement with HI and Handikos in not setting war victims apart from other, larger groups of persons with disability. However, it considers that specific needs and concerns of war and mine victims have to be recognised and that its first objective is to provide, as far as possible, immediate responses to them.[293]

Based on its experiences, VVAF claims that although many are services available in Kosovo the main problem is to get people to the right place. The lack of a database on where, what type, and what international assistance can be provided throughout Kosovo, has often hindered referrals and overall coordination. VVAF strongly recommends that UNMIK establishes such a database with information on what organisations in Kosovo are doing, in order to improve coordination and avoid overlapping services and assistance (VVAF, 2000a:10).

289. Discussion with Halit Ferizi, 8 February 2001.
290. Discussion with Evelyn Arnold, 5 February 2001.
291. The objectives of the assessment were not only to assess existing rehabilitation services available for landmine victims but also identify unmet needs and recommend key services to be strengthened or established. (See VVAF, 1999.)
292. Information provided by Sarah Warren, 29 January 2001.
293. *Ibid*.

Oxfam[294]

Oxfam's programme in Kosovo incorporates a range of activities aimed to address the basic rights of persons with disability, including information and workshops, trainer of trainers, financial support to the Handikos network and lobby on education and accessibility issues.

Oxfam stresses the need to change attitudes towards persons with disability in Kosovo, both among professionals and among the public. It has provided information and organised workshops on disability rights and social models of disability with a view to increasing the participation of persons with disability and raising awareness of issues among those without disability. As a result, 70 per cent of staff in Handikos' offices are persons with disability.[295] Gender issues linked to disability were also introduced within these workshops, which was especially important *"given Kosovo's traditional highly patriarchal society"*.

International Centre for the Advancement of Community-Based Rehabilitation (ICACBR), Queen's University[296]

The ICACBR, a Canadian NGO, started work in Kosovo in 1999 in partnership with HI. The goal of this organisation is to promote the development of citizenship and equal participation in society of persons with disabilities. Its main objectives are to upgrade and reform the rehabilitation education[297] and delivery system, influence attitudes and perceptions on the rights and needs of persons with disability, and increase the understanding of policies required to promote community integration and rights for persons with disability. It believes that the sustainability of community-based rehabilitation will depend on the degree of its integration into the health and social welfare system. In cooperation with HI, ICACBR has already provided CBR training courses to six out of the ten Handikos community centres and plans to develop similar activities in the future.

Danish Council of Organisations of Disabled People (DSI)[298]

This NGO works in Kosovo on disability issues in partnership with HI and Handikos at a policy level. As such, DSI take an active role in the work of the Task Group on Disability and its Working Groups, contributing in the elaboration of relevant guidelines. DSI also works with Handikos to help with the re-organisation of CBR network, and to the creation of associations for persons with disability covering all kind of disabilities.

294. Information provided by Dukagjin Kelmendi, Oxfam, Pristina, 6 February 2001.
295. Oxfam has been actively involved with Handikos since 1995.
296. Information provided by Carolyn Beatty, Programme Manager - Kosovo, ICACBR, Pristina, 7 February 2001.
297. ICACBR has been designated by HI to participate in the post-secondary physiotherapy school project above mentioned. This participation is not yet clearly defined but the NGO is preparing itself to work actively on the curriculum elaboration, the training of the physiotherapists' trainers and in providing supervision and support by Canadian experts on administrative, education and evaluation aspects. An agreement between HI and ICACBR is under consideration. ICACBR will also provide education for rehabilitation practitioners already in activity in Kosovo, i.e. physiotherapists, physiotherapy technicians and community-based physical rehabilitation workers, in order to adapt the old system to the future new one, upgrading their capacities, modernising the way they work, and changing the way they think.
298. Discussion with Karen Reiff, 8 February 2001.

The Society of War Invalids Members of KLA

This association was started by a group of 13 KLA veterans who are with disability as a result of the war (VVAF, 1999:15). According to information provided by the association it comprises branches across Kosovo and is registered by UNMIK. According to its President, the aim of the association is to take care of war wounded persons with disability and to integrate them back into the society. The main activities that it intends to carry out include medical care and rehabilitation, assistance with living conditions, food and other materials, organisation of cultural and sports activities and assistance on education and reintegration into the community.

United Nations agencies and bodies

WHO has been active in the province of Kosovo since 1997. Activities stopped during the conflict but since the peace agreement, WHO has built up a humanitarian and development presence focusing on health sector planning, reform and development. It had been hoped that WHO, as leading agency, would have appointed and funded the Victim Assistance Officer within the MACC.[299]

UNICEF has been engaged in mine action mainly through mine awareness activities (UNICEF, 2000). The organisation acknowledges that it has not done a great deal with regard to mine victim assistance, although between July 1999 and November 2000, it provided some support and psychological care to children who have been injured by mines and UXO. UNICEF claims that disability issues will be a significant part of their overall work in 2001, in collaboration with UNMIK Department of Health and Social Welfare and NGOs. The main objectives are to increase: (a) awareness and acceptance of children with disabilities by society; (b) knowledge and understanding of the situation of children with disability; (c) the capacity of the Department of Health and Social Welfare in addressing the needs of children with disability; and (d) local NGO capacity to deal with this issue. UNICEF will also seek to develop services for children with disabilities in order to provide them with adequate support, to ensure their full reintegration and participation into the society, to develop local NGO capacity in responding to their needs, and to help building the capacities of UNMIK's Department of Health and Social Welfare in developing appropriate responses and services for children with disability.

In accordance with one of the MACC's objectives for 2001 to develop a register of accessibility for schools, parks and public buildings, UNICEF has been asked to provide a list of schools with access facilities for persons with disability. Collaboration and funding support have also been asked from UNICEF in order to finance the Run for Fun and the Charity Concert planned by the MACC.[300]

Concluding remarks

According to its most recent information, the MACC in Kosovo believes that close to 500 people have been involved in mine- or UXO-related incidents since June 1999. It is recognised that the needs of Kosovo mine and UXO victims are very similar to those of any person with disability and it is generally agreed that the success of any

299. Remarks by Leonie Barnes, 2 February 2001.
300. Meeting between the MACC and UNICEF, Pristina, 8 February 2001.

programme in favour of mine/UXO victims must be based on this recognition. The concern generally expressed by the various actors is to meet the specific needs of mine/UXO victims without setting them apart from larger groups such as victims of trauma and people with other disabilities, in order to fully reintegrate them back into the society.

Even though the actual number of mine and UXO victims may be small, providing these persons with the necessary assistance will have an important long-term effect. There is a widespread belief that rehabilitation and reintegration initiatives will need greater emphasis and that the resources currently available to deal with the immediate and long-term specialised treatment of mine victims are inadequate.
An extensive network of medical support already exists across the province such that mine victims can generally reach a medical facility within a relatively short period of time. The quality of these facilities, however, varies widely and there is considerable room for improvement in efficiency in the health sector in general and hospitals in particular, Pristina Hospital being the only one capable to deal with major trauma cases.

Although physical rehabilitation is relatively well ensured, mainly by Handicap International, there remains a lack of physical rehabilitation professionals in Kosovo. In addition, no national capacity currently exists to fit upper limb and above-knee prostheses in Kosovo, although such cases can be referred abroad.

The weakest link in the chain is in psychosocial support, vocational training and other forms of social reintegration. Indeed, Kosovo has had little tradition of psychosocial treatment or community care and support and local NGOs such as Handikos still have limited capabilities in this area. The Socio-Economic Survey clearly outlines the considerable work left to do in this regard.

The MACC has effectively recognised mine and UXO victim assistance as an integral part of mine action, and has been active in ensuring visibility of the victims through the elaboration of a data collection system. It acknowledges, though, that improvements can be made to the data gathering system in order to increase the standard and accuracy of reporting. The MACC will continue to ensure that the most pressing needs of mine and UXO victims are addressed, but regrets the lack of sufficient funding as well as specific victim assistance expertise within its headquarters. To date, relatively few of the plethora of mine action organisations operational in Kosovo have incorporated a victim assistance component in their work.

In sum, given adequate resources and competence, the MACC believes that the most urgent needs of survivors can be met by the end of 2001. Furthermore, it is confident that mine and UXO victim assistance will be a finite activity, which in the longer term will fall directly under the mandate of the UNMIK Department of Health and Social Welfare.

Chapter 4

The case of Nicaragua

Introduction

Nicaragua's ratification of the Mine Ban treaty which took effect on 1 May 1999, not only governs the use, production, stockpiling and transfer of weapons that pollute Nicaraguan soil, along with other unexploded munitions, it also requires other actions, primarily of a social and political nature.

The presence of landmines represents a well-documented threat to the well-being of entire communities, especially in rural areas, which also impedes their productivity and their mobility. Among the victims of landmines are many farmers who were killed or wounded while working the soil. The Mine Ban Treaty directly addresses the need to confront this multi-faceted threat and deal with its tragic consequences: in addition to its core obligations, the Treaty also requires preventive measures as well as assistance for the victims, to ensure their physical and psychological rehabilitation and social and economic reintegration.

This case study reviews the existing role of mine action in assistance to mine and UXO victims in Nicaragua. It addresses the extent to which victims' needs are met within the wider context of assistance to war and other persons with disability and how mine action has contributed to strengthening this response. In doing so, the authors stress the need to take into account the socio-economic context of Nicaragua, a country in which the legacy of years of conflict is severe and endemic poverty.

The socio-economic context in Nicaragua

Poverty and Nicaragua

Nicaragua, which has a population of almost five million, is classified by UNDP in its *Human Development Report* as the poorest country in Latin America after Guatemala and Haiti. The International Monetary Fund and the World Bank have accorded it the status of "heavily indebted nation". It entered the 1990s with a partially destroyed and

dysfunctional economy, the painful legacy of many years of bitter civil war.

Beginning in 1994, after an initial period during which the economy had stagnated under the weight of neo-liberalism and foreign debt, there was a gradual — but inconsistent — improvement as a result of the economic upturn that reached Central America amid the rapid globalisation of the world economy. In 1994, Nicaragua's gross domestic product (GDP) grew by 3.2 per cent; by 1999, annual growth had attained 7 per cent, (Banco Central de Nicaragua, 1999) due to the significant increase in public investment in reconstruction following the catastrophe of Hurricane Mitch. Despite these advances and the general revival of the productive sectors, Nicaragua has the lowest GDP as well as GDP per capita in Central America (UNDP, 2000).

The country is predominantly agricultural, with produce from this sector representing 50 per cent of Nicaragua's total exports and employing 43 per cent of its economically active population (Banco Central de Nicaragua, 1999). Notwithstanding the strength of the agricultural and livestock sector, Nicaragua is unable to satisfy the basic food needs of its population and its economy depends to a significant extent on foreign assistance, amounting to 22 per cent of its GNP in 1998.

The industrial sector is somewhat antiquated and has gone through a period of recession; in contrast, the informal economy has been growing significantly. Energy, transport and communication infrastructure is relatively poor.

The country's economic vulnerability can be seen from its heavy external debt, three times the size of its GDP. Attempts to satisfy the demands of the nation's creditors have had a high financial cost that has largely cancelled out the benefits of external aid, engendering severe economic adjustment with a corresponding impact on the social sector.

Indeed, the economic changes inflicted during the 1990s have failed to reduce the level of poverty, which continues to be the main challenge for economic policy. It is estimated that more than 60 per cent of the population lives in poverty, the rural areas being especially affected.[301] Indeed, rural poverty, together with the high concentration of income in the cities, represents major social division within the country and continues to obstruct efforts to ensure the wellbeing of the entire population.

Education and health

The same divisions between the city and the countryside can be seen in the level of education and health among the population. Whereas the urban population over 10 years of age has received an average 6.2 years of schooling, the figure for the rural areas is only 3.2 years, and in some areas of extreme poverty it drops to 2.3 years. On a national level, illiteracy affects a fifth of the population over 10 years of age, yet in the rural areas one-third of the population cannot read and write, and in the poorest areas the figure reaches one-half (Instituto Nacional de Estadística y Censos, 1998).

In the health sector, a number of successes have been achieved in recent years, with a

301. The percentage of the population living below the poverty line varies depending on the method employed. According to the UNDP *Human Development Report*, in 1998 72.6 per cent of households in Nicaragua were unable to meet their basic needs, including 80.2 per cent of rural households, while in the same year the proportion of the population below the poverty line was 47.9 per cent, including 68.5 per cent of those living in rural areas.

significant reduction in infant mortality and a general improvement in the level of health provision. Community participation played a key role in this achievement, and has helped to establish effective coordination between civil society and the Ministry of Health. Nationally, however, health problems continue to be serious, especially in the poorest and most vulnerable areas where illness and premature death are caused by malnutrition and infectious and endemic diseases. The majority of health infrastructure is to be found in the cities, as are most health professionals. In 1997, maternal mortality was 139 per 100,000 living births, which represents the second highest rate in Central America after Honduras (Instituto Nacional de Estadística y Censos, 1998).

Democracy and participation

In the space of almost half a century, Nicaraguan society has undergone three major institutional changes (1950-1977; 1980-1989; and 1990-1996). These changes have not, however, resolved the social basis of political conflict in the country; indeed, the country's social and political polarisation has obstructed the provision of a basic standard of living being ensured to all Nicaraguans.

Although progress has been achieved in the promotion and protection of human rights through the adoption of new legislation and the creation of institutions dedicated to the implementation of this legislation, the institutionalisation of civil society participation in public decision-making, a key factor in democratic development, remains weak, and in some cases has even declined in recent years. Indeed, the State still seems wary of civil society, especially NGOs, which have tended to act as an independent voice in the country.

