

**PHYSICAL REHABILITATION PROGRAMME**

# **ANNUAL REPORT**

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**ICRC**



**ICRC**

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# FOREWORD

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and other violence and to provide them with assistance. Established in 1863, the ICRC is at the origin of the International Red Cross and Red Crescent Movement. It strives through its 80 delegations and missions around the world to fulfil its mandate to protect and assist the millions of people affected by armed conflict and other violence.

The term “rehabilitation” refers to a process aimed at removing – or reducing as far as possible – restrictions on the activities of disabled people, and enabling them to become more independent and enjoy the highest possible quality of life in physical, psychological, social and professional terms. Different measures, such as medical care, therapy, psychological support and vocational training, may be needed for this. Physical rehabilitation, which involves providing physiotherapy and assistive devices (prostheses, orthoses, walking aids and wheelchairs), is an important part of the rehabilitation process. It is not an objective in itself, but an essential part of fully integrating disabled people in society. Restoring mobility is the first step towards enjoying such basic rights as access to food, shelter and education, getting a job and earning an income and, more generally, having the same opportunities as other members of society.

Although the ICRC had undertaken some physical rehabilitation activities before 1979, setting up the Physical Rehabilitation Programme that year marked the beginning of a major commitment in this field. Since 1979, the Programme’s activities have diversified and expanded throughout the world, from two projects in two countries in 1979 to a total of 82 projects in 24 countries in 2009. This is due to a variety of factors that have caused physical rehabilitation as part of humanitarian aid to evolve well beyond the emergency-response stage, since those needing physical rehabilitation will need that

service for the rest of their lives. Over time, the ICRC has acquired a leadership position in physical rehabilitation, mainly because of the scope of its activities worldwide, the development of its in-house technology, its acknowledged expertise and its long-term commitment to assisted projects. In most countries where the ICRC has provided physical rehabilitation support, such services were previously either minimal or non-existent. In most cases, ICRC support has served as a basis for establishing a national rehabilitation service that cares for those in need.

In addition to its operational Physical Rehabilitation Programme, the ICRC is also aiding in the field of physical rehabilitation through its Special Fund for the Disabled. Created in 1983, the ICRC’s Special Fund for the Disabled provides support similar to the Programme. It is primarily the political context and the specific needs that decide which channel the ICRC uses in a given situation. The Special Fund’s mission is to support physical rehabilitation in low-income countries, with priority for projects formerly run by the ICRC. In 2009, the Special Fund assisted 63 projects in 30 countries. Throughout 2009, the Special Fund helped rehabilitate close to 15,000 people with disabilities in the supported centres. This included fitting some 7,900 prostheses and 11,900 orthoses and furnishing 5,500 pairs of crutches and 300 wheelchairs, tricycles and special seats.

This report describes the worldwide activities of the ICRC Physical Rehabilitation Programme in 2009.

Information on the activities of the Special Fund for the Disabled may be obtained from the Fund’s Annual Report for 2009 ([www.icrc.org/fund-disabled](http://www.icrc.org/fund-disabled)).

# 1 – INTRODUCTION

Rehabilitation is aimed at removing – or reducing as far as possible – restrictions on the activities of disabled people and enabling them to become more independent and enjoy the highest possible quality of life. Depending on the type of disability, various measures – such as medical care, physical rehabilitation, vocational training, social support or help in achieving economic self-reliance – may be needed for this. Physical rehabilitation is an integral part of the process needed to ensure the full participation and inclusion in society of people with disabilities. It includes providing assistive devices such as prostheses, orthoses, walking aids and wheelchairs, together with the therapy that will enable disabled persons to make the fullest use of their devices. Physical rehabilitation must also include maintaining, adjusting, repairing and renewing the devices. It is not an end in itself, but an essential part of the process of ensuring the full integration of disabled persons in society. Restoring mobility is the first step towards enjoying such basic rights as access to food, shelter and education, getting a job and earning an income and, more generally, having the same opportunities as other members of society.

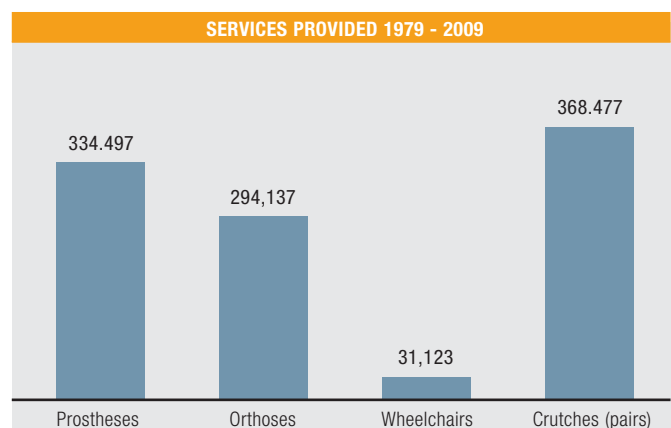
In order to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms, Article 20 of the Convention on the Rights of People with Disabilities requires the States Parties to take effective measures to ensure that people with disabilities have access to assistive technology for mobility. Common types of this technology include crutches, orthoses, prostheses, sticks, canes, walking frames, wheelchairs, and tricycles. These mobility devices are a matter of equity for people with disabilities since they facilitate participation in education, work, family and community. Although there are differences between different countries, it has been estimated that about 1% of the world's population need manual wheelchairs and 0.5% need orthoses and prostheses. However, only 5-15% of the people who require assistive technologies in developing countries have access to them.

The main objectives of a national rehabilitation programme are to ensure the following: that services are accessible, that they meet existing needs and are of good quality, and that they will continue to function over the long term. Physical rehabilitation focuses on helping a person recover or improve the use of his body, with physical mobility as the primary goal. ICRC aid in this realm is designed to strengthen rehabilitation services in a given country, improving their accessibility and their quality, and helping to ensure their availability over the long term.

## HISTORY

Although the ICRC had done some rehabilitation work before 1979, the setting up of the Physical Rehabilitation Unit that year marked the beginning of a serious commitment in this field. Two operational projects were started that year under the newly established physical rehabilitation programme.

Since 1979, the ICRC's rehabilitation work has diversified and expanded worldwide. Between 1979 and 2009, the Physical Rehabilitation Programme supported 128 projects in 41 countries and one territory.



Over half the centres were newly built, frequently with substantial ICRC co-funding of construction and equipment. The programme's activities expanded from two centres in two countries, in 1979, to a total of 82 assisted projects in 23 countries and one territory in 2009. A direct result of this steady increase in the number of assisted centres is the rise in the number of beneficiaries.

Since 1979, many people have benefited, with ICRC help, from services such as the provision of prostheses, orthoses, wheelchairs and walking aids, physiotherapy, and follow-up (repairs and maintenance of devices). Patients keep benefiting from the facilities and expertise after their treatment is finished. The true number of beneficiaries is therefore higher than indicated in the statistics, which do not include patients treated after the ICRC's withdrawal from the assisted centres.

## APPROACH

The Physical Rehabilitation Programme strives to meet the basic physical rehabilitation needs of disabled people affected by conflict and other situations of violence, and to do this in the most prompt, humane and professional way possible. These basic needs include access to high-quality, appropriate and long-term physical rehabilitation services (prostheses, orthoses, physiotherapy, walking aids and wheelchairs).

In the conflict-racked countries where the ICRC discharges its mandate, it is not only people directly affected by the conflict (those injured by landmines, bombs and other ordnance) who need physical rehabilitation, but also people indirectly affected – people who become physically disabled because the breakdown of normal health services prevents them from receiving proper care and/or vaccinations. The projects assisted by the ICRC offer services to all those in need.

ICRC physical rehabilitation projects are planned and implemented in such a way as to strengthen the physical rehabilitation services offered in the country concerned, the primary aims being to improve the accessibility of services for the physically disabled, upgrade the quality of those services, and ensure their long-term availability.

- **Improving accessibility:** The ICRC takes all possible measures to ensure that everyone in need of physical rehabilitation has **equal** access to it basis, regardless of social, religious, ethnic or other considerations. Special attention is given to vulnerable groups, such as women and children.
- **Improving quality:** The ICRC promotes the application of internally developed guidelines based on international norms. It also promotes a multidisciplinary patient-management approach, which includes physiotherapy. In addition, it sees to it that the ICRC technology used to produce appliances and aids for the disabled remains appropriate and up to date.

- **Ensuring sustainability:** The ICRC works with the local partner and strengthens its capacity from the start. In addition, whenever necessary, the ICRC ensures project continuity through the Special Fund for the Disabled. This long-term approach not only takes into account the ICRC's residual responsibility but also reduces the risk of loss in terms of human resources, capital and materials invested.

In order to achieve these aims, the ICRC has taken a twin-track approach: aid is given to both the national system and to users of its services. Aid to the national system aims to ensure that the system has the means to provide services. It includes support at centre level to the authorities responsible. This support may include construction/renovation of facilities, donation of machines, tools, other equipment, raw materials and components, developing local human resources and supporting the development of a national strategy for physical rehabilitation. Aid to users is intended to ensure that they have access to the services. This includes covering travel, accommodation and food expenses as well as the cost of treatment at the centres.

ICRC projects aim to help bring about full integration of the disabled into society, both during and after the period of assistance. Although its focus is on physical rehabilitation itself, the ICRC's Physical Rehabilitation Programme recognizes the need to work with others to ensure that beneficiaries have access to other services in the rehabilitation "chain". In all projects, referral networks are established with local and international organizations that are directly involved in other segments of the rehabilitation chain. In addition, where the ICRC is engaged in activities such as hospital support and economic-security projects, steps are taken to ensure that beneficiaries of physical rehabilitation projects have access to proper medical care and to ICRC socio-economic projects implemented.

## DEVELOPING NATIONAL CAPACITY

ICRC projects are designed and implemented to strengthen the overall physical rehabilitation services in a given country. For that reason, it supports local partners (governments, NGOs, etc.) in providing these services. The level of support varies from country to country but the aim is always to develop national capacity. However, in certain circumstances the ICRC may substitute entirely for the authorities. Ninety percent of the ICRC's projects have been, and continue to be, managed in close cooperation with local partners, primarily government authorities. Few centres have been or are run by the ICRC alone. There are two situations in which this may be the case: when there is no suitable partner at the outset, and when a centre is set up to treat patients from a neighbouring country. In 2009, apart from one centre in Pakistan (Muzaffarabad), one centre in Iraq (Arbil), and all seven projects in Afghanistan, assisted centres were either government-run or managed by NGOs.

Although the ICRC's withdrawal from functioning rehabilitation projects has been successful in many cases, in other cases the result after a year or so has been an empty centre without materials, trained personnel or patients. In countries with limited financial resources, the needs of the disabled, including rehabilitation, are seldom given priority. The result is poorly funded and poorly supported centres. Besides the impact this has on patients and personnel, it represents a significant loss in terms of investment of human capital and materials. As noted above, disabled people need access to functioning rehabilitation services for the rest of their lives. In order to improve the chances of services continuing to function, the ICRC uses a long-term approach when setting up and managing its projects. While the top priorities are to maintain high quality and increase accessibility, the ICRC is always attentive to fostering its partners' management capacity from the outset. It does this by training and mentoring, by improving facilities, and by promoting an effective physical rehabilitation policy within the government.

Since 1979, the ICRC has developed several tools (stock management, patient management, treatment protocols, etc.) to support managers of assisted centres. These management tools have also been distributed to other organizations working in the same realm.

Since the quality of services depends largely on the availability of trained professionals, the training component of ICRC-assisted projects has gained in importance over the years. In addition, the presence of trained professionals increases the chances of rehabilitation facilities continuing to function in the long term. In 2003, an in-house training package for orthotic/prosthetic technicians (Certificate of Professional Competency – CPC) was developed by the ICRC and recognized by the International Society for Prosthetics and Orthotics (ISPO). Since 1979 the ICRC has run formal prosthetic and orthotic (P&O) programmes leading to a diploma in more than 12 countries, as well as formal training in physiotherapy in one country. It has also provided scholarships enabling a number of candidates to be trained at recognized schools in P&O or physiotherapy.

Even when the ICRC has completely withdrawn from a country, the organization's Special Fund for the Disabled can follow up. This long-term commitment to patients and facilities, unique among aid organizations, is much appreciated by the ICRC's partners in both centres and governments. It is one of the ICRC's major strengths.

## **PROMOTING ACCESS TO OTHER SERVICES IN THE REHABILITATION CHAIN**

The aim of rehabilitation is to remove – or to reduce as far as possible – restrictions on the activities of disabled people, and to enable them to become more independent and enjoy the highest possible quality of life. Various measures, such as medical care, physical rehabilitation,

vocational training, social support, and programmes promoting economic self-reliance, may be needed. Physical rehabilitation is thus one measure among many that may be required to achieve full rehabilitation. Although its focus is physical rehabilitation, the ICRC's Physical Rehabilitation Programme recognizes the need to develop projects in cooperation with others so as to ensure that patients have access to other services in the rehabilitation chain.

In all projects, referral networks are set up with local and international organizations directly involved in other parts of the rehabilitation chain. In addition, where the ICRC is carrying out other activities, such as hospital support and economic-security projects, coordination is needed to ensure that beneficiaries of physical rehabilitation projects have access to proper medical care and to ICRC socio-economic projects.

## **VICTIM ASSISTANCE FOR SURVIVORS OF MINES AND EXPLOSIVE REMNANTS OF WAR (ERW)**

Among the 26 States party to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Mines and on their Destruction (Mine Ban Convention) that have acknowledged their responsibility for numerous landmine survivors, the ICRC has, over the years, provided support to 16 of them (Afghanistan, Albania, Angola, Cambodia, Chad, Colombia, Democratic Republic of the Congo, Eritrea, Ethiopia, Iraq, Mozambique, Nicaragua, Sudan, Tajikistan, Uganda and Yemen) and is still supporting 11 of them (Afghanistan, Cambodia, Chad, Colombia, Congo, Eritrea, Ethiopia, Iraq, Sudan, Uganda and Yemen). Since 1997, the ICRC-assisted network of centres has furnished 117,849 prostheses for mine survivors and 3,540 orthoses along with physical therapy. In addition, many survivors have received wheelchairs and walking aids.

## **POLYPROPYLENE TECHNOLOGY**

The ICRC initially used raw materials and machinery imported from established Western suppliers to produce prosthetic and orthotic components. However, it soon started developing a new technology using polypropylene as the basic material, thus bringing down the cost of rehabilitation services. Recognition for the vital role played by the ICRC in making rehabilitative appliances more widely available – by introducing low-cost, high-quality technology – came in 2004 in the form of the Brian Blatchford Prize awarded by the ISPO. The technology developed by the ICRC is now standard practice for the production of prostheses and orthoses and is currently being used by a significant number of organizations involved in physical rehabilitation.

To mark the ICRC's role in developing and promoting better technology such as polypropylene, a brochure on



the subject was published in 2007. It contains information about the advantages and appropriateness of using this technology in developing countries.

## SPECIALIST SUPPORT

Besides developing technologies and training professionals, the ICRC uses its specialists to promote quality services. It has by far the largest international pool of experts among the international organizations working in the same field. Over time, the average number of expatriates per project has dropped from seven (in 1979) to 0.7 in 2009, mainly because of greater experience on the part of the ICRC and the growing number of locally trained professionals working in assisted centres.



Ash Sweeting/British RC



## 2 – OVERVIEW OF ACTIVITIES IN 2009

In 2009, the ICRC continued its efforts to improve the accessibility of services, enhance their quality and promote their long-term availability.

### IMPROVING ACCESSIBILITY

#### Projects worldwide

In 2009, the Physical Rehabilitation Programme assisted 82 projects in 23 countries and one territory: apart from the two local component factories (in Cambodia and Afghanistan) and the local unit manufacturing crutches in Iraq, all projects were rehabilitation centres. Also in 2009, the ICRC began rehabilitation aid in Mexico (1 project) and Guatemala (3 projects). In addition, it started aid for six additional centres in already-assisted countries: Nepal (1 project), Yemen (1), Uganda (1), Iraq (2) and Ethiopia (1). It also ended its support in Eritrea (3 projects) and Algeria (1).

In Africa, the ICRC supported 25 projects in six countries. In Chad, it supported the only two centres in the country: the Maison Notre Dame de la Paix in Moundou and the Centre d'Appareillage et de Rééducation de Kabalaye in N'Djamena, both managed by local NGOs. It also supported a referral system for disabled people from eastern Chad. While not directly supporting centres in the Democratic Republic of the Congo, the ICRC nevertheless continued to cover the cost of treatment for people directly affected by the conflict. This was furnished by several centres in the country and the ICRC strove to improve access to services. In Eritrea the project did not proceed as planned, and after several unsuccessful attempts to reach a cooperation agreement with the Ministry of Labour and Human Welfare, the ICRC decided to halt its support at the end of April 2009. In Ethiopia, the ICRC continued support

for six rehabilitation centres and initiated support for the Dire Dawa centre managed by Cheshire Service Ethiopia. The national strategy for the provision of physical rehabilitation services, developed by the Ministry of Labour and Human Welfare with ICRC support, was completed in May and submitted to the Ethiopian Centre for Disability and Development for review. It will be included in the 2010 National Social Welfare Policy. In Sudan, the ICRC continued to support the National Authority for Prosthetics and Orthotics in its network of centres. It also supported South Sudan's Ministry of Gender, Social Welfare and Religious Affairs. In November 2009, all 11 students enrolled in courses toward the Sudanese Diploma for Prosthetics and Orthotics passed the final exams for Module 1 (lower-limb prosthetics) under the supervision of ISPO. In Uganda, the ICRC continued supporting the Fort Portal Orthopaedic Centre and began supporting the Mbale Orthopaedic Centre, while at the same time aiding the Ministry of Health in drawing up a standard list of P&O materials for the central stores.

In Asia, the ICRC provided support for 26 projects in 10 countries. In Afghanistan, it continued to manage six rehabilitation centres throughout the country and one component factory in Kabul (also producing wheelchairs). In addition, it conducted a formal P&O training programme, continued to manage a special programme for people with spinal cord injuries (home-care programme) and continued to work for the social inclusion of people with disabilities. In Cambodia, the ICRC continued working with the Ministry of Social Affairs, Veterans and Youth Rehabilitation to support the work of the Battambang regional centre, the Kompong Speu regional centre and the Phnom Penh P&O component factory. In China, the ICRC continued to support the work of the rehabilitation centre in Kunming, Yunnan, managed by the Yunnan Branch of the Red Cross Society of China, and its two repair workshops located

in Malipo and Kaiyuan. In the Democratic People's Republic of Korea, the ICRC continued aiding the Ministry of Public Health by supporting the Songrim rehabilitation centre and continued to help the Ministry of Defence by supporting the Rakrang rehabilitation centre. In India, the ICRC continued supporting the Bone and Joint Hospital in Srinagar and the Government Medical College in Jammu. In Myanmar, only the Hpa-an rehabilitation centre, run jointly by the Myanmar Red Cross Society and the ICRC, continued to receive direct ICRC support. However, centres managed by the Ministry of Health (3) and the Ministry of Defence (3) continued to provide services with material and components furnished by the ICRC.

In Nepal, the ICRC continued supporting the P&O department of the Green Pasture Hospital in Pokhara and started support for the Yerahity rehabilitation centre in Kathmandu managed by the Nepalese army. This centre is the only government-run facility in Nepal and both military personnel and civilians have access to it. Since June 2008 it has provided rehabilitation for people with spinal cord injuries and, with ICRC aid, started fitting amputees in May 2009. In Pakistan, the ICRC maintained its support for the Pakistan Institute of Prosthetic and Orthotic Sciences in Peshawar, for the Quetta Christian Hospital rehabilitation centre and for the ICRC-managed Muzaffarabad rehabilitation centre. In addition, the ICRC managed a home-care project for the benefit of people with spinal cord injuries. In the Philippines, it continued working with the Davao Jubilee Centre, the only qualified provider of this service on the entire island. In Sri Lanka, the ICRC continued its support for the Jaffna Jaipur Centre for Disability Rehabilitation, the only centre supplying physical rehabilitation services on the Jaffna peninsula.

In the Americas, the ICRC supported 11 projects in four countries. In Colombia, it continued support for five centres: the Centro Integral de Rehabilitación de Colombia in Bogotá, the Centro de Rehabilitación Cardioneuromuscular in Cúcuta, the Fundación REI para la Rehabilitación Integral in Cartagena, Orthopraxis Ltda in Medellín and Ortopédica Americana in Cali. In addition, the ICRC worked closely with the Ministry of Social Protection and with the Centro Don Bosco in Bogotá to train staff in P&O (ISPO Cat. III), and with the Servicio Nacional de Aprendizaje to train staff in P&O (ISPO Cat. II). Finally, the ICRC maintained close contact with the victim-assistance department of the Programa Presidencial para la Acción Integral contra Minas Antipersonal. In Guatemala, the ICRC strove to improve access to rehabilitation for specific groups. It initiated support for three centres: the Asociación Guatemalteca de Rehabilitación de Lisiados for civilians (including migrants who had been injured in a train accident and returned to Guatemala), the Centro de Atención a Discapacitados del Ejército de Guatemala for military personnel, and the Hospital Infantil de Infectología y Rehabilitación for children under 18. In Mexico, the

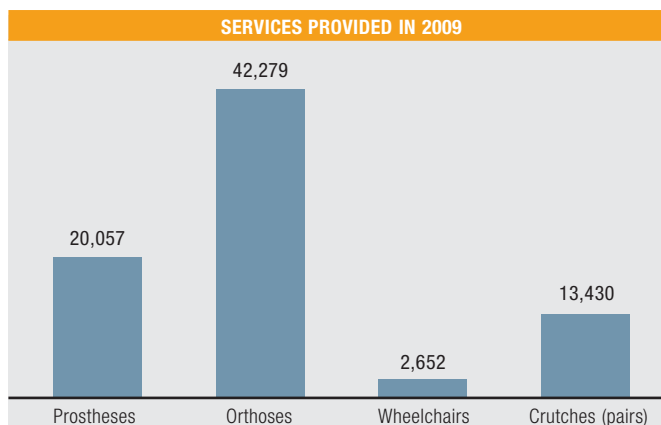
ICRC started support for the Orthimex Prosthetics and Orthotics Centre in Tapachula, Chiapas, with the primary objective of ensuring access to rehabilitation for migrants injured by falling off trains on the way to the United States.

