SPECIAL REPORT

Mine Action 2003

ICRC

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The Special Report Mine Action 2003 gives an overview of the ICRC's preventive activities relating to the problem of mines (promotion of adherence to and implementation of international legal norms; mine-action programmes) and mine-victim assistance (medical care and physical rehabilitation) carried out during the year. It fulfils the narrative-reporting requirements of donors who have contributed to the ICRC's five-year Special Appeal Mine Action launched in June 1999. Donors' financial-reporting requirements (statement of contributions and expenditure for the year 2003) will be met by a separate KPMG Auditors' report on supplementary information on the Special Appeal.

This year's report focuses on countries where there is a significant mine/ERW problem and substantial ICRC programmes of preventive action or victim assistance. A complete account of all of the ICRC's activities can be found in the ICRC Annual Report 2003.

The ICRC has issued a new Special Appeal for Mine Action 2004, covering one year and focusing exclusively on physical rehabilitation and mine-action programmes. Other areas of activity such as surgical assistance and the promotion of international legal norms are covered in 2004 by the ICRC's Emergency Appeals and Headquarters Appeal.

Front Cover: Explosive remnants of war (ERW) scattered over a football field in Iraq

TABLE OF CONTENTS

Executive Summary

In the five years covered by its Special Appeal Mine Action 1999-2003, the ICRC has:

- played a key role in efforts to achieve universalization and implementation of the Ottawa Convention banning anti-personnel mines
- initiated the development of a legal instrument to reduce the damage wrought by explosive remnants of war (ERW)[1] and was instrumental in the process leading up to its adoption in November 2003
- reduced mine risks in 27 countries by working with National Red Cross and Red Crescent Societies to implement mine-action programmes
- supported first-aid and surgical services for the war-wounded, enabling well over 4,000 mine/ERW victims to get the medical treatment they needed (870 in 2003)
- assisted rehabilitation services in areas affected by conflict around the world, providing nearly 48,000 mine victims with prostheses and physiotherapy (over 9,000 in 2003)

In combination with measures taken by governments and the work of other organizations, these activities have begun to contain the epidemic levels of landmine injuries, and have helped mine survivors lead fuller lives. Even so, mines and ERW continue to maim and kill thousands of people each year, and ending these losses, which are still staggering, will require a good deal more commitment on the part of governments and international and national organizations.

[1] In this report the term ERW (explosive remnants of war) is used to cover UXO (unexploded ordnance) and abandoned ordnance, excluding landmines.

Introduction

Tackling the problem of mines and ERW

Mines and ERW kill or injure thousands of people every year. Contaminating fields, pastures, roads and other key points, they slow the return of refugees and displaced people, block the delivery of humanitarian aid, limit trade and agricultural production, hamper reconstruction, and drain scarce medical resources in countries already devastated by conflict.

Since the late 1980s and early 1990s, when conflicts in Cambodia and Afghanistan brought the problem of mines/ERW into public view, mine action has expanded and developed considerably. Once landmines had been identified as a "global epidemic", efforts to develop legal instruments to reduce the risk they posed helped mobilize public and financial support for ground-level mine action to clear leftover explosive devices and help solve the problems they cause. Adopted in 1997, the Ottawa Convention prohibits the use, stockpiling, production and transfer of anti-personnel mines. Amended Protocol II of the Convention on Certain Conventional Weapons covers the anti-vehicle mines, which, though used in smaller numbers, have an enormous impact because they paralyse the transport of vital goods (trade or aid) and impede the movement of civilians, including refugees and IDPs.

By the end of 2003, development of clearance technology and methodology, better cooperation between governments, international organizations and other groups, and the process of developing and promoting respect for legal norms to address problems of humanitarian concern caused by mines/ERW had effectively reduced risks to civilians in many of the world's worst-affected countries. Attention previously directed towards landmines had broadened its scope to include other types of ERW which account for just as much death and injury, are as indiscriminate, but were not adequately covered by existing treaties: Protocol V of the CCW, which applies to unexploded ordnance (UXO) and abandoned ordnance was adopted late in 2003 to reduce the risks associated with these types of ERW.

The ICRC's role in mine action

For over 140 years, the ICRC has worked to protect and assist victims of war and internal conflict. Its worldwide field operations have for decades saved lives and/or improved the mobility of tens of thousands of mine/ERW survivors. At the same time, as part of its role as guardian of international humanitarian law, the ICRC has played a critical part in the development of international legal norms to address the problems caused by mines and ERW, encouraging adherence to and implementation of the Ottawa Convention and the relevant protocols of the Convention on Certain Conventional Weapons. In addition, ICRC mine-action programmes[2] have prevented injury and helped communities cope with problems caused by mine/ERW contamination.

The ICRC's dual role in assistance and preventive action, along with its extensive field operations in conflict-ridden areas and its position within the much larger International Red Cross and Red Crescent Movement have shaped the organization's unique capacity to confront the threat of landmines and ERW.

The International Red Cross and Red Crescent Movement and landmines

ICRC activities are often carried implemented in close cooperation with other partners from the International Red Cross and Red Crescent Movement. The Movement Strategy on Landmines was adopted in 1999 by the Council of Delegates[3] and extended both for another five years, and to cover ERW, in 2003. It spells out the respective roles of the ICRC, National Red Cross and Red Crescent Societies, and their International Federation in mine action. Numerous National Red Cross and Red Crescent Societies are actively engaged in activities benefiting mine/ERW victims, either by running their own programmes, engaging in bilateral projects, taking on projects delegated by the ICRC, or contributing financial, material or human resources to ICRC-run programmes. National Societies also play an important role in efforts to promote ratification and implementation of the Ottawa Convention and mine-action programmes.

[2] ICRC Mine Action Programmes are field-based activities that include: victim data gathering for mine action planning and prioritization; mine awareness; community-based risk reduction activities; the identification of contaminated areas and their prioritization for clearance.

[3] The Council of Delegates constitutes the assembly of the representatives of the ICRC, the International Federation and the National Societies of the Red Cross and Red Crescent. It meets every two years and is often asked to give an opinion on policy and subjects of common interest to all components of the International Movement of the Red Cross and Red Crescent.

ICRC mine action 1999-2003: results

The ICRC's Special Mine Action Appeal 1999-2003 funded many different elements of the organization's multidisciplinary approach to mine action. These included: surgical and physical rehabilitation programmes; ICRC/National Society mine-action programmes; and the promotion of humanitarian treaties relating to mines/ERW. These activities formed an integral part of ICRC's field and headquarters budgets. In addition, the Special Appeal contributed to the budget of the Special Fund for the Disabled (SFD)[4], which is separate from that of the ICRC.

Between 1999 and 2003:

- some 48,000 mine-injured amputees received artificial limbs from ICRC-supported physical rehabilitation centres; thousands more received prostheses from centres assisted by the Special Fund for the Disabled
- well over 4,000 people injured by mines received inpatient treatment in ICRC-supported hospitals; first-aid services in conflict zones, often run by National Societies, were set up or strengthened by the provision of ICRC materials, training or financial support, improving mine victims' chances of surviving until they reached the hospitals
- risks to mine-affected communities were reduced in over 25 countries as ICRC/National Society mine-action programmes were set up or strengthened
- significant progress was made toward the universalization and implementation of the Ottawa Convention, and a new protocol to the CCW was adopted to reduce the dangers posed by ERW

[4] see page 12

ERW: a longstanding problem keeps growing

Explosive remnants of war (ERW) are the unexploded or abandoned munitions that remain once an armed conflict has ended. They can include artillery and mortar shells, grenades, cluster bombs and other submunitions, rockets, missiles, and similar devices. Most have already been fired, but have failed to detonate. Others, like munitions stockpiles abandoned near battlefield positions, have never been used but have tragic consequences for civilians: visible above ground and sometimes brightly colored, they are used widely for fuel, scrap metal or mistaken as toys.

Like mines, ERW may take years to clear, and for years after the fighting has ended they kill and handicap civilians and slow post-war reconstruction and recovery. The injuries they cause are similar to those caused by mines, and require the same kind of costly, complicated and long-term health services—services that most post-conflict countries can ill afford.

The problem of ERW is not a new one: some countries in Europe are still clearing ERW from World War I. In Poland, some 10,000 people are estimated to have been killed or injured by ERW since the second world war. Much ERW was left behind in the wars in South-east Asia from the 50's to the 70's, as well: in Laos, cluster munitions are the main problem and estimated to have killed or injured approximately 11,000 people since 1974.

The threat from ERW has grown steadily in the past 40 years, mainly as a result of the proliferation of cluster munitions, weapons with sensitive fusing and a high failure rate. Over 80 countries are now estimated to be affected by ERW. In recent conflicts in Iraq and Kosovo, cluster munitions accounted for more casualties than mines, and in Afghanistan, ERW pose a risk to civilians as serious as the heavy landmine contamination. Other seriously affected areas include Angola, Bosnia and Herzegovina, Cambodia, Laos, the Russian Federation (Chechnya), and Chad.

Cluster munitions saturate a large target area with multiple bomblets. These bomblets are generally designed to disable armoured vehicles and at the same time to kill people within a wide radius. A high failure rate leaves many bomblets unexploded. Some penetrate the ground, later exploding when hit by a farmer ploughing his fields; others stay above ground, sometimes attracting children by the bright colors or interesting shapes that make them look like toys. Very durable, the bomblets remain lethal for years: in Laos, they have killed or injured 11,000 people since the Indochina conflict ended in the 70's.

New Protocol to address the problem of ERW

The Protocol on Explosive Remnants of War was adopted on 28 November 2003, as the fifth protocol annexed to the Convention on Certain Conventional Weapons (CCW). The Protocol seeks to address the problems caused by unexploded and abandoned ordnance other than the landmines, booby traps, and similar devices covered by the Ottawa Convention or the amended Protocol II of the CCW. States party to the CCW, which include all of the major powers, adopted the new protocol by consensus. It requires each party to an armed conflict to:

- mark and clear ERW in territory they control after a conflict
- provide technical, material and financial assistance to facilitate the removal of ERW that result from its operations and which are located in areas it does not control
- take all feasible precautions to protect civilians from the effects of ERW
- record information on the explosive ordnance employed by its armed forces during a conflict and, after the end of active hostilities, share that information with the other parties to the conflict and organizations engaged in ERW clearance or programs to warn civilians of the dangers of these devices

I. Mine injuries and assistance

Mines and ERW accidents cause a great deal of pain, loss, and social and psychological problems for survivors and their families. In addition, treating the injuries often creates a heavy burden for health-care systems that have been disrupted by conflict. With buildings looted or destroyed, electricity, water, and sewage systems damaged, supply lines or patient access blocked, and facilities deprived of resources by the collapse of economies and governments, health care systems in areas of conflict often struggle to provide even the most basic care. Hospital staff are often left to work for months without pay, or even forced to flee. Once conflict has ended overcoming these setbacks takes most health systems years; mine/ERW injuries may even increase after the fighting has stopped and keep occuring for years. Without outside help, health systems often find it difficult to provide the complicated and costly surgery and rehabilitation that mine/ERW victims need.

Mines cause three patterns of injury. A buried mine can tear off the foot or leg of a person stepping on it. A fragmentation mine, detonated by a trip wire, can leave injuries over many parts of the body. When handled, mines and ERW blow off fingers, hands, arms, or parts of the face; they can also blind their victims or cause injuries to the chest or abdomen.

People injured by mines often require immediate and extensive medical care. This includes evacuation, first aid, transport, surgical treatment, and rehabilitation. Appropriate first aid and timely transfer to a hospital save lives. Prostheses and/or orthoses can help those who remain disabled to recover their mobility, but leave them with a lifelong need for the regular repair and replacement of their appliances. Their psychological trauma and loss of self-image may ease with time, but the disabled depend on vocational training, family and community support, and useful employment to recover their productivity. Each of these services is a link in a chain of care whose outcome depends on the strength of all the other links.

ICRC medical and rehabilitation assistance is not aimed exclusively at mine victims. Instead it seeks to strengthen the overall health services that they and all other war-wounded depend upon, in a sustainable way.

A. Medical care

Pre-hospital care: evacuation, first aid and transport

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

Explosive remnants of war (ERW) in Iraq

Good first aid saves lives: its prompt and appropriate application is the most effective way to prevent complications, disability, or death. Inappropriate first aid, on the other hand, can make injuries worse. Tourniquets, devices for stopping the flow of blood through an artery, are still used far too often in many parts of the world. Applied too high on a limb or left on for too long, they may necessitate the amputation of the entire limb or lead to kidney failure.

First-aid training provides the skills to respond appropriately in the crucial period following a mine/ERW incident

In many countries, first-aid volunteers from National Red Cross or Red Crescent Societies are involved in the management and transfer of the war-wounded, and often provide training for military stretcher-bearers. As part of efforts to help over 80 National Societies enhance their ability to respond to conflict, the ICRC helps support National Society first-aid activities in over 80 countries. Its financial, technical, or material assistance helps National Socieites set up or maintain first-aid training, ambulance services, and other transport and evacuation. In countries where there is conflict, these activities focus on the areas of conflict. When needed, delegations also directly distribute dressing materials and other supplies and equipment directly to first-aid posts treating the wounded before they reach the hospitals where they can get surgery, and assist primary health care facilities in areas where situations generated by conflict compromise their function. This support helps maintain life-saving first-aid services in many of the areas where mine/ERW injuries occur most often.