The mine action context

The impact of the conflict: The nature of the threat

Landmines and UXO

As a result of civil war in Nicaragua that reached its height in the mid-1980s, a number of areas of the country remain affected by landmines and (though to a lesser extent) unexploded ordnance. Figure 1, below, details areas suspected to be affected by landmines.

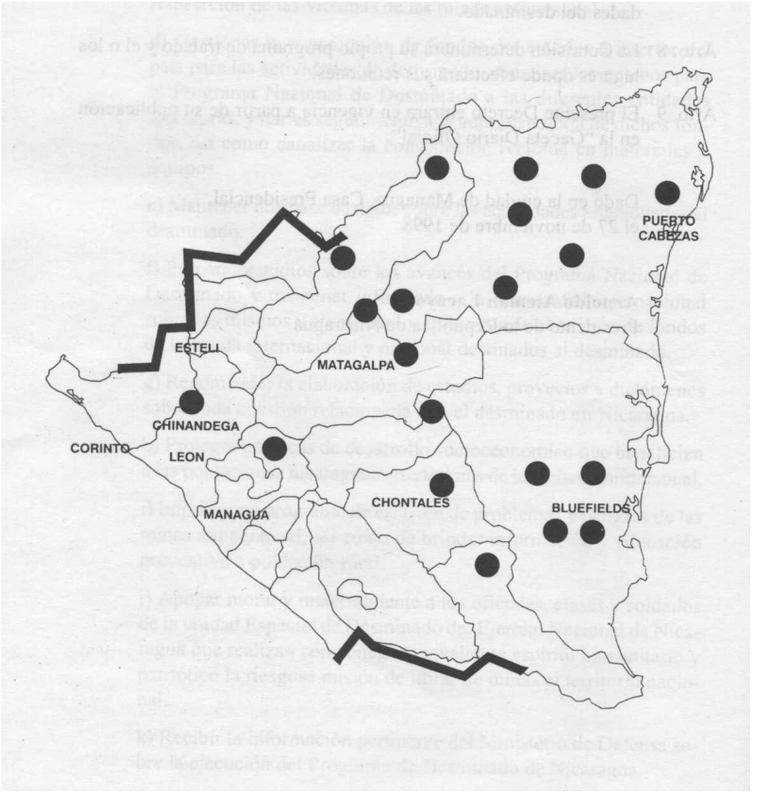
Mortality and morbidity rates

Significant difficulties have been encountered in the collection and analysis of mine victim data in Nicaragua. Each institution in the country has used its own form to record victims, which has led to the data being dispersed and not comparable. And, up until now, there has been no entity responsible for centralising and verifying the data. Thus, it has proved impossible to come up with an exact total of victims in the country.

To help understand the situation of the victims, we can illustrate the major historical tendencies of mine and UXO incidents in Nicaragua. Figure 2 clearly shows how the number of victims peaked during the war, then reduced after the fighting ended as mined areas became known (and hence avoided). A second, lower, peak came around

the time of Hurricane Mitch, when floods displaced a number of landmines, thereby increasing the risk of incidents.

Figure 1. Areas of Nicaragua suspected to be mine-affected



***Source*:** Center for International Studies, Managua.

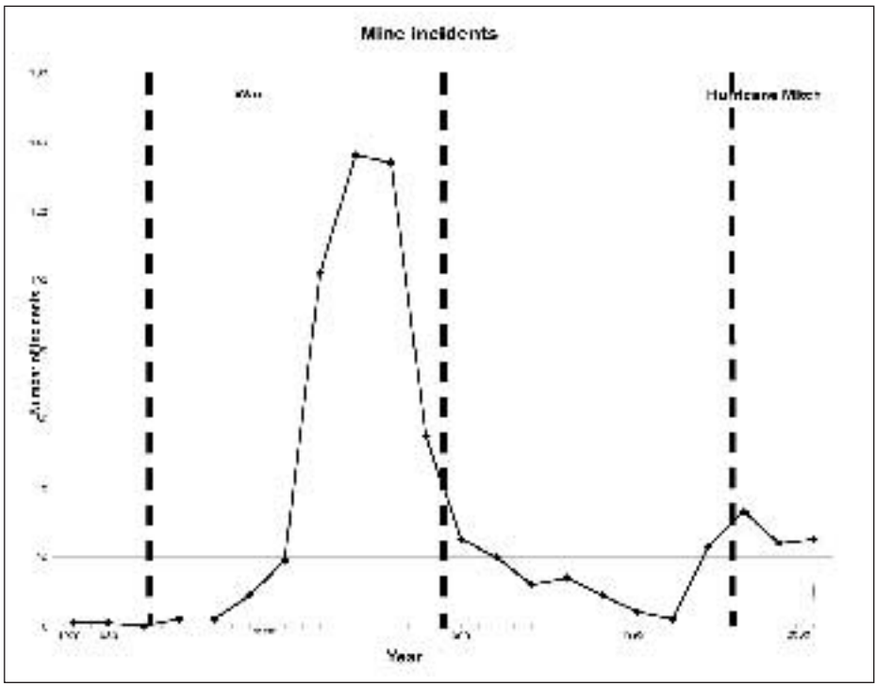
Figure 3, below, depicts the number of accidents and military injuries during demining from 1993-2001, Year 1 representing 1993, and Year 9, 2001. As can be seen, in 2000 no accidents were recorded, a fact that might suggest an improvement in the training of deminers and the management of operations. The low figure registered for 1994 may be explained by the reduced level of activity during that year.

Figure 4 compares deaths, amputations, and fragmentation injuries during demining operations over the same period. Of 33 victims, five were killed, 15 suffered amputation, and the remainder had fragmentation wounds. Of course, not only the survivors but also the families of the five fatalities will require assistance.

Figure 5 shows the gender breakdown of civilian mine incidents. An overwhelming number of the victims — 91 per cent — are male and this figure has been increasing since Hurricane Mitch. The figures are derived from IMSMA, which is now used by the Programme of Assistance to Demining in Central America (PADCA)[302] as its central database and which will contain all mine-related data in Nicaragua. Currently, it registers 350 mine victims and for each victim there is a record of basic victim information, which should enable ongoing monitoring of victim needs and the corresponding assistance provided.

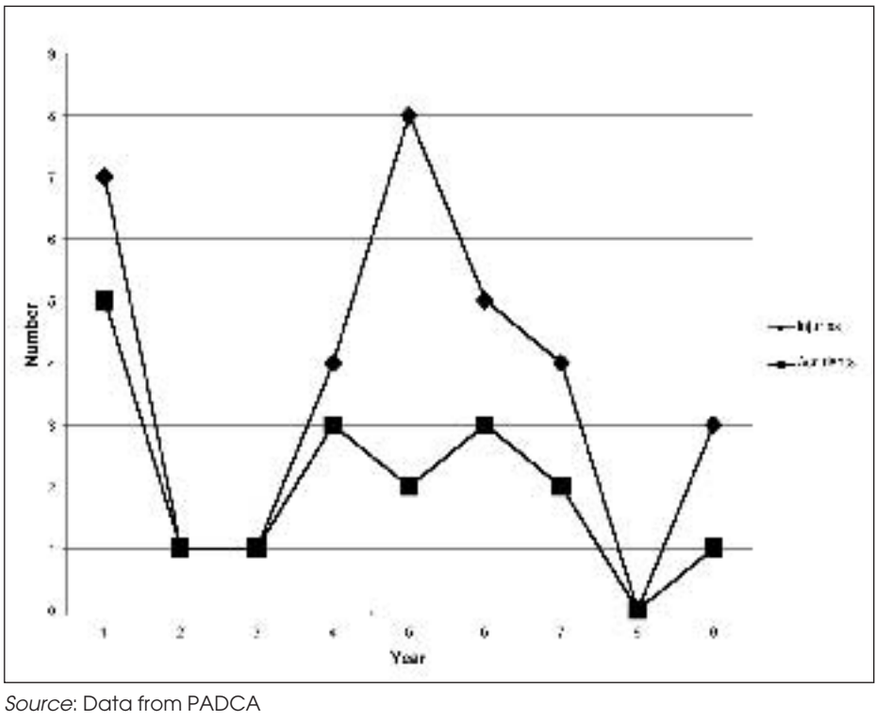
302. Set up by the Organization of American States (OAS).

Figure 2. Civilian mine incidents



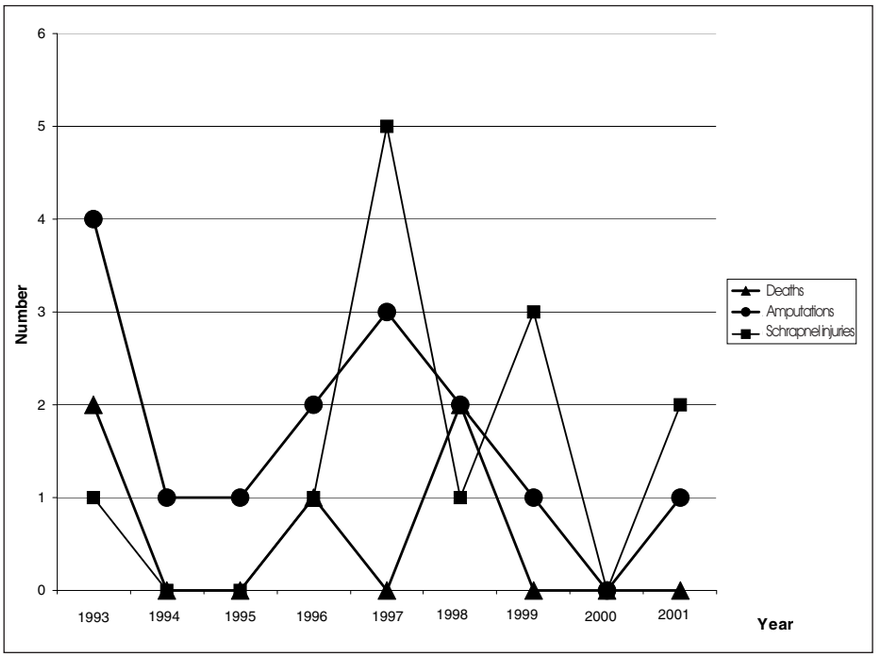
Source: Data from the National Prosthetic and Orthotic Centre, Managua .

Figure 3. Military mine accidents and victims during demining



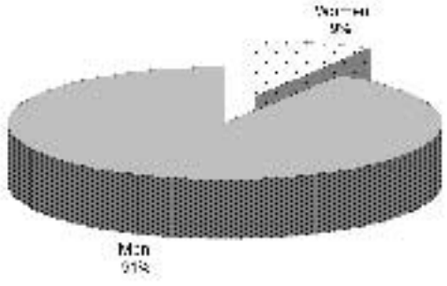
Source: Data from PADCA

Figure 4. Victim data on military mine accidents



Source: Data from PADCA

Figure 5. Gender breakdown of mine victims



Source: IMSMA Database (PADCA)

On the basis of information gathered during this case study, the authors believe that there are a total of 800 landmine amputees and some 3,500 other direct mine victims in Nicaragua. This is among a population of persons with disability of more than half a million.

Existing mine action responses

The National Demining Commission

National Assembly Decree 2007, which was signed into law by President Arnoldo Alemán in October 1998, not only supported the ratification of the Mine Ban Treaty, it also mapped out the entire mine action process for the country. Two months later, the

President signed the decree creating the National Demining Commission (Comisión Nacional de Desminado — CND).

The Commission is presided over by the Ministry of Defence and involves a variety of governmental institutions, notably the Army; the Police; the Ministries of Foreign Affairs, Education, Health, Agriculture and Forestry, Transport and Infrastructure, and External Cooperation; the National Assembly's Defence and Security Committee; the Nicaraguan Institute for Municipality Promotion[303]; and the Nicaraguan Institute for Social Welfare. A number of non-governmental institutions also participate, including the Red Cross, and NGOs such as the Nicaraguan Centre for Strategic Studies (CEEN) and an organisation for war disabled, the Joint Disabled Commission of Madríz, and the Network of Peace and Development Promoters. International organisations, such as the OAS and its PADCA mine action programme, UNDP, and UNICEF are also participants. The President of the Commission is the Minister of Defence, Adán Guerra, and the General Secretariat is under the responsibility of the Deputy Minister, María Auxiliadora Cuadra.

Among the main tasks of the Commission are the management, channelling, and oversight of the use of national and international resources, logistical support to demining operations, the development of preventive education programmes and rehabilitative care and social reintegration for mine victims. In 2000, three Sub-Commissions were created, respectively for Demining, Prevention, and Victim Assistance, each integrated through different institutions in accordance with their relevant skills. In January 2001, a fourth commission was set up to prepare the Third Meeting of States Parties of the Min Ban Treaty (TMSP), which took place in Nicaragua on 18-21 September 2001.

The Sub-Commission on Victim Assistance and Rehabilitation is chaired by Dr Norman Lanzas of the Ministry of Health. The Sub-Commission on Prevention is coordinated by the Ministry of Education, and the Sub-Commission for the Preparation of the TMSP is under the responsibility of the Ministry of Foreign Affairs. However, owing to repeated personnel changes within the Ministry of Defence, the Sub-Commissions have not functioned effectively, with 95 per cent of operations being devoted to stockpile destruction and mine clearance while the Sub-Commissions on Victim Assistance and Education have been neglected, and the Commission as a whole has been unable to establish a clear vision of how its different components should be integrated within national mine action.[304] Currently, efforts are being made to give these Sub-Commissions a new impetus.