In the European region, the ICRC's rehabilitation work in Georgia was threefold: support for the Georgian Foundation for Prosthetic and Orthopaedic Rehabilitation in Tbilisi, support for the Gagra centre in Abkhazia and a referral service for patients from South Ossetia (the ICRC covered the cost of devices for them).

In the Middle East and North Africa, the ICRC supported 20 projects in three countries and one territory. After nearly 10 years, the ICRC halted its aid for the Ben Aknoun P&O department in June. Enough materials and components were given to enable the department to continue providing services at least until the end of 2010. In southwest Algeria, where Sahrawi refugees live, the ICRC continued support for the activities of the Centre Martyr Chereif, managed by the Polisario Front's Public Health Authority. The centre was in the desert, about five km from Rabouni, where the Front had set up its administrative headquarters. In Gaza, the ICRC continued aid for the Artificial Limb and Polio Centre (ALPC) in Gaza City, managed by the city authorities. The ICRC also continued its collaboration with Al-Shifa Hospital and with the European Gaza Hospital. The general objective of the programme there was to ensure access to physical rehabilitation for wounded people in Gaza (aid to ALPC) and to post-surgical rehabilitation focused on physiotherapy (aid to hospitals). While the focus was on war-wounded people, ICRC support benefited all users of the assisted hospitals and the ALPC. In Iraq, the ICRC continued supporting 13 facilities around the country, nine of them managed by the Ministry of Health: four in Baghdad (Al-Wasity, the Medical Rehabilitation Centre, Baghdad Centre and Al-Salam Crutch Production Unit) and one each in Falluja, Basra, Najaf, Hilla, and Tikrit. One was managed by the Ministry of Higher Education (Baghdad P&O School) and one by the Ministry of Health of the Kurdistan Regional Government in Arbil (Helena Physical Rehabilitation Centre). In addition, the ICRC continued to manage the Arbil Physical Rehabilitation Centre and financed the construction of a new centre in Nasiriya, which should start providing services in 2010. In Yemen, the ICRC continued supporting the National Artificial Limb and Physiotherapy Centre in Sana'a, the Artificial Limb and Physiotherapy Centre in Mukalla and the Limb-fitting Workshop and Rehabilitation Centre in Aden. In addition, it supported the Sa'ada Physical Rehabilitation Clinic, based at the Al Jumhuri Hospital. This clinic was a joint venture between the Ministry of Public Health and Population, the Rehabilitation Fund and Care for Handicapped Persons, the Yemen Red Crescent Society, and the ICRC.

## Services provided

In 2009, more than 182,000 people benefited from various services at ICRC-assisted centres. These services included production of 20,057 prostheses and 42,279 orthoses, and the furnishing of 2,652 wheelchairs and 13,430 pairs of crutches. No statistics were compiled on the number of persons who received physiotherapy, but it was available for most of them, and the majority received it. An average of 9% more people received services in ICRC-assisted centres in 2009 than in the previous year. Children represented 26% and women 18% of the beneficiaries.



## Services for mine/ERW survivors

In 2009, the ICRC aided 11 (Afghanistan, Cambodia, Chad, Colombia, the Democratic Republic of the Congo, Eritrea, Ethiopia, Iraq, Sudan, Uganda and Yemen) of the 26 States party to the Mine Ban Convention that had acknowledged their responsibility for landmine survivors. In all these countries, survivor access to services was facilitated by the ICRC. This was also the case with survivors from China, the Democratic People's Republic of Korea, Georgia, India, Myanmar, Nepal, Pakistan and Sri Lanka.

The ICRC-assisted network of centres provided 7,138 prostheses for mine survivors (total prostheses: 20,057) and 535 orthoses (total orthoses: 42,279), along with the appropriate physical therapy. In addition, many survivors received wheelchairs and walking aids. Children accounted for 4% and women 8% of the total number of survivors who received prostheses and orthoses. In Afghanistan, Cambodia, Chad, Colombia, Ethiopia, Iraq, Myanmar and Sudan, the ICRC continued to be the main international organization providing, and assisting in the provision of, physical rehabilitation.

## Promoting access to other services in the rehabilitation chain

Two ICRC physical rehabilitation projects (in Afghanistan and Colombia) had built-in socio-economic components

in 2009. The project in Afghanistan combined physical rehabilitation with activities aimed at reintegrating the disabled into society. In 2009, more than 2,000 people benefited from various activities promoting social inclusion (job placement, special education, vocational training, micro-credits, etc.). Since 1993, acting on the conviction that physical rehabilitation is a step towards a disabled person's reintegration into society, the project has pursued a policy of "positive discrimination". In order to set an example, to prove that a disabled person is as capable as an able-bodied person, all the centres had trained and employed only people with disabilities. At present, almost all 600 employees of the project, male and female, have disabilities. In Colombia, 25 survivors received micro-economic assistance from the ICRC.

In addition, beneficiaries at assisted centres in the Congo, in Pakistan and in Iraq had access to the services of the ICRC's micro-economic initiative programme. In Cambodia, the ICRC maintained close contact with the micro-economic initiative programme run by the Cambodian Red Cross. At all other assisted centres, referral networks were set up with local and international organizations directly involved in other parts of the rehabilitation chain.

## IMPROVING QUALITY

A number of factors helped improve services: training for locally recruited and expatriate professionals, the skills brought by expatriate specialists, improvements in ICRC-developed polypropylene technology, treatment guidelines, promoting a multidisciplinary patient-management approach and the emphasis on the quality rather than the quantity of services provided.

### Improved ICRC-developed polypropylene technology

Satisfaction with the quality of the prosthetic/orthotic components produced by CR Equipements SA was monitored over the year through systematic feedback from the field projects. Research continued to upgrade and further develop the full range of products. New products included a single-axis ankle joint for prosthetics. Production began of offset-type orthotic sidebars in adult and child sizes.

A field test of the CR Sach Foot was carried out by the Ministry of Labour, Invalid and Social Affairs at the Ho Chi Minh City centre in Viet Nam. The progress of 38 of the 41 transtibial amputees initially fitted was reviewed after nine and 18 months of use.

The second exam revealed a 17% failure rate. No early deterioration of the polyurethane-foam foot cover was observed. The failure rate was lower than the 2006 field-test results with the same profile of transtibial amputees, when a 27% failure rate was recorded after 18 months.

The result was positive, as was steaming the foot immediately after it came out of the mould. This process, which reinforces polyurethane-foam stability and helps improve foot life span, had been in place at the CRE since January 2007. The polyurethane improvements address the foot-geometry weaknesses, i.e. they strengthen foot resistance during the roll-over phase of walking. The new keel design successfully passed the mechanical test of two million cycles (as per the ISO 10328 test) without any breakage in either the keel or the polyurethane.

### Enhancing local capacity

While ICRC expatriates (ortho-prosthetists and physiotherapists) continued to give on-the-job training and mentoring in all projects, efforts were maintained to increase the number of qualified local professionals by providing and sponsoring training in prosthetics, orthotics and physiotherapy and updating the skills and knowledge of those already working.

### Improving physiotherapy

Throughout the year, physiotherapy in the assisted centres was enhanced by several means. The ICRC's physiotherapy technical commission continued developing the Physiotherapy Reference Manual and guidelines for physiotherapists. Various short courses for expatriates (POP immobilizations and limb traction, prosthetic gait defaults and analysis) were designed in order to strengthen the skills of field personnel. In addition, a one-month course in physiotherapy for lower-limb amputees was developed at the Special Fund for the Disabled's regional training unit in Addis Ababa.

Physiotherapists strove to strengthen the link between the Physical Rehabilitation Programme projects, hospitals and community-based rehabilitation projects. In Gaza, the physiotherapy project in the Palestinian hospitals appeared to be effective in preventing disabilities and ensuring referral of needy cases to the rehabilitation services. In Muzaffarabad and the rest of Pakistan, developing a link with a local community-based rehabilitation association helped the ICRC to find people with disabilities and ensure better follow-up.

In 2009, thirteen persons completed or continued formal training in physiotherapy subsidized by the ICRC.

Project	No. of students	School	Year	Diploma
Sudan	2	Kigali Health Institute	2007 - 2010	BSc. Physiotherapy
	2	St Mary's University	2006 - 2010	BSc. Physiotherapy
DPRK	4	Mobility India	2009 - 2010	Rehabilitation Therapy Assistant
Cambodia	5	Singapore General Hospital (course in Cambodia)	2009	PT Upgrade Training

In addition, the ICRC helped train physiotherapists by:

- supporting a two-year training programme in Afghanistan
- sponsoring participation by five therapists in a one-month refresher course on managing lower-limb amputees at the ICRC's Special Fund for the Disabled regional training unit in Addis Ababa
- implementing continuous training for physiotherapists in Algeria (Sahrawi project), Ethiopia, Cambodia, the Democratic People's Republic of Korea, Sudan, Gaza, and Pakistan
- conducting refresher courses for physiotherapists in Iraq, Ethiopia, Yemen, Uganda and Nepal
- sponsoring one therapist from Nepal and one from Myanmar for a two-month placement in a centre in Cambodia

The ICRC also supported physiotherapy by:

- financing the construction of a new physiotherapy department at the Centre d'Appareillage et Rééducation Kabalaye in N'Djamena, completed in 2009
- donating equipment to several facilities in Colombia
- ensuring access to post-surgical rehabilitation at the Al Shifa Hospital and at the European Gaza Hospital (by donating equipment and training and mentoring physiotherapists).

### Improving P&O

P&O services at assisted centres were enhanced by several means. Consistent effort was made by ICRC technical commission members and field P&O experts to promote and develop internal P&O standards and new technical manuals. Manufacturing guidelines were prepared for hip-disarticulation prostheses, prostheses for Syme amputation and ankle-foot orthoses with free-motion ankle joint. Their publications was planned for the second half of 2010.

In 2008, 50 persons completed, continued or began P&O courses subsidized by the ICRC. The ICRC also continued its courses in Sudan and Afghanistan and conducted several technical P&O seminars in assisted projects.

In Afghanistan, the ICRC continued, in cooperation with the Ministry of Public Health, a three-year course in P&O. Twenty-two trainees were enrolled and the training took place at the ICRC's training facility at the Kabul limb-fitting and rehabilitation centre. The first examination (Module 1: lower-limb prosthetics) was scheduled for March 2010 (under ISPO supervision).

In Sudan, the ICRC worked with the National Authority for Prosthetics and Orthotics, and the El Geraif College and the Ministry of Higher Education continued a P&O course, leading to the Sudanese Diploma for Prosthetics and Orthotics. In November 2009, all 11 students passed



Project	No. of students	School	Year	Diploma
Iraq	3	CSPO <sup>1</sup>	2007 - 2010	ISPO Cat. II
	2	CSPO	2008 - 2011	ISPO Cat. II
	3	CSPO	2009 - 2012	ISPO Cat. II
	1	TATCOT <sup>2</sup>	2009 - 2013	ISPO Cat. I
Sudan	2	TATCOT	2007 - 2010	ISPO Cat. II
	3	TATCOT	2006 - 2009	ISPO Cat. II
	5	TATCOT	2008 - 2009	Single-discipline diploma (Cat. II)
Nepal	1	CSPO	2008 - 2011	ISPO Cat. II
Philippines	1	CSPO	2007 - 2010	ISPO Cat. II
DPRK	5	CSPO	2007 - 2010	ISPO Cat. II
Colombia	2	Don Bosco University	2007 - 2010	ISPO Cat. II through distance learning
	6 <sup>3</sup>	Don Bosco University	2008 - 2011	ISPO Cat. II
India	2	Mobility India	2007 - 2008	ISPO Cat. II
	1	Mobility India	2008 - 2009	ISPO Cat. II
Yemen	3	Mobility India	2008 - 2011	ISPO Cat. II
	4	Mobility India	2006 - 2009	ISPO Cat. II
Pakistan	2	PIPOS <sup>4</sup>	2007 - 2010	ISPO Cat. II
	1	PIPOS	2007 - 2009	PIPOS Modular Course
	1	TATCOT	2009 - 2013	ISPO Cat. II
Gaza	2	Mobility India	2009 - 2010	Single-discipline diploma (Cat. II)

<sup>1</sup> Cambodian School for Prosthetics and Orthotics

<sup>2</sup> Tanzania Training Centre for Orthopaedic Technologists

<sup>3</sup> Students sponsored jointly by ICRC and ISPO / Leahy War Victims Fund

<sup>4</sup> Pakistan Institute of Prosthetic and Orthotic Sciences

the final exams in Module 1 under ISPO supervision and gained the diploma.

The ICRC also promoted professional development for P&O practitioners by:

- conducting refresher courses in Colombia, Afghanistan, Iraq, Eritrea, Ethiopia and the Democratic People's Republic of Korea
- sponsoring two P&O technicians from Nepal for a two-month placement in a centre in Cambodia,
- sponsoring 10 technicians at refresher courses organized by the Special Fund for the Disabled regional training unit in Addis Ababa
- sponsoring 11 technicians at refresher courses offered by Don Bosco University (El Salvador) with support from the Special Fund for the Disabled.

### Improving wheelchair services

Though wheelchairs are made available in most assisted projects, providing them has always been problematic. First, affordable and individualized wheelchairs remain scarce in many of the countries where the ICRC works. Second, even when wheelchairs are available, they are often not readily adaptable to the user's needs. Another source of concern is the competence of those providing wheelchairs: their ability to properly assess the patients' needs and to set out appropriate treatment, which includes selecting the proper wheelchair and modifying it to the user's needs.

Throughout the year, the ICRC supported provision of appropriate wheelchairs by:

- organizing training for P&O and physiotherapy professionals from Afghanistan, Cambodia, Iraq, and Ethiopia
- continuing to upgrade the wheelchair-production unit in Kabul
- donating spare parts for production in Eritrea.

### PROMOTING LONG-TERM FUNCTIONING OF SERVICES

The ICRC endeavoured throughout the year to ensure services over the long term not only by supporting training but also by implementing projects in close cooperation with local partners, continuing to develop management tools, supporting the work of bodies coordinating local rehabilitation, and promoting development of national policies for the provision of physical rehabilitation services.

#### Local partners

To help services continue functioning after it has withdrawn, the ICRC has adopted a long-term approach to implementing and managing its rehabilitation projects. Implementing projects with local partners is the cornerstone of this strategy. Of the 82 projects assisted by the ICRC in 2009, 48 had been undertaken in conjunction with governments (ministries of health or of social affairs), 15 with local NGOs, three with private entities, and six with National Societies. Ten other projects were implemented directly by the ICRC.

The ICRC launched several activities to ensure services over the long term:

- In Ethiopia, the National Strategy for physical rehabilitation, developed by the Ministry of Labour and Social Affairs with ICRC support, was completed in May and submitted to the Ethiopian Centre for Disability and Development for review. It was to be included in the 2010 National Social Welfare Policy.
- In Sudan, the ICRC covered the cost of an external consultant who conducted, at the request of the National Authority for Prosthetics and Orthotics, a feasibility study on transforming the Authority from a government body into an autonomous body.
- In the Democratic Republic of the Congo, the ICRC maintained contact with the National Community-Based Rehabilitation Programme.
- It supported the Ugandan Ministry of Health in developing a standard list of P&O materials for the central stores.
- It continued strengthening the capacity of the Cambodian authorities to manage all activities at the centres and the component factory.
- In Afghanistan, the ICRC maintained close contact with authorities, helped develop national P&O



guidelines and took part in the Disability Stakeholder Commission Group, a working group set up by the Ministry of Martyrs, Disabled and Social Affairs to promote reintegration into society.

- ▶ In Nepal, the ICRC participated in the first national workshop on rehabilitation, organized by the Nepalese army. The workshop was mainly intended for the participants to introduce their activities.
- ▶ In Colombia, it worked closely with the Ministry of Social Protection and with the Centro Don Bosco (Bogotá) on a course in P&O (ISPO Cat. III), and with the Servicio Nacional de Aprendizaje on a course in P&O (ISPO Cat. II).
- ▶ In Iraq, the ICRC continued to work closely with ministries involved in rehabilitation, actively participated in meetings of the Higher Committee for Physical Rehabilitation and organized a three-day workshop in Arbil, also attended by representatives from 16 centres, and the Ministry of Health (national and directorate level).
- ▶ It supported the work of several national rehabilitation-coordinating bodies (in Afghanistan, Cambodia, Colombia, Iraq and Sudan).

### Supporting management at centres

The ICRC also helped management staff in assisted centres to improve their management skills and their knowledge of physical rehabilitation. In most of its assisted projects, it introduced an ISPO cost-calculation system, which enabled managers to draw up budgets for their centres. In addition, close support was given to managers to develop and implement standard working

procedures (human resources management, stock management, patient management, etc.).

During the first six months of the year, ICRC specialists helped the managers of the assisted centres improve management of stock and orders, administration of the annual budget and fund allocation, organization of machinery and equipment maintenance, patient management (by means of a database), and wheelchair services. In Cambodia, the ICRC provided financial support that enabled the managers of the Kompong Speu and Battambang centres to enrol in a three-year management-training course.

### COOPERATION WITH OTHER BODIES

In order to set technology standards, draw up guidelines for training P&O personnel in developing countries, etc., the ICRC continued interacting with various bodies involved in physical rehabilitation and disability issues (the ISPO, the World Confederation for Physical Therapy, and the WHO) as set out below.

#### International Society for Prosthetics and Orthotics

Throughout the year, the Physical Rehabilitation Programme maintained close contact with the Society. This included participation in the ISPO board meeting, educational committee meetings and several activities organized by the ISPO.



Zenon Dewet/ICRC

### International non-governmental organizations

In addition to the regular and ongoing contacts maintained at field level between the ICRC and other organizations, the Physical Rehabilitation Programme held regular meetings at headquarters level with organizations such as Handicap International, Cambodia Trust, the Christoffel Blinden Mission, and Motivation, in order to share information and to coordinate activities.

### Academic institutions in developed and developing countries

In 2009, several activities were carried out with academic institutions to improve the ICRC-developed polypropylene technology. These included:

- Norwegian University of Science and Technology: initiating a life-cycle analysis of its polypropylene technology
- Geneva University Hospital: performing a biomechanical study comparing CR-SACH-foot performance with SACH foot purchased on the open market
- continued cooperation with the Bloorview Research Institute (Toronto, Canada) and the University of Melbourne (Australia): improving CR knee-joint functionality (Initial proposals were ready and the prototype was being prepared.)
- Stanford University: contact on a project based on the existing 4-bars linkage knee joint design, the “Re-motion project Jaipur knee”.

### National and international groups aiding mine/ERW and cluster-munitions victims

Throughout the year, the Physical Rehabilitation Programme continued its efforts at headquarters and in the field to ensure that survivors receive the help they need to play an active role in society. In 2009, the Physical Rehabilitation Programme participated in the work prescribed by the Mine Ban Convention, including meetings of the Standing Committee on Victim Assistance and Socio-Economic Reintegration, as well as the Second Review Conference, held in Cartagena, Colombia.

Ten years after the entry into force of the Mine Ban Convention, its Second Review Conference – also referred to as the “Cartagena Summit on a Mine-Free World” – gathered over 1,000 representatives of the States party to the Convention, observer States, international and non-governmental organizations (Cartagena, 29 November to 4 December 2009). The Conference adopted a series of outcome documents, including one reviewing progress and challenges to implementation since the First Review Conference in 2004, an Action Plan for 2010-14 and a political declaration reaffirming the States Parties’ commitment to the Convention’s objectives and to overcoming the remaining challenges.

The most concrete of these documents is the Cartagena Action Plan, which commits the States Parties to a range of specific measures over the next five years to boost implementation of and promote universal adherence to the Convention. The Action Plan focuses on the main areas in which the Convention is facing challenges, i.e. inadequate progress in victim assistance; slow progress in mine clearance in many countries (resulting in numerous extension requests); and three cases of non-compliance with stockpile-destruction deadlines.

In the Cartagena Action Plan, the States Parties committed themselves to 67 specific measures that they will undertake between 2009 and 2014 to enhance implementation and promotion of the Convention. The Action Plan provides the political framework for implementation efforts during the next five years, reminding the States Parties of their commitments, supporting them in setting priorities for that period and promoting full implementation. Measures of particular interest for victim assistance include:

- increasing the availability of and access to services for mine victims, particularly in rural and remote areas and with a focus on vulnerable groups
- victim assistance at the national level, including assessing needs and the availability and quality of services, developing and implementing national plans and allocating the necessary funds, setting up national coordination mechanisms, strengthening national commitment, building national capacities, and monitoring and evaluating progress
- including mine victims and their organizations in all relevant activities and raising awareness of victims’ rights and available services.

Both Norway as president and Colombia as host country had identified victim assistance as the priority for the Conference. While the requirement to provide victims with assistance was a major achievement of the Mine Ban Convention, this is an area in which progress has been difficult to effect and measure. The ICRC welcomed the Action Plan’s comprehensive and clear commitments regarding victim assistance but stressed the need to ensure its practical and timely implementation. The ICRC stated that the coming period should focus “almost entirely on increasing the resources provided for victim assistance and on concrete actions that will make a difference for individual victims and their families.”

In June 2009, the ICRC and the Norwegian Red Cross convened an international meeting of survivors and those aiding victims. Participants concluded that while the overall number of new landmine casualties has dropped – dramatically in States party to the Convention – far too many people still die at the site of their injury or while being transported long distances for emergency medical care. Most survivors have yet to see a substantial improvement in their lives and in access to medical care, physical rehabilitation, psychological support, social services, education and employment.

### Fédération Africaine des Techniciens Orthoprothésistes

The ICRC initiated talks with the Fédération toward an agreement under which both organizations would work to further improve and promote rehabilitation in Africa. In addition, the ICRC's Physical Rehabilitation Programme participated in the Fédération's fifth international seminar, in Tunisia, sponsoring the attendance of several participants.

### ICRC / Iranian Red Crescent Society seminar on a comprehensive approach to rehabilitation

An international seminar entitled "Comprehensive approach to provision of physical rehabilitation services" was organized by the ICRC and the Red Crescent Society of the Islamic Republic of Iran from 26 to 30 September in Tehran. It was attended by 32 representatives of ministries responsible for disability affairs and rehabilitation as well as international organizations (WHO, ISPO, Fédération Africaine). Participants came from Afghanistan, Algeria, Azerbaijan, Canada, Chad, Ethiopia, Georgia, Iran, Iraq, Mauritania, Pakistan, Senegal, Sudan, Switzerland, Tajikistan, and Yemen.