In 2003, the vast majority of ICRC support to first-aid services was given in the form of support to the National Societies who implemented the activities. These are not reflected in ICRC statistics. The number of first-aid posts supported directly was reduced as posts supported in Afghanistan and other areas were closed. Primary-health-centre support remained stable overall, providing about 10% more consultations than in the previous year.

ICRC support to first-aid posts and primary health care, 2003

- first-aid posts regularly supported: 8
- war-wounded receiving first aid in posts supported: 303
- primary health-care (PHC) facilities supported: 305
- consultations given in PHC facilities: 2.4 million

Hospital care

Mine/ERW injuries require skilled surgery: the surgeon must remove dead and contaminated tissue and any foreign materials that have been driven into the wound, and often must amputate severely damaged limbs. Effective care uses large amounts of blood for transfusion, antibiotics and other drugs, and dressing materials; it requires prolonged hospitalization, and support services (such as radiology, laboratory), and takes up a great deal of nursing time and other resources. Surgery and hospital care for those injured by mines and ERW require techniques and procedures that surgeons in civilian practice are often not familiar with. If the surgery is performed incorrectly more surgery may be required or rehabilitation could be less effective, and if good techniques are not applied throughout the surgery and post-operative care, patients can die unnecessarily, or become more severely handicapped.

It was the absence of adequate care and treatment for the war-wounded that prompted the founding of the ICRC in 1864. Providing surgical care for war-wounded civilians and combatants has traditionally been one of ICRC's main activities. Over the past two decades, ICRC-run hospitals have treated tens of thousands people wounded in conflicts, and offered protection and assistance to hundreds of other hospitals in the world's conflict zones, sometimes enabling them to stay open when the breakdown of lines of supply and staff security, and other problems would otherwise have forced them to close.

The ICRC currently provides direct assistance to hospitals and surgical facilities that care for the wounded in all of the worlds' most conflict-affected areas. This assistance includes: the repair and renovation of infrastructure, and water and sanitation facilities; the supply of equipment, medicines and other consumable surgical items; incentives that enable doctors, nurses, and other hospital staff to stay on the job; training, particularly in surgical care for the wounded; and reinforcement of support services such as blood banks and radiographic services.

All of ICRC assistance, of course, requires that local health staff be present to provide services. When there is no staff available locally, the ICRC sends expatriate hospital teams to provide the care needed. In 2003, nine ICRC hospital teams worked in Afghanistan, Kenya (Lokichokio); Liberia (Monrovia), Sudan (Juba), and Somalia. Furthermore, ICRC staff shared their expertise in management and patient care with hospitals in conflict zones around the world.

In some cases ICRC hospital support is run in partnership with National Societies, who manage, staff, and fund programmes that are implemented within the framework of ICRC operations.

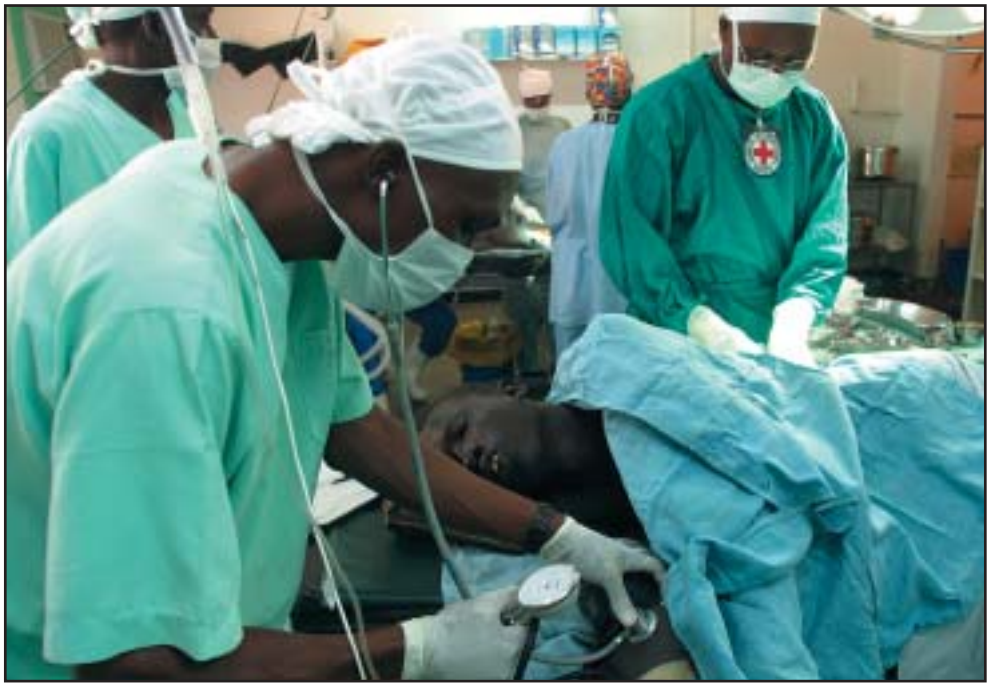
In 2003, ICRC hospital support continued without large programme changes, and overall the number of war-wounded that it treated remained stable. The rate of mine injuries that they treated, however, dropped by about half. There are no changes in ICRC assistance programmes that have been identified to account for this drop.

ICRC hospital support, 2003
- hospitals supported: 67 (in 18 countries)
- war-wounded treated: more than 15,900
- operations performed: more than 88,800
- outpatient consultations given in supported hospitals: more than 556,000
- mine/ERW victims treated: some 870

Training

Through its worldwide activities, the ICRC has accumulated much experience in the treatment of the war-wounded. Through seminars and on-the-job training, the ICRC shares this expertise with surgeons, nurses, and other health professionals caring for the war-wounded. It gives in-house training and organizes regional, national, and international courses, seminars, and conferences, as well as developing educational materials.

In 2003, the ICRC offered seminars in Geneva on war-surgery and hospital management, which were attended by over 35 health-care professionals from around the world. The ICRC also organized seminars on different aspects of the treatment of war-wounded in six countries: Guinea, Indonesia, Israel, the Occupied Territories and the Autonomous Territories, Nepal, the Russian Federation (Moscow and northern Caucasus), and Sri Lanka. These seminars included training on the treatment of mine injuries.

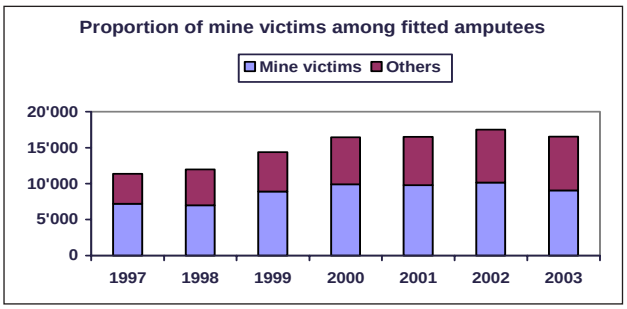


Treating mine injuries requires surgical expertise and skilled nursing care

B. Physical rehabilitation

In 25 years of assistance to rehabilitation programmes, the ICRC has provided over 315,000 prostheses and orthoses, helped over 188,000 amputees and other disabled people be more active at homes, at work and in their communities. Its support has made vital contribution to establishing, maintaining and enhancing the quality and efficiency of rehabilitation services in most of the worlds' most mine-affected areas.

Between 1999 and 2003, mine victims received 48,000 prostheses from ICRC-supported rehabilitation centres-they account for 60% of the total number of amputees the centres serve.



ICRC support enables physical rehabilitation centres to provide prostheses (devices to replace a missing limb), orthoses (devices to support a malfunctioning limb), other orthopaedic appliances (such as wheelchairs and crutches), and physiotherapy not only to amputees, but also to people who have been disabled by other causes. With the aim of providing sustainable, free-of-charge rehabilitation services to all those who cannot afford them, the ICRC helps centres finance investment and running costs for imported materials and equipment, and gives technical assistance for the development of patient guidelines, staff training, and the introduction of suitable technology in order to improve the quality of prostheses produced and the technical services provided.

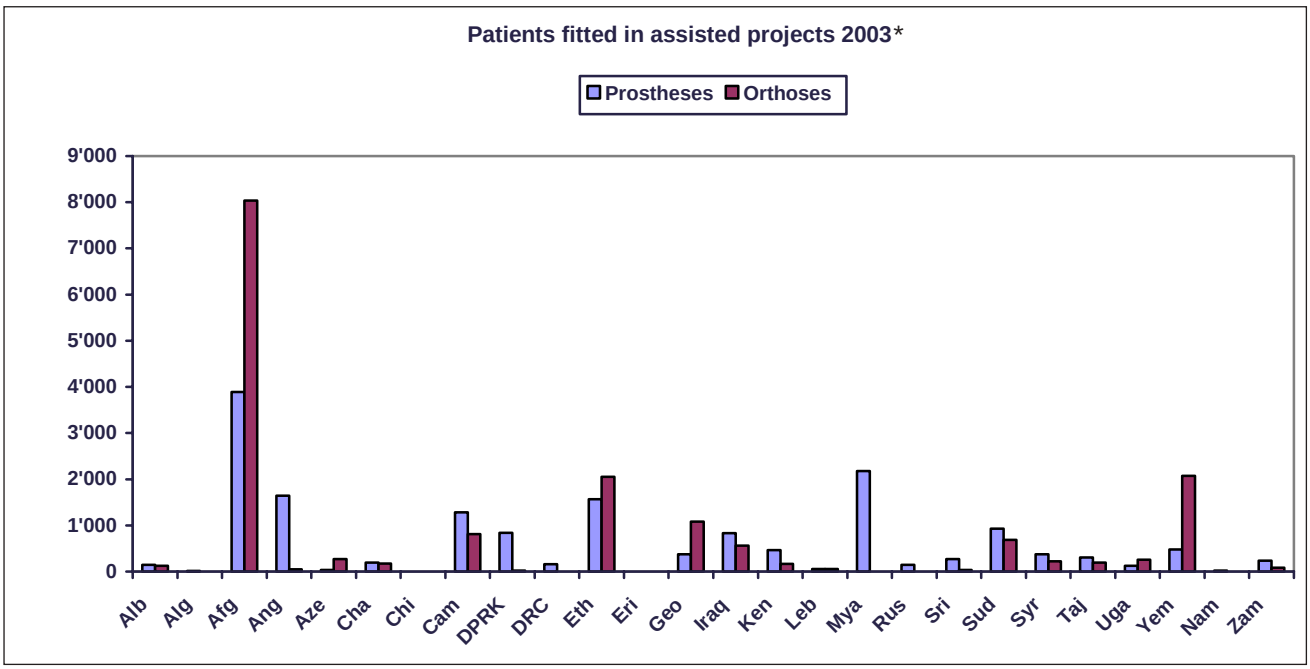
Because physical rehabilitation is usually part of the national health system, most (75%) of the rehabilitation projects that the ICRC has supported have been run in close cooperation with government ministries. In other cases, projects have been run either with National Societies (9%), or NGOs (8%). When the ICRC has been unable to find a suitable local partner, it has run the centres itself.

Technology
Taking into account both the needs of amputees and the difficulty of sustaining services in countries where health-care resources are limited, the ICRC has developed a special polypropylene prosthetic technology that balances the needs for prosthesis comfort with durability, affordability and accessibility of materials. The technology used, and the skill of the staff producing and fitting it, determine the comfort and durability of an appliance. These not only affect how much the disabled person can work or contribute to family and community activities, but by influencing how often repairs and replacements are needed, they also affect the long-term costs of maintaining services. While the ICRC provides the centres it supports with the training and materials needed to adopt polypropylene technology, some use other technologies alongside it.

Training
The ICRC's training policy is based on the organization's extensive experience and on internationally recognized guidelines developed by the International Society for Prosthetics and Orthotics (ISPO) and WHO. It aims to have some of the staff members in each facility practising at an internationally recognized level. Training ranges from basic knowledge to advanced education, and is provided on the job or during refresher courses, upgrading programmes, and formal training. When possible, the ICRC sends staff to nationally or internationally recognized schools of prosthetics and orthotics; when this is not possible, the ICRC uses its own training package which it has developed in consultation with the ISPO. Students continue to work and earn while they are being trained.

Accessibility of care
Often, rehabilitation facilities are located in capital cities far from the areas where mine injuries occur; travel to the centres may therefore be too expensive or risky for most of those needing their services. Whether by helping to decentralize the system, or by finding solutions to facilitate transport to, and lodging at, the centres, or by making field trips to ensure follow-up in remote areas (in some cases in cooperation with National Societies), the ICRC works to make sure that rehabilitation services reach those living in the areas affected by conflict where most amputees and other disabled people live. These areas are usually the areas most affected by mines and ERW.

Sustainability
The issue of sustainability is an important one for physical rehabilitation services: adult amputees need prostheses replaced every three to five years, and children need them replaced every six to 12 months.