Similarly, there has been an intention to broaden the participation of civil society representatives in the Commission, especially of NGOs involved in mine action. The involvement of those most directly affected by mines, however — that is to say, the victims — continues to be weakest of all. An ongoing task is the consolidation of mine victim data, since information held by the different entities involved in victim assistance is dispersed and contradictory. With this in mind, it is intended that a single victim information form, which has already been used in other countries, will be administered by PADCA, whose task it is to centralise and maintain the IMSMA database.

303. *Instituto Nicaragüense de Promoción de las Municipalidade*s.
304. Authors' assertions based on their research.

Mine clearance

The Nicaraguan Army: The National Demining Plan

According to information provided by the National Demining Commission, Nicaragua's National Demining Plan has had four phases:

Phase I: 1989-1992 — The Army first initiated mine clearance operations in 1989, concentrating on affected areas in the departments of Jinotega, Chontales and Chinadega. In 1990, the Government requested assistance from the OAS to undertake an assessment of the uncleared mines situation in Nicaragua prior to the implementation of a General Demining Plan. The Plan itself established that some 150,000 landmines remained uncleared on Nicaraguan soil, with the location of 80 per cent of the mines identified in army records. The decision was taken to form, train and equip engineering teams from the Army for demining operations, and a corresponding request for technical and financial assistance was made to the OAS.

Phase II: 1993 — Under the auspices of the OAS a Mission to Support the Removal of Mines in Central America (MARMINCA) was created, comprising 15 officials from South American armed forces to train and supervise the demining operations. The result of this phase was the constitution of a Special Demining Unit (UED), made up of five demining platoons, with Standing Operating Procedures for mine clearance operations. Phase II was interrupted in November 1993 because of a lack of funding, after 2,300 mines had been destroyed and an area of about 30,000 square metres cleared.

Phase III: 1994-1995 — The Army continued its operations with the UED without international support using funds taken from its own budget, from the Ministry of Transport and Infrastructure and the National Electricity Generating Company. It is recorded that during this phase some 18,000 landmines were destroyed and an area of some 145,000 square metres cleared.

Phase IV: 1996-1999 — Nicaragua's National Demining and Management Programme was presented by the Nicaraguan government to the international community in July 1995 at the International Meeting on Mine Clearance in Geneva. The initiative was received positively by donors and subsequently a number of governments provided funding support either bilaterally to the Nicaraguan Army, or through the OAS. The ICRC began a mine awareness programme (as did the OAS) and provided ambulances. Between 1996 and 1999, a German bilaterally-funded programme under MARMINCA/OAS auspices destroyed 6,933 mines and cleared an area of 64,378 square metres in Estelí, Matagalpas, León and Chontales, suffering four accidents in which nine people were injured.

The official report on Phase IV states that some 33,000 landmines were destroyed and 1.14 square kilometres of land was cleared. In addition, the programme was extended until 2004, with a diversification in detection methods and an improvement in the localising of buried mines.

National Humanitarian Demining Programme

Nicaragua's National Humanitarian Demining Programme, which is carried out by the Nicaraguan Army using its engineering corps, has continued its operations in order to achieve its objective set for 2004: to declare Nicaragua free of emplaced mines.

(Nicaraguan Army, 2001: 43-46) The programme is implemented with the support of the National Demining Commission and the OAS. Operations include not only demining itself, but also the destruction of stockpiles, mine awareness, and victim assistance for civilians. During 2000, it is reported that 20,000 stockpiled mines were destroyed[305] and 6,155 mines cleared from Nicaraguan territory. The Nicaraguan Army Engineer Corps is working in five separate zones of operations affected by mines, the fifth zone being initiated in June 2000 to address the situation in the North Atlantic Autonomous Region (*Región Autónoma del Atlántico Norte*).

In September 2000, a special plan for the destruction of unexploded ordnance was implemented with the support of the Ministry of Defence, the Nicaraguan Red Cross, the ICRC, the Civil Defence, PADCA, and the Ministry of Health.

Box 1. Areas of operations of the Nicaraguan Army Engineer Corps

Operations area	Sector of work
First Operations Area	Nicaragua's northern border, departments of Chinandega and Estelí, bridges and electricity pylons in the West
Second Operations Area	Nicaragua's southern border, San Juan river
Third Operations Area	Central Nicaragua, department of Chontales, Zelaya Central, El Rama and Bluefields
Fourth Operations Area	Nicaragua's northern border, department of Madriz and Nueva Segovia
Fifth Operations Area	North Atlantic Autonomous Region

Source: Nicaraguan Army (2001).

Mine awareness education

Many mines are detonated either because of carelessness on the part of the local population in affected areas, for instance by burning land or removing fencing so that livestock can graze. Occasionally there have been accidents caused by "village demining", especially in the border areas where the population is no longer afraid of explosive objects. Demining is conducted so that the land can be used; sometimes a local man or former combatant is paid to demine.[306]

In addition to its core provisions, the Mine Ban Treaty requires the creation, where appropriate, of mine awareness programmes for affected communities, so as to minimise the risk of incidents and injuries through a process of information exchange, skills training and education. It is also a mechanism whereby the local population can be encouraged to become active participants in mine action.

For the CND, prevention is a key theme. However, the Commission has not managed to ensure effective coordination in this area between the different organisations and

305. Press reports at the end of March 2001 stated that the Nicaraguan army had blown up a further 15,000 stockpiled anti-personnel mines on 29 March at Condega, leaving 81,813 to be destroyed. In declaring that Nicaragua's stockpile destruction programme would be completed by 2001-2002, the Minister of Defence called for a further US$29 million funding to complete the national clearance and destruction programme *"without including rehabilitation and reintegration"*(Olivas, 2001).
306. Information provided by the Red Cross and UNICEF.

institutions involved.[307] As a consequence, a number of entities have been trying to do so, starting with the Army.

Survivor stories: José

José M. is a 23-year-old soldier from Juigalpa who lost a leg while demining. The accident occurred on 26 January 2001 in San Francisco Libre, in Operations Zone No 1.

"*There were three of us involved in the accident, the other two suffered slight fragmentation wounds. There was a doctor and a paramedic there who gave us immediate medical attention. They took us by helicopter to the hospital where I spent 17 days. I knew this could happen to me. I had taken two training courses and I had seen seven accidents. But I could earn a bit more doing this work – 1700 córdobas a month – and with that I could help my family financially. I can't go back to doing that kind of work. I'm going to stay at home. I don't know how much they're going to give me for this, with the insurance money I'm going to buy a business. I'm hoping to get some training so that I can run it properly.*"

On 29 March 2001, José was a special guest invited to preside over the destruction of 15,000 anti-personnel mines from Nicaraguan stockpiles at Condega. He was awarded the Medal *Reconocimiento al deber Primera Clase* by the President of Nicaragua.

The Army's Mine Marking Platoon

As part of the mine awareness process, the Army has created a "Mine Marking Platoon" which is responsible for marking all mined areas across the country. This effort has not, however, always been successful, on the one hand because the areas mined by the resistance are not always known, and, on the other, because of displacement of mines by natural phenomena, such as wind or rain. Thus, during Hurricane Mitch, a significant number of mines were moved from their original emplacement.

The child-to-child programme

In 1996, to complement the programme of minefield marking, a campaign coordinated by the army and the Nicaraguan Red Cross with the support of the ICRC and UNICEF was targeted at children. UNICEF believes that many civilian victims are children who come across mines when taking their animals out to pasture, collecting firewood, or simply moving around and playing in the fields.

The Red Cross has promoted an innovative methodology whereby safety messages are transmitted from child to child. Girls and boys between 10 and 14 years of age are trained as relays, passing on warnings to other children about mines and how to avoid them. In the initial phase, five teams of child relays and adult coordinators were trained in five of the most affected departments of the country, developing a campaign of social mobilisation during which 5,473 people, mostly boys, girls and adolescents, received mine awareness directly. To broaden the reach of the programme, work began with the Ministry of Education to create school-based trainers and to integrate mine awareness education into the school curriculum.

307. The first meeting of the Sub-Commission on Prevention did not take place until the end of March 2001; until then, efforts to integrate prevention within mine action were made by UNICEF and the Red Cross outside the CND.

Among the educational materials used were "home-made" items developed on site, which had unclear and inappropriate messages that could be extremely dangerous, such as "*If you encounter a mine, mark it with rocks and retrace your footsteps!*". In addition, an educational package was distributed that included a comic book produced by DC Comics whose main characters were Superman and Wonder Woman. This material has been widely criticised — for its lack of realism, use of personalities unfamiliar in the rural areas, and indirect use of a message that suggested that the solution to the mine problem lay in outside intervention, using magical powers.

Another weakness in this educational model was the use of outside facilitators, which failed to encourage the growth of local trainers who would be more aware of the local problem and who could ensure ongoing mine awareness as well as monitor the effectiveness of the education already provided.

In 2000, the programme entered its second phase. On the basis of lessons learned it was decided to revise all awareness materials, drop the use of the comic book, and transmit the information directly to the communities. The new teams that were created comprised a (local) adult coordinator and two adolescents from each community. It was also decided to broaden the zone of intervention to cover five departments (San Francisco Libre in Managua, Chinandega, Madriz, Nueva Segovia, and Jinotega) and four autonomous regions (Siuna, Waspán, Puerto Cabezas, and El Rama).

The Peace and Development Promoters

The Nicaraguan Centre for Strategic Studies (CEEN) used a different education model working together with the Network of Peace and Development Promoters, using local resources. The preventive work was developed in coordination with the different zones of operation of the Army Engineer Corps in the departments of Chinandega, Madriz, and Nueva Segovia. Before initiating the programme a needs assessment was conducted in the affected communities to determine the level of mine threat and the existence of local resources, involving the mayors from towns and communities in the priority areas, based on suggestions from the army. The assessment concluded that there were some 6,000 people at particular risk in the areas in which they were planning to carry out awareness activities.

At the end of the assessment, a network of local facilitators was established using individuals respected in the community, such as teachers, priests, the mayors, and especially ex-combatants from the army and the resistance; these included a number of war wounded with disability. In each of the 18 municipalities selected, around 45 workshops were organised; in total it is estimated that between 6,000 and 7,000 people were educated about the danger of mines. The facilitators were also able to act as intermediaries between the authorities and the local population, keeping everyone informed about mine incidents, and passing on relevant information to the army.

Perhaps the most important aspect of the programme was its integration in wider peace-building and reconciliation, using former antagonists — the demobilised soldiers from the army and the ex-combatants from the resistance — transforming them all into peace promoters in their communities. Despite the clear reduction in the number of incidents in areas where the mine awareness education was carried out, unfortunately the programme was halted for lack of funds.

The future of mine awareness education

To ensure future coordination of efforts and messages, in April 2001 OAS and UNICEF jointly convened a workshop to involve all actors working in the area of prevention in mine action. The specific objectives of the workshop were to:

- Share and identify clear direction for the educational messages in particular and mine awareness in general. For instance, in case of an incident, to whom should one be directed;
- Establish a working group that will drive and monitor the awareness and education work;
- Determine concrete actions that could be jointly undertaken.

It was hoped that all the workshop participants would undertake not to use any educational material that had not previously been certified by the group as a whole.

Mine ban advocacy

Since 1 May 1999, Nicaragua has been a State Party to the Mine Ban Treaty. National implementing legislation was signed into law on 7 December 1999. Nicaragua has served as co-chair of the Standing Committee of Experts on Victim Assistance (ICBL, 2000:281). On 5 December 2000, the government ratified Protocol II as amended on 3 May 1996 to the 1980 Convention on Certain Conventional Weapons.

Victim assistance

The OAS has led in the provision of assistance to mine victims in Nicaragua. For the last two-and-a-half years, OAS-PADCA has offered comprehensive medical and rehabilitative assistance to mine victims, including diagnosis, transport, food and treatment, using the National Prosthetic and Orthotic Centre (CENAPRORTO). Psychological support is also offered. At the end of March 2001, the Director-General of the OAS Secretariat in Nicaragua announced that an assessment would be conducted in May of the situation of mine victims in the country "*to enable the implementation of programmes in favour of the affected population*" (Olivas, 2001).

In general, however, very little is done to support the social and economic reintegration of mine victims. Indeed, the most significant attempt at a governmental level in Nicaragua to promote the social and economic reintegration of mine victims comes from a joint initiative of Canada, Mexico and the Pan-American Health Organisation entitled *Assistance to Landmine Survivors in Central America*.

The tripartite initiative, which is coordinated by the OPS, proposes to:

- Extend and improve rehabilitative services;
- Increase the participation and coordination between private, public, community-based and disability organisations;
- Elaborate a database that includes basic data enabling evaluation to take place;
- Train health and education personnel from NGOs and the government to provide information on the location of mines and UXO in safety and identify persons with disability in rural areas;
- Prepare and disseminate printed materials to support patients in their re-education, so that they may adapt to using their prosthesis or other assistance

devices;

- Facilitate the integration of persons with disability in the economic and social life of the community; and
- Include the families, communities and persons with disability in the process of decision-making.

The OPS participates in the work of the National Demining Commission and its Sub-Commission on Rehabilitation.