The seminar's purpose was to share experience in providing rehabilitation with a view to improving services by ensuring:

- ▶ a thorough understanding of basic concepts related to disability and rehabilitation
- ▶ an understanding of how to implement and manage a comprehensive rehabilitation programme
- ▶ the sharing of experience and expertise on services for disabled people, with emphasis on rehabilitation.

### ICRC / International Trust Fund meeting on a comprehensive approach to rehabilitation and reintegration for mine victims and other disabled people

A regional workshop entitled "Comprehensive approach to rehabilitation and reintegration services for mine victims and other persons with disabilities" was organized by the ICRC and the International Trust Fund for Demining and Mine Victims Assistance from 1 to 3 May 2009 in Tbilisi, Georgia. The workshop was hosted by Georgia's Ministry of Healthcare and Social Issues. The seminar's objectives were to:

- ▶ enhance the participants' understanding of basic concepts related to disability, rehabilitation and victim assistance
- ▶ share experience and expertise on rehabilitation for mine victims and other disabled people within the region and beyond
- ▶ promote the development of programmes to ensure access to comprehensive services for physically impaired people (i.e. victim assistance programmes, national programmes for the disabled, etc.).

The workshop was attended by 40 representatives of ministries responsible for disability affairs, rehabilitation centres and mine-action centres, as well as of international organizations (Geneva International Centre for Humanitarian Demining - GICHD, ICRC, and International Trust Fund) and local NGOs from Albania, Armenia, Azerbaijan, Bosnia-Herzegovina, Georgia, Slovenia, Switzerland and Tajikistan.

The following conclusions were reached by the participants of these two seminars:

- ▶ Governments have a responsibility to ensure that physical rehabilitation is accessible. While they may not be directly involved in providing those services, they must define national strategy, financially support and regulate the sector, give professional recognition and oversee all activities, whoever is carrying them out.
- ▶ An effective coordination body in each country is essential for the coordination of these activities. This body should include representatives from all relevant ministries, supporting organizations, organizations for the disabled, professional organizations, etc).
- ▶ It is vital to recognize and adapt the contemporary concept of rehabilitation, which is comprehensive, needs advocacy, is rights-based, requires a multidisciplinary team approach and involves complementary action by the relevant ministries and other concerned entities.
- ▶ It is essential to make disabled people, their families and communities aware of their rights and to ensure that government are aware of the benefits of rehabilitation.
- ▶ Supporting organizations should aim to strengthen rehabilitation services, improving their accessibility and quality, and developing local capacities to ensure their long-term viability.
- ▶ Supporting organizations are still needed to set up and improve services by helping develop national policy and strategy, specifically by means of:
  - financial, technical and professional aid
  - increasing and training staff in an array of rehabilitation professions (e.g. certified prosthetic-orthotic technicians, occupational therapists, physiotherapists, clinical psychologists, specialists in physical and rehabilitation medicine), providing peer support, and developing the skills of the decision-makers
  - developing community-based rehabilitation in accordance with the WHO guidelines and socio-economic re-integration initiatives
- ▶ Regional and international cooperation is essential to develop comprehensive services for disabled people and training staff.



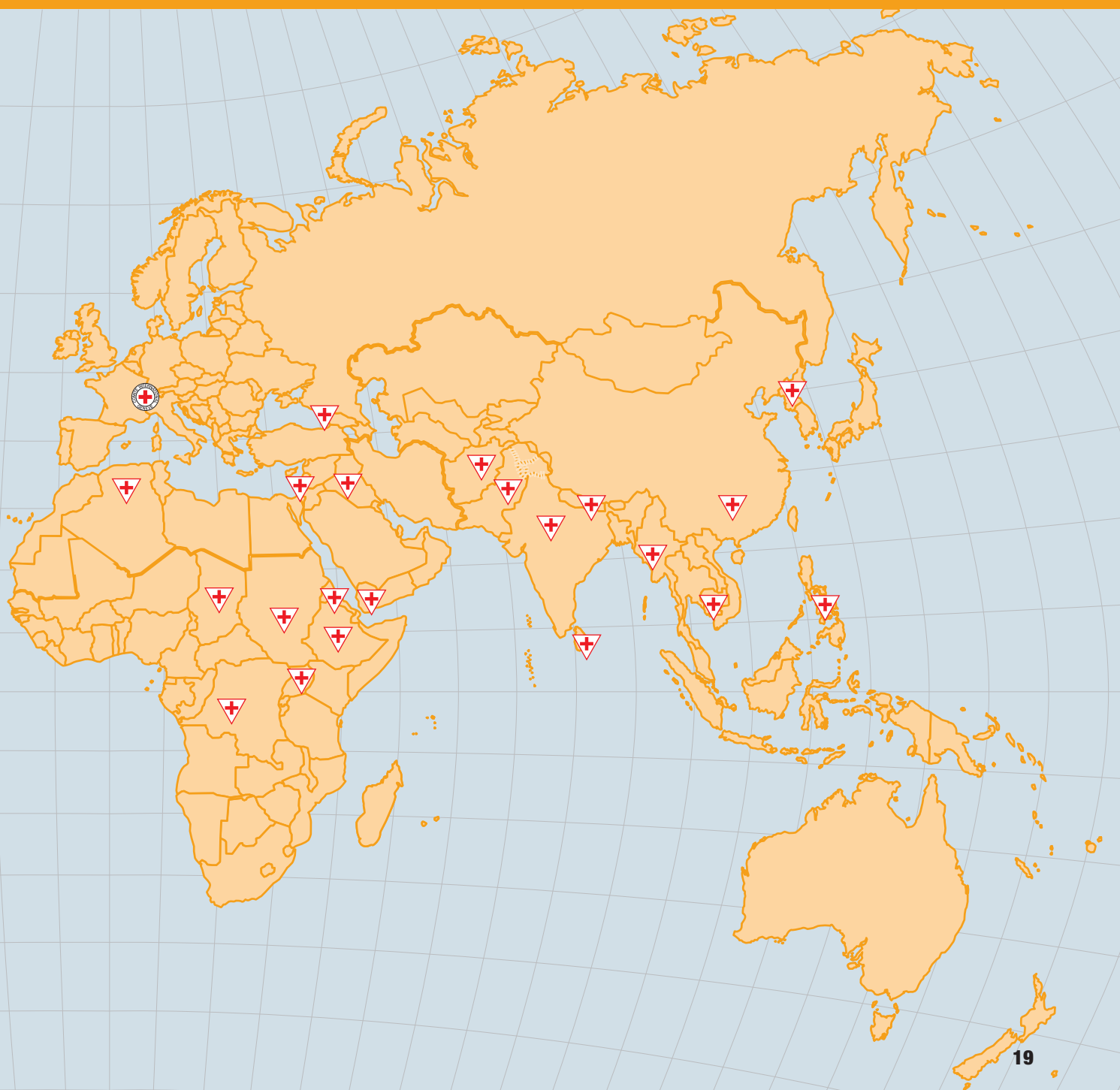


### 3 – AROUND THE WORLD: PHYSICAL REHABILITATION PROGRAMME





<b>AFRICA</b>	6 Countries:	<b>25 projects</b>
<b>ASIA AND THE PACIFIC</b>	10 Countries:	<b>26 projects</b>
<b>EUROPE AND THE AMERICAS</b>	4 Countries:	<b>11 projects</b>
<b>MIDDLE EAST AND NORTH AFRICA</b>	3 Countries and one territory:	<b>20 projects</b>
<b>TOTAL IN THE WORLD</b>	23 Countries and one territory:	<b>82 projects</b>



## 4 – PROJECT ACTIVITIES

## 4.1 – AFRICA





## ICRC SUPPORT IN AFRICA AT A GLANCE

In 2009, the ICRC supported 25 projects in six countries: Chad (2), the Democratic Republic of the Congo (5), Eritrea (3), Ethiopia (7), Sudan (6) and Uganda (2).

- In Ethiopia, the ICRC started support for the Dire Dawa Physical Rehabilitation Centre, managed by Cheshire Service Ethiopia.
- In Uganda, it started support for the Mbale Orthopaedic Centre at the end of the year.
- In Eritrea, it halted support at the end of April for the Ministry of Labour and Human Welfare with its network of centres (3).

### Services provided

Patients	16,156
New patients fitted with prostheses	2,062
New patients fitted with orthoses	2,298
Prostheses delivered	4,117
Orthoses delivered	4,115
Wheelchairs distributed	828
Walking aids distributed (pairs)	3,155

Children represented 24% and women 21% of beneficiaries.

### Developing local capacities

10 candidates sponsored to attend P&O courses

4 candidates sponsored to attend physiotherapy courses

In Sudan, the ICRC continued holding its P&O course (11 participants)

In Eritrea, the ICRC implemented a four-month refresher course in lower limb orthotics

12 candidates (7 P&O technicians and 5 physiotherapists) sponsored for refresher courses at the ICRC Special Fund for the Disabled's regional training unit in Addis Ababa

### Promoting long-term functioning of services

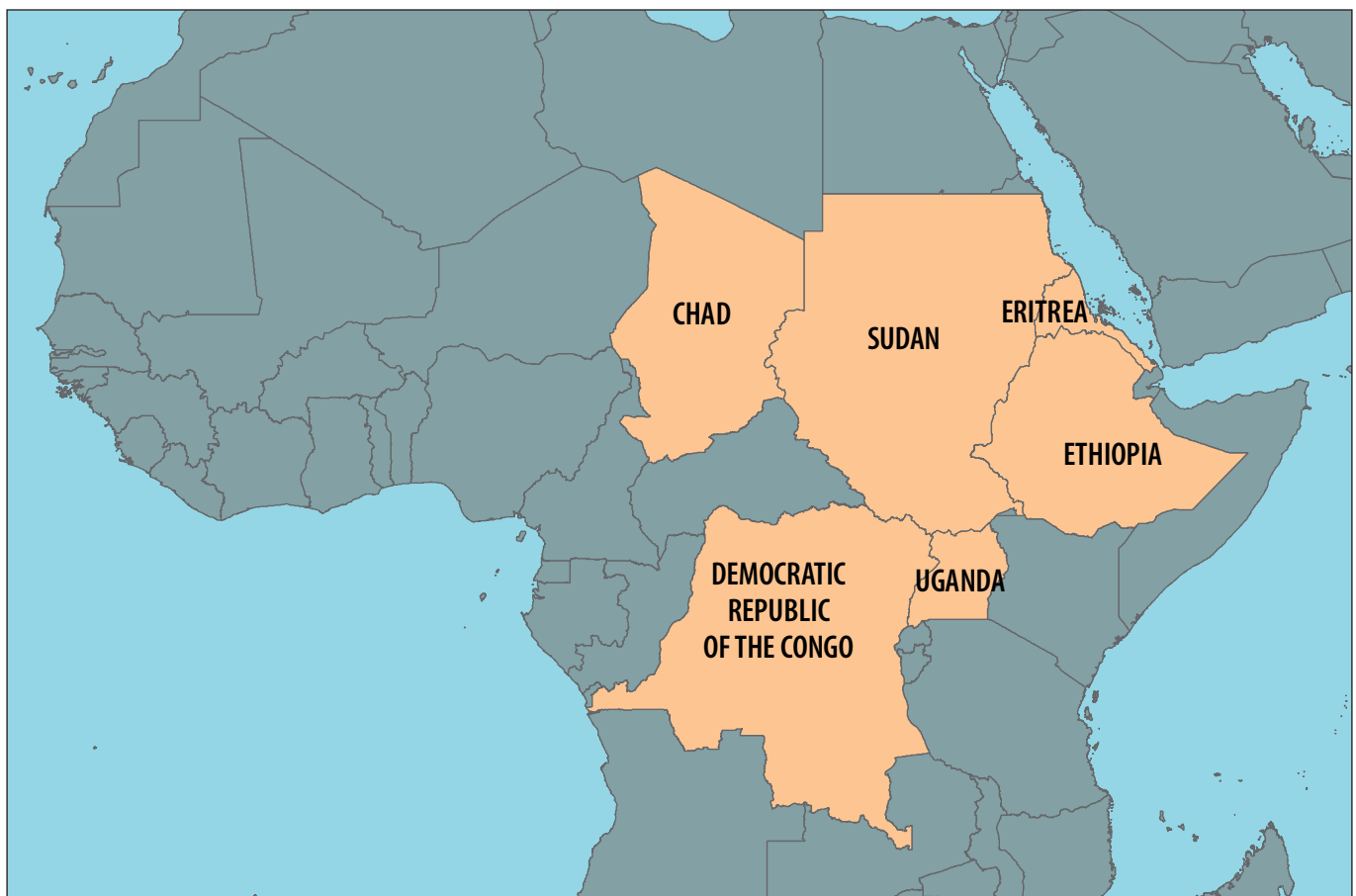
In Ethiopia, the national rehabilitation strategy, developed with ICRC support by the Ministry of Labour and Social Affairs, was completed in May and submitted for review to the Ethiopian Centre for Disability and Development. It will be included in the 2010 National Social Welfare Policy.

At the request of the National Authority for Prosthetics and Orthotics in Sudan, the ICRC covered the cost of an external consultant for a feasibility study on transforming the Authority from a government body into a parastatal body.

In the Congo, the ICRC maintained contact with the National Community-Based Rehabilitation Programme.

In Uganda, it continued supporting the Ministry of Health in its efforts to develop a standard list of P&O items for the central store.

In Chad, it continued working to develop the skills of those managing the assisted centres.



In Chad, access remained difficult for most of those needing rehabilitation. The lack of facilities and professionals, the cost of transport (when available) and the security situation were the main causes of difficult access. The ICRC continued its support for the only two centres in the country: the Maison Notre Dame de la Paix in Moundou and the Centre d'Appareillage et de Rééducation de Kabalaye in N'Djamena, both managed by local NGOs. In addition, the ICRC continued to support a referral system for disabled persons from eastern Chad and financed their transportation to N'Djamena and accommodation there while undergoing treatment. The ICRC signed an agreement with the Association d'Entraide aux Handicapés Physiques du Tchad, under which the Association housed and fed patients from eastern Chad with the financial support from the ICRC.

In the Congo, while not providing direct support for centres in the country, the ICRC continued to cover the cost of treatment for people directly affected by the conflict. After assessing patients, the ICRC referred them to centres with which it had cooperation agreements: the Centre de Rééducation pour Handicapés Physiques and the Centre Orthopédique Kalembe Lembe in Kinshasa, the Hôpital St-Jean Baptiste Kansele in Mbuji Mayi, the Centre Shirika La Umoja in Goma, and the Centre pour Handicapés Heri Kwetu in Bukavu. The ICRC took several measures to enhance access to services. In Goma, Bukavu and Mbuji Mayi, it identified guesthouses in which beneficiaries could be housed and fed during treatment (cost covered by the ICRC). Throughout the country and particularly in the North Kivu, the ICRC expanded its referral network, reaching ever more people. It also covered the cost of transport for most beneficiaries of its aid.

In Eritrea, the ICRC supported the Ministry of Labour and Human Welfare in ensuring that its network of centres (Asmara, Keren and Assab) functioned well. However, the project did not proceed as planned and, after several unsuccessful attempts to reach a cooperation agreement with the Ministry, the ICRC decided to halt its support at the end of April.

In Ethiopia, the National Strategy for physical rehabilitation services, developed by the Ministry of Labour and Social Affairs with ICRC support was completed in May and submitted for review to the Ethiopian Centre for Disability and Development. It will be included in the 2010 National Social Welfare Policy. The ICRC continued its support for six rehabilitation centres (Dessie, Mekele, Arba Minch, Asela, Bahir Dar, and Menegasha) and started support for the Dire Dawa centre, managed by Cheshire Service Ethiopia. Throughout the year, materials and components were donated to the centres, which provided ongoing services. In addition, the ICRC aided disabled people directly by paying patients' registration fees at the centres, transportation costs and expenses for food. This was done to improve access to services for the disabled. To further improve access, the ICRC helped organize outreach visits from the Bahir Dar, Dessie and Asela centres.

In Sudan, the ICRC continued its support for the Khartoum national referral centre and the Nyala, Kadugli, Kassala and Damazin centres, all managed by the National Authority for Prosthetics and Orthotics. It also continued supporting the Ministry of Welfare and Social Development to ensure services in Southern Sudan. The ICRC took several steps to improve access to services: subsidizing the cost of transport and accommodation for people attending the Juba and Nyala centres, supporting an information campaign on the services available, recording the identities of potential users during its field operations, donating materials and components, etc. In November, all 11 students enrolled in the course for the Sudanese Diploma for Prosthetics and Orthotics passed their final exams in Module 1 (lower-limb prosthetics) under ISPO supervision.

In Uganda, the ICRC continued supporting the Fort Portal Orthopaedic Centre and started supporting the Mbale Orthopaedic Centre at the end of the year. The ICRC took several steps to improve access to services. With materials, components and equipment donated by the ICRC, the Mbale centre began functioning in early December (with 19 devices delivered that month). Materials and components were also donated to the Fort Portal centre and the cost of travel and accommodation for several beneficiaries was covered by the ICRC. Throughout the year, the ICRC supported the Ministry of Health in drawing up a standard list of P&O materials for the central store. The process was aided by a better understanding of the financial aspects of incorporating this objective in national policy.



## CHAD

*Local partner*

Secours Catholique et de Développement (N'Djamena)  
Maison Notre Dame de la Paix (Moundou)

*Project locations*

N'Djamena and Moundou

*Patient services in 2009*

Patients attending the centres	3,533
New patients fitted with prostheses	167
New patients fitted with orthoses	245
Prostheses	367
Orthoses	437
Wheelchairs	38
Crutches (pairs)	591

*Beginning of assistance: 1981*

The ICRC continued supporting the only two centres in the country: the Maison Notre Dame de la Paix, in Moundou, and the Centre d'Appareillage et de Rééducation de Kabalaye (CARK) in N'Djamena, both managed by local NGOs. The ICRC also continued supporting a referral system for disabled persons from eastern Chad and financed their transportation to N'Djamena and accommodation there while undergoing treatment. The ICRC signed an agreement with the Association d'Entraide aux Handicapés Physique du Tchad, under which the Association accommodated and fed those coming from eastern Chad, with ICRC financial support. Access to rehabilitation remained difficult for most of those in need. The lack of facilities and professionals, the cost of transport (when available) and the security situation were the main causes of difficult access.

In Chad, access to medical and social services is limited for most people. In 2004, the authorities estimated that 5.3% of the total population had some form of disability, over a third of them amputees. But as there is no accurate data available, it is difficult to confirm these numbers. However, it was obvious that the two functioning centres did not have the capacity to meet the needs. In 2009, there was no direct involvement by the government in physical rehabilitation, and those seeking services had to pay for them. In addition to the lack of services, Chad also had a shortage of rehabilitation professionals.

Throughout the year, assisted centres were provided with raw materials and components. The construction of a new physiotherapy department at the CARK was completed (with financial support from the ICRC) and several disabled people from eastern Chad received treatment at the CARK, with ICRC aid (transport, accommodation, food and cost of treatment). In all, the ICRC financed the treatment of 265 beneficiaries at the CARK. In total, over 3,500 people benefited from various services at ICRC-assisted centres in 2009, including production of 367 prostheses (72% of them for mine survivors) and 437 orthoses (2% of them for mine survivors), and provision of 38 wheelchairs and 591 pairs of crutches. Children represented 41% and women 17% of the 3,315 beneficiaries.

The quality of the services provided by both centres was enhanced by technical and clinical mentoring from ICRC specialists (an ortho-prosthetist and a physiotherapist). ICRC specialists provided on-the-job training for all staff from both centres. In addition, the ICRC furnished financial support to enable six staff members from the centres to attend refresher courses in P&O and physiotherapy given by the regional training unit of the ICRC Special Fund for the Disabled, in Addis Ababa.

To ensure services over the long term, the ICRC continued supporting both centres in their efforts to find additional sources of income and in their efforts to improve their management.

**In 2010, the ICRC intends to:**

- enhance the quality of services by continuing to provide an expatriate ortho-prosthetist and a physiotherapist and by sponsoring personnel from assisted centres to attend refresher courses given by the regional training unit of the ICRC Special Fund for the Disabled in Addis Ababa, as well as a course in P&O and physiotherapy
- facilitate access to services by continuing to support both the CARK in N'Djamena and the Maison Notre Dame de la Paix in Moundou, by operating a referral system for disabled people from eastern and northern Chad and by covering their transport and accommodation costs, and by covering the cost of treatment for some beneficiaries at the CARK
- promote the long-term functioning of services by supporting assisted centres in their efforts to find additional sources of income, and by continuing to help make their managerial staff self-sufficient.

**DRC****DEMOCRATIC REPUBLIC OF THE CONGO***Local partners*

Red Cross Society of the Democratic Republic of the Congo, Ministry of Health, and local NGOs

*Project locations*

Kinshasa (2), Mbuji Mayi, Goma and Bukavu

*Patient services in 2009*

Patients receiving services directly supported by the ICRC	740
New patients fitted with prostheses	327
New patients fitted with orthoses	24
Prostheses	695
Orthoses	83
Wheelchairs	16
Crutches (pairs)	378

*Beginning of assistance: 1998*

In 2009, the ICRC did not directly support centres in the country, but it covered the treatment costs of people directly affected by the conflict. After identifying and assessing patients, the ICRC referred them to centres with which it had cooperation agreements: the Centre de Rééducation pour Handicapés Physiques and the Centre Orthopédique Kalembe Lembe in Kinshasa, the Hôpital St-Jean Baptiste Kansele in Mbuji Mayi, the Centre Shirika La Umoja in Goma, and the Centre pour Handicapés Heri Kwetu in Bukavu.

Though responsible for physical rehabilitation, the Ministry of Health did not manage any centres and its involvement in rehabilitation remained modest. The National Community-Based Rehabilitation Programme was the Ministry of Health's coordinating body for physical rehabilitation, but remained weak and lacked funding. The country had no specific legislation for disabled people. Physical rehabilitation was provided either by religious organizations or local NGOs, and for most who needed it, physical rehabilitation remained difficult to access for several reasons, including lack of funding to cover the cost of transport and to cover the cost of treatment.

The ICRC took several measures to enhance access to services. In Goma, Bukavu and Mbuji Mayi, delegates identified guesthouses where beneficiaries could be accommodated and fed during treatment (cost covered by the ICRC). Throughout the country and particularly in North Kivu, the ICRC expanded its referral network to reach more people. In addition, the ICRC covered the cost of transport for most of those it helped. In 2009, it covered the treatment costs of 740 patients, who received 695 prostheses (9% of them for mine survivors), 83 orthoses (6% of them for mine survivors), 378 pairs of crutches and 16 wheelchairs. Children represented 7% and women 14% of the beneficiaries.