* For exact figures, see Annex II, Rehabilitation production figures.

A child injured at the age of 10 years, with a life expectancy of another 40 to 50 years, will need some 25 appliances during his or her lifetime, all fitted individually by a skilled technician. The health-care systems in war-torn countries have often been disrupted and impoverished. Saddled with huge health problems, the treatment of which often takes priority over the need for physical rehabilitation, health services seldom have the human or financial resources to take over rehabilitation services at the point when the country has stabilized and the ICRC's mandate to maintain its operations there -- linked to the situation of conflict -- has ended.

In spite of its use of a practical technology, its reliance on local partners, and its emphasis on strengthening their capacities, the ICRC's local partners often still need support to be able to maintain the provision of costly rehabilitation services. For this reason, the ICRC set up the Special Fund for the Disabled to provide the support that the centres still need until they can be run without external support.

The Special Fund for the Disabled was set up to help support ICRC-supported centres maintain their services after ICRC operations had ended in the country.

Physical rehabilitation activities 1999-2003

- supplied: over 81,000 prostheses (nearly 48,000 for mine victims); some 5,400 wheelchairs; some 93,000 pairs of crutches

Comfortable, light and well-fitted prostheses allow amputees to be more active and ease their social reintegration

Physical rehabilitation services in 2003
The 68 centres that the ICRC supported included six centres in Afghanistan (2,800 mine victims), three in Angola (over 1,200 mine victims), two in Cambodia (nearly 2,000 mine victims), eight in Iraq (over 400 mine victims), and six in Myanmar (over 1,500 mine victims). Only the centres in Afghanistan and Lokichokio, Kenya, (serving amputees from Somalia) were run by the ICRC itself.

The ICRC started or resumed assistance to 13 projects in 2003; they were located in Chad, China, the Democratic Republic of the Congo, Eritrea, Lebanon, the Russian Federation, Syria, Sudan, Yemen, and Zambia. The project in China, run in Yunan province with the Chinese Red Cross Society, was set up to provide rehabilitation services for people disabled in the Chinese-Vietnamese conflict in the 1970s. In Zambia, the ICRC began working with the physical rehabilitation centre of the University Teaching Hospital in order to ensure that rehabilitation services were available for disabled Angolans living in refugee camps in the west of the country. In Azerbaijan, the ICRC helped decentralize rehabilitation services by offering support to a project in Nakhichevan. The ICRC took over projects in Chad and Syria from the Special Fund For the Disabled. The ICRC's support to centres in Rundu (Namibia), Keren and Asmara (Eritrea), Freetown (Sierra Leone), Tirana (Albania) and Jaffna (Sri Lanka) was phased out during the year.

The ICRC rehabilitation programme supported more projects in 2003 than ever before. Its production of prostheses remained stable, while orthosis production went up by more than a quarter. First-time patients received 40% of the prostheses and 50% of the orthoses it provided.

While most projects still required the full-time presence of expatriate staff, a growing number had achieved more technical autonomy and only required periodic visits providing technical assistance. In 2003, the ICRC sponsored 24 students (from Angola, China, Ethiopia, Myanmar, Sudan, and Uganda) attending formal training programmes recognized by the ISPO. It also offered seven short training programmes - of two to eight weeks -- in physiotherapy for staff members of projects in Afghanistan, Angola, Myanmar, Sudan, and Tajikistan.
Physical rehabilitation assistance, 2003
- delivered: 16, 537 prostheses; 16,804 orthoses
- distributed: 1,606 wheelchairs; 15,843 pairs of crutches
- total projects: 68 (in 25 countries)
- new projects:13
- ·projects completed: 6
- expatriate specialists employed: 50
- mine victims assisted: 9,152

In 2003, ICRC-supported rehabilitation centres provided prostheses or orthoses to over 9,000 mine victims.

Challenges
The ICRC has helped improve the mobility of of thousands of disabled people; through its choice of technology, development of care guidelines, and extensive training activities it has strengthened the technical autonomy of rehabilitation services in conflict areas around the world. Holding on to these gains, however, is still a challenge. More than three quarters of the centres supported by the ICRC over the past 25 years still require external support in order to maintain the production and quality of services needed by the mine/ERW victims and other disabled patients that they serve.

It will take a firm financial commitment on the part of host countries, assisted by international donors, before health systems of the areas worst affected by mines and ERW are able to assume full responsibility for maintaining the services needed.

The Special Fund for the Disabled
Working out of regional centres in Addis Ababa (Ethiopia), Managua (Nicaragua), and Ho Chi Minh City (Vietnam), the Special Fund for the Disabled (SFD) provides technical training and material and financial assistance to centres formerly supported by the ICRC, helping them stay open and continue producing the volume and quality of devices needed. It also assists centres in other developing countries, helping them adopt the ICRC's prosthetic/orthotic technology. In its centre in Addis Ababa, a one-month training course in this technology is organized 10 times a year for technicians from the projects assisted. In Asia, the SFD organizes a similar programme in Ho Chi Minh City.

The SFD is not funded from the ICRC budget. It was created in 1983 in response to Resolution XXVII of the International Red Cross and Red Crescent Conference. In 2000, the SFD became an independent foundation and opened its board to members outside of the ICRC. It entered the Geneva Trade Register as a new non-profit organization in 2001.

In 2003, the SFD budget grew, permitting it to put greater emphasis on quality control and management in the centres it assisted. Two new projects were initiated at prosthetic and orthotic schools in Marrakech (Morocco) and Lomé (Togo). The SFD also continued its training courses in the centres in Addis Ababa and Ho Chi Minh City, and sponsored the participation of prosthetic/orthotic technicians in training programmes.

In 2003, the SFD:
- assisted: 35 projects in 16 countries
- delivered: over 6,500 prostheses to amputees

In 2003 an estimated 2,000 mine-victims received prostheses from the SFD. Most were from Vietnam and Nicaragua. They account for some 30-40% of all the amputees assisted.

II. Preventive Action

ICRC preventive action refers to activities aimed at reducing, and ultimately eliminating, civilian injuries from landmines and other explosive remnants of war (ERW). Preventive action includes promoting adherence to and implementation of the relevant international standards (the Ottawa Convention and the Convention on Certain Conventional Weapons and its Protocols), raising awareness about the dangers of mines/ERW in affected communities to encourage a change in behaviour, and making representations to the authorities in order to protect civilians at risk.

A. Promoting international legal norms

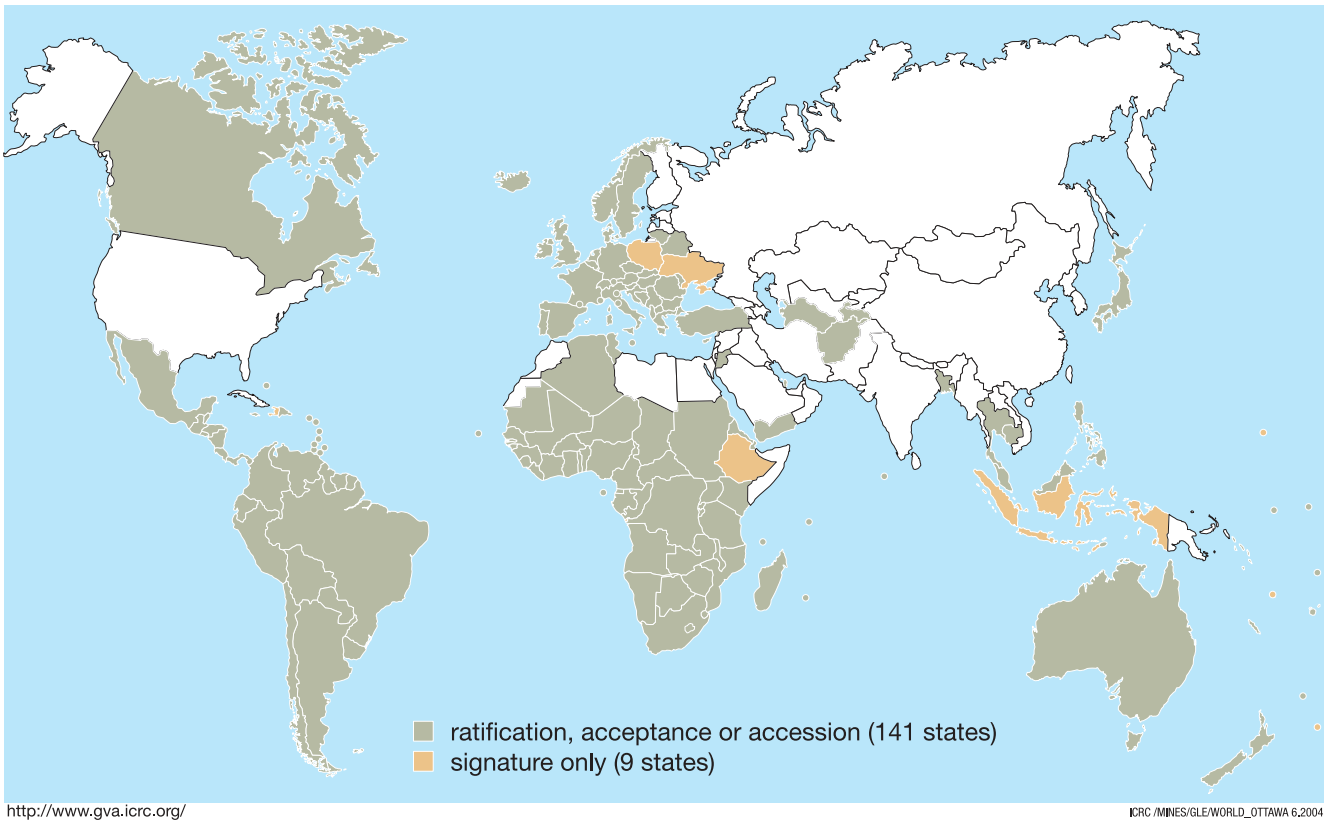
In its role as guardian and promoter of international humanitarian law (IHL), the ICRC has a mandate and responsibility to promote the development of, universal adherence to, and full implementation of IHL, including conventions prohibiting or limiting the use of landmines and other weapons. Through its headquarters in Geneva and its delegations in countries around the world, the ICRC actively promotes these rules in meetings of international and regional organizations, of the States Parties to the relevant treaties, and of national agencies and authorities. The ICRC is also working with governments and military authorities to ensure full implementation of the treaties.

Ottawa Convention: progress towards universalization and implementation

Since its adoption, there has been impressive progress toward universalizing and implementing the Ottawa Convention. The momentum continued in 2003 as East Timor, Lithuania, Belarus, Burundi, Serbia & Montenegro, Sudan, Greece and Turkey adhered to the treaty. By the end of the year:

- most of the approximately 50 States Parties known to be affected by mines have started mine-clearance activities
- use, production and trade in anti-personnel mines had fallen dramatically
- over 31 million anti-personnel mines had been destroyed
- 36 States Parties to the Ottawa Convention had enacted legislation to enforce the treaty

OTTAWA TREATY: signatures, ratifications / accessions as at 31 December 2003



- States Parties had mobilized 1.1 billion US dollars for mine action
- 141 governments (close to three quarters of the countries in the world, including most of those worst mine-affected) had adhered to the Ottawa Convention prohibiting anti-personnel mines

Throughout 2003, the ICRC continued to play a lead role in promoting adherence to and full implementation of the Ottawa Convention banning antipersonnel landmines. It reminded States Parties (both mine-affected and donor) of the importance of sustaining and even increasing commitments to mine action in order to ensure that mine clearance deadlines, (which fall in 2009[5] for many mine-affected States) will be met. The ICRC continued to urge mine-affected States Parties to develop national programmes and to assess and make known their resource requirements for mine clearance and victim assistance -- at the latest by the First Review Conference of the Ottawa Convention at the end of 2004. The ICRC also continued to urge States Parties to pay greater attention to the needs of mine victims, to promote the faithful implementation of the Convention's key provisions, and to encourage adoption of national legislation.

Meetings of States Parties to the Ottawa Convention

The ICRC actively participated in: the Fifth Meeting of the States Parties to the Ottawa Convention, held in Bangkok in September 2003; the biannual inter-sessional meetings of the four Standing Committees (dealing respectively with victim assistance, mine clearance, stockpile destruction, and the general status and operation of the treaty); informal contact groups on universalization, resource mobilization and reporting; as well as in discussions on preparations for the Convention's First Review Conference, to be held at the end of 2004.

Promoting Amended Protocol II to the CCW

In all its efforts, the ICRC also continued to encourage adherence to Amended Protocol II of the Convention on Certain Conventional Weapons (CCW). Even with the entry into force and widespread adherence to the Ottawa Convention banning anti-personnel mines, Amended Protocol II remains an important instrument, as it regulates anti-vehicle mines, booby traps, and other similar devices not covered by the Ottawa Convention, but which can have just as indiscriminate and devastating effects. The ICRC continued throughout 2003 to actively participate in formal and informal meetings of States Parties to the CCW discussing measures to reduce the risk of civilian death or injury as a result of anti-vehicle mines.