Victim assistance

The definition of disability

According to Dr Norman Lanzas, the Coordinator of the Rehabilitation Committee in the Ministry of Health, roughly 12.5 per cent of the Nicaraguan population is with disability, compared to a worldwide average of 10 per cent. On this basis, it can be estimated that 600,000 Nicaraguans are with disability. The majority do not benefit from any assistance for health, training and employment.

Although Article 3 of Nicaragua's Law 202 on Disability contains a broad definition of disability,[308] in practice there appears to be a perception that, at least in the case of mine victims, injuries other than amputation, for example psychological trauma or fragmentation wounds that affect one's capacity to work, are not considered as disabilities. Records that have been kept tend only to include individuals who have lost lower or upper limbs. These amputees often receive relatively swift — and free — physical rehabilitation from PADCA and the ICRC.

Mine and UXO victim needs

Survivor stories: Américo

Américo C. is a 72-year-old mine victim from Matagalpa. His accident occurred in La Cruz de Río Grande on 20 October 1986 in Jinotega where he lost both his legs. He used to be a businessman, and on the day of the accident he was going with his wife to buy things for his business when the truck in which they were travelling hit an anti-tank mine, killing most of the people inside, including his wife.

"*I lost everything – my wife, my legs, my business, I was left with nothing. Today I'm dependent on others, but people look at me as if I come from another planet. The government has forgotten us, we're left to get by completely on our own.*"

Mine victims often refer to the need for a holistic provision of assistance. Although they generally receive prostheses if they need them, other medical problems caused by the mine incident are not treated by the health system. They refer to problems such as weaknesses in the spinal column caused by the bodily imbalance resulting from a

308. *"For the purpose of this Law, the following definitions shall be used: a) Handicap: a permanent or temporary, psychological, physiological or anatomical loss or abnormality of the body or bodily function…" ("Para los efectos de esta Ley, se consideran las siguientes definiciones: a) Deficiencia: una pérdida o anormalidad permanente o transitoria, psicológica, fisiológica o anatómica de estructura o función...")*, Ley 202, Reglamento y políticas sobre Discapacidad en Nicaragua, p. 6.

lower-limb amputation, ophthalmic problems often caused by the smoke given off in a mine explosion, and problems with other organs linked to the incident. The health system is not able to treat these patients' needs effectively.

One of the most serious problems that amputees face is the lifespan of the prosthesis, which lasts only three years even when it is made out of polypropylene, which is the toughest material. The cost of a below-knee prosthesis of this type is about US$350, which is extremely high for a Nicaraguan, particularly as most victims are from the countryside where incomes are particularly low. Although prostheses are currently available without charge, this is reliant on external aid, and there is no evidence that the government is prepared to continue this free service once outside funds dry up.

As far as psychosocial needs are concerned, only rarely is any assistance provided. The national health system has no psychological rehabilitation capacity, with the exception of the support provided by CENAPRORTO prior to and immediately following the fitting of a prosthesis.

Civilian mine victims are not entitled to any specific social welfare payments or provision as a result of their special circumstances. If, however, deminers are injured by a mine while conducting mine clearance, they receive compensation that varies depending on the extent of the injuries. After the accident, the deminers are given sick leave from the army and civilian status. There is no vocational retraining programme that would enable injured deminers subsequently to undertake administrative tasks.

The existing provision of assistance

The Ministry of Health has 996 health centres around the country, of which nearly half are located in the Pacific zone. It has a total of 31 hospitals, 11 of which are located in Managua. Hurricane Mitch damaged 108 buildings, mainly in the countryside in the north of the country. Overall, according to official figures, around 8.5 per cent of the population does not have any access to health services, but the urban-rural distribution is extremely unequal with only 1 per cent of those living in the cities having no access, whereas in the countryside the figure is 20 per cent. On a departmental level, the weakest coverage is along the Atlantic Coast and in the north and centre of the country (Instituto Nacional de Estadística y Censos, 1998).

In 1998, the public health budget represented 5.4 per cent of GDP, putting Nicaragua above the Central American average of 3.8 per cent (OPS and Ministry of Health, 2000). However, the lower size of Nicaragua's GDP means that expenditure per capita is the lowest in the region.

The Nicaraguan Institute for Social Welfare has 51 clinics, which offer medical assistance to those who are insured. In a country where the informal sector is the mainstay of economic activity, only a small number have access to their services, most of these living in the cities.

There are currently few governmental initiatives to provide assistance to persons with disability. In a small number of departments, there are rehabilitation wards in the main hospitals.

Plans do exist, however, to respond to the needs, notably through The National Council

for Prevention, Rehabilitation and Equal Opportunities for Persons with Disability, which was created in August 1998 and is chaired by the Ministry of Health. The Council is the entity responsible for promoting, encouraging and coordinating governmental efforts on behalf of persons with disability and the population in general for the attainment of the objectives set out by the institutions and organisations involved in implementing the provisions of Law 202.

In addition to the Ministry of Health, the Council is made up of representatives of the Ministry of Social Welfare, the Ministry of Labour, the Ministry of Education, the President of the Executive Board of the Nicaraguan Institute for Municipal Promotion, a representative of the Nicaraguan Institute for Technical Assistance (INATEC), two representatives of organisations for persons with disability, an expert representative, and a representative of each of the regional councils of Nicaragua's Atlantic Coast.

The Council coordinates its work with PADCA and cooperates with the tripartite initiative of Canada, Mexico and the Pan-American Health Organisation (OPS),[309] which finances some of its activities. It also forms part of the National Demining Commission. One of the biggest problems the Council faces is that it does not have a share of the national budget to finance its work, which means its effectiveness is accordingly limited.

Pre-hospital care

For deminers, the army engineer corps has a health unit that provides first aid and other medical assistance to personnel working in the various operation zones. Civilians generally do not benefit from this assistance.

Survivor stories: María

María L., a 25-year-old woman from Masaya, lost both her legs as the result of a mine explosion. She used to have a small cheese factory for which she had to travel around the country. The incident took place in 1994 on the road to Río Blanco, at the Paso Real bridge, while she was bathing in the river.

"*No one wanted to help me because they were afraid that there were other mines, my husband got me out as best he could. From then on, my life changed, now my job only brings me 500 córdobas*[a] *a month, which isn't enough to get by on, but I can't get a better job because as soon as people see me, they don't want to hire me. It's really difficult to manage without special assistance.*"

a. About US$40.

Hospital and medical care

The National Council for Prevention, Rehabilitation and Equal Opportunities for Persons with Disability provides primary health care and hospitalisation costs to civilian victims injured in the operation zones. Normally the hospitals have a traumatologist who decides on the intervention needed. After the intervention, there is a cycle of pre-prosthesis therapy before the patient is handed over to CENAPRORTO for physical rehabilitation.

309. See below.

Physical rehabilitation

The task of CENAPRORTO, which falls under the auspices of the Ministry of Health, is to provide physical rehabilitation to civilians and soldiers alike, including a lower or upper prosthesis, on the basis of a social non-profit approach (even though the Centre is supposed to be self-sufficient). In the 1980s it provided assistance to war wounded, initially with the support of the ICRC and Oxfam. But at the end of the decade the number of victims fell and with it the funding, leading to a financial crisis that left those in need unprotected.

Currently the Centre is made up of:

- A prosthetic and orthotic construction workshop with a hostel with 23 beds for men and women;
- A gymnasium with extra rooms;
- A diagnosis department;
- A psychotherapy department; and
- A physiotherapy department.

The Centre's annual productive capacity is 615 prostheses. It assumes part of the cost of the prosthesis, seeking funding from international organisations, such as the ICRC, which this year will provide 450 prostheses, 3,750 days of accommodation, 120 wheelchairs, and many crutches.

The Centre specialises in the treatment of victims of any kind of accident, including amputations as a result of a mine explosion. Staffing include five qualified prosthetisists who received additional training outside the country on the use of polypropylene in manufacturing prostheses. CENAPRORTO coordinates with PADCA to ensure that mine victims who need prostheses receive them. Since the 1980s, a total of 301 mine victims have been treated. The Centre appears to function effectively, the main drawback being the reliance on international funding.

Social and economic reintegration

The army provides deminers with life and accident insurance in case of amputation: US$10,000 for loss of work, US$40,000 for loss of life or disability. Civilians receive no assistance, apart from medical treatment.

Survivor stories: José M.

José M. is a 33-year-old from Matagalpa who was injured while serving as a soldier. When he suffered his accident he was only 20; he lost a leg and was left partially blind by the smoke from the explosion.

"I was conscripted for military service, before that I used to be a farmer, and I was helping my family. Now I can't work because sowing the fields means I have to walk long distances and I'm too tired. I do odd jobs to get by. If I were given a loan I would buy some cows so that I could sell the milk and with that I could live a little better."

In general, most of the attempts to promote social and economic reintegration of mine victims, within the wider context of assistance to persons with disability, come from

the non-governmental sector, especially NGOs and voluntary associations. Thus, for example, in addition to its involvement in mine awareness education, the **Joint Disabled Commission of Madríz** (CCD) provides assistance to 497 persons with disability of whom 98 are mine victims. The programme is conducted in coordination with PADCA, the Ministry of Health and other donor agencies. It includes training in welding, carpentry and electricity, implemented with the support of an international NGO. It also provides courses in agronomy and plumbing in other municipalities.

The philosophy that underpins its work is the reinforcement of peace and reconciliation across the country. In the municipalities of Somoto and Madriz it appears to have achieved good results in promoting the peaceful existence of the population. It is the only organisation of ex-combatants that participates in the National Demining Commission.

The **Organisation of Disabled Revolutionaries** (ORD), one of the members of the Joint Disabled Commission, is an NGO with national coverage. It was founded 20 years ago and currently has 15,000 members. Despite its Sandanista origins, its philosophy and its statutes do not discriminate on the basis of politics, ideology or religion. Its members are with disability, not only because of war but also traffic accidents and natural phenomena; it believes that 4,800 members have been directly or indirectly affected by landmines.

The ORD organises union activities in support of the social reintegration of all persons with disability. This includes training workshops with INATEC, covering cooperatives, administration, leadership, and the cultivation of basic foodstuffs. During 2001, ORD will be developing 40 courses in different departments across the country. It requested to be part of the National Demining Commission but the request was not accepted.

The **Association of Disabled of the National Resistance** was created upon the demobilisation of the *Contras* in 1990. Its mission is to promote and defend the rights of persons with disability in Nicaragua in the context of international solidarity. Among its members are mine victims, who have received prostheses through coordination with PADCA, CENAPRORTO and *Walking Unidos*. They coordinate courses with INATEC on leadership and basic accounting, and develop credit schemes. The Association does not participate in the National Demining Commission, and is currently establishing a parallel body with FECONORI (the Nicaraguan Federation of Organisations for Rehabilitation and Integration).

FECONORI comprises 29 organisations that work with persons with disability, including but not exclusively, mine victims, in assistance and especially social reintegration. The Federation was established in 1997 and it coordinates its activities with the National Council for Rehabilitation. The Federation is funded by a number of NGOs and international organisations, with Handicap International being the biggest donor.

Among the Federation's members is **Walking Unidos**, which has a small centre making prostheses from polypropylene for amputees who cannot afford them. Their recipients include mine victims. Three fifths of the staff at the centre are themselves with disability.

Disability legislation

Law 202 was promulgated on 23 August 1995. It constitutes the work plan for the National Council for Prevention, Rehabilitation and Equal Opportunities for Persons with Disability. Decree 50-97 contain the Regulations for Law 202. These instruments are the legal framework for the action that all sectors of Nicaraguan society must carry out in the area of rehabilitation and equality of opportunity. Some of the most important provisions are:

Under Chapter I, Article 3(d) it is provided that:

> *"Rehabilitation is a process whereby a combination of social, educational and vocational measures support disabled individuals to attain the highest possible level of functionality and to reintegrate into society."*

Likewise, in Chapter II, Article 5 (b) it is stated:

> *"Physical, mental and social rehabilitation enables the full recovery of persons with disability person."*

The greatest obstacle faced by this law and its accompanying regulation is its implementation through State institutions.

Law 119, Decree 491 also governs assistance to war victims. This legislation, which was drafted by the Sandanista government and reformed by the government of Violeta de Chamorro, provides protection to soldiers from the army and the resistance. In addition, Decree 975 governs pension rights for war wounded.

Concluding remarks

Since December 1998, when Nicaragua ratified the Mine Ban Treaty, considerable progress has been made in the process of mine action. However, progress has not been homogeneous across all aspects of mine action with the result that it is not possible today to speak of an integrated process. Mine clearance has advanced at a steady pace in the different demining zones and there exists an action plan with dedicated human and financial resources that enables optimism as to its successful completion.

The processes of prevention, awareness and education for affected populations have also advanced using innovative methodologies. However, these experiences have been principally driven by private organisations, with little involvement from governmental institutions. This has occasioned a certain dispersion of experiences, and has made it almost impossible to monitor the results of the various activities carried out and to evaluate methodologies. Following controversy surrounding the use of comic books, produced by DC Comics, it was hoped that the workshop on media and messages planned for April would bring the different organisations onto a common path. The challenge remains for mine awareness education to overcome the dangerous over-familiarity with explosive objects in certain areas of the country. This, combined with the pressing need for the population living in rural subsistence agriculture to farm their land, continues to have tragic consequences.