Service quality was enhanced by the work of ICRC ortho-prosthetist and physiotherapists (expatriate and local). The organization sponsored three technicians and two physiotherapists to attend refresher courses at the regional

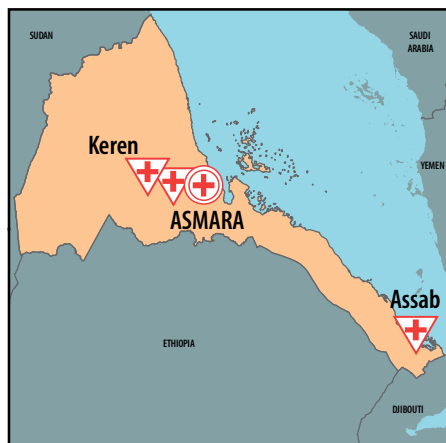
training unit of the ICRC Special Fund for the Disabled in Addis Ababa.

To ensure services over the long term, the ICRC maintained regular contact with the National Community-Based Rehabilitation Programme (NCBRP) and continued supporting the managers of the assisted centres. In addition, it sponsored two persons (the Centre Orthopédique Kalembe Lembe manager and NCBRP coordinator) to attend the congress in Tunisia of the Fédération Africaine des Techniciens Orthoprothésistes.

**In 2010, the ICRC intends to:**

- facilitate access to services by continuing direct support for patients (covering the cost of treatment), by strengthening cooperation with local organizations, the UN Mine Action Centre and the Direction des Oeuvres Sociales Militaires of the Ministry of Defence as a means of identifying people in need of services, by donating equipment to centres as needed and by implementing a specific referral programme for those coming from Kananga and Kisangani
- improve services by monitoring the quality of rehabilitation in assisted centres through the presence of ICRC ortho-prosthetist and a physiotherapist, by sponsoring refresher training for staff, for example the courses at the regional training unit of the Special Fund for the Disabled in Addis Ababa
- promote the long-term functioning of services by participating in local forums, by providing ongoing support to centre managers and by maintaining close contact with the relevant ministries.

## ERITREA

*Local partners*

Ministry of Labour and Human Welfare, Ministry of Health

*Project locations*

Adi Guadad, Keren and Assab

*Patient services in 2009**No figures available*

Patients attending the centres

New patients fitted with prostheses

New patients fitted with orthoses

Prostheses

Orthoses

Wheelchairs

Crutches (pairs)

*Beginning of assistance: 2007*

Physical rehabilitation in Eritrea was managed by the Department of Social Affairs of the Ministry of Labour and Human Welfare. The department was also responsible for other services for disabled people, such as social re-integration and vocational training. Two of its divisions were directly linked with rehabilitation: the limb-fitting division, responsible for rehabilitation, and the rehabilitation division, responsible for activities such as community-based rehabilitation and socio-economic reintegration. The national network of centres included the main centre in Asmara (Adi Guadad), and two smaller centres in Keren and Assab. Both Keren and Assab were “satellites” of Adi Guadad, meaning they were under the direct supervision of the Asmara centre director.

In 2009 the project did not proceed as planned and, after several unsuccessful attempts to work out a cooperation agreement with the Ministry of Labour and Human Welfare, the ICRC decided to halt its support at the end of April.

The ICRC donated materials and components for the production of prostheses and orthoses and spare parts for the production of wheelchairs. It also organized a four-month course in lower-limb orthotics between January and April.



## ETHIOPIA



### Local partners

Ministry of Labour and Social Affairs, Tigrean Disabled Veterans Association, Arba Minch Rehabilitation Centre, Cheshire Services Ethiopia

### Project locations

Mekele, Dessie, Arba Minch, Asela, Menagesha, Dire Dawa, and Bahir Dar

### Patient services in 2009

Patients attending the centres	9,271
New patients fitted with prostheses	1,017
New patients fitted with orthoses	1,553
Prostheses	1,852
Orthoses	2,620
Wheelchairs	773
Crutches (pairs)	1,421

Beginning of assistance: 1979

The ICRC continued its support for six physical rehabilitation centres in Dessie, Mekele, Arba Minch, Asela, Bahir Dar, and Menagesha, and started support for the Dire Dawa Physical Rehabilitation Centre, managed by Cheshire Service Ethiopia. In Ethiopia, overall responsibility for rehabilitation rested with the Ministry of Labour and Social Affairs. However it was the regional Bureau of Labour and Social Affairs that was in charge of those services for each region. There was a network of rehabilitation centres managed either by the regional bureaux or by local NGOs.

Throughout the year, materials and components were donated to centres to ensure services. In order to improve access, the ICRC provided direct support to disabled people by covering their fees at the centres (3,444 persons), transportation costs (3,335 persons) and food expenses (3,421 persons). It also supported “outreach” visits from the centres in Bahir Dar, Dessie and Asela to identify potential patients. In total, over 9,200 people benefited from various services at ICRC-assisted centres in 2009. Those services included production of 1,852 prostheses (25% of them for mine survivors) and 2,620 orthoses (0.5% of them for mine survivors), and provision of 773 wheelchairs and 1,421 pairs of crutches. Children represented 20% and women 22% of the 9,271 beneficiaries. The assisted centres (Dire Dawa excepted) boosted services by 15% and production by 4.1% compared with 2008.

The quality of the services at ICRC-assisted centres was enhanced by continued mentoring from ICRC ortho-prosthetists and physiotherapists. In addition, the ICRC conducted a refresher course for P&O technicians on upper-limb prostheses and conducted a course on wheelchairs and postural support for seven P&O technicians and six physiotherapists.

The ICRC helped centres and the authorities, at both regional and national levels, to promote the long-term functioning of services. The national rehabilitation strategy, developed by the Ministry of Labour and Social Affairs with ICRC support was completed in May and

submitted for review to the Centre for Disability and Development. It will be included in the 2010 national social welfare policy. The five-year plan, developed for all assisted centres, was adapted during the annual seminar involving the ICRC, the Ministry and the Bureaux. In 2009 the ICRC, a long-time member of the Ethiopian National Disability Action Network (non-governmental network of organizations working on disability in Ethiopia), became a board member. The network’s aim is to strengthen cooperation and information-sharing among its members and the different Ministries involved in disability work.

### In 2010, the ICRC intends to:

- enhance quality through continued support from expatriate ortho-prosthetists and physiotherapists, by promoting multidisciplinary patient-management, by conducting short courses for personnel in assisted-centres (wheelchairs and Ponseti Method) and by conducting a three-year course in P&O for 20 candidates
- facilitate access to services by directly supporting patients (covering the costs of transportation, food and registration fees), by donating needed raw materials and components to the seven assisted centres, and by supporting outreach visits
- promote long-term functioning of services by maintaining support for managerial staff, by training them in various aspects of management, by helping each Bureau of Labour and Social Affairs to implement the five-year plan, by assisting the Ministry in its efforts to launch a national rehabilitation strategy and by continuing to participate in the Ethiopian National Disability Action Network.



## SUDAN



### Local partner

National Authority for Prosthetics and Orthotics, South Sudan's Ministry of Gender, Social Welfare and Religious Affairs

### Project locations

Khartoum, Nyala, Kadugli, Kassala, Damazin and Juba

### Patient services in 2009

Patients attending the centres	2,372
New patients fitted with prostheses	504
New patients fitted with orthoses	356
Prostheses	1,114
Orthoses	843
Crutches (pairs)	748

Beginning of assistance: 1985

The ICRC continued supporting the Khartoum national referral centre and the Nyala, Kadugli, Kassala and Damazin centres, all managed by the National Authority for Prosthetics and Orthotics (NAPO). It also continued aiding South Sudan's Ministry of Gender, Social Welfare and Religious Affairs.

Responsibility for physical rehabilitation in Sudan's northern regions rested with the NAPO, a State body affiliated to the Ministry of Welfare and Social Development. The NAPO managed the national referral centre in Khartoum and satellite centres in Dongola, Kassala, Kadugli, Nyala, Gedaref, and Damazin from 2009 onwards. Despite a significant decrease in the Ministry of Finance's budget allocation for the NAPO, which hampered activities at the Khartoum centre (fewer patients were accepted for six months) and the satellite centres, the situation improved at the end of the year. South Sudan's Ministry of Gender, Social Welfare and Religious Affairs was in charge of physical rehabilitation in that part of the country while Central Equatorial State ran the Juba Rehabilitation Centre. The Southern Sudan War Disabled, Widows and Orphans Commission, created in November 2006, had the mandate to formulate and promote policies and legislation for the protection, care and welfare of persons with war-related disabilities, war widows and war orphans, and to advise the government of South Sudan on how best to implement those policies.

Sudan signed the Mine Ban Treaty on 4 December 1997 and ratified it on 13 October 2003, becoming a State party on 1 April 2004. In 2009, the ICRC participated in several meetings of the Victim Assistance Coordination Group, which had the mandate to develop strategies and policy for rehabilitation services in South Sudan.

In Sudan, all those in need were supposed to have equal access to physical rehabilitation. However, long distances, the lack of a transportation system and security-linked constraints hampered accessibility. The ICRC conducted several activities aimed at improving accessibility: helping with the cost of transport and accommodation for those attending the Juba and Nyala centres, helping with an information campaign to make known the services

available, identifying and registering potential users by its field delegates, donating material and components, etc. However, the total number of patients fell compared with 2008. This was mainly due to the NAPO's financial difficulties and to the ICRC's security-related problems gaining access to the assisted centres. Over 2,300 people benefited from various services at ICRC-assisted centres. They included producing 1,114 prostheses (9% of them for mine survivors) and 843 orthoses (0.2% for mine survivors), and providing 748 pairs of crutches. Children represented 19% and women 24% of the 2,372 beneficiaries.

To improve quality, ICRC specialists (ortho-prosthetists and a physiotherapist) continued their support and mentoring. In November, all 11 students enrolled for the Sudanese Diploma for Prosthetics and Orthotics (SDPO) passed their final exams in Module 1 (lower-limb prosthetics) under ISPO supervision. The SDPO course is conducted by the ICRC in cooperation with the NAPO, El Geraif College and the Ministry of Higher Education and Scientific Research. The ICRC also provided scholarships for 14 persons to begin, continue or complete courses in P&O at the Tanzania Training Centre for Orthopaedic Technologists (10) or physiotherapy at the Kigali Health Institute (2) or at the St. Mary University in Juba (2). All these activities were undertaken to build local capacity for high-quality services, essential to ensuring long-term functioning.

To promote long-term functioning of the NAPO, the ICRC covered the cost of an external consultant to conduct, at NAPO's request, a feasibility study on transforming it from a government body into an autonomous body. In addition, regular managerial and technical meetings between ICRC and the NAPO in Khartoum and the ICRC and the Ministry of Gender, Social Welfare and Religious Affairs in Juba were held to discuss and implement and/or improve rehabilitation services (patient registration and admission, working procedures, disciplinary measures, storekeeping, etc.).



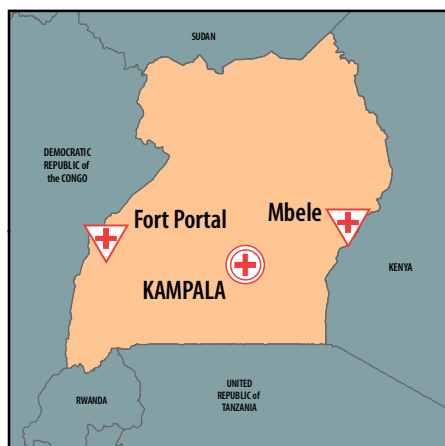
**In 2010, the ICRC intends to:**

- facilitate access to services by supporting the NAPO and its satellite centres, by maintaining support for the referral centre in Juba, by donating materials and components, and by covering the costs of transportation, accommodation and food for some patients
- enhance quality by continuing to conduct the SDPO course, by continuing to award scholarships for courses in P&O and in physiotherapy, by giving training in wheelchair services, and by maintaining the support from its ortho-prosthetists and physiotherapists
- promote the long-term functioning of services by maintaining its support for the NAPO in managing physical rehabilitation activities, and by doing likewise for the Ministry in South Sudan.



Thierry Gassmann/ICRC

## UGANDA



### Local partner

Ministry of Health

### Project locations

Fort Portal, Mbale

### Patient services in 2009

Patients attending the centres	240
New patients fitted with prostheses	47
New patients fitted with orthoses	120
Prostheses	89
Orthoses	132
Wheelchairs	1
Crutches (pairs)	18

Beginning of assistance: 2007

The ICRC continued supporting the activities of the Fort Portal Orthopaedic Centre and started, at the end of the year, to aid the Mbale Orthopaedic Centre.

Two ministries are actively involved in disability issues: the Ministry of Health, responsible for rehabilitation, and the Ministry of Gender and Social Affairs, responsible for the socio-economic reintegration of disabled people. Rehabilitation was available through a network of 14 centres managed by the Ministry of Health. In addition, there was a P&O training centre at the Malago Hospital Complex. Uganda had legislation to protect the rights of disabled people, who have representatives at various government levels. As part of its obligations under the Mine Ban Treaty, Uganda developed the "Comprehensive Plan of Action on Victim Assistance 2008–2012", aimed at respecting the rights and meeting the needs of all disabled people including survivors of mines and ERW. It encompasses the six key elements of victim assistance.

The ICRC conducted several activities aimed at improving access to services. After the ICRC donated material, components and equipment, the Mbale Orthopaedic Centre started operation in early December (19 devices delivered in one month). Material and components were also given to the Fort Portal Orthopaedic Centre and the cost of transport and accommodation was covered for several beneficiaries. In all, 240 people benefited from various services at ICRC-assisted centres. They included production of 89 prostheses (21% of them for mine survivors) and 132 orthoses, and provision of one wheelchair and 18 pairs of crutches. Children and women represented 58% of the beneficiaries.

Quality was enhanced through ongoing support and mentoring provided by an ICRC ortho-prosthetist and a physiotherapist. The ICRC sponsored one P&O technician to attend a refresher course at the ICRC Special Fund for the Disabled Regional Training Unit in Addis Ababa. The multidisciplinary approach to treatment and issues regarding respect for the patients and proper gait training were discussed by the ICRC physiotherapist.

The ICRC continued to support the Ministry of Health in its desire to compose a standard list of P&O materials intended for the central store. Development of this store of P&O items was progressing, albeit slowly, thanks to a better understanding of how best to incorporate it financially in national policy. Measures were being taken to increase the availability of imported materials through the National Medical Store (NMS) in Kampala. Changes in national policy had resulted in hospitals now being obliged to buy 100% of their medicines on the Central Drug List from the National Medical Stores. The Disability Prevention and Rehabilitation section of the Ministry worked with the ICRC to fix the portion of this budget to be allocated to the limb-fitting workshops.

### In 2010, the ICRC intends to:

- improve access to services by continuing to support the activities of the Fort Portal and Mbale Orthopaedic Centres, by covering the cost of transport and accommodation for a specific group of beneficiaries and by raising awareness of the services available at assisted centres
- enhance quality through the support and mentoring provided by the ICRC ortho-prosthetist and physiotherapist
- promote the long-term functioning of services by continuing support for the Ministry in setting up the central store



## 4.2 – ASIA



## ICRC SUPPORT IN ASIA AT A GLANCE

In 2009 the ICRC supported 26 projects in 10 Asian countries: Afghanistan (7), Cambodia (3), China (3), the Democratic People's Republic of Korea (2), India (2), Myanmar (1), Nepal (2), Pakistan (4), Sri Lanka (1), Philippines (1).

- In Nepal, the ICRC started to provide support to the Yerahity Rehabilitation Centre, the sole government-run facility in Nepal, located in Kathmandu and managed by the Nepalese army.

<b>Services provided</b>	
Patients attending the centres	100,853
New patients fitted with prostheses	3,778
New patients fitted with orthoses	6,434
Prostheses delivered	10,170
Orthoses delivered	14,311
Wheelchairs distributed	1,686
Walking aids distributed (pairs)	8,619

Children represented 19% and women 16% of the beneficiaries.

In Afghanistan, over 2,000 disabled people were aided by the various activities of the social-inclusion programme (job placement, special education, vocational training, micro-credits, etc.).

In Afghanistan, the ICRC-managed component factory, continued to provide components to four non-ICRC centres free of charge.

In Cambodia, the ICRC-supported component factory in Phnom Penh continued producing for all centres nationwide, thus ensuring proper care throughout the country.

### Developing national capacities

14 persons sponsored for P&O courses

9 persons sponsored for physiotherapy courses

22 persons enrolled in three-year P&O course conducted by the ICRC in Afghanistan

### Promoting long-term functioning of services

The ICRC continued fostering the ability of the Cambodian authorities to manage the work of the centres and the component factory.

In Cambodia, two centre staff were sponsored for a management course.

In Afghanistan, the ICRC maintained close contact with the relevant authorities and helped develop national P&O guidelines and took part in the Disability Stakeholder Commission Group, a working group set up by the Ministry of Martyrs, Disabled and Social Affairs to promote reintegration into society.

In Nepal, the ICRC participated in the first national workshop on rehabilitation organized by the Nepalese army. The workshop was mainly intended for the participants to introduce their activities.





In Afghanistan, the obstacles to rehabilitation services (and health care generally) are numerous: ignorance, lack of professionalism among medical personnel, prejudices against the disabled, poverty, distances and lack of transport, violence, ethnicity and political divisions. While ICRC aid was intended to remove some of these obstacles, much work remained to be done to improve access to services and to allow disabled people to play an active role in their communities. The ICRC continued to manage six rehabilitation centres throughout the country and one P&O component factory in Kabul (which also produced wheelchairs). In addition, the ICRC continued running a P&O training programme, managing a home-care programme for people with spinal-cord injuries and promoting social inclusion for disabled people. The ICRC-managed component factory continued providing components to four non-ICRC centres free of charge, thus promoting proper care throughout the country.

In Cambodia, the ICRC continued working with the Ministry of Social Affairs, Veterans and Youth Rehabilitation to support the activities of the Battambang Regional Physical Rehabilitation Centre, the Kompong Speu Regional Physical Rehabilitation Centre and the Phnom Penh P&O Component Factory. In 2004, the ICRC began reducing its management role for the assisted projects and focused on strengthening the Ministry's management capacity at national level and within the centres. It gradually transferred all responsibilities to the Ministry and by 2009 ICRC staff were acting as advisers for management and provision of services.

In China, the ICRC continued supporting the activities of the Orthopaedic Rehabilitation Centre in Kunming, managed by the Yunnan branch of the Red Cross Society of China and its two repair workshops in Malipo and Kaiyuan. The Yunnan branch conducted four outreach sessions out of 10 planned, visiting about 200 amputees and repairing 98 prostheses on the spot. The repair technicians from Malipo, Kaiyuan and the western region are reported to have carried out 48 follow-up visits, seeing about 300 amputees and repairing 120 prostheses.

In the Democratic People's Republic of Korea, the ICRC continued aiding the Ministry of Public Health by supporting the Songrim Physical Rehabilitation Centre and continued aiding the Ministry of the People's Armed Forces by supporting the Rakrang Physical Rehabilitation Centre. To improve access to services, the ICRC continued donating materials and components to the assisted centres. Despite plans for outreach visits and ICRC willingness to support them, no such visits were organized during the year. To improve the quality of services in the assisted centres, ICRC ortho-prosthetists and physiotherapists continued support and mentoring for local personnel at the centres.

In India, the ICRC continued to support the Bone and Joint Hospital (Srinagar) and the Government Medical College (Jammu). This included the donation of materials and components for the manufacturing of prostheses

and orthoses, and of wheelchairs and walking aids. Direct support was provided for patients living far from the centres (reimbursement for transport, accommodation and food costs). Quality was ensured through on-the-job training and mentoring by ICRC expatriates and local ortho-prosthetic technicians and a physiotherapist. The ICRC continued to sponsor three staff members from the Bone and Joint Hospital on a P&O course at the Mobility India centre in Bangalore.

In Myanmar, government restrictions imposed on the ICRC since 2005 continued to prevent it from discharging its mandate in accordance with its standard working procedures, which are internationally recognized and which the Myanmar authorities had accepted in previous years. Since 2007, the delegation had adapted its activities, including rehabilitation, accordingly: only the Hpa-an Orthopaedic Rehabilitation Centre, run jointly by the Myanmar Red Cross Society and the ICRC, continued to receive direct support from the ICRC. However, ICRC-assisted centres managed either by the Ministry of Health (3) or the Ministry of Defence (3) received enough materials to ensure that all centres under their supervision could continue to operate.

In Nepal, access to rehabilitation remained a challenge for most people with impaired mobility. The escalation of general strikes frequently brought all means of transport to a halt. Patients hesitated to travel long distances, not knowing whether they could reach the centres and then return home. Limited public transport, especially in rural areas, and high fares were additional hurdles. In 2009, the ICRC continued supporting the P&O department of the Green Pasture Hospital, in Pokhara, and started support for the Yerahity Rehabilitation Centre in Kathmandu, managed by the Nepalese army. This centre was the sole government-run centre in Nepal, and both military personnel and civilians had access. Since June 2008, it had been providing rehabilitation for people with spinal cord injuries. With ICRC assistance, it started fitting amputees in May 2009.

The ICRC continued supporting the Pakistan Institute of Prosthetic and Orthotic Sciences in Peshawar, the Quetta Christian Hospital Rehabilitation Centre, and the Muzaffarabad Physical Rehabilitation Centre (managed by the ICRC). The ICRC also managed a home-care project in Peshawar intended to reintegrate victims of spinal cord injuries in their families and communities and thus restore their dignity. Throughout the year, the primary objectives of the ICRC's physical rehabilitation projects in Pakistan were to increase the accessibility and quality of services for disabled people in Baluchistan, the North-West Frontier Province and Pakistan-administered Kashmir.

In the Philippines, people with impaired mobility living in Mindanao faced recurrent difficulties with access to regular rehabilitation. Ongoing clashes between armed groups and fears of arrest on suspicion of belonging to or supporting opposition groups discouraged them from

travelling to Davao. High travel fares and fitting costs for most potential beneficiaries further limited the number of patients. The ICRC continued aiding the Davao Jubilee Foundation by supporting the work of its centre in Davao, the sole qualified centre on the island.