Adoption of a new protocol to address threats of ERW

In December 2002, the States Parties to the CCW approved the recommendation of a group of government experts that a new instrument on ERW be negotiated, heeding the ICRC's call of two years earlier for new rules to address the ERW problem. The ICRC actively participated in the negotiations and submitted a number of working papers, including a detailed commentary on the draft instrument under consideration. The negotiations ended successfully in November 2003 with the adoption of the Protocol on Explosive Remnants of War by the States Parties to the CCW. The protocol aims to reduce the human casualties and socio-economic impact of these weapons, notably through: the clearance of ERW; information-sharing between clearance organizations, organizations conducting mine/ERW risk education, and humanitarian organizations; and other measures to protect civilians from the effects of ERW. The ICRC hailed the adoption of the protocol as an important step towards addressing the global ERW problem.

28th International Conference of the Red Cross and Red Crescent

The International Conference of the Red Cross and Red Crescent meets every four years and brings together the States Parties to the 1949 Geneva Conventions (virtually all of the world's countries) and the Red Cross and Red Crescent Movement, which consists of National Red Cross and Red Crescent Societies, the International Federation of Red Cross and Red Crescent Societies, and the ICRC. The 28th Conference met in Geneva in December 2003, and adopted an Agenda for Humanitarian Action which included two final goals regarding anti-personnel mines and the CCW respectively. The first (Final Goal 2.1) called for global mine-action efforts to be increased and the eventual elimination of all anti-personnel mines to be pursued, with the aim of ending the suffering caused by these weapons. The second (Final Goal 2.2) called for increased adherence to the CCW, its Protocols, and the amendment extending its scope of application to non-international armed conflicts. The ICRC and many National Red Cross and

[5] Pursuant to Article 5 of the Ottawa Convention, a State Party that has mined areas under its jurisdiction or control is required to clear them of mines within 10 years of entry into force of the treaty for that State Party. The mine clearance deadlines of many mine-affected States Parties, for whom the treaty entered into force in 1999, therefore fall in 2009.

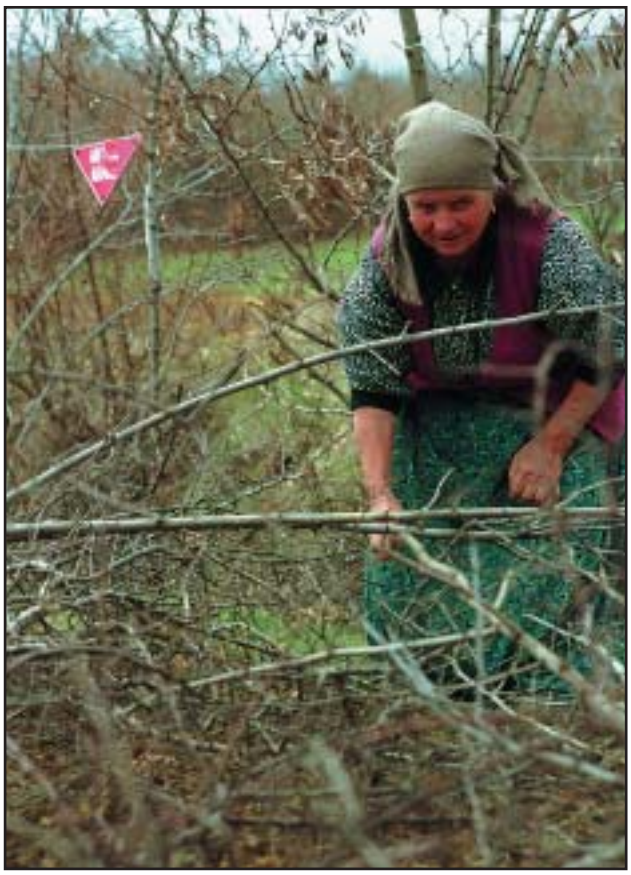
Red Crescent Societies actively supported the inclusion of these commitments in the Agenda for Humanitarian Action.

Legal advice and support
In 2003, the ICRC continued to provide legal advice and support to States on ratification procedures and the drafting, adoption and amendment of national legislation to implement international humanitarian law treaties, including the Ottawa Convention and the CCW. With regard to the Ottawa Convention in particular, the ICRC's Information Kit on the development of national legislation to implement the Convention on the Prohibition of Anti-personnel Mines, and its model legislation for common-law States continued to serve as a useful tools for States Parties in the development of their implementing legislation as required by Article 9 of the treaty.

Encouraging reflection within armed forces
Through its IHL dissemination and training programmes for armed forces and others bearing weapons around the world, the ICRC promoted better understanding of the international standards relating to landmines and ERW. In particular, it continued to encourage reflection on the limited military utility of anti-personnel mines as compared to their high human costs, on the basis of the study, Anti-personnel Landmines: Friend or Foe?, commissioned by the ICRC in 1996.

National and regional events
In 2003, the ICRC organized or supported -- including through the participation of its representatives as expert speakers and the provision of its specialized publications -- the following meetings:

- conference on the Ottawa Convention for national authorities in Ukraine, co-organized by the UNDP, the ICRC, and the government of Ukraine, held in Kyiv
- workshop on the implementation of the Ottawa Convention in the Republic of the Congo and the Democratic Republic of the Congo, for national authorities of both States, organized by the governments of the Republic of Congo and Canada, held in Brazzaville
- workshop on the Ottawa Convention, in the context of the third ICRC Southern African Regional Seminar on IHL, for government representatives of the region, organized by the ICRC, in Pretoria
- regional seminar on mine action in the Americas, organized by the Organization of American States and the governments of Peru and Canada, held in Lima
- national workshop on the implementation of the Ottawa Convention in Belarus, organized by the government of Belarus and the International Campaign to Ban Landmines (ICBL), held in Minsk
- meeting on ERW and development organized by Pax Christi Ireland and hosted by the government of Ireland



Despite knowing about the dangers posed by mines, economic necessity often leaves villagers with little choice but to take risks.

Other activities aimed at promoting the Ottawa Convention and the CCW

In addition, in 2003 the ICRC:

- published a brochure entitled Explosive Remnants of War: the lethal legacy of modern armed conflict, which gives an overview of the human and socio-economic costs of ERW
- distributed a wide variety of documentation and videos on the Ottawa Convention and the CCW, including a booklet published in 2002 containing the full text of the CCW, incorporating the latest amendments and Protocols, in all UN languages
- sponsored travelling exhibitions (in English and Arabic) on the Ottawa Convention, and worked with National Red Cross and Red Crescent Societies to organize such exhibitions, including in Ukraine and Poland

- gave technical or financial support to a variety of activities organized by National Societies (including those of Spain and Poland) to raise awareness of the devastating human costs of anti-personnel landmines

B. Mine/ERW action programmes

The challenge: knowing is not enough

To support themselves or their families in economies disrupted by war, civilians often have no choice but to collect water and firewood, carry out farming or graze livestock in areas they know are contaminated with mines and other explosive remnants of war (ERW). Accident data have consistently shown that victims were often aware of the risks they were taking when injured, but for economic reasons or for basic survival, they felt there was no alternative. In these circumstances, simply telling people about the dangers of mines and other ERW, or the location of dangerous areas is not enough. The challenge is to reduce the risks they face through the provision of interim alternatives such as safe water or fuel sources, to modify the behaviour of those who do have a choice and, ultimately, to ensure that effective and appropriate clearance takes place. Although the ICRC does not directly engage in clearance activities, it works closely with national authorities, UN mine-action centres and mine-action NGOs, using its community-based approach to ensure that effective and timely clearance takes place.

The concept

In the mid-nineties, the ICRC began to support mine-awareness activities, usually in close cooperation with the National Societies of the countries involved. Because National Red Cross and Red Crescent Societies are rooted in their communities through their branch and volunteer networks, the ICRC considers them as strategic partners in mine action. Since this time, in close cooperation with partner National Societies, it has gradually refined its strategy so as to focus better on the specific needs of populations at risk and therefore increase the impact of mine/ERW-action programmes. Aimed at addressing the threat from mines and explosive remnants of war more effectively, these programmes are currently based on three main principles:

- victim data gathering: gathering accurate information in order to identify vulnerable groups and determine where mine action is needed most
- community involvement: involving mine-contaminated communities in the development of appropriate solutions involving a combination of raising awareness of risks, short-term risk-reduction measures (e.g. marking, or safe play areas), and defining and prioritizing clearance activities
- cooperation with other actors: including governments or other organizations involved in mine action, or those working in other sectors such as water, shelter, food, or health

Information collection

In order to develop an effective programme, it is first necessary to accurately identify the groups at risk. To do this, whenever possible, the ICRC first carries out an assessment of needs, usually with the National Society, taking into account victim data, information on dangerous areas, and the way in which contamination affects communities. The level of community knowledge, attitudes about mines and other ERW, and actual behaviour are also assessed. This enables the ICRC and the partner National Society to determine the profiles of victims, the locations and circumstances of accidents, and the types of behaviour that caused the accidents, and use this information to tailor a mine-action strategy to the local situation. If carried out on a national scale (such as in Afghanistan) the data, which is analysed and shared with others, supports the development of coordinated and targeted humanitarian assistance, victim assistance, clearance, and awareness activities. Along with the United Nations and other organizations involved in mine action, the ICRC and National Societies use the IMSMA (Information Management System for Mine Action) mine-incident and -accident forms, to ensure that data collected from different sources, by different organizations, can be centrally collated and analysed. Within the mine-action community, the ICRC and National Societies are increasingly taking on the key role of data-gathering, most notably in Afghanistan, Bosnia and Herzegovina, and Chechnya.

Community involvement

Any mine/ERW-action activities that take place are community-based, involving those at risk in identifying the problem and possible solutions, customized to each community's situation. The decision on how best to implement a programme will depend on the threat, and on cultural and social influences, and will always be specifically targeted to the most vulnerable groups.

In the West Bank town of Jenin, for example, where children were playing over rubble that was infested with unexploded devices, the establishment of a safe play area provided them a safe alternative. ICRC/National Society mine-action programmes have also established safe play areas in Nagorny Karabakh and Kyrgyzstan.

Other solutions include community mapping and the establishment of uncontaminated areas for grazing livestock or collecting wood. Until clearance has freed enough fields, forests, pastures, and water sources from mine/ERW contamination, short term solutions like the provision of fuel, clean water, or food are needed to fill the gap.

Cooperation with other actors

If they are to be effective in reducing risks of accidents, these activities must be carried out in close cooperation with governments, organizations involved in clearance, and others. In Afghanistan and Angola the ICRC made agreements with clearance NGOs, ensuring that the information and other input that they give lead to more timely and effective clearance.

Mine/ERW action in 2003

In 2003, the ICRC conducted mine/ERW-action activities directly or through the National Red Cross or Red Crescent Societies in 25 countries around the world, starting new programmes in India, Iran and Jordan.

ICRC and National Society mine/ERW-action activities, 2003

Country or region	Data collection	Mine-awareness activities
Afghanistan	x	x
Albania	x	x
Angola		x
Armenia and Azerbaijan	x	x
Bosnia and Herzegovina	x	x
Cambodia	x	x
Croatia		x
Ethiopia		x
Eritrea	x	
India		x
Iran		x
Iraq	x	x
Israel, the Occupied Territories and the Autonomous Territories)	x	x
Jordan		x
Kosovo	x	
Kyrgyz Republic	x	x
Lebanon		x
Former Yugoslav Republic of Macedonia	x	x
Namibia	x	
Nagorny Karabakh		x
Nicaragua		x
Peru		x
Russian Federation (including Chechnya and Daghestan)	x	x
Southern Serbia	x	x
Tajikistan	x	x

III. Assistance and preventive mine/ERW action by country

AFRICA

ANGOLA

As a result of almost 30 years of conflict, countless mines and other explosive remnants of war (ERW) are scattered throughout Angola, making it probably the most mine-affected country in Africa. Mines/ERW contaminate at least 15 of its 18 provinces and over 3,000 people are known to have been victims of mine/ERW incidents since 1996.

Following the ceasefire in April 2002, huge numbers of refugees and IDPs returned home or resettled. Official statistics from the mine-action database of the National Institute for Demining (INAD) indicate 93 mine/ERW-related casualties in 2003. However, weaknesses in the national data-collection system probably resulted in underreporting; the ICRC estimates that the number of mine/ERW casualties during the year was closer to 300.

Others at risk include residents in rural areas seeking to farm, collect wood and water, or sell wares. The presence of mines/ERW reduces their ability to work and hinders access to health facilities and schools. As a result, returnees tend to congregate in overcrowded cities and towns rather than risk mine/ERW-affected rural areas.

Clearance activities have been conducted over the last 10 years by a number of national and international organizations, mostly around the main towns and in their surrounding areas. Since the ceasefire, these players have been able to extend their work to new areas, but large areas remain contaminated. The National Inter-Sectorial Commission for Demining and Humanitarian Assistance to Mine Victims (CNIDAH) coordinates the mine-action response.

Angola ratified the Ottawa Convention in July 2002, and this entered into effect in 2003. The country is not party to Amended Protocol II of the CCW.