Important initiatives are being developed in the area of direct assistance to mine victims, yet obstacles remain that must be overcome. Perhaps the most obvious relates

to the victim register. The different organisations involved in assistance to victims hold different figures and until recently there was no centralised registry to verify data collected. The ultimate success of the IMSMA database, however, will also require resolution of the conceptual debate about the definition of who constitutes a mine victim. Restricting the definition to amputees seems excessively narrow and omits other types of injury or disability. Likewise, not considering the families of the victims, living or dead, as also those who have suffered from landmines is inappropriate and has significant implications for the design of programmes and strategies to promote economic and social reintegration.
In effect, the area of economic and social reintegration for civilian mine victims is almost non-existent. Only in the case of military victims is accident insurance provided, and this alone will not ensure social and vocational reintegration. Civilian victims do not even receive this payment, unless they have work insurance, which is only the case for a tiny percentage of the population working in the affected areas. Despite Law 202, there are no national plans, policies or programme that effectively support persons with disability to reintegrate into the social and economic life of the country.

Indeed, the empirical evidence collected for this case study has shown that despite the passing of laws and decrees regulating assistance and rehabilitation for all persons with disability, whatever the origin of their disability, the efforts being made to set up programmes to promote the social and economic reintegration of those in need are grossly inadequate. To date, neither the National Rehabilitation Council nor the Sub-Commission on Rehabilitation of the National Demining Commission has been able to work effectively, the former for lack of funds, the latter also due to instability caused by the frequent change of ministers and civil servants in the upper echelons of the Ministry of Defence and the Ministry of Health.

Considerable work is being done by civil society, especially in vocational training, including by organisations of ex-combatants. Their best efforts fall far short of the need, however. Without persistent and comprehensive governmental commitment to more than half a million persons with disability in Nicaragua, the future for all, including the victims of mines, looks bleak.

Bibliography

General

Bad Honnef (1997)
"Mine Action Programmes from a development-oriented point of view", drafted at First International Conference of Experts, Germany.

Boddington, M.A. (1999)
"Sustainability of Prosthetic and Orthotic Programmes", *Journal of Mine Action*, Vol. 3 (3), pp. 22-24.

Coupland, R.M. (1997)
Assistance for victims of anti-personnel mines: Needs, constraints and strategy, ICRC, Geneva.

Dunne, J. (2001)
Synopsis of victim assistance program in N. Iraq – 2000, United Nations Office of Project Services, New York.

GICHD (2001)
A Study of Socio-Economic Approaches to Mine Action, GICHD, Geneva.

Handicap International (2000)
Towards Real Assistance to Landmine Victims: The Position of Handicap International, Development and Strategies Collection.

Handicap International (2000a)
"Victim Assistance: Thematic Report 2000, a review of reported casualties and victim assistance", Thematic Coordinator for the Landmine Monitor, HI, Lyon.

Harte, C. (1999)
"Prosthetics and Orthotics: A personal view from Cambodia", *Journal of Mine Action*, Vol. 3 (3), pp. 13-17.

Hastie, R. (1997)
"Disability and Conflict", in *Disabled Children in a society at war: A casebook from Bosnia*, Oxfam UK and Ireland, pp. 93-108.

ICBL (International Campaign to Ban Landmines) (1999/2000)
Victim Assistance: Contexts, Principles, and Issues, Position Paper of the ICBL Working Group on Victim Assistance.

_____ (2000)
Guidelines for the Care and Rehabilitation of Survivors, Working Group on Victim Assistance.

_____ (2000a)
Report on activities: Second Meeting 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.

_____ (2000b)
Landmine Monitor Report 2000: Toward a Mine-Free World, Human Rights Watch, September.

_____ (2001)
Landmine Monitor Report 2001: Toward a Mine-Free World, Human Rights Watch, September.

International Physicians for the Prevention of Nuclear War (2000),
Primary Care of Landmine Injuries in Africa, A Basic Text for Health Workers, Massachusetts.

Landmine Monitor (2000)
Landmine Monitor Report 2000, Toward a Mine-Free World, Human Rights Watch, September.

Physicians for Human Rights (2000),
Measuring Landmine Incidents and Injuries and the Capacity to Provide Care, A Guide to Assist Governments and NGOs in Collecting Data about Landmine Victims, Hospitals and Orthopaedic centres, Boston.

Roberts, S. and Williams, J. (1995)
After the Guns Fall Silent: The Enduring Legacy of Landmines, Vietnam Veterans of America Foundation, Washington DC.

Save the Children Alliance (1996)
Promoting Psychosocial Well-Being Among Children Affected by Armed Conflict and Displacement: Principles and Approaches, International Save the Children Alliance Working Group on Children Affected by Armed Conflict and Displacement.

Second Meeting of the States Parties (2000)
Report of the Standing Committee of Experts on Victim Assistance, Socio-economic Reintegration and Mine Awareness, Second Meeting 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, Geneva, 11-15 September.

Standing Committee on Victim Assistance Socio-Economic Reintegration and Mine Awareness and ICBL Working Group on Victim Assistance (2000)
Portfolio of Landmine Victim Assistance Programs, September.

_____ (2001)
Providing Assistance to Landmine Victims, A Collection of Guidelines, Best Practices and Methodologies, May.

Swiss Agency for Development and Cooperation (undated)
Victim Assistance: A Comprehensive, Integrated Approach, SDC, Bern.

United Nations (1993)
Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by UN General Assembly resolution 48/96 of 20 December 1993.

WHO/ICRC (1997)
WHO/ICRC Strategy on Landmine Victims Assistance, WHO, Geneva.

WRF (World Rehabilitation Fund) (2001a)
Guidelines for Socio-Economic Integration of Landmine Survivors, WRF, New York.

_____ (2001b)
Mine Victim Assistance Support Visit, World Rehabilitation Fund working in partnership with United Nations Development Programme, Mozambique Country Visit 2-15 November 2001, WRF, New York.

The case of Cambodia

Action on Disability and Development (1999)
Action on Disability and Development: Working with Disabled People for Positive Change, An Overview of our Work, Phnom Penh.

Bullpitt, I. (2000)
Mine Action Within Cambodia Beyond 2000: Summary of Discussions and Recommendations Relating to National Strategy and Management of the Mine Action Sector within Cambodia in the Short and Long Term Beyond 2000, CMAC, Phnom Penh.

Cambodian Disabled People's Organization (CDPO) (2000a)
Draft Legislation on The Rights of Persons with Disabilities, Cambodian Disabled People's Organization, Phnom Penh.

_____ (2000b)
Cambodian Disabled People's Organization: Annual Report 2000, CDPO, Phnom Penh.

Cambodian Mine Action Authority (CMAA) (2001)
Sub-Decree: Organization and Functioning of Cambodian Mine Action and Victim Assistance Authority, CMAA, Phnom Penh, 27 January.

Cambodia Mine/UXO Incident Database Project (2000)
Mine and UXO Casualties in Cambodia: Bi-Annual Report 1998-1999, Phnom Penh, October.

_____(2001),
Cambodia Mine/UXO Incident Database Project: Monthly Mine Incident Report, Phnom Penh, February.

Cambodian Researchers for Development (1995)
Cambodian Children and Women with Artificial Limbs, The Children and Women's Prosthetic Outreach Programme of the Cambodia Trust, Phnom Penh.

Cambodia Trust (2000)
Cambodia Trust: 5 Year Plan 2000-2005, The Cambodia Trust, Phnom Penh.

Center for Advanced Study (2000),
Mental Health of Landmine Survivors in Cambodia: A Report for Social Services of Cambodia and Japan International Cooperation Agency (Second Draft), March.

Cooperation Committee for Cambodia (2000)
Directory of International Development Assistance in Cambodia, Phnom Penh.

Coughlan, D. (ed.) (2000)
Show us the Way: Jesuit Service – Cambodia 1999–2000, Jesuit Service, Phnom Penh.

Disability Action Council (DAC) Secretariat (1999a)
Disability Action Council: Annual Report, Sept 1998–Sept 1999, DAC, Phnom Penh.

_____ (1999b)
Cambodian Plan of Action for the Disability and Rehabilitation Sector: Working Draft for Comments, DAC, Phnom Penh, September.

_____ (2000a)
"Certainty Instead of Charity", Phnom Penh.

_____ (2000b)
Socio-Economic and Behavioural Pilot Survey on the Situation of the Disabled Persons in Cambodia: Phase 1: March–June 2000, DAC, Phnom Penh, December.

_____ (2001a)
National Coordination and the Disability Action Council: Supporting the Coordination and Initiation of Services and Assistance for/with People with Disabilities including Landmine Victims in Cambodia, Phnom Penh.

_____ (2001b)
Study on Persons with Disabilities (Cambodia), Phnom Penh, February.

Disability/Injury Prevention and Rehabilitation Department, Social Change and Mental Health Cluster, and WHO (1998),
Disability and Rehabilitation Team: Proposed Strategy Paper 1999-2000, Phnom Penh, December.

Fong, L. H. (1995)
The Situation of Disabled Persons in Cambodia: Statistics, Programs, Service Providers, Government Policies and Plans, Cost Analysis, Needs Assessment and Recommendations, National Task Force for Disabled Persons, MSALVA, Phnom Penh, December.

Food and Agriculture Organization (2001)
Staying Alive Along Route 5: The Mobilization and Empowerment of Rural Communities along the Asian Highway (Route 5) in Cambodia to Reduce HIV Vulnerability, Phnom Penh.

French, L. (1992)
Amputees on the Thai-Cambodian Border: The Political Economy of Injury and Compassion, Harvard University Department Of Anthropology, 30 November.

Handicap International (HI) (1999)
Handicap International: Annual Report Cambodia, HI, Phnom Penh.

_____ (2000)
Capacity Building of People with Disability in the Community (CABDIC) in Cambodia: Evaluation, Report, Phnom Penh, October.

Horwood, C. and A. Crossland (2000)
External Evaluation of UNICEF-Supported Activities to Prevent Mine Incidents, Phnom Penh, June/July.

ICBL (International Campaign to Ban Landmines) (1997)
Guidelines for the Care and Rehabilitation of Survivors, ICBL Working Group on Victim Assistance, Washington DC.

_____ (2000)
Landmine Monitor Report 2000: Toward a Mine-Free World, Human Rights Watch, September.

Jesuit Service (2000)
Show the Way: 1999–2000, A 12-Point Plan to indicate if a landmine victim has enough to live in simple dignity; Jesuit Service, Phnom Penh.

Landmine Monitor (2000),
ASEAN and the Banning of Anti-personnel Landmines, Bangkok.

Krom Akphiwat Phum (1999),
Small Beginnings: Village Social Development Stories, November.

Ministry of Education, Youth and Sport and the Department of Planning (1999),
Education in Cambodia, Phnom Penh, July.

Ministry of Education, Youth and Sport (2000),
Education Indicators 1999–2000, Phnom Penh.

Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation (MSALVY) (1996),
A National Strategy for MSALVY and NGOs of the Rehabilitation Sector on Disability and Integration of Disabled People in Cambodia: Summary Report, Task Force on Disability Issues, October.

National Institute of Statistics, Ministry of Planning (1998)
General Population Census of Cambodia, Phnom Penh, March.

_____ (1999)
Report on the Cambodian Socio-Economic Survey, Phnom Penh.

Norwegian People's Aid Cambodia (NPA) (1997)
Norwegian People's Aid, Cambodia: Annual Report, NPA, Phnom Penh.

_____ (1998)
Norwegian People's Aid, Cambodia: Annual Report, NPA, Phnom Penh.

Sopha, Y. (2000)
Internal Survey, Action Nord Sud, Battambang, April.

Tickner, V. (1996)
Food Security in Cambodia, A Preliminary Assessment, Discussion Paper, United Nations Research Institute for Social Development, Geneva, October.

UNHCR Cambodia (2000)
Mine Safety and Reintegration UNHCR Cambodia: Lessons Learned 1999-2000, Phnom Penh, August.

UNICEF (2001)
Master Plan of Operations 2001 – 2005: Children in Need of Special Protection (CNSP), Phnom Penh.

United Nations (2000)
Second Country Cooperation Framework for Cambodia (2001-2005) for the Executive Board of the United Nations Development Programme and of the United Nations Population Fund, New York, December.

World Bank/Social Services of Cambodia (1999)
The Impact of Armed Conflict on Social Capital: A Study of Two Villages in Cambodia, Phnom Penh, March.

World Bank (2000)
World Development Indicators 2000, The World Bank, Washington DC, March.

The Case of Eritrea and Ethiopia

DanChurchAid (DCA)/Action by Churches Together (ACT) (2000)
Eritrea Proposal for a Humanitarian Mine Action Programme, Asmara, December.

_____ (2001)
Eritrea Humanitarian Mine Action Programme, Asmara, January.

EWDFA (Eritrean War Disabled Fighters Association) (1996)
Plan & Strategies 1997-2001, Asmara, November .

Gebremedhin, N. (1997)
"Reconstruction and Development Following Armed Conflict ", *Environment and Security*, Vol. 1, No. 2.

Government of Switzerland (1998)
Berne Manifesto on Assistance for Mine Victims, Berne, September.

HI (Handicap International) (2000)
Victim Assistance: Thematic Report 2000, A Review of Reported Casualties and Victim Assistance, Handicap International, Lyon, September.

Human Rights Watch (2000)
Clinton's Landmine Legacy, Report, Human Rights Watch, Washington DC, July.

ICBL (International Campaign to Ban Landmines) (1997)
Guidelines for the Care and Rehabilitation of Survivors, ICBL Working Group on Victim Assistance, Washington DC.

_____ (2000)
Landmine Monitor Report 2000, Toward a Mine-Free World, Human Rights Watch, New York, September.

LSN (Landmine Survivors Network) (2001),
Landmine Survivors Rehabilitation Database, <http://www. lsndatabase.org>.