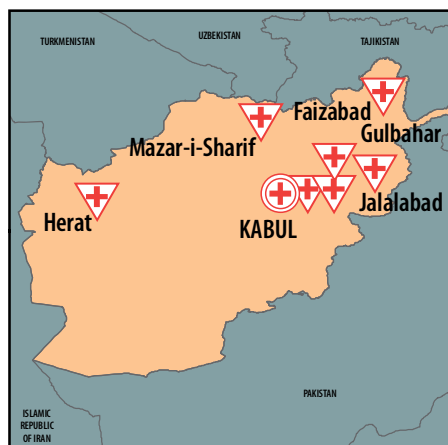
While the situation in Sri Lanka improved during the year, disabled people on the Jaffna peninsula continued to face many obstacles accessing rehabilitation that they needed. Although distances in Jaffna peninsula are small,

high prices and irregular bus service could make a trip of even a few kilometres difficult and time consuming. The ICRC continued its support for the Jaffna Jaipur Centre for Disability Rehabilitation. The centre provided comprehensive services including prosthetics, orthotics, various mobility aids (wheelchairs, tricycles, crutches, etc), physiotherapy, microcredits and financial support for disabled students. It is the only centre on the Jaffna peninsula that provides rehabilitation.



Philippe Fichard/ICRC

## AFGHANISTAN



### Local partner

None

### Project locations

Kabul (2), Mazar-i-Sharif, Herat, Jalalabad, Gulbahar and Faizabad

### Patient services in 2009

Patients attending the centres	70,894
New patients fitted with prostheses	806
New patients fitted with orthoses	3,976
Prostheses	3,734
Orthoses	9,626
Wheelchairs	982
Crutches (pairs)	4,403

*Beginning of assistance: 1987*

The ICRC continued managing six physical rehabilitation centres throughout the country and one component factory in Kabul (also producing wheelchairs). In addition, the ICRC continued to conduct a programme of P&O courses, to manage a special programme for spinal cord injuries (home-care programme) and to help disabled people reintegrate into society.

Several Afghan ministries – including the Ministry of Public Health, the Ministry of Martyrs, Disabled and Social Affairs, and the Ministry of Education – were actively dealing with disability-related issues. The Ministry of Public Health was responsible for medical treatment and physical rehabilitation. The Disability Unit, a team of 10 specialists working for the ministry's Curative and Diagnostic Directorate, was the ministry's focal point for disabilities. The ministry's strategy and plan of action were set down in the Basic Package of Health Services and the Essential Package of Hospital Services. Physiotherapy services were included in both schemes, while prosthetic and orthotic services were covered by the EPHS only. The Ministry of Martyrs, Disabled and Social Affairs was responsible for social reintegration. The ministry drafted a "disability law", designed to be the backbone of any legislation on disability. It set out the rights of the disabled and the duties of the government. Approved by both houses of the National Assembly, at year's end it was still awaiting presidential endorsement. In 2009, the Ministry of Education endeavoured to improve the general level of education in the country and to ensure access to schools and inclusive education for disabled children. Afghanistan's Mine Action Coordination Centre was the coordinating agency in the disability field. It had two representatives working in each of the three above-mentioned ministries.

The obstacles to rehabilitation (and health services generally) were numerous: ignorance, lack of professionalism among medical personnel, prejudices against disability, poverty, the distances and transportation difficulties, violence, ethnicity and political divisions. While ICRC aid aimed to remove some of these obstacles, much work remained to be done to improve access to services and allow disabled people to play an active role in their com-

munities. The ICRC continued working with various entities to boost access to services. In 2009, close to 71,000 people benefited from various services at ICRC-managed centres. These services included the provision of 3,734 prostheses (64% for mine survivors) 9,626 orthoses (0.4% for mine survivors), 982 wheelchairs and 4,403 pairs of crutches. Most of those receiving these devices also received physiotherapy. Children represented 22% and women 17% of the beneficiaries.

The ICRC-managed component factory continued furnishing components free of charge for four non-ICRC centres. Under the ICRC's home-care programme for paraplegics with spinal cord injuries, 1,328 persons were aided during 7,454 home visits. The ICRC also ran a special physiotherapy programme for children with cerebral palsy. There were 475 children with clubfoot registered at ICRC centres; over 70% of them were treated with the Ponseti method.

The ICRC's rehabilitation project in Afghanistan combined physical rehabilitation with activities aimed at social inclusion. The patients living in areas to which the ICRC had access were offered reintegration opportunities such as education, vocational training, microcredits and employment. More than 2,000 disabled people were aided by the social inclusion programme.

The ICRC maintained its support for the professional development of local P&O technicians and physiotherapists working in ICRC-managed centres. Besides mentoring and other forms of support from ICRC staff, the organization continued conducting a three-year P&O course in conjunction with the Ministry of Public Health. Twenty-two trainees were enrolled for this training at the ICRC facility in Kabul. The first examination (Module 1: lower-limb prosthetics) was scheduled in March 2010 (under ISPO supervision). In addition, the ICRC specialists conducted upgrading training in spinal orthotics and management of cerebral palsy for P&O technicians and physiotherapists already working.

To ensure services over the long term, the ICRC maintained close contact with the relevant authorities and



participated in the drawing up of national guidelines for P&O services and in the Disability Stakeholder Commission Group (Ministry of Martyrs, Disabled and Social Affairs), a working group set up to promote social reintegration. To ensure long-term functioning of services, the ICRC agreed that responsibility for the programme should be handed over to the relevant ministries: to the Ministry of Public Health for rehabilitation and the Ministry of Martyrs, Disabled and Social Affairs for social reintegration. For the moment this was not possible, however, since these ministries preferred the role of coordinating the work of NGOs rather than directly managing rehabilitation facilities. Nevertheless, in order to make a future handover feasible, the ICRC continued developing the skills of Afghan employees with the aim of eventually transferring all management responsibilities to them.

#### In 2010, the ICRC intends to:

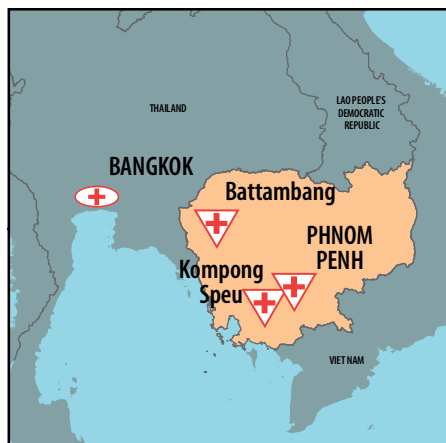
- enhance the quality of services by continuing to conduct the three-year P&O course, continuing to improve the components and wheelchairs produced at the Kabul factory, maintaining its support for the training of physiotherapists, and continuing support from ICRC expatriate ortho-prosthetists and physiotherapists
- facilitate access to services by continuing support for the six centres, conducting outreach visits, maintaining a good working relationship with health-care facilities and with other organizations, supporting the development of referral networks (especially in areas where no service is available), continuing to donate components to non-ICRC centres, and financially supporting construction of a satellite centre in Lashkar Gah
- continue its social inclusion programme
- promote long-term services by developing local capacities, participating in any forum on disability issues and supporting government action to promote physical rehabilitation and social reintegration.



Jason Tanner/ICRC



## CAMBODIA

*Local partner*

Ministry of Social Affairs, Veterans and Youth Rehabilitation

*Project locations*

Phnom Penh, Battambang and Kompong Speu

*Patient services in 2009*

Patients attending the centres	10,236
New patients fitted with prostheses	268
New patients fitted with orthoses	305
Prostheses	1,714
Orthoses	1,214
Wheelchairs	325
Crutches (pairs)	1,287

*Beginning of assistance: 1991*

In 2009, the ICRC continued its cooperation with the Ministry of Social Affairs, Veterans and Youth Rehabilitation in support of the Battambang Regional Physical Rehabilitation Centre, the Kompong Speu Regional Physical Rehabilitation Centre and the Phnom Penh P&O Component Factory. In 2004, the ICRC began reducing its role in managing the assisted projects and has been focusing on strengthening the ministry's capacity (at national and centre level) and gradually transferring all responsibilities to the ministry. ICRC staff has acted as advisors for ministry personnel in running the centres.

The Ministry of Social Affairs, Veterans and Youth Rehabilitation is the core ministry with responsibility for providing disabled people with rehabilitation and vocational training. To ensure full participation and equal opportunities, the ministry worked with various government and non-government organizations (such as the Disability Action Council and the Cambodian Disabled Persons Organization) to draft the National Law on the Protection and Promotion of the Rights of Disabled People, which was adopted by the National Assembly on 29 May and by the Senate on 16 June, and promulgated by the King on 3 July. In accordance with its obligations under the Mine Ban Treaty, Cambodia drew up a plan of action encompassing the rights and needs of all persons with disabilities, including mine/ERW survivors, and covering the six key elements of victim assistance. Landmines and ERW continued to be a threat for many rural communities. However, since 2006 there had been a drop in the number of mine/ERW casualties, with 150 reported between January and June 2009 by the Cambodian Mine/UXO Victim Information System against 172 for the same period in 2008. As in previous years, most accidents occurred in the five northern and western provinces (Battambang, Banteay Meanchey, Pailin, Oddar Meanchey and Preah Vihear) covered by the Battambang Regional Physical Rehabilitation Centre.

In June 2008, a memorandum of understanding was signed between the ministry and all organizations supporting this sector, with a view to equipping the ministry

with the managerial, technical, and financial skills to take on the role of managing the rehabilitation centres by the end of 2011. Progress in implementing this memorandum was slower than planned, mainly because of the ministry's lack of funds and other means. There were 11 rehabilitation centres throughout the country, including two supported by the ICRC (Battambang and Kompong Speu). The others were mostly managed by international organizations. In addition to the 11 centres, there was the ICRC-supported Phnom Penh Component Factory, the Cambodian School for Prosthetics and Orthotics, and a physiotherapy school managed by the Ministry of Health.

To improve access to services, the ICRC continued direct support for patients (reimbursing, together with the ministry, the cost for patients of transportation and accommodation at the centres). It maintained its support for the centres' outreach programmes (8,743 patients examined, 4,349 P&O appliances and 780 wheelchairs repaired, 1,214 pairs of crutches distributed) and helped develop a comprehensive network of potential partners within each centre's catchment area. To ensure adequate wheelchair service, it was decided to stop distributing wheelchairs during outreach visit and instead to refer disabled people to the centre, where they could receive training and seating adaptation. To promote economic reintegration, ministry social workers referred 75 people to vocational training institutions. ICRC-assisted centres produced 1,714 prostheses (87% for mine survivors) and 1,214 orthoses (2% for mine survivors). Children represented 7% and women 12% of the 10,236 beneficiaries. In addition, the component factory in Phnom Penh continued providing components for all centres in Cambodia, thus ensuring proper care for all the centres' patients.

To improve the quality of services, the ICRC continued developing the skills of local personnel. In addition to ongoing mentoring for all personnel, ICRC ortho-prosthetists and physiotherapists organized several courses. The ICRC also continued to sponsor advanced training for five physiotherapists in a programme in



Alberto Buzzola/Rhythms Monthly

Cambodia run by the Singapore General Hospital Postgraduate Allied Health Institute.

Besides promoting access to centres and improving service quality, the ICRC continued implementing its strategy to boost the ministry's ability, at central and provincial levels, to manage the centres and the component factory. The ICRC continued promoting the long-term functioning of services by participating in several committees that addressed the disability issue. In addition, delegates met with officials at various levels of the Ministry of Social Affairs, Veterans and Youth Rehabilitation and with the Ministry of the Economy and Finance on the need to allocate more funds. The ICRC also continued giving scholarships for the managers of both centres to study for a bachelor's degree in business management.

**In 2010, the ICRC intends to:**

- continue enhancing quality of services with the help of an ICRC ortho-prosthetist and a physiotherapist, and through support for local capacity-building in order to develop the centres' autonomy
- facilitate access to services by maintaining support for the Battambang and Kompong Speu centres and the Phnom Penh component factory, supporting the centres' outreach programmes, financially assisting patients, strengthening the referral networks in the areas covered (including strengthening the link with the Cambodian Red Cross Society's micro-economic initiative programme)
- promote long-term functioning of services by participating in the Physical Rehabilitation Committee, developing the skills of ministry personnel (at national and centre level) in managing rehabilitation, and the ministry's capacities generally, to enable it to shoulder greater responsibility, continuing to transfer management responsibilities to ministry personnel in the centres, and continuing to urge the ministry to increase its annual rehabilitation budget.

## CHINA

*Local partner*

Red Cross Society of China, Yunnan branch

*Project locations*

Kunming, Malipo and Kaiyuan

*Patient services in 2009*

Patients attending the centres	486
New patients fitted with prostheses	72
Prostheses	184
Crutches (pairs)	2

*Beginning of assistance: 2003*

In 2009, the ICRC continued to support the activities of Kunming's Orthopaedic Rehabilitation Centre managed by the Yunnan Branch of the Red Cross Society of China and its two repair workshops in Malipo and Kaiyuan.

China had an estimated 83 million people with various categories of disabilities, according to official data from the Second National Sampling Survey on Disabilities, conducted in 2006. The Chinese Disabled Person's Federation (CDPF) estimated that nearly 10 million of them were living under the poverty level. China ratified the UN Convention on the Rights of People with Disabilities in August 2008, but not its Optional Protocol. Article 45 of China's constitution stipulates that the State must guarantee equal rights and protection for people with disabilities. In 2007, the State Council promulgated "regulations concerning employment for persons with disabilities", requiring employers to ensure that disabled people represented no less than 1.5% of their work force.

The Ministry of Civil Affairs was in charge of administering the country's P&O profession. The ministry's China Training Centre for Orthopaedic Technologists was in charge of training technical staff. Set up in 1988, the Chinese Disabled People's Federation had a nationwide network, operating some 68 rehabilitation centres. Economically vulnerable people with impaired mobility nevertheless relied on the CDPF's lottery fund, which randomly allocated free services.

China had still not acceded to the Mine Ban Treaty. It was party to the Convention on Conventional Weapons and its Amended Protocol II on landmines. The Yunnan branch of the Red Cross reported one new mine-related accident for 2009. It occurred in April and the survivors received services in August (at the Yunnan Orthopaedic Rehabilitation Centre).

Throughout the year, the ICRC continued supporting the Yunnan Orthopaedic Rehabilitation Centre and its two repair workshops, allowing services to be brought closer to beneficiaries living far from Kunming. The Yunnan Red Cross branch conducted four outreach sessions out of the 10 planned, visiting about 200 amputees and

repairing 98 prostheses on the spot. Technicians are reported to have carried out 48 outreach follow-up visits, seeing about 300 amputees and fixing 120 prostheses. In all, the Yunnan centre produced 184 prostheses and 244 already fitted people had their prostheses repaired. Children represented 3% and women 20% of the 486 the beneficiaries.

The Yunnan Red Cross branch remained fully responsible carrying out rehabilitation and ensuring the proper functioning of its facilities. The phase-out of ICRC support for the branch was set out in an initial cooperation agreement (covering July 2008 to August 2009). Following the joint assessment conducted in March 2009, the two parties signed in August a final cooperation agreement covering September 2009 to December 2010. To ensure a smooth transition, the ICRC agreed to prolong its donations of components until the end of 2010.

**In 2010, the ICRC intends to:**

- continue supporting the Yunnan Orthopaedic Rehabilitation Centre by donating the materials and components needed to ensure service
- provide regular support and mentoring for local personnel (technical, clinical and managerial) through regular visits by an ICRC specialist.



**DPRK****DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA***Local partner*

Red Cross Society of the DPRK, Ministry of Public Health, Ministry of Defence

*Project locations*

Songrim and Pyongyang

*Patient services in 2009*

Patients attending the centres	1,485
New patients fitted with prostheses	684
New patients fitted with orthoses	12
Prostheses	1,477
Orthoses	31
Wheelchairs	77
Crutches (pairs)	805

*Beginning of assistance: 2002*

In 2009, the ICRC continued to aid the Ministry of Public Health by supporting the Songrim Physical Rehabilitation Centre and continued assisting the Ministry of the People's Armed Forces by supporting the Rakrang Physical Rehabilitation Centre.

In 2003, the DPRK adopted the Law for the Protection of Disabled People to ensure equal access for disabled people to public spaces, transportation and public services. The Korean Federation for the Protection of the Disabled (KFPD), the Ministry of Public Health and the Military Medical Bureau of the Ministry of the People's Armed Forces were the DPRK's sole providers of physical rehabilitation. The KFPD ran the Physical Rehabilitation Centre in Hamhung. The Ministry of Public Health was in charge of the Physical Rehabilitation Centre in Songrim (in cooperation with the ICRC), the Orthopaedic Factory in Hamhung and three repair workshops in Pyongyang, Chongjin (North Hamgyong province) and Sonchon (North Pyongyang province). In conjunction with ICRC, the Military Medical Bureau provided rehabilitation at the Rakrang Centre. The DPRK had as yet no national rehabilitation structure or standards. The ICRC's counterparts, including the KFPD, showed interest in developing these, especially since the first foreign-trained P&O technicians were working in Hamhung (4), Rakrang (3) and Songrim (2). A technical seminar was organized in November 2008. The second seminar took place in Hamhung in December 2009. The following main topics were discussed: standardizing technologies and treatment protocols, setting up a network of rehabilitation centres and repair workshops, and the differences between the conventional and polypropylene technologies with regard to the quality of maintenance and repairs.

To improve accessibility of services, the ICRC continued to donate essential materials and components to the assisted centres. Despite the planning of outreach visits and the ICRC's willingness to support them, none took place. In all, 1,485 people benefited from various services provided at ICRC-assisted centres. These services included the provision of 1,477 prostheses, 31 orthoses, 77 wheelchairs and 805 pairs of crutches.

Most of those who received devices also received physiotherapy. Children represented 2% and women 17% of the beneficiaries.

To improve the quality of services at the assisted centres, ICRC ortho-prosthetists and physiotherapists continued supporting and mentoring local personnel. ICRC staff conducted several courses in upper-limb prosthetics management and ankle-foot orthoses for P&O technicians and physiotherapists. The ICRC also continued sponsoring five persons being trained in P&O at the Cambodian School for Prosthetics and Orthotics in Phnom Penh and four learning physiotherapy at Mobility India in Bangalore.

**In 2010, the ICRC intends to:**

- facilitate access to services by continuing its support for the Songrim and Rakrang rehabilitation centres and by helping the Ministry of Public Health and the Red Cross Society of the DPRK with its outreach programme
- enhance quality by maintaining the support and mentoring of ICRC ortho-prosthetists and physiotherapists, continuing to sponsor people in P&O and physiotherapy training, and conducting refresher/upgrading courses in P&O and physiotherapy
- promote the long-term functioning of services by strengthening the local capacity in managing rehabilitation services and by supporting any local initiatives for a national rehabilitation policy.



## INDIA

*Local partner*

Indian Red Cross Society

*Project locations*

Jammu and Srinagar

*Patient services in 2009*

Patients attending the centres	568
New patients fitted with prostheses	92
New patients fitted with orthoses	71
Prostheses	129
Orthoses	81
Wheelchairs	29
Crutches (pairs)	58

*Beginning of assistance: 2004*

The ICRC continued supporting the Bone and Joint Hospital (Srinagar) and the government medical college (Jammu). Support included the donation of materials and components essential to manufacturing prostheses and orthoses, and of wheelchairs and walking aids. In addition, the ICRC subsidized patients living far from the centres (reimbursement for transport, accommodation and food costs).

A government census carried out in 2001 showed that there were 25 million people disabled people in India – 2.13% of the total population. Seventy five per cent of them lived in rural areas, 49% were literate and only 34% were employed. India's physical rehabilitation sector was coordinated by the Ministry of Social Justice and Empowerment. The Rehabilitation Council of India, a statutory body within the ministry, regulated all training facilities for P&O and physiotherapy. India had signed and ratified the UN Convention on the Rights of People with Disabilities but not its Optional Protocol, which allows monitoring of the Convention's implementation. However, India had legislation to protect and assist disabled people (Disabilities Act). The central government in New Delhi had set up five composite regional centres as well as rehabilitation centres in most districts of the country, catering for the entire spectrum of disabilities. While the composite regional centres were funded directly by the central government, the district rehabilitation centres were run by implementing agencies, including Indian Red Cross state and district branches, which managed over 20 district centres. Access to rehabilitation nevertheless remained difficult for the poorest people for a number of reasons such as that most facilities were not fully operational owing to insufficient funds for equipment, materials and professional staff, lack of facilities in rural areas, lack of awareness of existing services and of legislation, lack of schemes to cover costs during treatment (accommodation, food), and difficult access due to the high cost of transportation.

The ICRC-assisted centre produced 129 prostheses (9% for mine survivors) and 81 orthoses, and distributed 58 pairs of crutches and 29 wheelchairs. Children represented 7% and women 20% of the 568 beneficiaries.

Quality was ensured by continued on-the-job training and mentoring by ICRC expatriates and local ortho-prosthetic technicians and a physiotherapist. The ICRC continued sponsoring three staff from the Bone and Joint Hospital in Srinagar on P&O courses at Mobility India in Bangalore.

The ICRC continued to promote the long-term functioning of services by strengthening the capacity of the various partners: the Indian Red Cross, the government medical college in Jammu and the Bone and Joint Hospital in Srinagar.

**In 2010, the ICRC intends to:**

- continue essential support for the Bone and Joint Hospital and the government medical college to ensure high-quality services in Jammu and Kashmir
- continue subsidizing the cost of transportation, accommodation and food
- strengthen the skills and knowledge of local technicians and physiotherapists
- develop the skills of assisted-centres managers
- assess needs in other states and, if necessary, support the Indian Red Cross and other organizations in promoting access to rehabilitation.

## MYANMAR



### Local partner

Myanmar Red Cross Society

### Project locations

Hpa-an

### Patient services in 2009

Patients attending the centres	5,223
New patients fitted with prostheses	796
New patients fitted with orthoses	469
Prostheses	1,635
Orthoses	926
Wheelchairs	1,181
Crutches (pairs)	12

Beginning of assistance: 1986

Myanmar government restrictions imposed on the ICRC since 2005 continued to prevent the organization from discharging its mandate in accordance with its standard working procedures, which are internationally recognized and which the Myanmar authorities had accepted in previous years. In June 2007, after taking stock of the situation, the ICRC was left with no choice but to publicly denounce significant and repeated violations of international humanitarian law committed against civilians, including detainees, who were being used as porters, in some conflict-affected border areas. Its delegation then adapted its activities, including rehabilitation. Since then, only the Hpa-an Orthopaedic Rehabilitation Centre, run jointly by the Myanmar Red Cross Society and the ICRC, continued to receive direct ICRC aid. However, formerly ICRC-assisted centres now managed by the Ministry of Health (3) or the Ministry of Defence (3) were given enough materials to ensure that the centres under their supervision could continue operation. Though these centres continued to receive materials and components from the ICRC, service declined in most governmental-run centres.