Medical care
In 2003 the ICRC lent significant support to the hard-hit Angolan health sector by repairing or constructing water points, latrines and waste-disposal facilities. As part of a policy to hand back responsibility for health to the government, the ICRC ended its support to 16 health posts in 2003. It also stopped providing medicines and other medical supplies for the paediatric department of Huambo Central Hospital, having donated a total of three months worth of supplies to facilitate the transition.

Hospital assistance, 2003
- admissions: some 17,000 paediatric patients
- mine victims treated: 9

Physical rehabilitation
Working closely with the Ministry of Health, the ICRC ensures that victims of mines/ERW can receive free physical rehabilitation at three prosthetic/orthotic centres -- Luanda, Huambo and Kuito. By the end of 2003, the ICRC had assisted amputees in Angola for 24 years, providing over 17,500 people with approximately 28,000 prostheses-of which some 11,000 were for mine victims. In recent years the centres have provided 45% of all prostheses delivered to amputees in Angola's eight rehabilitation centres. The ICRC encourages and supports the Ministry of Health in implementing a national strategy for physical rehabilitation.

In 2003, more disabled patients were able to reach rehabilitation centres from remote areas owing to better security on the roads, and a joint ICRC/National Society programme continued to cover patients' transport costs. Radio broadcasts made more people aware of the rehabilitation services. The ICRC supplemented staff salaries at the centres and provided training in physiotherapy, prosthetics and orthotics.

Physical rehabilitation assistance, 2003
- delivered: 1,643 prostheses; 54 orthoses; 2,600 pairs of crutches: 271 wheelchairs
- new patients fitted: 674 with prostheses; 48 with orthoses
- prostheses/orthoses to mine victims: 1241 (75% of total prostheses)

Mine victims have received some 11,000 prostheses from ICRC-supported rehabilitation centres in Angola, which for two decades have supplied most of the prostheses for the country's amputees.

The ICRC now provides 45% of the prostheses in Angola and all of the crutches produced there. Mine/ERW victims receive 75% of all of the prostheses it provides.

Mine action programme
For the second consecutive year, the ICRC supported the Angolan Red Cross in its mine-awareness activities by helping train a network of 40 volunteers in Benguela and Bié provinces, and providing them with uniforms, bicycles and waterproof material for the rainy season. During the course of their visits to the communities, the volunteers raised awareness of the dangers of mines/ERW among residents and returnees. They also gathered information about contaminated areas, passing it on to the relevant authorities and demining organizations and encouraging them to clear or signpost them. Interviews on the radio were used to raise awareness of the dangers of mine/ERW.

In 2003, the ICRC began handing over technical and managerial responsibility for the mine action programme to the National Society. Any information that could be useful to other organizations involved in mine action was shared at regular coordination meetings organized by the CNIDAH. To ensure that Angolan refugees were also aware of the dangers, representatives of the ICRC in Namibia and the Zambian Mine Action Centre participated in workshops organized with the Angola Red Cross.

Mine action programm, 2003
- mine-awareness sessions: nearly 300
- participants: 26,000 adults; 22,000 children

BURUNDI

For a decade Burundi has been caught up in a civil war that has caused many deaths and injuries and forced hundreds of thousands of people to flee their homes. For much of 2003 fighting continued, ending only in the last few months of the year with a newly agreed ceasefire. The former fighters generally observed the ceasefire although there were pockets of ongoing conflict. With more security in the country, refugees - of whom there were an estimated 600,000 -- started returning to Burundi. Some 90,000 refugees returned during the year.

The extent and nature of mine use in the country remains unclear.

Burundi ratified the Ottawa Convention on 22 October 2003 but has not yet ratified Amended Protocol II of the CCW.

Medical care
In 2003, the ICRC continued to provide medicines and other medical supplies to six hospitals and eight health-care centres in Burundi, which had difficulty meeting the needs of the population. It upgraded sanitation facilities at the hospitals, repairing water and sewerage systems that had been damaged by years of conflict and neglect. It provided medical training for staff and an ICRC surgeon participated in a week's seminar on war surgery for doctors and nurses at Bujumbura's Prince Regent Charles hospital.

Medical assistance, 2003
- supported: 6 hospitals; 8 health-care centres
- admissions: over 15,000 patients (surgical, medical, obstetric, gynaecological, paediatric), including 1,508 war-wounded
- surgical operations: 2,063
- mine victims treated: 37

CHAD

For many years there has been fighting in northern and north-eastern areas of Chad, mainly around Tibesti and Faya Largeau. During 2003, the Movement for Democracy and Justice (MDJT), an armed opposition group in the north, was substantially weakened. Relative calm also returned to eastern Chad with the signing of a peace accord between the government and the opposition National Resistance Army.

Chad's National High Commission on Demining, established in 1998, plans and coordinates mine-action activities, with assistance from the UN Development Project. In 2002, Chad developed a "National Strategic Plan To Fight Mines and ERW: 2002-2015." Demining is under way, carried out by the German NGO, HELP. Mine clearance has progressed well, with the exception of the Tibesti region in the far north where sporadic fighting continues and mines and ERW contaminate fields and pastures, water sources, housing areas, and major roads, posing risks for civilians. Exact statistics regarding the number of mine/ERW victims are not available, but the military hospital in N'Djamena said it admitted 200 mine-related casualties in 2002 and new victims continued to be reported in 2003. Medical and rehabilitation services for mine victims are basic, particularly in the north.

Chad ratified the Ottawa Convention in 1999, but is not yet party to Amended Protocol II of the CCW. In January 2003, Chad reported that it had completed the destruction of its stockpile of some 4,490 mines.

Medical care
The ICRC provides medical supplies, as needed, to treat war-wounded patients at the military hospital in N'Djamena and the regional hospitals in Faya-Largeau (north) and Sahr (south). It also keeps an emergency medical stock to treat up to 200 war-wounded people. In 2001, the ICRC trained first-aid-post personnel in Tibesti and shared expertise in a seminar for war surgeons in Chad. In April 2002, the ICRC assessed surgical facilities in N'Djamena and Faya-Largeau. A report was handed over to the authorities recommending measures -- including ICRC training for the medical staff -- to restore the surgical capacity of Faya-Largeau Hospital, which treats a significant number of mine victims. A follow-up meeting was held with the health minister in March 2003. The report was well received. The authorities, however, face a number of obstacles, particularly the isolated location of Faya-Largeau in an oasis 1,000 kilometres from the capital.

Physical rehabilitation
Since 1981 the ICRC has been supporting the Kabalaye Orthopaedic and Rehabilitation Centre in N'Djamena run by the NGO *Secours catholique pour le développement*. Until 1993, this support included materials and equipment, funds to renovate the facility, and training for 10 technicians. Since 1993, the ICRC has been providing the centre with materials as well as covering the cost of fitting victims of mines/ERW with artificial limbs and other appliances. In 2003, the centre delivered 99 prostheses for mine victims, which is a 21% increase on last year. A contributing factor was the broadcast on national and local radio of 10 half-hour programmes, produced by the ICRC and the Red Cross of Chad, promoting the free physical rehabilitation service.

Physical rehabilitation assistance, 2003
- supported: 1 physical rehabilitation centre
- delivered: 197 prostheses; 172 orthoses
- new patients fitted: 84 with prostheses; 92 with orthoses
- delivered: 2 wheelchairs; 235 pairs of crutches
- prostheses/orthoses to mine victims: 102 (51% total prostheses delivered)

DEMOCRATIC REPUBLIC OF THE CONGO

Landmines were laid extensively throughout the DRC during the recent five-year conflict. The government has estimated that there were mined areas in 11 provinces but lack of access to some affected areas leaves the extent of the problem unclear. Over 200 mine casualties have been recorded in the past five years (up to June 2003). According to the Landmine Monitor, people enter mine/ERW-infested areas primarily to tend crops; others avoid risks by not cultivating arable land. During the political transition period, the risk of injury may rise with the return home of hundreds of thousands of internally displaced people. Refugees too are likely to return to their homes.

The Mine Action Coordination Centre (MACC) was established in February 2002 under the auspices of the UN peacekeeping force, MONUC.

So far demining efforts have been limited, conducted by the armed forces and Handicap International Belgium.

In May 2002, the government acceded to the Ottawa Convention and created a national commission to fight the problem of anti-personnel mines. It has not yet acceded to Amended Protocol II to the CCW.

Medical care

First aid
The ICRC worked with the National Society to train first-aid instructors, volunteers and stretcher-bearers, and provide them with suitable materials.

Hospital care
After years of conflict, the hospitals lacked supplies and skills needed to provide much needed medical services. The ICRC, therefore, supplied seven hospitals and 25 health centres with medicines and materials, and, in some cases, war-surgery training. As security improved, more people had access to the services.

Hospital assistance, 2003
- supported: 7 hospitals; 25 health centres
- admissions: 7,352 (paediatric)
- mine victims treated: 1

Physical rehabilitation
The workshop in Kalembe-Lembe serves both civilian and military amputees and is the main workshop providing prosthetic services in Kinshasa. Most of the disabled treated there are from Kinshasa and Bas Congo. The ICRC began supporting the workshop in 1998: it renovated the facility, installed new equipment, trained staff and supplied materials.

Physical rehabilitation assistance, 2003
- delivered: 161 prostheses
- distributed: 112 pairs of crutches and sticks; 1 wheelchair
- new patients fitted: 153 with prostheses
- prostheses/orthoses to mine victims: 20 (12% of total prostheses delivered)

ERITREA

Eritrea's thirty-year struggle for independence and two-year border conflict with Ethiopia has left the country littered with mines. The main contamination is along the 1,000-kilometre border between Eritrea and Ethiopia. During 2003, a spate of incidents involving newly laid mines was reported along the border.

Figures on mine-related casualties are not systematically reported, but available data suggest a high number of mine/ERW victims are young people. With the cessation of hostilities, the progressive return of IDPs has increased the risk of mine injuries. In addition, drought-related crop failures in 2002 caused some people to move to mine-risk areas to find arable land.

Demining began in 1991, but advanced slowly. In July 2002, the government formed a new body, the Eritrean Demining Authority (EDA), to take over mine action in the country, except for activities supporting the UN peacekeeping Mission in Ethiopia and Eritrea (UNMEE), and the pegging out of the new border ruled on in 2002 by the Eritrea-Ethiopia Boundary Commission. At Eritrea's request, all international NGOs active in mine action in the country left between August 2002 and June 2003. In October 2003, with tension high between Ethiopia and Eritrea over the border ruling, the Boundary Commission postponed the border-demarcation process, including demining, indefinitely. By the end of 2003, the EDA, with UN support, had started a mine-risk education programme, but had not yet begun to clear mines.

Eritrea acceded to the Ottawa Convention in 2001. It is not a party to Amended Protocol II of the CCW.

Medical care

Training
As medical training was centred in Addis Ababa before independence, Eritrea has a shortage of trained surgeons. In 2003, the ICRC and the Ministry of Health together organized two intensive courses on trauma management, attended by 32 doctors and nurses. At the same time, eight Eritrean medical staff were trained to take over the teaching of the courses, with the ICRC continuing to provide funds and expertise, as needed. In the last four years, some 270 local surgeons and other medical personnel have attended ICRC trauma-management courses or seminars on war surgery.

Rebuilding health care
Eritrea's Ministry of Health says about 45 health-care facilities in the border regions of Debub and Gash Barka were destroyed or badly damaged during the war with Ethiopia. Since the cessation of hostilities in December 2000, the ICRC, in coordination with the Ministry of Health and local authorities, has repaired six health-care facilities in the two regions, including two centres in 2003 (Shilao and Shambuko). The authorities have taken over the centres, which provide first aid and curative care to a combined population of some 188,000.

Upgrading the ambulance service
The Eritrean Red Cross ambulance service responds free of charge to medical emergencies countrywide. The ICRC is working to help upgrade the service and make it self-financing. In 2003, the organization provided funds to cover most of the ambulance service's operating costs, as well as salaries for 18 drivers. The ICRC also worked with the Eritrean Red Cross to solicit support for the fleet from municipal authorities. To further reinforce the capacity of the national society to respond to emergencies, the ICRC organized first-aid training for Red Cross staff and volunteers and donated five four-wheel drive vehicles for field work, as well as first-aid kits and stretchers. In July, the Eritrean Red Cross launched its first mobile first-aid teams at branch level.

Physical rehabilitation
Eritrea's three prosthetic/orthotic workshops (Keren, Asmara and Assab) are not yet able to cope with the over 40,000 disabled people registered for rehabilitation in the country. The ICRC supported the rehabilitation facility in Asmara from 1982 to 1986 (before independence) and again from 1992 to 1995. In recent years, the organization has also trained 42 physiotherapists, in cooperation with the Ministry of Health. In March 2002, the ICRC began providing Keren centre with materials and training, but after discussions with government officials, the project was discontinued late in 2002. In 2003, the ICRC donated prosthetic and orthotic materials and equipment to the Ministry of Labour and Human Welfare, while continuing a dialogue with the Ministry on redefining the ICRC's support for Eritrea's rehabilitation services.