Lark, B. (2000),
Evaluation of RaDO Mines Awareness Programme, Final Report, UNICEF Addis Abeba, December.

Essen, S. and O. Botillen (2001),
Mine Action Assessment in Ethiopia, Norwegian People's Aid Mine Action Unit, January.

OCHA/ICC (Office for the Coordination of Humanitarian Affairs/Information and Coordination Centre) (2001a)
Humanitarian Update, Asmara, 22 January.

_____ (2001b)
Humanitarian Update, Asmara, 7 February.

OCHA Integrated Regional Information Network (2001),
Ethiopia-Eritrea: Eritrea submits crucial mine information, 21 March.

RaDO and UNICEF (2000),
Tigray Mine and UXO Victim Report No 1, UNICEF Addis Abeba, October.

Sethi, D. (2000),
Potential for Landmine Injury Surveillance in Ethiopia, World Health Organisation, Geneva, October.

State of Eritrea (2000)
Landmine and UXO Casualties, Demining Headquarters Eritrea, September.

United Nations (1998)
Assessment Mission to Ethiopia, UNDP, New York, June.

United Nations (2000a)
Inter-Agency Technical Mine Action Mission to Ethiopia and Eritrea, (Report on Eritrea), UNMAS, New York, October.

_____ (2000b)
Reducing the Landmine/Unexploded Ordnance Threat to Civilians in Ethiopia: A Strategy for Coordinated Humanitarian Mine Action, Addis Abeba.

_____ (2001a)
Consolidated Appeal Process (CAP) in Ethiopia, UN Country Team, Addis Ababa.

_____ (2001b)
Consolidated Appeal Process (CAP) in Eritrea, UN Country Team, Asmara, February.

United States Department of State (1998)
Hidden Killers, Office of Humanitarian Demining Programs, Washington DC.

The Case of Kosovo

DSI (Danish Council of Organisations of Disabled People) (2001)
Towards a society for all, Report on Working Group on Accessibility, Pristina, January.

_____ (undated)
Recognition of a Task Group on Disability - A step forward to create a society for all, undated document provided in February 2001.

HALO Trust (1999)
Consolidated Minefield Survey Results Kosovo, Pristina, August.

HI (Handicap International) (2000a)
Proposal for Physical Medicine and Rehabilitation Policy and Strategy in Kosovo, Pristina, November.

_____ (2000b)
Assessment of physiotherapy human resources for health structures in Kosovo, Pristina, October.

_____ (2000c)
Synthesis report of operation, Pristina, January.

_____ (2001a)
Handicap International - Mission in Kosova, January.

_____ (2001b)
Report of Activities on National Ortho-prosthetic Workshop and Rehabilitation Centre of Kllokot, August 1999 - December 2000, January.

ICBL (International Campaign to Ban Landmines) (1997)
Guidelines for the Care and Rehabilitation of Survivors, ICBL Working Group on Victim Assistance, Washington DC.

_____ (2000)
Landmine Monitor Report 2000, Toward a Mine-Free World, Human Rights Watch, Washington DC, September.

International Catholic Migration Commission (2000)
Needs of the Kosovo Centres for Social Work - to the end of 2000 and beyond, Pristina, November.

IOM (International Organization for Migration) (2000)
Kosovo, Demographic, Socio-Economic and Reproductive Health Survey, Basic Results, May.

Judah, T. (2000),
Kosovo, War and Revenge, Yale University Press, New Haven, US.

Krug. E. G. and A. Gjini, (1999)
"Number of Land Mine Victims in Kosovo is High", *British Medical Journal*, 14 August.

Mines Awareness Trust., (2001)
Victim Assistance pertaining to Mine/UXO and DU, Pristina, undated document but provided in February 2001.

NATO (North Atlantic Treaty Organisation) (1999),
NATO-dropped Cluster Munitions, Document presented to the UN Mine Action Coordination Centre.

Ross, S. (2000),
The War in Kosovo, Wayland Publisher, UK.

Survey Action Center (SAC) (2000)
Modified Level One Impact Survey: Setting Mine Action Priorities in Kosovo, Washington DC, 31 March.

UNICEF (2000)
Mine Awareness in the Community: Passing the Message On, Mine/UXO Awareness Report, Pristina, December.

United Nations (UN) (1993)
Standards Rules for the Equalisation of Opportunities for Persons with Disabilities, *Resolution 48/96,* 20 December.

UN Civil Administration, Health and Social Services (1999)
Strategy for the Treatment of Physically and Mentally Disabled in Kosova, September.

UN Interim Administration Department of Health and Social Welfare (2000a)
Interim Health Policy Guidelines for Kosovo, Pristina, draft document, August.

_____ (2000b)
Interim Health Policy Guidelines for Kosovo, Pristina, November.

_____ (2000c)
Memorandum of Understanding between UNMIK and Handicap International, Pristina, November.

UNMIK Department of Health and Social Welfare (2000)
Capacity Building of Centres for Social Work in Kosovo, January-November, Pristina.

UNMIK-MACC (1999)
Report (untitled), August.

_____ (2000a)
Untitled document, December.

_____ (2000b)
Quarterly Report, 1 June - 30 September 2000, Pristina, October.

_____ (2000c)
Monthly Summaries, 1 June 1999 - 31 January 2000, Pristina, 8 February.

_____ (2000d)
The Mine UXO Situation in Kosovo, Information document, Pristina, 15 June.

_____ (2000e)
Monthly Summaries, 1 June 1999 - 30 November 2000, Pristina, December.

_____ (2001a)
Victim Assistance Activity Report 2000, Pristina, January.

_____ (2001b)
UNMIK Mine Action Programme Exit Strategy Discussion Paper, Pristina, January.

_____ (2001c)
Annual Report 2000, Pristina, January.

VVAF (Vietnam Veterans of America Foundation) (1999)
Assistance for People Disabled by War in Kosovao Assessment of Rehabilitation Services, Pristina, December.

_____ (2000a)
Socio-Economic Survey of Mine/UXO Survivors in Kosovo, Pristina, November.

_____ (2000b)
Assistance to Persons with War-Related Disabilities/Kosovo, Interim Report, 15 November-30 June, Pristina, July.

WHO (World Health Organization) (1999a)
"WHO finds heavy toll from landmines in Kosovo", Press Release, Geneva, 15 July.

_____ (1999b)
WHO recommendations for assistance to victims of mine injury, Pristina, November.

_____ (2000)
WHO Operations In Kosovo, Action Plan for 2000, WHO Regional Office for Europe, Pristina.

The Case of Nicaragua

Banco Central de Nicaragua (1999)
Indicadores Económicos, Vol. V, Managua.

Centro de Estudios Estratégicos Nicaraguense (CEEN) (2000)
Cuidado!! Terreno Minado, Manual de Prevención de Minas, Managua.

_____ (undated)
Programa para la Prevención de Accidentes por Minas Terrestres Antipersonas, paso a paso ganando personas, Managua.

Centro de Estudios Internacionales (CEI) (1999)
Las Minas Antipersonales en Nicaragua, First Independent Report, Managua, March.

_____ (2000)
Las Minas Antipersonales, Second Independent Report, Managua, September.

ICBL (2000)
Landmine Monitor Report 2000, Toward a Mine-Free World, Human Rights Watch, New York, September.

Instituto Nacional de Estadística y Censos (1998)
Encuesta Nacional de medición del Nivel de Vida (1998), Managua.

Nicaraguan Army (2001)
Report of the Nicaraguan Army 2000, Managua, February.

Organization of de American States (OAS) (2000a)
Incidents/Accidents, Regiones del País/IMSMA, Managua, February.

_____ (2000b)
Programa PADCA, Desminando, March.

_____ (2000c)
Programa PADCA, Desminando, May.

Olivas, A.O. (2001)
"Destruyen 15 mil minas antipersonales en Condega", *La Prensa*, Managua, 30 March.

Organization Panamericana de la Salud (OPS) (1998)
Apoyo a los Sobrevivientes de Minas Terrestres en América Central, una Iniciativa Conjunta Canadá y México, October.

OPS and Ministry of Health (2000)
Análisis del sector salud en Nicaragua, primer borrador, Managua.

UNDP (2000)
Human Development Report, Oxford University Press, New York.

Glossary of acronyms

ACT	Action by Churches Together
ADRN	Association of Disabled of the National Resistance
APEK	Association of Paraplegics and Paralysed Children of Kosovo
BAC	Battle Area Clearance
CCD	Joint Disabled Commission (*Comisión Conjunta de Discapacitados de Madriz*), Nicaragua
CCPM	Commission for Coordination with the UN Peacekeeping Mission (Eritrea)
CDPO	Cambodian Disabled Persons Organisation
CEEN	Nicaraguan Centre for Strategic Studies
CENAPRORTO	National Prosthetic and Orthotic Centre
CIMIC	Civil-Military Coordination Centre, Eritrea
CMAA	Cambodian Mine Action Authority
CMAC	Cambodian Mine Action Centre
CND	National Demining Commission (*Comisión Nacional de Desminado*), Nicaragua
CRC	Cambodian Red Cross
CSW	Centres for Social Work
CVD	Cambodian Vision in Development
CWARS	Cambodian War Amputees Rehabilitation Service
DAC	Disability Action Council, Cambodia
DCA	DanChurchAid
DFID	Department for International Development (UK)
DSI	Danish Council of Organisations of Disabled People
EDP	Ethiopian Demining Project
EHDP	Eritrean Humanitarian Demining Project
EMAC	Eritrean Mine Action Centre
EOD	explosive ordnance disposal
EWDFA	Eritrean War Disabled Fighter's Association
FECONORI	Nicaraguan Federation of Organisations for Rehabilitation and Integration
FRY	Federal Republic of Yugoslavia
GDP	gross domestic product
GICHD	Geneva International Centre for Humanitarian Demining

GIS	Geographic Information System
HI	Handicap International
ICACBR	International Centre for the Advancement of Community-Based Rehabilitation
ICBL	International Campaign to Ban Landmines
ICRC	International Committee of the Red Cross
IMSMA	Information Management System for Mine Action
INATEC	Nicaraguan Institute for Technical Assistance
IOM	International Office for Migration
JCBL	Japan Campaign to Ban Landmines
JIAS	UNMIK Joint Interim Administrative Structures Departments
JS	Jesuit Services
KFOR	Kosovo Protection Force
KLA	Kosovo Liberation Army
KPC	Kosovo Protection Corps
LSN	Landmine Survivors Network
MAC	(National) Mine Action Centre
MACC	Mine Action Coordination Centre
MAG	Mines Advisory Group
MAP	Mine Action Programme
MARMINCA	Mission to Support the Removal of Mines in Central America
MAST	Mine Awareness Support Team, Kosovo
MAT	Mine Awareness Action Team
MNB	Multi-National Brigade, Kosovo
MSF	Médecins sans Frontières
NCDP	National Centre for Disabled People, Cambodia
NGO	non-governmental organisation
NOPC	National Ortho-Prosthetic Centre, Ethiopia
OAS	Organization of American States
OPS	Pan-American Health Organisation
ORD	Organisation of Disabled Revolutionaries, Nicaragua
PADCA	Programme of Assistance to Demining in Central America
POC	Prosthetic/Orthotic Centre, Ethiopi
QA	Quality Assurance
RaDO	Relief and Development Organisation
RCAF	Royal Cambodia Armed Forces
SAC	Survey Action Center
TMSP	Third Meeting of States Parties of the Ottawa Convention
TSZ	Temporary Security Zones, Eritrea and Ethiopia
UED	Special Demining Unit, Nicaragua
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNMAS	United Nations Mine Action Service
UNMEE	United Nations Mission for Ethiopia and Eritrea
UNMIK	United Nations Mission in Kosovo
UNOPS	United Nations Office for Project Services
UNTAC	United Nations Transitional Authority in Cambodia
UXO	inexploded ordnance
VVAF	Vietnam Veterans of America Foundation
WHO	World Health Organization
WRF	World Rehabilitation Fund

Appendixes

Appendix A

Terms of reference for the User Focus Group

The United Nations defines mine action as containing five distinct pillars: Mine Clearance, Mine and UXO Awareness, Mine Ban Advocacy, Mine Stockpile Destruction, and Mine and UXO Victim Assistance. Yet, of the five pillars, victim assistance has not received the same attention as the others, and practitioners have often been unclear as to its operational role within mine action.

The time is ripe for field-level research that will provide straightforward guidance to mine action practitioners vis-à-vis their role in victim assistance initiatives. Accordingly, the GICHD is conducting a *Study of the Role of Mine Action in Victim Assistance.*

Responsibilities of the User Focus Group

The Study User Focus Group's specific responsibilities are to:

a. Submit comments on the study background paper.
b. Attend a User Focus Group meeting.
c. Comment and provide input on the first draft of the study.
d. Contribute electronically to the revision of the study.

Composition

The User Focus Group should be comprised of field representatives of potential study users, including concerned governments, mine action practitioners, disability experts, the United Nations, and the GICHD.

Meetings and correspondence

It is envisaged that the User Focus Group will meet formally once at a meeting in Geneva; other input will be received through electronic mail.