The ICRC continued to support the Hpa-An Orthopaedic Rehabilitation Centre, jointly run by the Myanmar Red Cross and the ICRC since September 2002. Both organizations also ran the prosthetic outreach programme, set up in 1990 in collaboration with the Ministry of Health. This programme consisted in identifying the most vulnerable amputees, particularly those living in remote and border areas in southeast Myanmar, and referring them to the centre for fitting of prostheses and physiotherapy training. All related costs such as transport, accommodation, food, physiotherapy, P&O devices, repairs, crutches and wheelchairs were covered by the ICRC. In 2009, the programme referred 208 patients (22 women and 9 children) to the centre. Forty-two of them had never been equipped before. The area covered by the programme included Mon State, Kayin State, Thanintharyi Division and eastern Bago Division.

In all, 5,223 people benefited from various services at the Hpa-An centre (1,412) and at Ministry of Health and Ministry of Defence centres (3,811). These services included provision of 1,635 prostheses (64% for mine survivors), 926 orthoses (2% for mine survivors), 12 wheelchairs and 1,181 pairs of crutches. Children represented 5% and women 12% of the beneficiaries. Figures for the Hpa-An centre were: 640 prostheses (60% for mine survivors), nine orthoses, 12 wheelchairs and 506 pairs of crutches. Children represented 3% and women 8% of the beneficiaries.

In-house theoretical and on-the-job training was given throughout the year by ICRC expatriates for P&O technicians and assistant physiotherapists in Hpa-An. In addition, the ICRC sponsored one person on a one-month placement in an ICRC-assisted centre in Cambodia to gain additional experience in managing lower-limb amputees.

### In 2010, the ICRC intends to:

- facilitate access to services by continuing support for the Hpa-an centre and the outreach programme
- enhance quality through support by an ICRC specialist and by providing a scholarship for one person to attend P&O courses
- conduct quarterly technical visits in centres managed by the Ministry of Health to promote continuity of services
- promote long-term functioning of services by strengthening the capacity to ensure sustainable rehabilitation programmes.

## NEPAL

*Local partner*

International Nepal Fellowship, Nepalese army

*Project locations*

Pokhara and Kathmandu

*Patient services in 2009*

Patients attending the centre	1,156
New patients fitted with prostheses	110
New patients fitted with orthoses	85
Prostheses	114
Orthoses	94
Crutches (pairs)	96

*Beginning of assistance: 2004*

The ICRC continued supporting the P&O department of the Green Pasture Hospital in Pokhara and started support for the Yerahity Rehabilitation Centre in Kathmandu, managed by the Nepalese military. This centre was the sole government-run facility in Nepal and since June 2008 had provided physical rehabilitation for people with spinal cord injuries. In May, it began with ICRC assistance to fit amputees. Both military personnel and civilians had access to it.

On 27 December, parliament unanimously ratified the UN Convention on the Rights of People with Disabilities and its Optional Protocol. Although the Ministry of Women, Children and Social Welfare was in charge of this sector, there was virtually no government involvement despite apparent financial resources available for rehabilitation. Apart from the Nepalese military's Yerahity Rehabilitation Centre, rehabilitation was provided by international or national organizations. The International Nepal Fellowship ran the ICRC-supported Green Pastures Hospital and its rehabilitation centre. There were also five other centres, in Kathmandu, Biratnagar, Nepalgunj, Sarlahi and Kanchanpur. Access to rehabilitation remained a challenge for most people with impaired mobility. With the escalation of general strikes, all means of transport frequently came to a standstill. Beneficiaries hesitated to travel long distances, since they never knew if they could reach the centres and then return home. Limited public transport, especially in rural areas, and high fares were additional hurdles.

To facilitate access to rehabilitation, the ICRC reimbursed 195 patients for travel expenses to and from the Green Pasture centre. It also reimbursed 53 amputees, victims of the recent conflict, for treatment costs. To further improve patient access to care, the ICRC started supporting the P&O department of the Yerahity Rehabilitation Centre. The centre was renting a nearby apartment for eight amputees during their fitting period and made an agreement with a restaurant to ensure reasonably priced meals. The ICRC agreed to reimburse civilians for those costs. In November, the Green Pasture Hospital and the ICRC organized a follow-up camp in

Butwal, south-west of Pokhara, at which 75 amputees and two persons with polio were assessed. Twenty-six orthopaedic appliances were repaired on the spot (15 feet changed, six prosthetic sockets fixed). Thirty-six amputees were referred to the Green Pasture Hospital (22) and the Yerahity Rehabilitation Centre (14) for major adjustment or replacement of their devices. More than 1,150 people benefited from various services at ICRC-assisted centres. These included production of 114 prostheses (14% for mine survivors) and 94 orthoses, and provision of 96 pairs of crutches. Children represented 9% and women 24% of the beneficiaries.

Ongoing support and mentoring was provided by ICRC specialists (ortho-prosthetists and a physiotherapist) to centre personnel with the aim of improving the quality of services. ICRC staff conducted several in-house courses in pre- and post-fitting physiotherapy, management of cerebral palsy, wheelchair and postural seating, upper-limb prosthetics, and fitting complex amputations. The ICRC continued to provide a scholarship to one person to attend P&O courses at the Cambodian School of Prosthetics and Orthotics in Phnom Penh. It also sponsored two junior P&O technicians from Green Pasture on a two-month placement at the Battambang Physical Rehabilitation Centre in Cambodia to gain additional experience in fitting upper-limb and trans-femoral prostheses, and different types of lower-limb orthoses.

In February, the Nepalese military organized the first-ever national workshop on rehabilitation. Some 16 international and national organizations attended this event, including the Green Pasture Hospital. UNICEF, WHO and the UN Mine Action Unit. It was mainly intended for participants to present their activities. The director of the Yerahity Rehabilitation Centre said he planned to develop a national rehabilitation system in Nepal.



**In 2010, the ICRC intends to:**

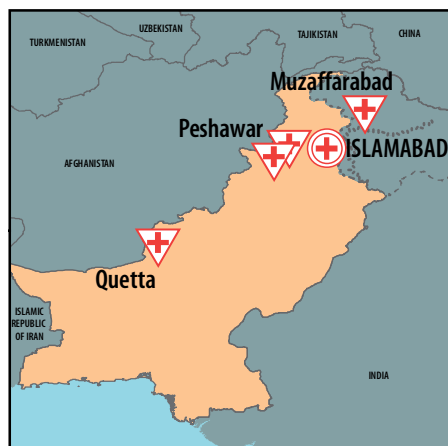
- improve access to services by continuing support for the Green Pasture Hospital and the Yerahity Rehabilitation Centre, reimbursing patients for the cost of accommodation and transport and some for the cost of treatment, supporting development of follow-up services at both centres, and supporting the Green Pasture Hospital for follow-up camps
- improve quality by continuing to provide support and mentoring from ICRC staff, continuing scholarships for training, and conducting refresher courses in physiotherapy and P&O supporting field follow-up visits by hospital personnel
- promote the long-term functioning of services by helping the managers of the Yerahity Rehabilitation Centre set up a comprehensive budget and facilitating the organization of a national workshop to promote the development of a national rehabilitation policy.



Ben Milpas/ICRC



## PAKISTAN



### Local partner

Ministry of Health, Quetta Christian Hospital, and the Pakistan Institute of Prosthetic and Orthotic Sciences

### Project locations

Peshawar (2), Muzaffarabad and Quetta

### Patient services in 2009

Patients attending the centres	9,648
New patients fitted with prostheses	850
New patients fitted with orthoses	1,453
Prostheses	855
Orthoses	2,227
Wheelchairs	192
Crutches (pairs)	713

Beginning of assistance: 2004

The ICRC maintained its support for the Pakistan Institute of Prosthetic and Orthotic Sciences in Peshawar, the Quetta Christian Hospital Rehabilitation Centre, and the Muzaffarabad Physical Rehabilitation Centre, all managed by the ICRC. In addition, it managed a home-care project in Peshawar, aimed at reintegrating patients with spinal cord injuries into their families and communities and restoring their dignity. The primary objectives of the ICRC's physical rehabilitation projects in Pakistan were to increase access to services and raise their quality for disabled people in Baluchistan, the North-West Frontier Province and Pakistan-administered Kashmir.

In Pakistan, the Ministry of Health was responsible for ensuring access to rehabilitation. The 1998 National Census Report estimates that only 2.49% of the population had some type of disability. In 2002 Pakistan adopted its National Policy for Persons with Disabilities "to provide by 2025 an environment that would allow full realization of the potential of persons with disabilities through their inclusive mainstreaming and providing them full support of the government, private sector and civil society. The goal is empowerment of persons with disabilities, irrespective of caste, creed, religion, gender or other consideration for the realization of their full potential in all spheres of life, specially social, economic, personal and political." Rehabilitation was available through a network of governmental-managed centres and the private sector.

In 2009, the ICRC strove to enhance access to the centres it assisted by reimbursing patients for transportation and accommodation costs and for the cost of treatment for patients referred by the ICRC to the Pakistan Institute of Prosthetic and Orthotic Sciences and by conducting outreach visits (5) in five districts of Pakistan-administered Kashmir (follow-up for 117 patients). More than 9,600 people benefited from various services at ICRC-assisted centres. These included production of 855 prostheses (32% for mine survivors) and 2,227 orthoses (10% for mine survivors), and provision of 192 wheelchairs and 713 pairs of crutches. Children represented 25% and women 15% of the 9,648 beneficiaries. The home-care project, implemented in Peshawar, directly assisted 229 people in Peshawar City, Mardan, Nowshera and Charsadda districts and the

Khyber Agency. The ICRC also started working with the Lady Health Workers in Pakistan-administered Kashmir to improve access to services for disabled people. Quality was improved through continued mentoring and on-the-job training provided by ICRC ortho-prosthetists and physiotherapists. ICRC staff conducted several courses in clubfoot management and wheelchair services. The ICRC also continued sponsoring three persons for P&O training (ISPO Cat. II) at the Pakistan Institute of Prosthetic and Orthotic Science and provided a scholarship for one person to attend P&O courses (ISPO Cat. I) at the Tanzania Training Centre for Orthopaedic Technologists. The ICRC held bi-monthly meetings with the Ministry of Health in Pakistan-administered Kashmir to develop a strategy for handing over the ICRC-managed Muzaffarabad Physical Rehabilitation Centre to the authorities. It also continued to support the management of capacity development in all assisted centres.

### In 2010, the ICRC intends to:

- enhance quality by continuing to provide support from ICRC ortho-prosthetists and physiotherapists, placing students from the Pakistan Institute of Prosthetic and Orthotic Sciences in assisted centres, continuing sponsorship of P&O trainees at the Institute, and enhancing the expertise of those working in the home-care programme
- facilitate access to services by continuing to cover the cost of treatment for patients at the Institute, continuing to donate materials and components to the Baluchistan Community Rehabilitation Centre, maintaining support for the home-care programme, supporting the centre in Muzaffarabad, continuing to work with the Lady Health Workers Programme, and continuing support for Afghan refugees in gaining access to services in Jalalabad
- promote long-term functioning of services through close contact with the Ministry of Health in Pakistan-administered Kashmir to ensure a smooth handover of the Muzaffarabad centre and by supporting the directors of assisted centres in developing their management skills.

## PHILIPPINES



### Local partner

Davao Jubilee Foundation

### Location of cooperating centre

Davao

### Patient services in 2009

Patients referred by the ICRC	31
New patients fitted with prostheses	11
Prostheses	26
Orthosis	1
Crutches (pairs)	11
Wheelchair	1

### Beginning of assistance: 2000

The ICRC continued aiding the Davao Jubilee Foundation by supporting its centre in Davao. Physical rehabilitation is fully complementary to the ICRC's health-related assistance and protection for conflict-affected people in Mindanao. The excellent cooperation with the Foundation makes it possible to restore people's mobility without having to be directly involved in the centre's management or subsidize its running costs. The Foundation ensures equitable access to its services for all disabled people, irrespective of any affiliation to opposition groups and of financial means.

The Philippines ratified the UN Convention on the Rights of People with Disabilities in April 2008, but not its Optional Protocol. The Republic Act No. 9442, also known as the Magna Carta for people with disabilities, outlines the rights of the handicapped, including employment quotas and health benefits. It stipulates that disabled people are entitled to a 20% discount on medical/dental care, medicines, public transport and assistive devices. The National Council on Disability Affairs was mandated by the government to formulate policies, coordinate the activities of government agencies and monitor the implementation of legislation. Physiotherapy was generally well developed and accepted in the Philippines. However, as in other sectors, there was a chronic shortage of qualified specialists. Physical therapy graduates were mainly working abroad and the country had no P&O schools.

People on Mindanao with impaired mobility faced recurrent difficulties with access to regular rehabilitation. Ongoing clashes between armed groups and fears of being arrested on suspicion of belonging to or supporting opposition groups discouraged them from travelling to Davao. High fares and fitting costs for most potential beneficiaries further limited the number of patients. Finally, since the centres in Cotabato (west) and Cagayan de Oro (north) had closed, the Davao Jubilee Centre remained the only qualified centre for the entire island.

Over 2008 and 2009, the ICRC strove to meet more comprehensively the needs of conflict-affected patients on Mindanao. In addition to reimbursing them for

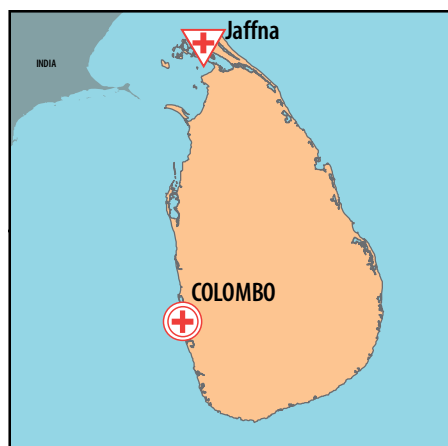
rehabilitation costs, it also promoted the professional expertise of centre staff, sponsoring a P&O course and practical training abroad, and providing on-the-job training. The Davao centre provided services for 31 persons with ICRC support. This included provision of 26 prostheses, one wheelchair and 11 pairs of crutches. The ICRC also met transportation, lodging and food costs. Children represented 3% and women 10% of the 31 beneficiaries.

The ICRC took several steps to improve the quality of the centre's services. It sponsored a two-month placement there for a physiotherapist, allowing her to gain experience in patient-management, pre/post fitting therapy, prescribing orthopaedic appliances and analysing socket fits and gait deviations. The ICRC also continued its scholarship for one person to attend P&O courses at the Cambodian School of Prosthetics and Orthotics.

### In 2010, the ICRC intends to:

- facilitate access to services for victims of the internal conflict by continuing to subsidize the cost of services (first fittings, replacements, repairs, etc), covering transportation, lodging and food expenses, and supporting development of a follow-up programme at the centre
- consolidate quality through the support of an ICRC ortho-prosthetist, by sponsoring training for one physiotherapist and one P&O technician in Cambodia, and by continuing to sponsor one trainee at the Cambodian School of Prosthetics and Orthotics.

## SRI LANKA

*Local partner*

Jaffna Jaipur Centre for Disability Rehabilitation

*Project locations*

Jaffna

*Patient services in 2009*

Patients attending the centre	1,126
New patients fitted with prostheses	89
New patients fitted with orthoses	62
Prostheses	302
Orthoses	112
Wheelchairs	68
Crutches (pairs)	66

*Beginning of assistance: August 2007*

The ICRC continued supporting the Jaffna Jaipur Centre for Disability Rehabilitation, which provided comprehensive services including prosthetics, orthotics, various mobility aids (wheelchairs, tricycles, crutches etc), physiotherapy, microcredits and financial support for disabled students. It was the only centre supplying physical rehabilitation on the Jaffna peninsula. While most of the planned activities were implemented, some were not owing to the impossibility of obtaining a visa for the ICRC specialist needed to support them.

The Ministry of Healthcare and Nutrition (Directorate of Rehabilitation for Youth, Elderly, Disabled and Displaced) and the Ministry of Social Services and Social Welfare shared responsibility for disability issues, the former in the medical realm (including rehabilitation), the latter in the social realm. The total number of persons with disabilities in Sri Lanka was unknown. There were approximately 15 centres around the country providing rehabilitation. They were managed either by the government or by local NGOs. In addition to this network, there was a school to train P&O professionals: the Sri Lankan School for Prosthetics and Orthotics.

Though the situation improved during the year, disabled people on the Jaffna Peninsula continued to face many obstacles in obtaining the rehabilitation they needed. Although distances on the peninsula are small, high fares and irregular bus service could make even a very short trip difficult and time-consuming. In order to make services more accessible, the ICRC continued to donate the materials and components needed for the centre to operate. It also continued reimbursing some patients for the cost of treatment. To cope with the increased workload, the centre began working six days a week in September. More than 1,100 people benefited from various services provided with ICRC assistance. This represented an increase of 33% over 2008. Services included the provision of 302 prostheses (44% for mine survivors), 112 orthoses (12% for mine survivors), 68 wheelchairs and 66 pairs of crutches. Children represented 4% and women 25% of the 1,126 beneficiaries.

The quality of the services provided at the centres was improved by the continued mentoring and on-the job training provided by ICRC ortho-prosthetist.

**In 2010, the ICRC intends to:**

- enhance the quality of services by maintaining the support provided by an expatriate ortho-prosthetist and a physiotherapist, conducting short training courses in several areas of P&O and physiotherapy, and by donating equipment to update the physiotherapy department
- facilitate access to services by continuing to reimburse patients for their transportation expenses as needed, supporting the organization of outreach visits, donating raw materials and components and financially supporting the construction of a new centre in Anuradhapura
- promote the long-term functioning of services by helping its partner organization to improve working procedures and methods of generating income



## 4.3 – EUROPE AND THE AMERICAS



## ICRC SUPPORT IN EUROPE AND THE AMERICAS AT A GLANCE

In 2009, the ICRC supported 11 projects in four countries: Colombia (5), Georgia (2), Guatemala (3) and Mexico (1)

- In Azerbaijan, though it had halted its aid, ICRC contact was maintained with the Almedhi Centre in Baku as service provider for specific groups. In 2008, a group of amputee Chechen refugees were assisted and in 2009 the ICRC ensured that foreign and Azeri detainees with lower-limb amputations received care.
- Though the ICRC terminated its direct assistance to the Grozny Orthopaedic Centre in 2008, regular monitoring was carried out.
- In Guatemala and Mexico, the ICRC started assistance with the primary aim of ensuring services for migrants injured when falling from trains on their way to the United States.

### Services provided

Patients attending the centres	26,545
New patients fitted with prostheses	268
New patients fitted with orthoses	347
Prostheses delivered	1,354
Orthoses delivered	7,728
Wheelchairs distributed	22
Walking aids distributed (pairs)	212

Children represented 43% and women 24% of the beneficiaries.

The ICRC directly helped 286 new patients and 562 others with the cost of transport, housing and food to enable them to benefit from rehabilitation at ICRC-assisted centres in Colombia.

In Colombia, the ICRC offered 25 ERW victims micro-economic enterprise training and/or economic aid to help them earn a living and reintegrate into society.

In Georgia, seven persons from South Ossetia were treated with ICRC support at the Vladikavkaz Orthopaedic Centre in the Russian Federation.

### Developing local capacities

Seven people were sponsored for P&O training.

### Promoting long-term functioning of services

In Colombia, the ICRC worked closely with the Ministry of Social Protection and the Centro Don Bosco (Bogotá) to organize an ISPO Cat. III training and with the Servicio Nacional de Aprendizaje to set-up an ISPO Cat. II training.

With ICRC support, the Colombian Ministry of Social Protection has drafted a decree that should help ensure high-quality services.

In Georgia, the ICRC worked with the International Trust Fund for Demining and Mine Victims Assistance to organize a regional workshop entitled "Comprehensive approach to rehabilitation and reintegration services for mine victims and other persons with disabilities". It was hosted by Georgia's Ministry of Healthcare and Social Issues and attended by 40 representatives from ministries responsible for disability affairs, rehabilitation centres, mine-action centres, international organizations and local NGOs from Albania, Armenia, Azerbaijan, Bosnia-Herzegovina, Georgia, Slovenia, Switzerland and Tajikistan.



In Colombia, the ICRC continued its support for five centres around the country: the Centro Integral de Rehabilitación de Colombia in Bogotá, the Centro de Rehabilitación Cardioneuromuscular in Cúcuta, the Fundación REI para la Rehabilitación Integral in Cartagena, Orthopraxis Ltda in Medellín and Ortopédica Americana in Cali. The ICRC also worked closely with the Ministry of Social Protection and with the Centro Don Bosco to organize an ISPO Cat. III training and with the Servicio Nacional de Aprendizaje to organize an ISPO Cat. II training. Finally, the ICRC maintained close contact with the victim-assistance department of the Programa Presidencial para la Acción Integral contra Minas Antipersonal. To ensure access to adequate rehabilitation and regular access to follow-up care and maintenance of devices, the project implemented a decentralization strategy, working with several partners around the country. To ensure that the services could be provided, the ICRC donated equipment, materials and components. In return, the centres provided services free of charge to patients referred by the ICRC. ICRC aid was benefiting not only people affected by conflict but all disabled people needing rehabilitation. Providers such as the Centro de Rehabilitación Cardioneuromuscular and the Fundación REI saw their production rise thanks to ICRC support.

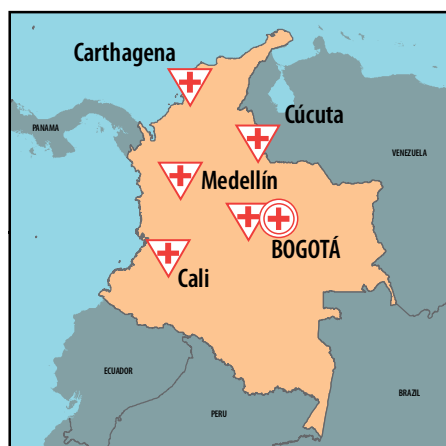
The ICRC's rehabilitation project in Georgia had three major components: support for the Georgian Foundation for Prosthetic and Orthopaedic Rehabilitation (GEFPOR) in Tbilisi, support for the Gagra centre in Abkhazia, and a referral service for patients from South Ossetia (for whom the ICRC covered the cost of devices). In both Tbilisi and Gagra, various steps were taken to transfer all responsibilities (managerial, technical and financial) to local partners. In March, Lloyd's Register Quality Assurance awarded GEFPOR the ISO certification (with the ICRC and Johanniter International providing financial support). In conjunction with the International Trust Fund for Demining and Mine Victims Assistance, the ICRC organized a regional workshop entitled "Comprehensive approach to rehabilitation and reintegration services for mine victims and other persons with disabilities".