Mine action programme
The Eritrean Red Cross has been made responsible for collecting data on mine/ERW injuries until the EDA is operational. A survey conducted in 2002 by the Red Cross to determine the need for further mine-action activities revealed that many people knowingly took risks in order to support themselves and their families. On the basis of the survey, the Eritrean Red Cross, with ICRC support, launched a small-scale mine-action project in 2003, focusing on data collection from health-care facilities and mine awareness in affected communities, in coordination with the EDA. A week-long training workshop covering these two subjects was organized jointly by the ICRC, the Eritrean Red Cross, the EDA and UNMEE's Mine Action Coordination Centre for 30 Red Cross volunteers. The volunteers then held several mine- awareness sessions for communities in contaminated regions, and started collecting data, which were forwarded to the EDA and the UNMEE Mine Action Coordination Centre.

ETHIOPIA

Ethiopia is one of the world's 10 most heavily mined countries, with some two million mines littering the country, according to the Landmine Impact Survey completed in March 2004. The UN-backed survey was carried out by Norwegian People's Aid, in close cooperation with the Ethiopian Mine Action Office. The mines are a legacy of successive conflicts over the last 70 years, the most recent being the 1998-2000 war with Eritrea. The survey found the areas of Tigray and Afar states that border Eritrea and the Somali National Regional State in the east to be the most contaminated regions. It also revealed that over the past two years 16,000 people have been involved in mine incidents, of whom some 1,300 were killed or injured. Many of the mines and minefields are near populated areas, posing a danger for civilians and their livestock. The presence of mines/ERW is also a factor discouraging displaced people from returning home to Tigray.

In December 2001, the Ethiopian Mine Action Office (EMAO) was established to coordinate and implement mine action in the country. With international funding, including a World Bank loan, and training and logistic back-up from the UN and other international organizations, a clearance programme in Tigray and Afar began under EMAO auspices in May 2002. On the basis of the Landmine Impact Survey, the EMAO is developing a national strategy and seeking more international funding to speed up mine clearance and expand support for mine victims and the mine-risk education programme. With UNICEF support, the Rehabilitation and Development Organization, an Ethiopian NGO, has been conducting mine-risk education in Tigray and Afar since 2000.

Ethiopia signed the Ottawa Convention in 1997, but has not ratified it. It is not party to Amended Protocol II of the CCW.

Medical care
Plans progressed in 2003 to upgrade the Ethiopian Red Cross ambulance service, which responds free of charge to medical emergencies countrywide. Meetings organized jointly by the ICRC and the National Society with municipal authorities resulted in over half (32) of Red Cross ambulance sites receiving community support to maintain the service. The ICRC also paid for 16 new ambulances and participated in an ambulance-review workshop in November attended by members of 23 national society branches and their municipal representatives. In addition, 27 national society branch instructors were trained in the management guidelines in the new ambulance manual.

Physical rehabilitation
An estimated 22,000 people, mostly veterans, have been left disabled by past conflicts in Ethiopia.

The ICRC has been supporting the prosthetic/orthotic sector in Ethiopia for over 25 years. Between 1979 and 1992, the ICRC established physical rehabilitation centres in Dessie, Harar and Debre Zeit, and since 1982 has provided the main prosthetic/orthotic centre in Addis Ababa with substantial support. This has included the introduction of ICRC polypropylene technology as the national standard for production of prostheses, conducting two three-year courses to train technicians and physiotherapists, and in 1995 setting up an African base in the capital for the Special Fund for the Disabled (see below).

In 2003, the ICRC supported eight physical rehabilitation centres. Addis Ababa, Dessie, Harar and Mekele centres all received funds, materials, technical back-up, training and supervision. A large part of the aid went towards reimbursing the centres for fitting people disabled as a result of the war with Eritrea. The other four centres -- Alert Hospital, Cheshire Home Polio Centre and Tibeb-Micili Land centre, which are all in Addis Ababa, and Arba Minch Rehabilitation Centre -- received ICRC-donated materials. The ICRC also held two round-table conferences in Addis Ababa for the heads of all the centres to discuss management techniques and caseloads.

The Ethiopian Ministry of Labour and Social Affairs and the World Bank launched a demobilization project in 2002 which included providing adequate physical rehabilitation services for disabled war veterans. In March 2003, as part of this initiative and at the Ministry's request, three ICRC specialists began teaching Ethiopia's first prosthetics/orthotics diploma course, attended by 21 students at the new Addis Ababa training centre. The ICRC was also sponsoring five Ethiopian technicians on one- to-three year courses at the Tanzania Training Centre for Orthopaedic Technologists (TATCOT).

Physical rehabilitation assistance, 2003
- supported: 8 prosthetic/orthotic centres
- delivered: 1,568 prostheses; 2,050 orthoses; 75 wheelchairs; 2,543 pairs of crutches
- new patients fitted: 852 with prostheses; 1,187 with orthoses
- prostheses/orthoses to mine victims: 764 (47% of total prostheses delivered)

Special Fund for the Disabled in Addis Ababa
In 1995, the ICRC-supported Special Fund for the Disabled (SFD) set up a training centre on the premises of the Prosthetics/Orthotics Centre in Addis Ababa, run by the Ministry of Labour and Social Affairs. Since then, SFD prosthetists based at the centre have carried out yearly technical inspections of former ICRC prosthetic/orthotic centres for the war-disabled and other rehabilitation facilities in Africa, and provided the centres with training, supplies and equipment. In 2003, the SFD supported 23 such centres in 10 African countries. Since the start of its training programme, the SFD in Addis Ababa has organized courses for more than 300 prosthetic/orthotic technicians in Africa and further afield.

In 2003, the SFD training centre in Addis Ababa:
- supplied 23 centres in 10 countries with prosthetic/orthotic equipment, technical expertise, and training
- held 10 courses, from 1 week to 6 months, in Addis Abeba, on ICRC prosthetic techniques for 41 trainee prosthetists and instructors from 18 countries
- organized 7 training sessions, from 5 to 10 days, at 6 prosthetic/orthotic facilities (schools, centres and hospitals) in 6 African countries for 64 participants
- contributed to the production of 1,472 prostheses and 2,087 orthoses by partner organizations
- initiated cooperation (providing equipment, materials and training to introduce ICRC polypropylene technology) with prosthetic/orthotic schools in Lomé, Togo (*École Nationale des Auxiliaires Médicaux*) and Marrakech, Morocco, (*Institut de Formation pour Carrières de Santé*)
- hosted, in Addis Ababa, directors of TATCOT and Mali's *Centre National d'Appareillage*

Orthopédique to exchange ideas on training programmes
- supplied spare parts for crutches to an Italian NGO in Uganda, the Orthopaedic Centre of the Somaliland Red Crescent branch in Hargeisa, and to ICRC prosthetic/orthotic programmes in Angola, the Democratic Republic of the Congo, and Zambia
- renovated and extended the SFD premises in Addis Ababa

Mine action programme
In November 2002, the Ethiopian Red Cross Society received approval from the Tigray authorities for a community-based mine-action project. During 2003, with ICRC support, the National Society held awareness sessions and distributed related leaflets, posters and stickers in communities in contaminated districts of Tigray. The ICRC also helped organize a six-day workshop on first aid for 89 Red Cross participants and set up first-aid teams in 32 Tigray municipalities. The project is being developed in coordination with the EMAO, the Tigray authorities and the NGOs concerned.

SOMALIA

There is little reliable information on the extent or nature of the problem of mines/ERW in Somalia, but there is some contamination. The Landmine Monitor Report 2003 says that central and southern Somalia are heavily contaminated, particularly the regions of Galgudud, Bakool, Bay, Hiran and Lower Juba. A year-long internationally funded Landmine Impact Survey of Somaliland, completed in March 2003 by the Danish Demining Group, reported that mines/ERW in this region affected some 1.3 million people and gave a figure of 276 recent victims. Because of security constraints, the survey covered just under 50% of Somaliland.

Following a workshop organized by the NGO Geneva Call, held in Eldoret, Kenya, representatives of Somalia's Transitional National Government and 15 Somali factions who were attending peace talks signed, on 12 November, a Deed of Commitment to ban mines.

Medical care

First aid
The ICRC provides funds and first-aid kits to 25 primary health-care posts run by the Somali Red Crescent, which offer free first aid and curative care to a combined population of some 580,000 residents and IDPs. The posts are located in remote, violence-prone areas of central and southern Somalia where little, if any, other health-care service is available (10 posts in Hiran, seven in Lower Juba, four in Galgudud, two in Gedo and two in Bakool).

The ICRC also positions emergency medical stocks in potential hot spots and distributes the supplies, as needed, to health-care facilities and community leaders to treat any influx of war-wounded.

As the year ended, the ICRC was carrying out an extensive assessment of medical care available in Somalia with a view to identifying and supporting more facilities that could treat minor injuries and stabilize seriously war-wounded patients before transferring them to an appropriate hospital. Thus far, Brawa Hospital in Lower Shabele has met the standards and received appropriate supplies and equipment.

Health-post assistance, 2003
- supported: 25 primary health-care posts
- consultations: more than 190,000

Hospital care
Without external support, medical facilities in Somalia would be unable to give adequate care to the war-wounded, including mine/ERW victims. In 2003, the ICRC was the only international organization supporting surgical care in Mogadishu. The organization provided funds, training, medical and surgical supplies, and food to the 110-bed Keysaney Hospital in Mogadishu North (opened by the ICRC in 1992 and now run by the Somali Red Crescent), and the 65-bed Medina Hospital in Mogadishu South. These two hospitals served as referral units for war-wounded people from a large part of the country; almost one-half of their surgical patients were war-wounded.

The ICRC also delivered first-aid supplies to Mudug Regional Hospital in Galkayo and Baidoa Hospital in the Bay region, both located in areas where there was ongoing fighting. This enabled both hospitals to treat minor injuries and stabilize the seriously war-wounded people before transferring them to referral hospitals.

Hospital assistance, 2003
- hospitals supported: 4
- admissions: 7,656 patients
- war-wounded treated: 3,156
- surgical operations: 6,432
- outpatient consultations: 13,006
- mine victims treated: 21

SUDAN

Two decades of north-south conflict have devastated southern Sudan. During 2003, Kenya-based peace talks between the Sudanese government and the Sudan People's Liberation Movement/Army made significant progress and ceasefires generally held in the south. Nonetheless, civilians continued to come under attack during sporadic clashes there. In a separate development in 2003, fighting escalated dramatically in the western region of Darfur, pitting government forces and militias against rebel groups. The consequences for civilians were dire, with an estimated one million people driven from their homes.

Little is known about mine/ERW contamination in Sudan, but it appears to be localized. As the peace talks have progressed, the survey and clearance of mines and mine-risk education have gradually expanded in the country. The Humanitarian Aid Commission, under the auspices of the Ministry of Humanitarian Affairs, is the government focal point for coordinating mine-action programmes. The UN Mine Action Service, together with UNICEF, has established mine-action centres in Khartoum and Rumbek in the south. A number of international and national NGOs are involved in surveying, mine clearance and mine-risk education.

Sudan ratified the Ottawa Convention on 13 October 2003, but has not yet ratified Amended Protocol II of the CCW.

Medical care

Owing to 20 years of conflict, there are few functioning medical facilities in southern Sudan and a severe shortage of trained personnel. Since 1987, the ICRC and other aid organizations have been transporting the war-wounded, including mine/ERW victims, to the ICRC's Lopiding Hospital (600 beds) located across the border in Lokichokio, Kenya. Inside Sudan, the ICRC provides the government-run Juba Teaching Hospital (JTH) in the south with staff, medical supplies, training, and food for some 900 personnel and 500 patients. In 2003, the ICRC also donated medical supplies to the hospital in Nyala, in the Darfur region, to help it cope with influxes of wounded people, and distributed first-aid material, as required, to treat victims of clashes in the south and the east.

During 2003, because of the lack of qualified staff at JTH, ICRC surgeons performed the majority of emergency operations. At the same time, the ICRC was involved in in-hospital training programmes, launched in 2002, for student medical assistants (10-month courses in cooperation with the Health Sciences Training Institute) and for certified nurses. As a result of the training, patient care improved, owing particularly to more accurate surgical diagnoses and better triage. The ICRC also provided the Health Sciences Training Institute with a medical library, furniture and incentives for the teaching staff, and supplied materials and technical expertise to help renovate the JTH Nursing School.

Sudanese amputees learn to walk with their new prostheses

With improved access to conflict-affected regions in 2003, the ICRC reassessed procedures for treating war-wounded people. This included a survey of the quality of medical services in some 20 health-care facilities in southern Sudan. The assessment would be used to draw up proposals, in coordination with other organizations, to improve surgical care inside Sudan.

Hospital assistance, 2003
- supported: 2 surgical hospitals
- admissions: 8,114 patients
- war-wounded treated: 712
- surgical operations: 4,917
- outpatient consultations: 37,474
- evacuations to Lopiding Hospital: 1,860 patients and their relatives
- mine victims treated: 7

Physical rehabilitation
In Sudan there are three prosthetic/orthotic workshops in government-controlled areas (the main centre in Khartoum, the Norwegian Association for the Disabled Centre in Juba, and a workshop in Kassala, which opened in June 2003). There are no centres in opposition-controlled areas. Many disabled people are unable to get appliances because security problems, poor roads, long distances, and poverty limit access to these facilities.