Appendix B

Membership of the User Focus Group

Akiko Ikeda, UN Mine Action Service, New York

Gulbadan Habibi, UNICEF, New York

Judith Dunne, UNDP, Northern Iraq

Leonie Barnes, UN Mine Action Coordination Centre, Pristina

Mike Kendellen, Vietnam Veterans of America Foundation, Washington

Norman Lanzas, Ministry of Health, Managua

Ouk Sisovann, Disability Action Council, Phnom Penh

Pascal Torres, Handicap International, Geneva

Sebastian Kasack, Medico International, Frankfurt

Appendix C

Terms of reference for the Steering Group

The United Nations defines mine action as containing five distinct pillars: Mine Clearance, Mine and UXO Awareness, Mine Ban Advocacy, Mine Stockpile Destruction, and Mine and UXO Victim Assistance. Yet, of the five pillars, victim assistance has not received the same attention as the others, and practitioners of mine clearance, survey and awareness have often been unclear as to victim assistance's operational role within mine action.

The time is ripe for operationally-focused field-level research that will provide straightforward guidance to mine action practitioners vis-à-vis their role in victim assistance initiatives. Accordingly, the GICHD is conducting a study of *The Role of Mine Action in Victim Assistance.*

Responsibilities of the Steering Group

The Steering Group (SG) is to be convened to provide oversight and direction to the Study as a whole, in particular by:

a. assisting in the finalisation of the Study Terms of Reference via electronic mail and discussion;

b. discussing the Study Report prior to its finalisation, to review programmatic implications and to assist in the definition of roles and responsibilities; and

c. publicising and institutionalising the resulting study recommendations.

Meeting

It is envisaged that the Steering Group input will be received through a half-day meeting in New York.

Appendix D

Membership of the Steering Group

Invitations to participate in the Steering Group were sent to the following organisations:

- UNMAS,
- WHO,
- UNICEF,
- ICRC,
- UNDP,
- GICHD,
- ICBL Working Group on Victim Assistance,
- Swiss Government.

Appendix E

Providing victim assistance services for all motor-disabled people in North Iraq

by UNOPS

Introduction

The planning of human services frequently gets mired in a web of "social" issues and "political correctness" and subsequently produces services that do not always serve the best interest of the beneficiaries. To avoid discrimination in favor of landmine survivors to the detriment of the other people with disabilities and for more equitable access to services, developing international opinion suggests that for planning purposes, landmine survivors should be grouped with all other people with disabilities. In contrast to this emerging opinion, "positive discrimination" of landmine and UXO survivors in N. Iraq has yielded a strengthened network of services capable of addressing the needs of all people with mobility disorders.

Addressing the needs of victims within the context of all people with disabilities and influencing social conscience is laudable as a moral and social principle. However, in an environment of donor reluctance to funding long-term disability needs, shifting donor priorities and increased competition for funding, service planning must adapt to its environment, identify opportunities and take on a more strategic and business-like approach. Good business planning involves a realistic assessment of the environment and the market and planners need to consider and adapt to the funding priorities "du jour" of the donor community. Attempting to shift social conscience without a strategic approach and solid transition planning puts services to landmine survivors at risk of being diluted into a melting pot that is known to generate donor indifference.

The case of Northern Iraq

The mandate to serve landmine survivors in Northern Iraq has allowed the United Nations Office for Project Services (UNOPS) Mine Action Program (MAP) to achieve the same results so greatly desired by those who would disassemble the pillars of Mine Action in the name of integration of health services for the disabled. By fully evaluating and capitalizing on opportunities before it, the use of solid service planning

and a holistic approach, the MAP has orchestrated a "reverse integration" and laid down the major paving stones to community-based rehabilitation to serve, if not all disabled at this time, at least all motor-disabled.

It is well known that development of services in post-conflict situations usually occurs in an environment where the normal infrastructure, local capacity and social fabric has collapsed or been seriously damaged. After imposing comprehensive sanctions on Iraq in 1990, the United Nations Security Council Resolution (SCR) 986 "Oil for Food" humanitarian program in N. Iraq was implemented in 1996 to provide for basic needs of food, medicines and infrastructure repair. Post-conflict reconstruction and development was not originally a part of the strategy in the SCR 986 memorandum of agreement with the Government of Iraq. Notwithstanding this fact, most organizations strive to develop in a manner that services that are left behind will be of use to their benficiaries.

Victim Assistance in N. Iraq emerged when the health system could not handle the load put on it by the demand for treatment of war injuries. The existing health system had neither the resources nor the expertise. As in most post-conflict situations, NGOs, and in this case, 986 funding provides for the needs of landmine and UXO victims while the health infrastructure rebuilds and, in the long-term, positions itself to take on the needs of war victims.

A common approach often used in analyzing the needs of landmine survivors is to view the services required as mostly specialized and medical in nature. Appropriate medical services are required for survivors, however these represent only a portion of the supports required to a survivor's eventual reintegration to his/her family and community. A "public health" approach to services requires community-based intervention that addresses the overall needs of its beneficiaries within their environment.

SCR 986 introduced an approach to funding and delivery of aid that ensured that appropriate agencies and institutions were available to provide the required service to meet immediate needs. Services were reliant on UN, public sector and private funding and focused on immediate war and sanction-related consequences. Needs and challenges were addressed individually, often by creating or establishing new agencies and services.

At the onset of the humanitarian program, most existing services provided good work and value in the provision of aid. But in the absence of a comprehensive vision to guide growth and development, services were not planned in the best interest of the beneficiaries; services worked in isolation and were often too fragmented. Those seeking aid as well as those delivering it were confused in the presence of so many disparate services. The system was complex, structured by function rather than by need, lacked coordination, and resulted in overlap and duplication.

Without a comprehensive vision to guide the growth and development of service delivery, many services were provided in isolation from others. In addition, they did not work together as a whole system and did not make the most efficient use of public and private funds.

In the absence of a "lead" organization or agency capable of addressing the need, UNOPS proposed to partner organizations that the population of N. Iraq could benefit

from a more targeted and coordinated approach to service planning and delivery for landmine/UXO victims. UNOPS also proposed to fully integrate Victim Assistance as a pillar of Mine Action. It was determined that this could be achieved by reshaping the system of services for landmine/UXO victims all while ensuring that change did not lead to a decline in standards or performance.

Planning within a new framework required important changes for key stakeholders. Minimum requirements were determined to form the framework needed to accommodate shifts in resources and functions.

Some key principles were established:
- Develop a full spectrum of services
- Promote a holistic approach to services
- Maximize the use of recognized and successful services models
- Build on existing resources
- Maximize efficiencies
- Make services accessible
- Avoid overlap and duplication of service
- Promote responsible decision-making
- Promote collaboration amongst services
- Increase capacity-building opportunities
- Design services to be sustainable.

To streamline and integrate the delivery of services, the strengths of the existing services needed to be preserved and the system needed to work better as a whole. Efforts were invested to create a system that:
- offered flexible and responsive services to meet specific needs of communities
- operated as part of a coherent system with measurable outcomes for communities
- set priorities so that essential supports were directed to those most in need
- helped individuals achieve independence by reducing their reliance on family and community
- worked more effectively with the services of others in the community.

To achieve this type of system, planners, funders and service providers needed to integrate their roles and responsibilities to effectively meet the needs of communities.

Some shifts in direction helped set the framework for establishing attainable goals and improving the delivery of services:

FROM:		**TO:**
Services that respond to entrenched problems	⇨	Services that anticipate problems, respond earlier and reduce the need for further services
Services organized by agency function	⇨	Services organized to respond to the needs of individuals, families and communities
Change through growth in funding	⇨	Change through better service delivery within existing resources
UN responsibility	⇨	Shared responsibility with local authorities and partner funders

The service system that evolved corresponds to recognized international guidelines for victim assistance and provides a continuum of accessible services for the disabled.

International guidelines	UNOPS victim assistance, Northern Iraq					
	1999	2000	2001	2002	2003	
Emergency/first aid care	11	12	14	17	23	First-aid posts
Medical/surgical care	2	2	2	2	3	Surgical centers
Physical rehabilitation	1	1	2	3	3	Rehabilitation centers
Prosthetic services	4	4	4	4	4	Prosthetic centers
Psychological and social support	10%	10%	30%	60%	100%	Supports
Employment and economic integration	20%	20%	30%	60%	100%	Supports
Capacity-building sustainability	and 90%	90%	99%	99%	100%	Nationalized
Legislation/public awareness	0%	10%	25%	75%	100%	Policy/legislation
Data collection	0%	25%	85%	100%	100%	Common database

The network provides for emergency first aid, surgical treatment, provision of ortho-prosthetic devices, physical and psychosocial rehabilitation, vocational training, income-generation and advocacy. All services are organized and delivered by local organizations, except for the specialized surgical services delivered by an international NGO, and approximately 60% of staff in the rehabilitation centers are people with disabilities.

Victim Assistance is a long-term issue and it is essential to support institutional development in all development plans. Improving management capacities and promoting new national partnerships must be part of the capacity building effort. Since the inception of UNOPS' support to victim assistance, through the use of SC 986 funds, every effort has been made to invest in the rebuilding and integration of services into the existing health and social service system. All, but one UNOPS funded organization, are local organizations, managed and staffed entirely by national local health authority staff. The other, a surgical center, is managed by an international NGO, with over 600 staff, of which there are only three internationals.

All planning for the development of new services has been done in conjunction with local political authorities from the health and humanitarian aid and cooperation sectors. Capacity-building, sustainability and building on existing resources were key principles applied to all joint planning and development efforts.

Victim Assistance is no different than other SC 986 programs, in that, should 986 funding end tomorrow, all established services would be at risk for lack of local funding.

The UNOPS Victim Assistance plan has always contained the development of a disengagement strategy that would provide the framework for transitional planning for local authorities to take back control of VA services. The key challenge to accomplishing hand-over of the system of services to the local health system is the provision of on-going funding. Measures have been taken, however, in the victim

assistance plan to ensure that all established services are prepared to continue operations without 986, save the funding issue: fully nationalized program, all staff are seconded local health authority employees, most salaries are within the range of locally paid salaries, all services are an extension of the health system, local authorities participate in planning of all new developments, training and practical rotation is provided to local health authority staff working in existing health system, all buildings belong to local health authorities etc. Since it is improbable that local authorities or the Government of Iraq would be able to provide adequate funding to maintain existing services, in a post-986 environment, various strategies have been explored with local authorities.

Conclusion

In 1998, in the absence of a "lead" organization, UNOPS integrated the pillar of victim assistance into its Mine Action Program to plan, coordinate and fund services for survivors. UNOPS is not a service provider. It recruited appropriate resources in human services system planning and it consulted and coordinated with key stakeholders, including community interest groups like associations for the disabled and women's unions. All funded services are delivered by non-profit organizations.

The availability of SCR 986 humanitarian funding is rather unique to N. Iraq and contrary to popular belief, it was not an exclusive factor in the development of a comprehensive service system for survivors. It is but one of the elements that has allowed victim assistance services to evolve from the simple provision of prosthetics to a comprehensive system that provides a continuum of service and meets recent international recommendations and frameworks. Vision, careful planning, strong principles, respect of existing resources and mandates, identification of gaps in the continuum of service and good honest collaboration form the principal foundation of the network.

The usual constraints or barriers were present during the planning process and continued to spontaneously arise just when it was thought they had been overcome. Issues of politics, security, lack of trained professionals, levels of poverty, lack of transportation, lack of coordination and agency competition constantly needed to be addressed throughout the planning and implementation processes, but a transparent and collective approach helped assuage and manage these challenges.

As the VA program began to introduce the concept of a framework for a complete spectrum of services, most stakeholders were reluctantly cooperative. As the discussions and planning environment evolved towards building on existing resources, avoiding duplication and promoting collaboration and coordination, most partners felt less threatened that their services would be duplicated or replaced and participated wholeheartedly in the process. Local political authorities became key partners in facilitating implementation. One of the most beneficial consequences of a joint planning process for local agencies was that it generated spontaneous collaboration and coordination of their efforts and services across the board. They developed joint tendering and procurement processes which generated great savings, standardized databases, shared training plans, standardized administration processes, best practices and developed coordination processes with local authorities and stakeholders.

Mine Action has historically been a very "technical" field of expertise, however it is concientiously moving toward a more inter-disciplinary approach to relieve the impact of landmines and UXO on communities. The recent implementation of an integrated approach to demining in N. Iraq, to include Mine Awareness, Mine Clearance and Victim Assistance, has demonstrated that a inter-disciplinary community-based approach can yield dividends that transcend the technical aspects of demining. This new approach has opened the door to many more people with disabilities, allowing them to access the network of services originally intended for landmine and UXO survivors.

The integrated teams aim to reduce the social, economic and environmental impact of landmine contamination in a given community. Together with the local villagers, the teams assess and define the community's needs for awareness, risk reduction education, clearance priorities and supports required from the community. The victim assistance field officers assess all villagers with disabilities and refer, as appropriate, to the required services. Landmine victims can often assist the clearance teams to identify the exact location of where their accident occurred thus providing crucial time-saving information.

Planning for the transition to a more participatory and community-based approach requires the Mine Action Program to ensure the availability of appropriate expertise to guide the process, whether it is provided from within the program or makes use of existing expertise from partner agencies.

Integrated Mine Action is an example of one of the few concerted efforts, amongst many services and organizations, to attempt an integrated and coordinated approach, using existing resources and expertise, to provide a more reliable and representative vision of the challenge and a more focussed and coordinated response to the impact of landmines and UXO on a community.