In Guatemala, the objective was to improve access to rehabilitation for specific groups. The ICRC began support to three centres in: the Asociación Guatemalteca de Rehabilitación de Lisiados (AGREL) for migrants injured falling from trains, the Centro de Atención a Discapitados del Ejército de Guatemala (CADEG) for military personnel of the Guatemalan armed forces, and the Hospital Infantil de Infectología y Rehabilitación (HIIR) for children under 18. In late 2009, the ICRC provided all three centres with the material, components and equipment needed to produce prostheses and orthoses. Before this donation arrived, the ICRC sponsored five technicians (one from AGREL, two from HIIR and two from CADEG) to attend a three-week course on the use of the ICRC-developed polypropylene technology at Don Bosco University in El Salvador. The ICRC also discussed the possibility of sponsoring people for P&O distance-learning courses offered by Don Bosco University.

In Mexico, the ICRC started supporting the Orthimex Prosthetics and Orthotics Centre in Tapachula (Chiapas State) with the primary objective of ensuring access to rehabilitation for migrants injured when falling off trains. These illegal immigrants from Central America had been a concern for the ICRC for many years. Their identification began at Tapachula since most victims were at the Hogar Jesus el Buen Pastor shelter there. Being illegal in Mexico, they had no access to any care. The idea was to provide them with prostheses before they were returned to their countries of origin. The project met their immediate needs, and migrants returning home would have access to other ICRC rehabilitation projects in Guatemala, Honduras, Nicaragua and El Salvador (these three countries received support from the ICRC's Special Fund for the Disabled). The organization donated materials, components and equipment needed by Orthimex to produce prostheses at affordable costs, using ICRC-developed polypropylene technology. Ten prostheses were fitted for migrants through the ICRC.



## COLOMBIA



### Local partner

Ministry of Social Protection, Local NGOs (CIREC in Bogotá and Fundación REI in Cartagena), Private providers (Orthopraxis in Medellín and Ortopédica Americana in Cali)

### Project locations

Bogotá, Cartagena, Cúcuta, Medellín and Cali

### Patient services in 2009

Patients attending the centres	25,468
New patients fitted with prostheses	150
New patients fitted with orthoses	25
Prostheses	1,050
Orthoses	7,049
Wheelchairs	22
Crutches (pairs)	74

### Beginning of assistance: 2006

In Colombia, the ICRC resumed its physical rehabilitation support in 2006 under the umbrella of the comprehensive mine-action programme implemented in conjunction with the Norwegian Red Cross. The ICRC continued its support for five centres around the country: the Centro Integral de Rehabilitación de Colombia in Bogotá, the Centro de Rehabilitación Cardioneuromuscular in Cúcuta, the Fundación REI para la Rehabilitación Integral in Cartagena, Orthopraxis Ltda in Medellín and Ortopédica Americana in Cali. The ICRC also worked closely with the Ministry of Social Protection and with the Centro Don Bosco to organize an ISPO Cat. III course and with the Servicio Nacional de Aprendizaje to organize an ISPO Cat. II course. Finally, the ICRC maintained close contact with the victim-assistance department of the Programa Presidencial para la Acción Integral contra Minas Antipersonal.

Physical rehabilitation in Colombia was the responsibility of the Directorate of Social Welfare at the Ministry of Social Protection. The ministry's main responsibilities were to define standards and guidelines for the management of disability units, development of disability strategies, payment of disability pensions and the activities of funds. While training was available in rehabilitation medicine and physical and occupational therapy, there was no P&O training available in the country. The vast majority of those working in this field were trained on the job. With strong urging and support from the ICRC, a potential solution began to be implemented with an ISPO Cat. II course organized by the Servicio Nacional de Aprendizaje and a Cat. III course by the Centro Don Bosco.

Colombia became a State party to the Mine Ban Treaty in March 2001. Victim Assistance was coordinated by the Programa Presidencial para la Acción Integral contra Minas Antipersonal. The main programme benefiting mine survivors as part of a larger group of conflict victims was the ruta de atención, a legal framework, in place since 1997, that stipulated assistance ranging from first aid to socio-economic reintegration. In principle, this was free of charge for civilians once they were recognized as victims of conflict. The Ministry of Social Protection

ran a "solidarity and guarantee fund", one of the main funds reimbursing services for conflict victims. The Agencia Presidencial para la Acción Social y la Cooperación Internacional, Acción Social ran the other main fund for victims of violence.

To ensure access to adequate rehabilitation and regular and continuous access to follow-up care and maintenance of devices, the project implemented a decentralization strategy in conjunction with several partners. To ensure service, the ICRC donated equipment, materials and components. In return, the centres cared free of charge for people referred by the ICRC. ICRC aid benefited not only conflict victims but all disabled people needing rehabilitation. Providers such as the Centro de Rehabilitación Cardioneuromuscular and the Fundación REI saw their production rise thanks to ICRC support.

The ICRC contributed to the rehabilitation of 25,468 people in Colombia. Children represented 44% and women 25% of the all beneficiaries, receiving various services at the five assisted centres, including the provision of 1,050 prostheses (20% for victims of explosive devices) and 7,049 orthoses (0.2% for such victims). The ICRC financially assisted 286 new victims and 562 existing ones (transport, housing and food). Of these, 150 (including 21 women and six children) were fitted with prostheses and 25 (including six women and nine children) with orthoses. The ICRC also covered the cost of 156 wheelchairs and pairs of crutches. In 2009, the ICRC offered 25 ERW victims training for microeconomic enterprises and/or financial assistance as a way of helping them find employment and reintegrate into society. To further improve access to services, the ICRC completed in November the second phase of renovations in an accommodation block for up to 60 beneficiaries receiving physical rehabilitation at Orthopraxis and the San Vicente de Paul University Hospital in Medellín. In Bogotá, renovation was also completed of temporary accommodation for up to 40 rehabilitation patients.

Throughout the year, ICRC staff (ortho-prosthetists and a physiotherapist) provided continuous mentoring and technical support to the assisted centres with the aim of

enhancing quality. The ICRC also continued scholarships for five persons enrolled in a P&O course at Don Bosco University in El Salvador as well as two distance-learning scholarships, with the aim of developing local capacities. Nevertheless, while many things were achieved, much work remained to consolidate progress and further improve care, especially regarding the interdisciplinary team approach physiotherapy management of amputation, manufacturing standards, quality control, follow-up, etc.

The ICRC continued working closely with local organizations to promote long-term functioning of services. With ICRC support, the Ministry of Social Protection drafted a decree to help improve quality. The section of best practices for manufacturing and adapting prostheses and orthoses still had not been approved by the end of the year. It was intended to set standards for P&O services in Colombia (including technologies approved, who should provide the services, what is included, etc.).

#### In 2010, the ICRC intends to:

- continue working with the Norwegian Red Cross on a comprehensive mine-action project involving (in addition to rehabilitation), data-gathering, support for the social and economic reintegration of survivors, mine-risk reduction and public education
- facilitate access to services by maintaining support for the five rehabilitation centres, starting to work with two new centres (Florescia and Bucaramanga), covering the cost of transportation and accommodation for beneficiaries, and strengthening the referral network
- enhance quality through scholarships for P&O training at Don Bosco University and continued support from ICRC specialists
- promote the long-term functioning of services by helping with rehabilitation management at the national level and in local centres.



Christoph von Toggenburg/ICRC

## GEORGIA



### Local partner

Georgian Foundation for Prosthetic and Orthopaedic Rehabilitation, Abkhazian Ministry of Health

### Project locations

Tbilisi and Gagra

### Patient services in 2009

Patients attending the centres	1,077
New patients fitted with prostheses	118
New patients fitted with orthoses	322
Prostheses	304
Orthoses	679
Crutches (pairs)	138

Beginning of assistance: 1994

The ICRC's physical rehabilitation project in Georgia had three major components: support for the Georgian Foundation for Prosthetic and Orthopaedic Rehabilitation (GEFPOR) in Tbilisi, support for the Gagra centre in Abkhazia, and a referral service for patients from South Ossetia (the ICRC covered the cost of devices for them). In both Tbilisi and Gagra, various steps were taken toward the transfer of all responsibilities (managerial, technical and financial) to local partners.

The Georgian Ministry of Healthcare and Social Issues was the regulator for rehabilitation services but, despite growing interest in taking them over, there was still little official support. Unfortunately, the planned 2009 call for tender was first announced by the ministry, then postponed until the end of the year. (The same thing occurred in 2008.) The fact that the minimum required bid was doubled in 2009 was a positive sign, but this sum remained insufficient to cover all the needs. The ministry was still working to develop a comprehensive national rehabilitation policy with an appropriate legislative and institutional framework for the protection of disabled peoples' rights. A parliamentary commission was set up for this purpose. In recent years, GEFPOR had become the first choice as P&O support for all local bodies striving to facilitate access to assistive devices. The GEFPOR was placed under contract by the ministry as the sole body responsible for the referral programme (which in 2009 received a substantial increase in funding). The Ministry of Defence assigned funds to the GEFPOR for the fitting of military personnel wounded in the recent war. In March, Lloyd's Register Quality Assurance awarded the GEFPOR ISO certification. The ICRC and Johanniter International provided financial support for this process.

In Abkhazia, the Ministry of Health supported the Gagra Physical Rehabilitation Centre and its repair workshop in Gali. In the absence of an internationally recognized status for the province, the importation of raw orthopaedic materials and components remains difficult for the authorities, who require continuing ICRC aid for transport. The authorities were becoming increasingly active. The handover of responsibilities in Abkhazia was virtually complete.

The GEFPOR provided 251 prostheses (4% for mine survivors) and 654 orthoses. In all, 778 people benefited from its services. Children represented 45% and women 12% of the beneficiaries. Through its patient-support system, the ICRC covered the cost of 184 devices (20% of the centre's total production). With ICRC support, the Gagra centre in Abkhazia provided 53 prostheses (49% for mine survivors) and 25 orthoses. In all, 299 people benefited from its services. Children represented 3% and women 18% of the beneficiaries. Seven persons from South Ossetia also received ICRC-supported care at the Vladikavkaz Orthopaedic Centre in the Russian Federation.

Working with the International Trust Fund for Demining and Mine Victims Assistance, the ICRC organized a regional workshop ("Comprehensive approach to rehabilitation and reintegration services for mine victims and other persons with disabilities") hosted by the Ministry of Healthcare and Social Issues. It was attended by 40 representatives of ministries responsible for disability affairs, rehabilitation centres, mine-action centres, international organizations and local NGOs from Albania, Armenia, Azerbaijan, Bosnia-Herzegovina, Georgia, Slovenia, Switzerland and Tajikistan.

### In 2010, the ICRC intends to:

- enhance quality through continued support from ICRC specialists
- facilitate access to services by continuing to cover the cost of treatment for a number of patients at the GEFPOR and the cost of treatment at the Vladikavkaz centre, and by supporting the Abkhazian authorities for the transport of materials.
- promote the long-term functioning of services through continued aid for the GEFPOR, by continuing support for the Ministry of Labour, Healthcare and Social Issues in its efforts to develop a national rehabilitation policy, and by assisting the Abkhaz authorities in developing and implementing a long-term strategy for the sustainability of the Gagra centre.



## GUATEMALA



### Local partner

Asociación Guatemalteca de Rehabilitación de Lisiados, Centro de Atención a Discapacitados del Ejercito de Guatemala, Hospital Infantil de Infectología y Rehabilitación

### Project locations

Guatemala City

### Patient services in 2009

No statistics available

Patients attending the centre

New patients fitted with prostheses

New patients fitted with orthoses

Prostheses

Orthoses

Wheelchairs

Crutches (pairs)

Beginning of assistance: 2009

To improve access to physical rehabilitation for specific groups, the ICRC initiated support for three centres in Guatemala:

- the Asociación Guatemalteca de Rehabilitación de Lisiados, this (AGREL) for migrants injured falling from trains
- the Centro de Atención a Discapacitados del Ejercito de Guatemala (CADEG) for personnel of the Guatemalan armed forces
- the Hospital Infantil de Infectología y Rehabilitación (HIIR) for children under 18.

Guatemala had a population of 13 million, making it one of the most populous countries in Central America. It had a per capita GDP roughly one-half that of Argentina, Brazil and Chile. A news article published in 2009 stated that approximately 1.5 million Guatemalans lived with some form of disability, most either in poverty or extreme poverty. Over half the population were illiterate and only 23% had access to health care and education. Disabled people endured this despite laws intended to protect their well-being. The National Council to Help the Disabled was the national agency responsible for disabilities policy. Rehabilitation was provided through a network of government, private and NGO-managed facilities. However, their capacity fell far short of what was needed.

In late 2009, all three centres were receiving from the ICRC the material, components and equipment needed to produce prostheses and orthoses. The ICRC was already sponsoring five technicians (one from AGREL, two from HIIR and two from CADEG) for a three-week course on the use of ICRC-developed polypropylene technology at Don Bosco University in El Salvador. Throughout the year, the ICRC discussed the possibility of supporting participants in P&O distance-learning courses offered by Don Bosco University.

While the above-mentioned projects were run by the Physical Rehabilitation Programme, follow-up and

monitoring were carried out by Special Fund for the Disabled staff based in Nicaragua.

### In 2010, the ICRC intends to:

- continue supporting the three centres by donating material and components and reimbursing specific groups for the cost of treatment
- support the development of the centres' human resources (training)
- provide further support and mentoring by ICRC specialists.

## MEXICO



### Local partner

Orthimex

### Project location

Tapachula

### Patient services in 2009

Patients attending the centre	8
New patients fitted with prostheses	8
New patients fitted with orthoses	
Prostheses	10
Orthoses	
Wheelchairs	2
Crutches (pairs)	33

Beginning of assistance: 2009

The ICRC started supporting the Orthimex Prosthetics and Orthotics Centre in Tapachula (Chiapas State) primarily to ensure access to adequate physical rehabilitation for migrants injured when falling off trains on the way to the United States. These illegal immigrants from Central America had been a concern to the ICRC for many years. Identifying the injured migrants started at Tapachula, since most were at the Hogar Jesus el Buen Pastor shelter there. Being illegal in Mexico, they had no access to health care. The idea was to provide them with prostheses before they were returned to their countries of origin. While the project met their immediate needs, they would have access to services through other ICRC physical rehabilitation projects in Guatemala, Honduras, Nicaragua and El Salvador. (The last three countries received support from the ICRC Special Fund for the Disabled.)

The ICRC donated the material, components and equipment needed to enable Orthimex to produce prostheses at affordable cost, using the ICRC-developed polypropylene technology. In 2009, 10 prostheses were delivered to migrant train victims with ICRC assistance. In addition, the ICRC donated wheelchairs and crutches to the Hogar Jesus el Buen Pastor shelter. It sponsored one technician from Orthimex for a three-week course on the use of polypropylene technology at Don Bosco University in El Salvador.

While the project was run by the Physical Rehabilitation Programme, follow-up and monitoring were carried out by Special Fund for the Disabled staff based in Nicaragua.

### In 2010, the ICRC intends to:

- continue supporting Orthimex to ensure access to services for migrants injured falling from trains, by donating materials, components, wheelchairs and crutches, and by reimbursing people for the cost of treatment
- Provide ongoing support and mentoring from ICRC specialists.

## 4.4 – MIDDLE EAST AND NORTH AFRICA





## ICRC SUPPORT IN THE MIDDLE EAST AND NORTH AFRICA AT A GLANCE

The ICRC supported 20 projects in three countries and one territory, i.e.: Algeria (2), Iraq (13), Gaza (1) and Yemen (4).

- In Yemen, the ICRC supported the setting up of the Sa'ada Physical Rehabilitation Clinic to improve access to services in that governorate.
- In Gaza, the ICRC began collaborating with the European Gaza Hospital.
- In Iraq, the ICRC began collaborating with the Helena Physical Rehabilitation Centre, managed by the Ministry of Health of the Kurdistan Regional Government in Arbil, and financed the construction of a new centre in Nasiriya which should start services in 2010.
- In Algeria, the ICRC halted aid for the Ben Aknoun P&O department.

### Services provided

Patients	39,158
New patients fitted with prostheses	2,713
New patients fitted with orthoses	18,547
Prostheses delivered	4,416
Orthoses delivered	16,125
Wheelchairs distributed	116
Walking aids distributed (pairs)	1,445

Children represented 33% and women 16% of the beneficiaries.

In Iraq, the ICRC's microeconomic programme enabled several beneficiaries at the Arbil centre to set up an income-generating scheme.

### Developing local capacities

18 candidates sponsored to attend P&O courses

Several refresher courses in physiotherapy and in P&O were given in Iraq, Gaza and Yemen.

### Promoting long-term functioning of services

In Iraq, the ICRC continued to work closely with ministries involved in rehabilitation, participated in meetings of the Higher Committee for Physical Rehabilitation and organized a three-day workshop in Arbil, also attended by representatives from 16 centres and from the Ministry of Health (national and directorate level).



In Algeria, the ICRC signed a cooperation agreement with the Ministry of Health and the Algerian Red Crescent in 2001. Initially, the project's objectives were to ensure access to services for (i) Sahrawi amputees living in the refugee camps in south-western Algeria, and (ii) Algerian destitute amputees (those not covered by the social security system). The project for the Sahrawi amputees lasted 18 months and benefited 64 people. Although it ended in 2003, the rehabilitation centre continued to offer services to the Algerian destitute. In 2007, the paramedic professional school (INPFP) proposed a tripartite collaboration agreement between the Ben Aknoun Hospital, the INPFP and the Algerian Federation of the Disabled. The aim was to use the P&O department of Ben Aknoun hospital as a training site for P&O students, using polypropylene process technology, and to enhance the quality of services to Algerian destitute amputees identified by the Algerian Federation. During 2008 and the first six months of 2009, only a few people benefited from this collaboration, despite the Algerian Federation's good work in identifying potential beneficiaries and the availability of materials donated by the ICRC. In June 2009, the ICRC halted its aid for the Ben Aknoun P&O department as planned. However, enough materials and components were given to enable the department to continue services at least until the end of 2010.

In 2009, the ICRC continued supporting the Centre Martyr Chereïf, managed by the Polisario Front's Public Health Authority. The centre was located in the desert, about five km from Rabouni, where the Front had set up its administrative headquarters. The Centre offered physical rehabilitation for the Sahrawi population living in refugee camps, participated in radio and TV interviews to promote the new centre and paid several visits to different camps in order to identify potential beneficiaries and disseminate information about the centre's services. Throughout the year, ICRC specialists provided advice to the centre's director and ongoing support for the five assistant ortho-prosthetic technicians and four assistant physiotherapists.

In Gaza, the ICRC continued aid for the Artificial Limb and Polio Centre (ALPC) in Gaza City, managed by the city authorities. It also continued its collaboration with Al-Shifa Hospital and with the European Gaza Hospital. The programme's general objective there was to ensure access to physical rehabilitation for the wounded in the Gaza strip (aid to ALPC) and to post-surgical rehabilitation focused on physiotherapy (aid to hospitals). While the focus was on war-wounded people, ICRC support benefited all users of the assisted hospitals and the ALPC. Throughout the year, the ICRC conducted several activities to ensure access to physical rehabilitation, including at the ALPC. For example, it donated materials, components and wheelchairs. The ICRC also financed the centre's expansion (construction of an additional floor), which started in October 2009 and should be completed by mid-April 2010. To ensure the availability of post-surgical rehabilitation at the Al Shifa Hospital and the

European Gaza Hospital, the ICRC donated equipment, and an ICRC physiotherapist provided on-the-job training and mentoring.

In Iraq, the ICRC continued supporting 13 facilities around the country, nine of them managed by the Ministry of Health: four in Baghdad (Al-Wasity, the Medical Rehabilitation Centre, Baghdad Centre and Al-Salam Crutch Production Unit) and one each in Falluja, Basra, Najaf, Hilla, and Tikrit. One was managed by the Ministry of Higher Education (Baghdad P&O School) and one by the Ministry of Health of the Kurdistan Regional Government in Arbil (Helena Physical Rehabilitation Centre). In addition, the ICRC continued managing the Arbil Physical Rehabilitation Centre and financed construction of a new centre in Nasiriya, which should start operating in 2010, thereby improving access to services in south-eastern Iraq. Throughout the year, the ICRC continued donating raw materials and components to all assisted centres. The ICRC also covered the cost of transport and accommodation to enable beneficiaries to receive services at the centres in Arbil, Falluja and Tikrit. To promote the long-term functioning of services, the ICRC continued to work closely with ministries involved in rehabilitation and participated in meetings of the Higher Committee for Physical Rehabilitation.

In Yemen, the ICRC continued supporting the National Artificial Limbs and Physiotherapy Centre in Sana'a, the Artificial Limbs and Physiotherapy Centre in Mukalla and the Limb-fitting Workshop and Rehabilitation Centre in Aden. In addition, it supported the Sa'ada Physical Rehabilitation Clinic, based at the Al Jumhuri Hospital. This clinic was a joint venture between the Ministry of Public Health and Population, the Rehabilitation Fund and Care for Handicapped Persons, the Yemen Red Crescent Society and the ICRC. The clinic was held every other week with a team from the Sana'a centre, accompanied by the Physical Rehabilitation Programme team. The quality of services at the Sana'a, Mukalla and Aden centres was maintained through continued support from an ICRC ortho-prosthetic technician and a physiotherapist, who provided on-the-job training and monitoring. In addition, the ICRC awarded scholarships to seven candidates for P&O training at Mobility India in Bangalore; four of them graduated this year, and the other three will complete their studies in 2011.

## ALGERIA

*Local partner*

Ministry of Health

*Project locations*

Algiers

*Patient services in 2009 (January-June)*

Patients	41
New patients fitted with prostheses	19
New patients fitted with orthoses	18
Prostheses delivered	18
Orthoses delivered	27

*Beginning of assistance: 2002*

In June 2001, the ICRC signed a cooperation agreement with the Ministry of Health and the Algerian Red Crescent. This agreement defined each partner's role and responsibilities in establishing a new P&O department in the rehabilitation unit of the Ben Aknoun hospital in Algiers. Initially, the project's objectives were to ensure access to services for (i) Sahrawi amputees living in the refugee camps in south-western Algeria, and (ii) Algerian destitute amputees (those not covered by the social security system). The project for the Sahrawi amputees lasted 18 months and benefited 64 people. Although it ended in 2003, the rehabilitation centre has continued to offer services to the Algerian destitute.