To provide rehabilitation services for disabled people in southern Sudan, as well as for Kenyans living in the area, the ICRC set up a limb-fitting centre in its Lopiding hospital in 1992, and has run the centre ever since. Treatment is free. In 2003, the centre delivered 462 prostheses, including 125 for mine victims. In addition, to improve and expand basic rehabilitation services inside Sudan, the Lopiding centre has, since 1999, trained up to 10 Sudanese every year, who run small prosthetic/orthotic repair workshops in southern Sudan.

Inside Sudan, the ICRC provides the main Khartoum centre, run by the National Authority for Prosthetics and Orthotics (NAPO), with funds, staff, materials and training. To enable amputees from the south to be fitted in Khartoum, the ICRC covers transport, accommodation, and treatment costs for patients from the southern centres of Wau, Malakal and Bentiu. In 2003, the organization helped the Khartoum centre standardize guidelines for treating patients, reorganize the production line, and introduce staff incentives. In addition, the ICRC held one-month refresher courses at the centre for all national prosthetic/orthotic and physiotherapy personnel, and sponsorshed four technicians attending three-year courses at Tanzania Training Centre for Orthopaedic Technologists.

Since 2000, the NAPO has also received considerable ICRC support - funds, training and technical expertise - for its initiative to set up four satellite workshops (Damazin in Blue Nile state; Dongola in Northern state; Kassala in Kassala state, which opened in June; and Nyala in Southern Darfur state). In addition, the ICRC has encouraged the NAPO to become more involved in supporting the Juba centre. The NAPO now supplies Juba with materials, donated by the ICRC, while the ICRC continues to organize training for Juba staff.

Physical rehabilitation assistance, 2003
- supported: 7 physical rehabilitation centres and smaller workshops
- delivered: 1,392 prostheses; 852 orthoses; 1,702 crutches; 49 wheelchairs
- new patients fitted: 217 with prostheses; 294 with orthoses
- prostheses/orthoses to mine victims: 241 (12% of total prostheses delivered)

TANZANIA

There is no evidence that mines are planted on Tanzanian territory, but a steady flow of war-wounded, including mine/ERW victims, from Burundi and the Democratic Republic of the Congo (DRC) cross into Tanzania's Western Corridor region for treatment, straining the country's medical system.

Tanzania ratified the Ottawa Convention in 2000. It is not party to Amended Protocol II of the CCW. In 2003, Tanzania declared a stockpile of 23,987 mines, of which it intended to retain 1,146 for training and research. The country destroyed a total of 15,236 mines over two stages in March and August. This is in line with its stated four-phase national plan to complete destruction of its stockpile by September 2004.

Medical care
In 2001, an agreement signed by the Tanzanian government, Caritas, the ICRC, the International Rescue Committee, and the UNHCR gave the ICRC the role of lead agency responsible for ensuring that war-wounded refugees arriving from Burundi and the DRC received appropriate medical care. The ICRC has maintained that role ever since. The organization pays for and regularly monitors the treatment of wounded refugees at Heri and Kigoma missionary hospitals and Kibondo District Hospital. It also distributes medical supplies, as needed, to 13 border

facilities, from first-aid posts to refugee reception centres, and nine refugee camps that administer first aid. It also arranges for wounded refugees to be transported to hospital. In November 2003, the ICRC reassessed the three hospitals and visited other main hospitals in the Western Corridor. The subsequent report would be used to restructure the surgical programme in 2004.

Hospital assistance, 2003
- supported: 3 hospitals and 7 first-aid posts (average per month)
- war-wounded treated: 33
- surgical operations: 56
- mine victims treated: 3

Physical rehabilitation
Since 2002, the ICRC has been identifying refugee amputees living in camps in Tanzania and paying for them to be fitted with artificial limbs at the Kilimanjaro Christian Medical Centre in Moshi, Tanzania.

- new patients fitted since October 2002: 26 refugee amputees with prostheses

ZAMBIA

Zambia has a landmine problem in six of its nine provinces that border Mozambique, Zimbabwe, Angola and Namibia, stated the Landmine Monitor Report 2003 citing the Ministry of Home Affairs. In addition, there are many Angolan refugees in Zambia, who have begun returning home. There is a huge risk of mines/ERW in Angola.

Zambia had prepared, with the assistance of the ICRC, implementing legislation for the 1997 Ottawa Convention. The final act received presidential assent on 11 December 2003.

Medical care
ICRC support in Zambia focused on building the capacity of the University Teaching Hospital in Lusaka to cater for the needs of both disabled Angolan refugees and Zambians.

Physical rehabilitation
The ICRC provided components, materials, training and advice to the university's prosthetics and orthotics department, strengthening its technical capacity and enabling it to provide its services to refugees as well as Zambians. An ICRC prosthetic/orthotic technician was posted there to assist with prosthesis production and monitor the quality of production and fitting. The ICRC ran an outreach service enabling patients in four refugee camps to be treated at the University. It also paid for their transport.

In the course of the year, the ICRC completed the construction of a 12-bed hostel to house patients from refugee camps or remote areas for the duration of their treatment.

Physical rehabilitation assistance, 2003
- delivered: 239 prostheses; 82 orthoses
- new patients fitted: 239 with prostheses; 67 with orthoses
- distributed: 108 pairs of crutches
- prostheses to mine victims: 183 (77% prostheses delivered)

Mine action programme
In May, two members of the Zambia Mine Action Centre (ZAMAC), with the support of the ICRC, participated in an eight-day ICRC training course on mine awareness in Kuito, Angola, that was aimed at tailoring dissemination to the needs of Angolan refugees. In June of the same year, ZAMAC started mine-awareness activities in the Nangweshi and Mayukwayukwa refugee camps, which were providing shelter to some 24,000 and 20,000 Angolan refugees respectively.

In the Meheba camp, with some 22,000 Angolan refugees, mine awareness was covered by the Japanese Association of Aid and Relief (AAR), whose two-year programme ended in January 2004. In the Ukwimi refugee camp, which hosted some 2,000 Angolan refugees, mainly former combatants, ZAMAC did not conduct any mine/ERW-awareness activities owing to a lack of funding.

ASIA

AFGHANISTAN

Over two decades of fighting (which has at different times involved the Soviet Union, various Afghan armed forces and groups, and the US-led international coalition), the extensive use of mines and sporadic aerial bombing have left mine and ERW contamination in most parts of Afghanistan. A decade of demining has diminished the problem, but Afghanistan is still one of the most mine-affected countries in the world and will not be fully cleared for years to come. Up to 90% of this mine/ERW contamination is in fields, pastures, roads, irrigation systems, and residential areas, providing barriers to reconstruction and economic recovery, and increasing risks to civilians as refugees and IDPs return home and pick up economic activities. Even when they know about the risk of injury, serious, widespread poverty and hardship still drive some Afghans to herd, farm, collect wood, or travel through contaminated areas as they struggle to make a living.

In 2003, at least 60 people a month were maimed or killed by mines or ERW -- over 40% fewer than in 2002. While this reflects the impact of demining and mine-awareness activities, accidents were probably underreported in areas of the south and east where security risks hampered data collection.

Because of heavy ERW contamination, children still accounted for nearly half of the mine/ERW casualties. Many more people were injured tampering with mines/ERW and travelling in vehicles, but fewer were injured by cluster munitions.

ICRC data on mine/ERW casualties, 2003
- victims recorded: 728
- civilians: 91%
- males: 20%
- children under 18: 48%
- activity at time of injury: 11% herding; 7% farming; 8% collecting wood, food, or water; 19% travelling (5% on foot, 14% in vehicles); 10% playing; 21% tampering with the object
- died: 18%
- handicapped: 30% (24% amputated; 6% blinded)
- areas most affected: Kabul, Parwan and Nangahar
- injured who reported having attended mine-awareness sessions: 11%

Afghanistan acceded to the Ottawa Convention in 2002. The UN Mine Action Centre in Afghanistan coordinates the activities of all agencies involved in mine-action activities.

Medical care
Afghan medical facilities have been dependent on external aid for years; damaged and poorly maintained, disorganized, underfunded, understaffed, and

Information on mine risks is integrated into the ICRC's door-to-door health teaching programme

poorly supplied, many have been unable to meet even very basic needs in terms of health care. In 2003, the Ministry of Public Health further developed the administrative structures, human and financial resources, and infrastructure needed to rebuild the health system, but there were still large gaps in the coverage of the costly and complicated surgical services needed to treat mine injuries.

Before it was able to work within Afghanistan, the ICRC's hospitals over the border in Pakistan gave surgical care to those wounded in nearby areas of Afghanistan. Nevertheless, since before the end of the Soviet occupation of Afghanistan, the ICRC has supported surgical facilities that provided care for the war-wounded within the country, either in major cities or near combat zones. In addition, the ICRC has helped set up first-aid posts, sometimes in cooperation with the Afghan Red Crescent Society (ARCS). This extensive support has been crucial for treating thousands of mine victims and others wounded in Afghan conflict, as well as many who needed surgery for other reasons.

In 2003, ICRC supported key hospitals in major cities (Kabul, Jalalabad, Kandahar, Mazar-i-Sharif) as well as selected provincial hospitals (including Ghazni, Shiberghan, Samangan, Taloqan, Bamiyan); these facilities accounted for some 15% of the country's hospital beds and 40% of its transfusion services. The support included training, fuel, medicines and other supplies, assisting blood banks and radiography units, and repairs to hospital water supplies, sanitation systems, and buildings. Some of this assistance, as well as support for Kabul ambulance services, was provided through projects delegated to internationally active National Societies of Japan, Norway, Finland, and Denmark.

Hospital assistance, 2003
- supported: 11 hospitals on a regular basis (water/sanitary improvements for 14)
- admissions: 75,313 patients
- surgical operations: 39,716
- outpatient consultations: 406,039
- mine victims treated: 411

ICRC-supported hospitals have given surgical care the war-wounded since 1988 and have treated over 2,000 mine victims since 2001.

Physical rehabilitation

There are tens of thousands of disabled people in Afghanistan, not only amputees who are mostly mine victims, but also victims of accidents, polio, or other diseases and congenital deformities.

Before it was able to set up services in the areas most affected within Afghanistan, the ICRC provided rehabilitation services for Afghan amputees from centres over the border in Pakistan. Since 1988, the ICRC has worked within the country and provided physical rehabilitation services to over 23,000 amputees, providing them over 47,000 prostheses-of which more than 28,700 prostheses were for mine victims. Its centres are located in key locations around the country and provide prostheses, orthoses, wheelchairs, crutches and physiotherapy. They now also offer education, job training, job placement and micro-credits to help the disabled develop or adapt their skills in order to take up or resume work or resume or other activities. Ninety percent of the centres' 350 national employees are themselves disabled. Staff from the centres also visit the homes of people with spinal-cord injuries, providing medical care, physiotherapy and social/psychological support for them and their families.

In addition to continuing to run six centres in 2003 -- located in Kabul, Herat, Jalalabad, Mazar-i-Sharif, Gulbahar and Faizabad -- the ICRC provided components for prostheses manufactured by other organizations, encouraged the health authorities to officially recognize the qualifications of the prosthetic/orthotic technicians employed in the centres, and continued a formal two-year training course for prosthetic/orthotic technicians.

Physical rehabilitation assistance, 2003
- ICRC-run centres: 6
- delivered: 3,887 prostheses; 8,036 orthoses; 782 wheelchairs; 9,674 pairs crutches
- new patients fitted: 873 with prostheses; 4,229 with orthoses
- training, schooling, job placement or micro-credits given to: 1,700 disabled people
- regular home visits: to 940 victims of spinal-cord injuries
- prostheses/orthoses to mine victims: 2,869 (73% of prostheses provided)

The main provider of rehabilitation services in Afghanistan for over a decade, the ICRC has provided mine/ERW victims with over 28,000 prostheses.

Mine action programme

The ARCS started mine-awareness activities covering mine-affected areas of the central region in 1994; soon afterwards the ICRC began financing the programme, and in 1998 it began to collect mine/ERW data to help establish priorities for mine action around the country. In 2002, after fighting in 2001 and 2002

disrupted mine action and left new areas of infestation, the ICRC stepped up its support for ARCS mine awareness: it further trained and supervised the eight ARCS teams in the central provinces and helped set up new mine-awareness activities for women. It also engaged its own mine-awareness teams to cover some northern and eastern regions. In the same year it combined mine-awareness and data-collection activities in its Mine Awareness Programme (MAP). This enabled it to supplement the data collected in clinics and hospitals with information taken directly from villages by the community-based network of mine-awareness trainers covering the central, eastern and northern regions, and also to improve the synergy of their operations.

