

The Constraints of Victim Assistance

The Victims in Victim Assistance

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One million people have been killed and maimed by anti-personnel mines. Twenty-six thousand people a year become victims, 70 people a day, or around one person every fifteen minutes. Three hundred thousand children and counting are severely disabled because of landmines. Half the people who step on an anti-personnel mine die from their injuries before they are found or taken to hospital. An even higher percentage of children die because, being smaller, their vital organs are closer to the blast. After the end of hostilities, decades afterwards, anyone who strays into a minefield is at risk. Everyone is vulnerable. Women collecting water, children playing, men working the land or tending cattle

If the horrifying thought suddenly strikes you that the field you are in might be mined there is not a lot you can do

Most minefields are unmarked, or have become unmarked after time, erosion, washouts and topographical changes have occurred. You may have no idea that you are in danger until it is too late. If the horrifying thought suddenly strikes you that where you are walking might be mined, there is not a lot you can do about it. You could painstakingly test each centimeter of the ground in front of you before each step. Perhaps sliding a knife into the ground at 30 degrees to see if there is anything dangerous underneath. You may

not discover the mine until you put your weight on it. At least 6 kilograms of weight may be necessary to activate it.

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

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

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

The Statistics of Anti-Personnel Mines

It is particularly distressing to note that landmine casualties often include a large proportion of women and children (21 percent on average, and sometimes up to one-third of all cases). In other words, one mine victim in five is a woman or a child. A study carried out in Peshawar from June to December 1992 showed that, at the time they were injured by a mine explosion, 85 percent of the 528 casualties treated were engaged in non-military activities, such as agricultural work, travelling, or looking after cattle. Moreover, injuries due to mines are severe: in International Committee of the Red Cross (ICRC) hospitals 84 percent

of all amputations are performed on mine victims. These dry statistics cannot portray the feelings of the surgeons, nurses, physiotherapists and prosthetists who, every year, have to treat thousands of non-combatants mutilated by these devices.

From 1985 to March 1995, ICRC hospitals and surgical teams have treated over 140,000 war-wounded, of whom about 30,000 (or just under a quarter) were victims of landmines, but even these figures represent only a very small proportion of the wounded in the conflicts concerned. The surgical office of the ICRC Medical Division has established a database carrying basic information on 23,767 war-wounded patients. There are 5,189 mine-injured registered up to now. This is one of the largest such databases in existence and permits a preliminary analysis of these patients, their wounds and the treatment they have received.

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

The proportion of landmine injuries out of total wounded in any conflict varies according to the type of military activity and the nature of the terrain. In ICRC's Khao-i-Dang hospital, 62 percent of all wounded treated there had been injured by landmines during the Cambodian war, including refugees who were placed in camps in a mine-infested jungle area. The Quetta and Peshawar hospitals, serving heavily mined, mountainous rural areas, reported incidences ranging from 18 percent to more than 60 percent according to the period and the circumstances. The ICRC surgical team in the Jalalabad University Hospital, in Afghanistan just across the border from Peshawar, noted an increase in landmine injuries from 35 percent to 60 percent of all war-wounded in early 1993, after the repatriation of large numbers of refugees to rural areas. Landmine injuries regularly accounted for less than 10 percent of all war-wounded admitted by the Kabul hospital, largely because mines are less used in cities and the inhabitants are mostly exposed to street fighting and artillery bombardment.

Obvious non-combatants, children, women, and elderly men make up 31.3 percent of all landmine victims in the ICRC database. How many injured males between the ages of 15 and 50 years were not members of the armed forces is a matter for conjecture, and puts the true figure of non-combatants higher still. Relative proportions of civilians and combatants injured by landmines also alter with changes in the political and military situations. In a study of 720 mine-injured patients admitted to the ICRC hospital in Peshawar after April 1992, when political changes in Afghanistan allowed the return of many refugees from Pakistan, the number of mine-injured admitted to the hospital rose sharply from 50 to 100 per month. Non-combatants constituted 34 percent of all mine-injured patients covered by this study, compared to 20 percent over the previous two years. Similar results were reported from the nearby Jalalabad hospital.

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

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

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

MINE INJURED IN ICRC HOSPITALS:

- ◆ Potential combatants males 15-50 years old - 68.7%
- ◆ Children < 15 years - 19.8%
- ◆ Women - 7.3%
- ◆ Males > 50 years - 4.2%

EVACUATION OF MINE VICTIMS TO ICRC HOSPITALS

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

Source: ICRC surgical database

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

The Ten Year Old Boy

A ten-year-old boy arrived at an ICRC first-aid post in a taxi hired by his father. Ten hours earlier, he had stepped on a small-buried anti-personnel mine, which had shattered the whole of his left foot. The boy told the staff at the first-aid post that he had been out collecting firewood. He had in fact been looking for unexploded mortars and shells to sell in the local market. He knew that there were mines in the area.

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

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

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

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

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

The Wife and Mother

A 32-year-old mother of three children was working in a rice field. A dark green object in the mud caught her eye. She picked it up, not knowing that it was a mine; it was the kind that explodes either on pressure or when tilted. When the mine exploded it blew off her right hand; her face and eyes received multiple small wounds from the vaporized mine casing. Some other people working in the rice field ran to her aid and tied

a strip of material tightly around her forearm just below the elbow. She was unable to see and was led out of the field. Someone went to tell her husband.

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

This treatment would be expensive and there were many other patients waiting for operations. Fortunately her husband had brought some money with him and was able to borrow more in the market. She had her arm amputated the following day. Her eyes were now red and painful and she was unable to open them. The doctor wrote a prescription for some eye drops, which the husband was able to buy on the market. The next day her husband had to leave to look after the children. Four days later the nurse told her that the amputation of her arm was infected and the stitches put in at the first operation were cutting out of the swollen skin. The infection and inflammation settled slowly over the following days. She remained in the hospital for three weeks, sharing food with some of the other patients. Her eyes remained inflamed but she recovered some sight in one; the other slowly became totally white. She eventually returned to her village in the car of an aid-agency worker.

Her husband told her that she would have to go and live with her mother, as he was unable to feed her and the children if only he was working. Her mother informed her that she would have to beg to bring some money in.

Constraints of Victim Assistance

Access

Mines injure people over large geographical areas. The wounded person may be far from any town and the incident may never be reported to either authorities or aid agencies. Without large and obvious needs constituting a "critical mass", agencies are sometimes reluctant to commit themselves. Thus, mine injuries remain a large-scale, scattered and yet largely unattended problem. A related problem is that an agency might have difficulty finding the wounded person. In other words, geography may not allow the victim to encounter the agency that can provide the transport or the medical care that he or she needs.

Lack of Protection

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

Security

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

Political and Administrative Constraints

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

Poverty

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

Lack of Educated Personnel and Social Structure

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

Lack of Funds

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

Donor pressure

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

Inter-agency Rivalry and Lack of Coordination

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

It is important that the constraints be put in the forefront so that we can better grasp how we can improve our aid to victims, and the organizations and politicians that promote and advocate victim assistance issues. It is equally important that we understand the social, economic and political environment that encompasses the village of the mine victim. It can be argued: What good is provided by an artificial limb when the person, once wounded, must now beg in the streets? We must treat the whole person-the family provider, the child, the wife, the farmer, the laborer, the mother. Victim Assistance, to be successful, must encompass more than medical treatment. It must encompass assimilation, rehabilitation, community awareness and involvement. By treating the whole person, we are treating the whole of the community. How do we begin this massive task? One victim at a time.

Sources:

ICRC
LSN
UNICEF