The Ministry of Health never showed any interest in the ICRC-assisted centre and never responded specifically to any proposal made by the ICRC. In 2007, the paramedic professional school (INPFP) proposed a tripartite collaboration agreement between the Ben Aknoun hospital, the INPFP and the Algerian Federation of the Disabled. The aim of this collaboration was to use the P&O department of Ben Aknoun hospital as a training site for P&O students, using polypropylene process technology, and to enhance the quality of services to Algerian destitute amputees identified by the Algerian Federation.

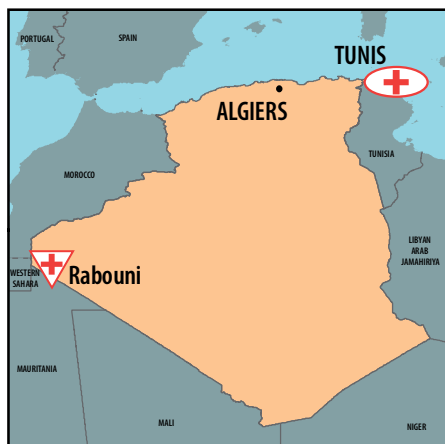
During 2008 and the first six months of 2009, only a few people benefited from the collaboration, despite the Algerian Federation's good work in identifying potential beneficiaries and the availability of material donated by the ICRC. The students' performance was never properly supervised by teachers at the school, and no effort was made by the hospital to maintain the workshop despite heavy investments in other services. Between January and June 2009, 41 people received various services at the ICRC-assisted centre. These included production of 18 prostheses and 18 orthoses. Children represented 22% and women 17% of those receiving services.

In June 2009, the ICRC halted its aid for the Ben Aknoun P&O department as planned. However, enough materials and components were given to enable the department to continue providing services at least until the end of 2010.



## ALGERIA

## (SAHARAWI REFUGEES LIVING IN SOUTH-WEST ALGERIA)

*Partner*

Polisario Front Public Health Authority

*Project locations*

Rabouni

*Patient services in 2009 (May-December statistics)*

Patients	257
New patients fitted with prostheses	14
New patients fitted with orthoses	37
Prostheses delivered	23
Orthoses delivered	50
Wheelchairs distributed	6
Crutches (pairs) distributed	22

*Beginning of assistance: 2007*

In 2009, the ICRC continued support for the Centre Martyr Chereïf, managed by the Polisario Front's Public Health Authority. The Centre Martyr Chereïf was in the desert, about five km from Rabouni, where the Polisario Front had its administrative headquarters. The centre offered physical rehabilitation for the Sahrawi population living in refugee camps.

An armed conflict between Morocco and the Polisario Front raged from 1975 to 1991, when a ceasefire went into effect. As a consequence of the conflict, thousands of Sahrawis became refugees. A large number of these refugees were living in five camps in the Tindouf region in south-western Algeria. The ICRC has sought to ensure access to physical rehabilitation for the Sahrawi population since 2000. An expatriate ortho-prosthetic technician was assigned in February 2007 to set up a centre that would provide services to the Sahrawi living in or close to the camps. One additional goal was to train Sahrawi staff to ensure project sustainability. Construction of the centre was completed in early 2008 and the first service was provided in May 2008.

The ICRC gave radio and TV interviews to promote the new centre. Staff also increased their lobbying of hospitals (Rabouni and Tindouf) and other organizations (UN, NGOs) to be allowed to present and explain the different types of services offered at the centre. In November, the ICRC was invited for the first time to a round-table attended by all the NGOs working in the health sector. In addition, the ICRC paid several visits to different camps in order to identify potential beneficiaries and disseminate information on the centre's services. In 2009, 257 people received various services at the ICRC-assisted centre. These included production of 23 prostheses (91% for mine survivors) and 50 orthoses (6% for mine survivors), and provision of 6 wheelchairs and 22 pairs of crutches. Children represented 16% and women 27% of the beneficiaries.

Throughout the year, the ICRC ortho-prosthetist and the physiotherapist provided ongoing mentoring and on-the-job training to the five assistant P&O technicians and four assistant physiotherapists. Most of the work was

done by local personnel under ICRC supervision. ICRC specialists also provided ongoing mentoring and advice to the director of the Centre Martyr Chereïf.

**In 2010, the ICRC intends to:**

- support the Centre Martyr Chereïf by donating materials and components, broadening the types of services provided, and visiting the different camps to identify those in need
- enhance quality by continuing to provide ICRC ortho-prosthetist and physiotherapists, and furnishing on-the-job training for technicians and physiotherapists working at the centre
- promote the long-term functioning of services by continuing to support the centre director in managing physical rehabilitation.

## GAZA

*Local partner*

Gaza city authorities

*Project locations*

Gaza

*Patient services in 2009*

Patients	1,721
New patients fitted with prostheses	84
New patients fitted with orthoses	282
Prostheses delivered	95
Orthoses delivered	305
Wheelchairs distributed	1
Crutches (pairs) distributed	18

*Beginning of assistance: 2007*

The ICRC continued aid for the Artificial Limb and Polio Centre (ALPC) in Gaza City managed by the Gaza City authorities. The ICRC also continued its collaboration with Al-Shifa Hospital and with the European Gaza Hospital. The programme's general objective was to ensure access to physical rehabilitation for the wounded in the Gaza strip (aid to the ALPC) and to post-surgical rehabilitation focused on physiotherapy (aid to hospitals). While the focus was on war-wounded people, ICRC support benefited all users of the assisted hospitals and the ALPC.

The Gaza Strip is one of two Palestinian territories; the other is the West Bank. The Strip borders on the Mediterranean Sea, Egypt and Israel, and its population density is one of the highest in the world. According to the WHO, the disabled population in need of P&O services averaged 0.5% of the population. That brought the estimated number of people in need there to 7,000. Because of the lack of reliable statistics, this figure could not be confirmed. However, the National Society for Rehabilitation (a local NGO) estimated that there were 11,400 people with physical disorders living in the Gaza Strip in September 2009. Moreover, people with disabilities were among the most vulnerable groups and usually over-represented in any count of those living in poverty. They were therefore severely affected by the ongoing crisis.

The ICRC implemented several activities to ensure access to rehabilitation. For example, it donated materials, components and wheelchairs. It also financed the centre's expansion, which started in October and should be completed by mid-April 2010. ICRC specialists (an ortho-prosthetic technician and a physiotherapist) continued to provide on-the-job training and mentoring for Palestinian P&O technicians, bench workers and physiotherapists. The ICRC also awarded scholarships to two candidates for P&O training at Mobility India in Bangalore. In 2009, 1,721 people received various services at the ICRC-assisted centre. These services included production of 95 prostheses and 305 orthoses, and provision of one wheelchair and 18 pairs of crutches. No statistics were compiled on the number of persons who received physiotherapy, but such treatment was available for most

who needed it. Children represented 45% and women 13% of the beneficiaries.

To ensure the availability of post-surgical rehabilitation at the Al Shifa Hospital and the European Gaza Hospital, the ICRC donated equipment, and an ICRC physiotherapist provided on-the-job and mentoring. ICRC staff monitored the reorganization of the physiotherapy department, the development of a referral system and the improvement of communication channels in each assisted hospital. In addition, ICRC specialists conducted several continuing education sessions to improve the quality of physiotherapy.

**In 2010, the ICRC intends to:**

- ensure access to physical rehabilitation for those in need by continuing support for the ALPC through donation of materials, components and wheelchairs
- ensure the availability of post-surgical rehabilitation by continuing aid for the Al Shifa Hospital (southern Gaza) and the European Gaza Hospital (northern Gaza) and by initiating the same kind of support at the Nasser Hospital
- improve quality by continuing mentoring provided by ICRC specialists, sponsoring people for P&O courses, and conducting refresher courses in P&O and physiotherapy.

## IRAQ

*Local partner*

Ministry of Health, Ministry of Higher Education and Ministry of Health of the Kurdistan Regional Government

*Project locations*

Baghdad (5), Najef, Hilla, Tikrit, Basrah, Falluja, Arbil (2)

*Patient services in 2009*

Patients	31,196
New patients fitted with prostheses	1,808
New patients fitted with orthoses	8,551
Prostheses delivered	3,447
Orthoses delivered	12,615
Wheelchairs distributed	96
Crutches (pairs) distributed	1,081

*Beginning of assistance: 1993*

The ICRC continued supporting 13 facilities around the country, nine of them managed by the Ministry of Health: four in Baghdad (Al-Wasity, Medical Rehabilitation Centre, Baghdad Centre and Al-Salam Crutch Production Unit), and one each in Falluja, Basra, Najaf, Hilla, and Tikrit. One was managed by the Ministry of Higher Education (Baghdad P&O School) and one by the Ministry of Health of the Kurdistan Regional Government in Arbil (Helena Physical Rehabilitation Centre). The ICRC also continued managing the Arbil Physical Rehabilitation Centre and financed construction of a new centre in Nasiriya, which should start operating in 2010.

Although security improved somewhat in 2008, it was shaken following the provincial election in early 2009, and the year ended with wider and even more devastating attacks targeting key government ministries and institutions. Several ministries were concerned with disability issues, but the Ministry of Health was mainly responsible for physical rehabilitation, although the Environment Ministry also had a victim-assistance component through its responsibility for explosive remnants of war. The Higher Committee for Physical Rehabilitation, a Ministry of Health body, dealt with all issues related to the provision of mobility aids nationwide, except for the north of the country, which was under the jurisdiction of the Kurdistan Regional Government. Unfortunately, no equivalent coordination body existed for Kurdistan. The ICRC's annual seminar therefore remained the only opportunity to discuss rehabilitation issues with all people concerned nationwide.

The series of conflicts that took place in Iraq and the ongoing turmoil there, together with the still weak public health-care system, resulted in an ever growing number of disabled people. Unfortunately, there was still no way to pinpoint that number with certainty. The WHO's estimate that 0.5% of the total population was in need of physical rehabilitation would put the figure at 156,000; since all of them would need a new orthopaedic device every three years, on average, which would mean an annual production of over 52,000, (still about three times the number of orthopaedic appliances delivered in 2009).

In Kurdistan, eight rehabilitation centres were functioning, including the ICRC-managed centre in Arbil. In the other parts of the country, 10 centres were functioning. Among them, eight were managed by the Ministry of Health (and supported by the ICRC), one was managed by the Ministry of Defence, and one by the Iraqi Red Crescent Society.

The ICRC continued donating raw materials and components to all assisted centres. To improve access to services in south-eastern Iraq, it financed construction of a new centre in Nasiriya, which should start operating in 2010. The cost of transport and accommodation was also covered to enable beneficiaries to receive services at the centres in Arbil, Falluja and Tikrit. In addition, the ICRC endeavoured to expand its links to NGOs and other public actors in order to make the services known to them and through them to others, and if possible to obtain their help in identifying potential beneficiaries who had no access to services. Meanwhile, the ICRC's micro-economic initiative programme enabled several beneficiaries at the Arbil centre to set up an income-generating scheme.

In 2009, 31,196 people received various services at ICRC-assisted centres. These included production of 3,447 prostheses (10% for mine survivors) and 12,615 orthoses (1% for mine survivors), and provision of 96 wheelchairs and 1,081 pairs of crutches. Children represented 30% and women 15% of the beneficiaries. All rehabilitation centres except Najaf significantly improved their output, with a total increase of 20% for prostheses and 28% for orthoses (Najaf's output fell by 10%). The proportion of new patients was 55%, compared with 26% in 2008, which tends to confirm that more people had access to ICRC-assisted centres. The jump of 25% in the number of prostheses and orthoses delivered compared with 2008 was not sufficient to absorb the increasing number of patients who sought services. As a result, by the end of the year most centres had a waiting list.

Apart from ongoing mentoring and support from ICRC specialists (ortho-prosthetists and a physiotherapist), several activities were undertaken to enhance quality of



services. At the ICRC-managed centre in Arbil, seven refresher courses were organized (two in gait training for physiotherapists and doctors, two in knee orthoses, two in transradial prostheses for ortho-prosthetic technicians, and one in wheelchair and postural support). Finally, the ICRC provided scholarships to eight persons for ISPO Cat. II training at the Cambodian School for Prosthetics and Orthotics and to one person for ISPO Cat. I training at the Tanzania Training Centre for Orthopaedic Technologists.

To promote the long-term functioning of services, the ICRC continued working with ministries involved in rehabilitation, actively participated in meetings of the Higher Committee for Physical Rehabilitation, and organized a three-day workshop in Arbil attended by representatives from 16 centres and from the Ministry of Health (national and directorate level). The aim of the workshop was to design a national treatment protocol and admission criteria.

#### In 2010, the ICRC intends to:

- facilitate access to services by donating raw materials, components, tools and physiotherapy equipment, and ensure the maintenance of facilities by: assessing the need to assist other facilities; persuading the Ministry of Health and local authorities (governorate, Department of Health, centre managers) to establish
- permanent accommodation in the various centres; continuing to cover the cost of transport and accommodation for destitute beneficiaries living in remote areas; improving dissemination to local entities and authorities of information on services available for disabled people; and mobilizing those entities to facilitate the transfer of potential beneficiaries (in coordination with the respective centres and the ICRC, if necessary)
- enhance quality by monitoring rehabilitation at assisted centres with the aid of ICRC specialists, organizing refresher courses in prosthetic, orthotic, physiotherapy, wheelchair and patient management, continuing to provide scholarships for P&O courses, persuading the relevant authorities to dispatch physiotherapists to P&O departments, and working with the Higher Committee to continue developing and implementing meaningful treatment protocols
- promote the long-term functioning of services by helping improve professional education through enhanced collaboration with the Ministry of Health in upgrading the curriculum; improve the teaching environment by helping the Higher Committee for Physical Rehabilitation develop a comprehensive national rehabilitation strategy; and tackling human resources issues by lobbying the Kurdistan Regional Government to create a body within the Ministry of Health, equivalent to the Higher Committee, that will coordinate all physical rehabilitation activities in the regions under its control.



Christoph von Toggenburg/ICRC

## YEMEN

*Local partner*

Ministry of Public Health and Population, Ministry of Labour and Social Affairs, Yemen Red Crescent Society, Rehabilitation Fund and Care for Handicapped Persons

*Project locations*

Sana'a, Mukalla, Sa'ada and Aden

*Patient services in 2009*

Patients	5,943
New patients fitted with prostheses	788
New patients fitted with orthoses	2,181
Prostheses delivered	833
Orthoses delivered	3,128
Wheelchairs distributed	12
Crutches (pairs) distributed	320

*Beginning of assistance: 2002*

The ICRC continued supporting the National Artificial Limbs and Physiotherapy Centre in Sana'a, the Artificial Limbs and Physiotherapy Centre in Mukalla and the Limb-fitting Workshop and Rehabilitation Centre in Aden. It also supported the activities of the Sa'ada Physical Rehabilitation Clinic, based at the Al Jumhuri Hospital. This clinic was a joint venture between the Ministry of Public Health and Population, the Rehabilitation Fund and Care for Handicapped Persons, the Yemen Red Crescent Society and the ICRC. The clinic was held every other week with a team from the Sana'a centre, accompanied by the Physical Rehabilitation Programme team. It ran until August, when activities were halted for security reasons.

The Ministry of Public Health and Population and the Ministry of Labour and Social Affairs were the main bodies in charge of rehabilitation. Three funds were created to alleviate the living conditions of the country's disabled. The Social Fund for Development, an independent body set up in 1997 as a major component of the Social Safety Net Programme funded by the World Bank, operated under the prime minister's authority. It assisted the disabled through government agencies, NGOs and disabled people's organizations in the realms of health, social protection, education, capacity-building and strategy development. The Rehabilitation Fund and Care for Handicapped Persons, a fund under the authority of the Ministry of Labour and Social Affairs, provided funding and other assistance to individuals and to the centres. Disabled people received an identity card that gave them free access to medical services and to walking and hearing aids provided by the Fund. It also aided disabled people's organizations and NGOs. Its budget came from customs duties and taxes on cigarettes and air tickets. The Social Welfare Fund assisted the disabled economically.

Rehabilitation centres were located in big cities such as Sana'a, Mukalla, Taiz and Aden, thereby excluding most people from rehabilitation services. Those who did receive services often had difficulty maintaining their devices because of the distance to the nearest workshop. Based on a number of local surveys, the Women's National Committee for the Implementation of the

Convention on the Elimination of All Forms of Discrimination against Women reported that there were 113,000 disabled people in Yemen, nearly 37,000 of whom were women.

The ICRC promoted access to services by donating raw materials and components to all assisted centres. It also supported the setting up of the Sa'ada Physical Rehabilitation Clinic, aimed at improving access to services in the governorate. In 2009, 5,943 people benefited from various services at ICRC-assisted centres. These included production of 833 prostheses (30% for mine survivors) and 3,128 orthoses (1% for mine survivors), and provision of 12 wheelchairs and 320 pairs of crutches. Children represented 45% and women 23% of the beneficiaries.

The quality of services at the Sana'a, Mukalla and Aden centres was maintained through continued support from an ICRC ortho-prosthetist and a physiotherapist, who provided on-the-job training and monitoring. Physiotherapy refresher courses on gait training were given in Mukalla and Aden. They were attended by 24 local physiotherapists. The ICRC provided scholarships to seven people in P&O training at Mobility India in Bangalore. Four of them graduated in 2009; the other three will complete their studies in 2011.

**In 2010, the ICRC intends to:**

- facilitate access to services by continuing to donate raw materials and components to the Sana'a, Mukalla and Aden centres, supporting the crutch-manufacturing unit at the Sana'a centre, aiding the Sa'ada mobile clinic and initiating support for the Taiz centre
- enhance quality by making an ICRC ortho-prosthetist and a physiotherapist regularly available to all centres, continuing its sponsorship of trainees at Mobility India (with four additional trainees in 2010), and providing guidance to the Rehabilitation Fund and Care for Handicapped Persons in setting up wheelchair service
- promote better coordination between interested parties through ongoing meetings and networking.

# ANNEX – ICRC PUBLICATIONS

The following documents are available through the ICRC website and in most cases, can be downloaded directly from the ICRC website.

## P&O Manufacturing Guidelines

In 2007, manufacturing guidelines for trans-tibial, trans-femoral, partial-foot, trans-humeral and trans-radial prostheses and ankle-foot, knee-ankle and patellar-tendon-bearing orthoses, and for using the alignment jig in the manufacture of lower-limb prostheses were published and widely distributed among all ICRC assisted-projects and NGOs and among stakeholders involved in providing P&O services in developing countries. Each manual contained material that should be of help in transferring know-how in projects.

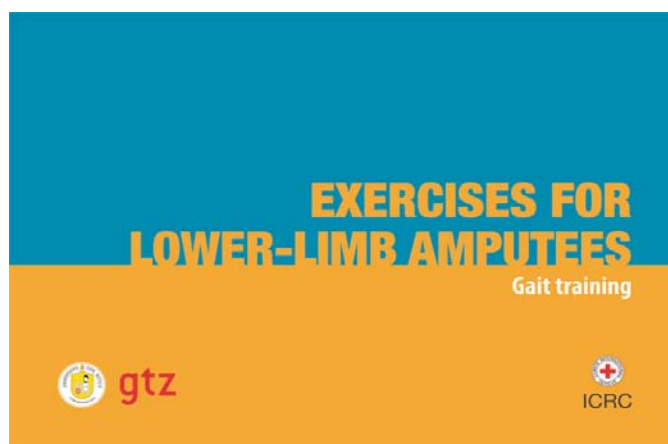


## ICRC Polypropylene Technology



To mark the ICRC's role in developing and promoting appropriate technology, such as the polypropylene technology, a brochure on the subject was published in 2007. It provides the necessary information about the advantages and appropriateness of using this technology for producing prosthetic and orthotic devices in developing countries.

## Physiotherapy



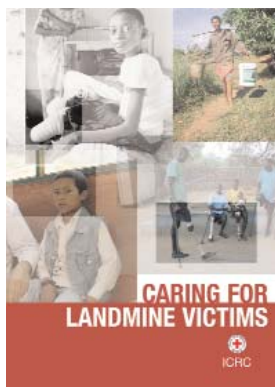
This booklet/CD-ROM provides examples of basic post-prosthetic exercises for use by physiotherapists, physiotherapy assistants, ortho-prosthetists and others involved in the gait training of lower-limb amputees. The aim of these exercises is to help amputees regain their self-confidence and to walk as well as possible.



## WEAPON CONTAMINATION

### Caring for landmine victims

Every year, tens of thousands of people are killed or injured by landmines and other explosive remnants of war. Those that survive are often disabled for life and need long-term care, not only rehabilitation but also social and economic support. This leaflet examines the challenges involved in providing assistance to the victims.



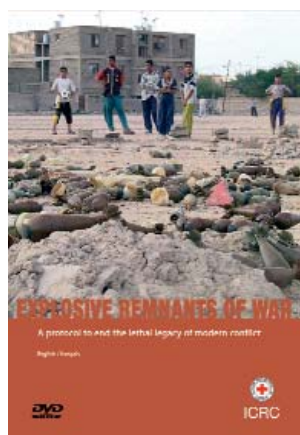
### Cluster Munitions

Cluster munitions have been a persistent problem for decades. These weapons have killed or injured tens of thousands of civilians in war-affected countries. In May 2008, more than 100 States adopted the Convention on Cluster Munitions, which prohibits the use, development, production, stockpiling and transfer of such munitions. It also requires States Parties to destroy their stockpiles, clear remnants, and assist victims. This DVD provides an overview of the cluster munitions problem, the main provisions of the Convention and the steps required to meet its commitments.



### Explosive remnants of war

The guns may stop firing and the soldiers return to base, but for many civilians the legacy of war will haunt them long after the conflict has ended. Millions of unexploded munitions in all shapes and sizes are left behind and all too often these Explosive Remnants of War (ERW) claim the lives or the limbs of innocent civilians. This film highlights the recent developments which have been made by the international community to reduce this suffering. It provides a detailed explanation of both the ERW issue and the new Protocol on Explosive Remnants of War adopted by States Parties to the Convention on Certain Conventional Weapons (CCW).



## **MISSION**

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.



ICRC