Appendix F

Conceptual framework for operational mine action

Appendix G

Guidelines for socio-economic integration of landmine survivors

by the World Rehabilitation Fund

Section A: Precedent factors

FACTOR 1: National Policies and Institutions

We formerly labeled this factor as "Nationwide Response". In general, an integrated response to landmine survivor needs should deal with issues such as access, coordination and collaboration. This factor deals with the capacity of government to deal with the needs of landmine survivors and people with disabilities, and the nature of legislation that aims at easing integration and service access.

1-1 Governmental mechanisms for basic services

All governments should set up programs to provide access for landmine victims and persons with disabilities to the following services:

a. Medical care
b. Rehabilitation
c. Support Services (i.e., provision of special supports such as assistive devices to assist persons with disabilities to increase their level of independence)
d. Education
e. Employment
f. Income maintenance and social security.

Such programs should be included within the mandates of existing ministries and involve a multiplicity of ministries such as Ministry of Health, Ministry of Social Affairs, Ministry of Labor and Ministry of Education. Programs of these ministries should include funding or partial funding for services, provision of specialized services, rules for equal access of services, rules for ensuring adequately qualified care providers in these areas and rules for providing preservice and in-service training for key service providers such as physicians, nurses, therapists, social workers, and special educators.

1-2 Policy development

Policies affecting services and legislation concerning persons with disabilities should be developed with input from representatives of government, service providers, advocacy groups and, especially, representatives of landmine survivors (and others with disabilities) and their families. A national policy group should be convened with representatives of all of the aforementioned sectors. Significant representation of persons with disabilities should be mandated in such a group.

1-3 Equal access and equal opportunity legislation

Legislation should at a minimum cover equal employment and educational opportunity, full access to health, recreation, and social services and the opportunity to fully participate fully in religious, political, civic and economic activities.

1-4 Information on landmine survivors and relevant services

This information is necessary to assure that national policies are responsive to the needs of the breadth and scope of landmine victims and their families and others with disabilities and their special needs. Also governments should be able to provide information to landmine survivors and others with disabilities on available services and eligibility requirements for such services.

1-5 Prevention and awareness

Activities to be promoted under this subpart include safety programs, landmine awareness programs and public campaigns to dispel myths and stereotypes concerning persons with disability and enlisting the general public, employers and service providers in providing fair and equal treatment for landmine victims and others with disabilities. Campaigns should stress focusing on abilities rather than disabilities of all individuals.

FACTOR 2: Medical care

The medical care system is frequently the first exposure to the service community for the landmine survivor and their family. Timely, clinically sound and coordinated responses of the medical care system are important and critical components that insure that the landmine victim survives their injury and subsequent disabling conditions. All nations undergo ongoing development and refinement of their healthcare systems. It is most critical to highlight the need for access, clinical appropriateness and coordination on behalf of all patients. As a medical service delivery system is under development, involvement of all parties in the design of the system is critical. Information about services is key to insuring proper and timely access.

2-1 Distribution of services

Services and facilities, including emergency and first aid services should provide timely access for landmine victims. Methods for referrals to differing levels of care should be in place since certain injuries are more likely in certain locales. Planning for distribution of services and facilities is a governmental function and will also involve the participation of providers, international organizations and community representatives.

2-2 Range and breadth of services

Landmine victims may be subject to a wide range of physical and psychosocial trauma, thus requiring the availability of a full range of specialized medical services such as orthopedic services, eye care, auditory care, gastro-intestinal services, plastic and reconstructive services and psychosocial services, particularly with regard to coping with physical disability and the effects of post-traumatic stress. Also of concern is that facilities have sufficient resources to meet the medical needs of persons in their catchment area.

2.3 Coordination of services

It is important that services are coordinated so that the landmine survivor can be referred in a timely and coordinated manner to appropriate services for multiple disabilities and multiple needs.

2.4 Human resources

A variety of healthcare staff should be distributed at national, regional and local levels to meet needs in an appropriate manner. Collaboration between government, NGOs and consumers should be utilized to establish plans for staffing and adequate training of health care providers.

FACTOR 3: Rehabilitative care

Rehabilitative care is the post-medical phase of treatment that insures that the landmine survivor is able to reach and sustain his/her optimal level of independence and functioning. As a part of the continuum of service delivery, rehabilitative care is linked closely to objectives, processes and services of the medical care system, as well as to other community-based efforts to ensure independence and sustainable futures.

Community based approaches should be encouraged to allow for maximum access for the landmine survivor. It is critical that all means possible are employed to insure that rehabilitative services are known and accessible to landmine survivors and their families as well as to others with disabilities. Issues 2-1 through 2-4 are also applicable to rehabilititative care. All nations should have the capacity to provide the following types of rehabilitation services for landmine survivors and others with disabilities.

3.1 Postacute rehabilitative care

This refers to services that provide the means by which maximum functioning is achieved. These services should function on a coordinated basis so that each specialization is maximally effective. Ongoing support of community-based workers by the rehabilitation professionals will maintain the gains achieved in the rehabilitation process. Services include physical therapy, occupational therapy, speech therapy, services for visually and auditorially impaired persons provided through a rehabilitation team approach.

3.2 Prosthetics/orthotics

These services are listed separately because of the high prevalence of need by landmine survivors. Prosthetics/orthotics should be provided in a cost-effective manner using

appropriate technology in terms of availability of materials. Services should include upper and lower limb prosthetics (above and below knee and elbow), the range of orthotic devices from ankle foot orthotics to trunk orthotics, repair and replacement services, and orthopedic shoes.

3.3 Assistive technology

In addition to prostheses and orthoses, other mobility devices, sensory aides etc. should be available. Devices should be appropriate to the realities of terrain and functional uses that are likely to occur in the particular country.

3.4 Psychosocial services

Landmine survivors and family members face rehabilitation problems beyond physical compensation for mobility impairment or onset of sensory disability. Victims must learn to cope behaviorally with being disabled. Family members, likewise, must learn to cope with adjusting to having a disabled family member. In addition, landmine survivors, in particular, may have psychological symptoms stemming from the traumatic disabling condition itself as well as the general stress of war that create difficult adjustment problems. Services should be developed to help landmine victims and their families cope with these psychological factors.

3.5 Community based rehabilitation

Much if not most rehabilitation services can be provided on a community basis using nonprofessional service providers provided that such providers are properly trained and are supported by more experienced and more trained rehabilitation experts for coping with more difficult problems. CBR is widely used particularly in rural areas away from central medical facilities. Family members and persons with disabilities themselves should be included in the delivery of services.

3.6 Service integration and coordination

Effective rehabilitation entails the use of coordinated teams of rehabilitation workers taking advantage of various expertises - (e.g. physicians, therapists, prosthetists). For example, fitting of artificial limbs without physical therapy follow-up is not an effective service delivery method. CBR service providers should be part of the team in following up persons who receive professional rehabilitation intervention at a facility. In addition, rehabilitation services should be rendered with the person with disability as an important member of the rehabilitation team with input taken into serious consideration by the rehabilitation team as a whole.

Section B: Direct socio-economic integration factors

FACTOR 4: Vocational rehabilitation/job development

In addition to medical and psychosocial rehabilitation services, services should be available to landmine survivors and others with disabilities to directly help the person with disability enter into the economic mainstream. Services provided to meet that end concern training the individual for the local job market and helping them to access

the world of work. This factor does not include the development of business enterprises, which constitutes a separate factor. This factor is concerned with training for specific jobs and provision of placement services to help people with disabilities enter into available employment opportunities.

4.1 Vocational assessment and planning

Fitting an individual to a job possibility starts with defining possibilities in relation to the strengths and weaknesses of the individual. Of key importance is the consideration of work options in the community (unless leaving the community is a realistic option) and the capabilities, potential and interests of the individual. Vocational rehabilitation, therefore, should start with defining the interests of the individual in the context of the labor market and the capabilities of the individual. Can the individual perform the functions of the job in question? Does the interests of the individual coincide with actual availability of job options? What does preparation for the specific job entail in relation to the pressures of immediate job needs? Are there gradual steps toward careers that are possible or feasible? In addition, care must be given not to rule out possibilities based on job functions that can be handled through reasonable job accommodations. The disabled person and the service provider should discuss and plan job possibilities that are as realistic as possible, but that at the same time does not lead to job possibilities that are lower than the individual's actual potential. The type of plan will depend upon the narrowness or wideness of the person's capabilities and interests and the realities of the job market.

4.2 Vocational training and education

Training programs that are available should relate to occupations that are viable and mainstream. Services should include job-seeking skills training and on-the-job-support. Training should reflect emerging job market trends. Training should be relevant to the rural/urban setting of the individual. Rural training should focus on production and/or agribusiness training rather than subsistence level food production. Landmine survivors should be able to access educational programs that can elevate qualifications and prepare survivors for higher level jobs such as professional jobs, technology related jobs, etc.where viable. Where possible training of landmine survivors and others with disability should be mainstreamed rather than exclusively for persons with disabilities, thus fostering integration rather than exclusion.

4.3 Placement and job development

Job placement services should be available to landmine survivors and others with disabilities. Such services should include the involvement of business and industry. Ideally, a national body representing business and industry should be encouraged to create an initiative to hire persons with disabilities and accommodate them into the economic mainstream. Local Business Advisory Councils should be developed to identify job leads and to advise training providers so that survivors and other trainees are prepared for actual industry jobs. The Councils also might be helpful in accessing industry based training for landmine survivors and others with disabilities. Job development activities should involve identifying jobs whose requirements match the skills of the trainees. Similarly, training programs should be tailored to meeting the available jobs. Trainees should be provided job-seeking skills and trained in handling job applications and job interviews.

4.4 Follow-along and follow-up

Programs that are involved in placing persons should provide follow-up so that problems are identified and assistance given to both trainee and employer in helping to make the job match work. This may involve helping the employer relate to the individual with disabilities, helping the survivor better understand workplace expectations, etc.

FACTOR 5: Economic development

Opportunities for economic development for landmine survivors and their families should be part of the ongoing development activity within the nation. Landmine survivors, in general, should be involved in income generation, microcredit, marketing and business development activity along with other citizens. Access to start up resources is the key to program development. Landmine survivors should receive vocational rehabilitation to prepare themselves for jobs with viable futures, based on traditional and emerging job market realities as described in Factor 4. If self-employment is a goal, preparation in small business management should be part of the training available.

5.1 Rural and urban settings

Landmine survivors should have opportunities in both urban or rural based economic activities. In rural areas training should focus away away from subsistence agriculture toward diverse production, agrobusiness and food security. These efforts should be associated with sustainable rural development initiatives. As citizens of a nation move from subsistence economic activity to more market based activity, increased real income will result in access to improved food, products and services for all - including landmine survivors and their families. In urban settings, specific approaches to primary rather than secondary labor market products and services (see 5.4) should be sought.

5.2 Community based activity and support

Integration of the landmine survivor into the local community should be supported and reinforced through locally available services. Thus, where possible, economic development should utilize a community approach with the economic development involving the whole community with landmine survivors and others with disabilities playing significant roles in the enterprise.

5.3 Planning and development

Economic development should involve planning. Technical assistance should be provided to assist the survivor and his/her associates to develop viable plans and identify how the business would unfold in terms of target market, business promotion, inventory control, production methods, distribution strategies, etc.

5.4 Sustainable income generation

To maximize success, income generation should be focused on opportunities with viable futures and not production of articles with limited market possibility such as crafts. The development of sound business plans and the involvement of the

community are factors that make the activity mainstream and increase the likelihood of viability. By involving the community together with the survivors creates an atmosphere of community integration, particularly when the rules of support mandate the inclusion of landmine survivors and persons with disabilities into the program. This also prevents further isolation of the landmine survivors where the community would see support only for this special population and at the expense of the rest of the community.

FACTOR 6: Sociocultural issues

Sociocultural aspects of the landmine survivor's life should be addressed throughout the process of rehabilitation and reintegration. These influences are important in defining options for socioeconomic integration. It is also important to flag aspects of the sociocultural situation that constitute barriers to successful integration but that might be amenable to change by carefully planned intervention strategies.

6.1 Role of family

The family can be extremely supportive in helping the landmine survivor to become integrated into society. It is important to incorporate the family and their needs into intervention strategies and to encourage the development and implementation of services to family members of landmine survivors who themselves are victims physically or psychologically of landmines and other disabling conditions. Families may have ties to socio-economic opportunities and be helpful or may prove burdensome because of the pressure they exert on the survivor to help them meet their own needs.

6.2 Cultural issues and awareness

Issues related to gender, age, religion and ethnic origin should be accounted for in program development and implementation. If certain occupations, for example, are typically reserved for one gender or one ethnic group, it has to be taken into account in vocational planning. Religious practices may make certain job options untenable. To the extent possible governments should be encouraged to remove gender, age, religion and ethnic origin as legitimate factors in considering employment options or access to services.

6.3 Urban/rural issues

Socio-economic integration programs should include opportunities for both urban and rural citizens.

6.4 Awareness and destigmatization

As part of the socio-economic integration initiative, countries should develop strategies to correct notions about disability and victims that interfere with consideration of their needs in an equitable manner. Sensitization campaigns should be considered to enlist the support of the community at large in dealing fairly with people with disabilities and in educating the public on the specific needs of this population. Special appeals should be made to the employer community to assist in the integration of such individuals into the economic mainstream.

Geneva International Centre for
Humanitarian Demining
Centre International de
Déminage Humanitaire - Genève

Geneva International Centre for Humanitarian Demining
7bis, avenue de la Paix
P.O. Box 1300
CH - 1211 Geneva 1
Switzerland
Tel. (41 22) 906 16 60, Fax (41 22) 906 16 90
www.gichd.ch