In 2003, a network of about 90 ARCS, ICRC and community-based volunteers helped collect data on mine accidents, alerted clearance agencies to areas of contamination, and promoted behaviour that reduces the risk of injury. Women employed in the ICRC's hygiene-promotion programme in Kabul, and ARCS first-aid trainers added mine-risk education and data collection to their activities. This data, combined with information gathered in a network of 450 different health-care facilities run by a number of different organizations around the country[6], was shared with other organizations involved in mine action. It provided some 95% of all information available on new injuries in Afghanistan. Agreements signed with HALO Trust sped up the response to ICRC clearance requests: in 2003 mine action groups cleared or marked over 65% of the 140 requests based on information that the ICRC had gathered - a rate three times higher than the previous year.

Mine action, 2003
- new mine victims interviewed: 728
- villages reached by mine-action workers: 5,766
- participants in sessions: 294,999

Data from ICRC/ARCS mine action programmes (95% of total collected by the UN countrywide) are vital to directing mine action where it can best prevent further death or injury; Red Cross/Red Crescent community-based activities reduce mine/ERW risks in highly contaminated areas of the north, central and eastern regions.

CAMBODIA

Almost 30 years of aerial bombing and widespread use of landmines have made Cambodia one of the most severely mine/ERW-affected countries in the world: there are some 30,000 mine victims in the country. Contamination, though affecting many parts of the country, is heaviest in the north and north-western parts of the country (Battambang, Banteay Meanchey, Oddar Meanchey and Preah Vihear provinces and the Pailin municipality), but also affects other areas, including the province of Kampong Spew, south-east of Phnom Penh. In rural areas it restricts access to water, roads, bridges, and farmland. A 2002 Landmine Impact Survey estimated that some five million Cambodians might still be at risk, and in 2003 some 735 mine accidents were recorded - over 100 fewer than the previous year. ERW caused more than half of these injuries, and children are particularly at risk: they accounted for over a third of all mine/ERW casualties. The Cambodian Red Cross community-based landmine-awareness project has trained over 1,500 Red Cross volunteers and Red Cross youth members in six target provinces (Banteay Meanchey, Battambang, Oddar Meanchey, Pailin, Preah Vihear, and Pursat). The project, which is supported by the Finnish Red Cross, is planned to continue until mine accidents have stopped.

Cambodia ratified the Ottawa Convention in July 1999 and has adopted national legislation to implement it. It is also party to the CCW and its Amended Protocol ll. The government reports that it has destroyed its stockpiles. In March 2003, Cambodia hosted a regional seminar on mine action in South-east Asia.

Physical rehabilitation
There are an estimated 50,000 people with motor disabilities in Cambodia. The ICRC has supported physical rehabilitation services in Cambodia since 1991, when it began cooperating with the Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation to support the orthopaedic-component factory in Phnom Penh, and to build the Battambang Regional Physical Rehabilitation Centre which serves amputees in the heavily contaminated areas of the north.

[6] Swedish Committee for Afghanistan, Afghan Red Crescent Society, International Federation of Red Cross and Red Crescent Societies, Aide Medical International, Ministry of Health, Health Net, Ibni Sina, Mercy Committee International, Afghan Health and Development Services, Norwegian Afghanistan Committee, Norwegian Project Office, Danish Afghan Committee, International Rescue Committee, *Médecins sans Frontières*, *Médecins du Monde France*, International Assistance Missions, and others.

The component factory in Phnom Penh manufactures all of the components used in the prostheses and orthoses produced in the country and provides them free of charge to all 14 prosthetic/orthotic centres. ICRC support to the factory continued throughout 2003.

With ICRC support, from 1991 to 2003, the centre in Battambang provided amputees from the north with some 16,000 prostheses; over 8,500 of them were for mine/ERW victims. The ICRC delegated the project to the Japanese Red Cross for three years, ending in 2003.

To improve access to its services, the centre has an outreach programme in the provinces of Battambang, Pailin, Bantey Meanchey, Oddar Meanchey and Pursat. In 2003, during 21 visits to five northern provinces, the ICRC assessed nearly 1,800 patients and repaired over 1,000 prostheses and other orthopaedic devices. Nearly 70% of all mine/ERW accidents in the country occur in the areas served by the centre in Battambang.

The ICRC continued to sponsor the participation of the centre's staff in training courses as well providing on-the-spot training.

Physical rehabilitation assistance, 2003
- delivered: 1,283 prostheses; 809 orthoses; 1,184 pairs crutches; 196 wheelchairs
- new patients fitted: 382 with prostheses; 503 with orthoses
- prostheses and other devices repaired during outreach visits: over 1,000
- components produced: sufficient for 5,000 prostheses; 2,000 orthoses
- prostheses/orthoses to mine victims: 1,193 (93% of prostheses provided)

The ICRC supports the Battambang physical rehabilitation centre, which has provided 14,600 prostheses for mine victims, and the orthopaedic-component factory in Phnom Penh, which manufactures components for all of the prostheses and orthoses produced in the country.

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Mines laid in connection with former hostilities on the peninsula may remain around the Demilitarized Zone in the Democratic People's Republic of Korea (DPRK), but there is little information available either on their distribution, or on any casualties that they may cause. In 2002, the DPRK carried out some demining as part of the two inter-Korean transportation projects to link railways and roads.

The DPRK has acceded to neither the 1997 Ottawa Convention nor the CCW and its Protocols.

Physical rehabilitation
Estimates of the number of amputees in the DPRK range from 11,000 (WHO) to over 30,000 (Ministry of Health). In cooperation with the Ministry of Public Health and the DPRK Red Cross Society, the ICRC launched a rehabilitation programme in the rehabilitation centre that it had helped set up in Songrim, 30 kilometres south of the capital Pyongyang. The centre mostly serves amputees from the western part of the country. The ICRC has trained staff and provided materials, components and equipment for prosthesis and orthosis production.

In 2003, the ICRC continued this assistance, enlarging the centre's dormitories and making further repairs and improvements to the building. It worked with the National Society to translate training and technical materials into Korean. Ten percent of the prostheses it produced were for mine victims.

Physical rehabilitation assistance, 2003
- delivered: 841 prostheses; 22 orthoses; 395 pairs of crutches; 98 wheel chairs
- new patients fitted: 791 with prostheses; 18 with orthoses
- prostheses/orthoses to mine victims: 85 (10% of prostheses delivered)

INDIA

India used mines in its three wars with Pakistan -- 1947-48, 1965 and 1971. Following the attack on Parliament on 13 December 2001, the Indian army began deploying anti-personnel and anti-vehicle mines along the 1,800-mile northern and western border with Pakistan. This was apparently one of the largest mine-laying operations anywhere in the world in years. Mines were laid on three different types of terrain: the mountains of Kashmir valley, the flat and fertile land of Jammu and Punjab, and the desert of Rajasthan.

Despite the precautionary measures taken by the army, civilian casualties occurred frequently, in particular when farmers entered into minefields to tend their crops or retrieve their cattle. Some of the mines had also shifted from their original location for a variety of reasons (heavy rains, snow, landslides or movement of sand dunes) causing accidents among the civilian population even outside marked and fenced minefields.

The army started with major mine-clearance operations at the end of 2002. A lot of formerly mine-affected areas in Rajasthan, Punjab and Jammu were cleared and land was returned to the population. However, some accidents have also occurred in the areas that were proclaimed free of mines.

In November 2003, after receiving funds from the Canadian Government, the Indian Campaign to Ban Landmines has started mine-victim data collection.

India is not party to the Ottawa Convention. It is party to the CCW and its Amended Protocol II.

Physical rehabilitation
At the request of the Indian Red Cross Society, the ICRC carried out an assessment at the end of 2003 to explore the possibility of providing support to the prosthetic and orthotic department at the Orthopaedic Centre of the Government Medical College in Jammu. The conclusion of the assessment was that the provision of the training, material and components needed for the centre to start producing polypropylene prostheses could improve the quality of services provided by the centre.

Mine action programme
In 2003, the ICRC began supporting the Indian Red Cross in launching a community-based mine/ERW-awareness programme in Rajasthan and Punjab. A workshop was organized in each of these two states in order to introduce the programme objectives to the local and state authorities. This was followed by a two one-day training sessions for some 50 National Society volunteers in Rajasthan. They were trained in collecting information and assessing the mine threat in affected communities as well as in delivering the basic safety messages. The programme is currently under implementation.

KYRGYZSTAN

Following clashes in Batken in 1999 between groups from the Islamic Movement of Uzbeksitan (IMU) and government forces, Kyrgyz-Uzbek borders were mined to prevent further IMU incursions. The clashes also left explosive remnants of war. In June 2001, the Government of Kyrgyzstan issued a decree for the clearance of mined areas in the country, and some areas have since been cleared. In 2003, however, mines still affected six villages surrounding the Sokh enclave in Batken. Five people were killed in mine accidents. Contamination in pastures and areas where firewood is collected posed the greatest danger to civilians, particularly shepherds and children.

Kyrgyzstan is neither party to the Ottawa Convention nor to the CCW and its protocols.

Mine action programme
The Red Crescent Society of Kyrgyzstan and the Ministry of Ecology and Emergency Situations requested that the ICRC support a mine-action programme in Batken Oblast. The programme began at the end of 2002, when the ICRC helped train Red Crescent mine-awareness volunteers in communities around the Sokh enclave. The ICRC and the Kyrgyz Red Crescent trained volunteers in community-based mine action, and they, in turn, trained local teachers and village leaders. This was done in close coordination with the Ministry of Ecology and Emergency Situations. Working with the communities concerned, the Red Crescent set up four safe play areas and three youth centres, and assisted mine victims.

MYANMAR

For 50 years, the government of Myanmar has been confronted with a number of armed ethnic or political organizations. Armed struggles with them, mostly in border areas, have left substantial contamination with landmines and other types of ERW. Nine of the 14 states and divisions in Myanmar are mine-affected, with contamination concentrated in the east of the country in the Shan and Karen states. There is no comprehensive information available on the number of people injured by mines and ERW, but in 2003 alone, ICRC-supported physical rehabilitation centres provided mine victims with over 1,000 prostheses.

The government of Myanmar has acceded to neither the Ottawa Convention nor the CCW and its Protocols.

Medical care
Mine victims and others wounded in connection with fighting are treated at hospitals or clinics in Myanmar or facilities over the border in Thailand. In Myanmar's conflict-prone and poverty-stricken border areas where most mine injuries occur, health services are weak, with hospitals run down and poorly staffed.

In 2003, the ICRC assisted three hospitals in Shan state, helping improve water supply, sanitation facilities and electrical installations, and making building repairs. It also gave individual assistance to over 50 war-wounded patients treated in Myanmar, and through its office in Changmai, helped cover the cost of treating over 30 more war-wounded patients over the border in Thailand.

Physical rehabilitation
Although there are no comprehensive figures regarding amputees in Myanmar, they are estimated to number about 6,000. There are five government-supported physical rehabilitation centres in the country (two in Yangon, and one each in Mandalay, Maymo and Yenanthar), but they are far from the remote border areas affected by conflict, and most amputees cannot afford to travel to the workshops.
Between 1990 and 1995 the ICRC and the Myanmar Red Cross Society worked together to improve patient access to physical rehabilitation centres. Their programme identified patients in remote areas, transported them to prosthetic workshops, and provided lodging and food while they were fitted. After the ICRC withdrew its full-time presence in 1995, the programme continued on a smaller scale, and the ICRC made periodic follow-up visits from Cambodia. In 1999 it resumed its full-time involvement, providing materials, staff training, technical advice, repairs to the centre, and equipment to upgrade the quality of services and level of productivity. It also continued a joint outreach programme (see below). Its support facilitated the production of 80% of the prostheses manufactured in the country. In 2002, the ICRC and the Myanmar Red Cross jointly set up a rehabilitation centre in Hpa-an (Kayin state) to improve access to rehabilitation services for amputees in the south-eastern part of the country.

A new ICRC rehabilitation centre in Hpa-An gives amputees in mine-affected border areas easier access to physical rehabilitation services

The ICRC is the only international organization directly involved in the fitting of prostheses in Myanmar. Mine victims have received 4,600 prostheses from ICRC-supported centres over the past three years, and make up 70% of the disabled people they serve.

Between 1990 and 2003, ICRC-supported services provided some 14,000 prostheses to more than 10,000 amputees in Myanmar.

In 2003, the ICRC continued its assistance to government rehabilitation centre, which enabling them to maintain a stable production of prostheses and increase crutch production. The centre in Hpa-an significantly improved access to rehabilitation services for amputees and other disabled people in the south-east, some of whom had been unable to obtain prostheses for over 10 years. With ICRC support, the Myanmar Red Cross ran an outreach programme which took physical rehabilitation services to amputees unable to travel to the centre. The programme reached nearly a third more people than in 2002, helping over 720 amputees from remote, mostly border areas get the physical rehabilitation they needed.

The ICRC also helped train staff in government centres, sponsoring two prosthetists attending ISPO[7]-approved training in Cambodia, and giving two physiotherapy courses.

Physical rehabilitation assistance, 2003
- provided: 2,177 prostheses; 960 pairs of crutches
- new patients fitted: 1,384
- prostheses to mine victims: 1,527 (70% of total prostheses provided)

Mine action programme
In 2003, the ICRC carried out an assessment mission to explore the feasibility of setting up mine/ERW-action programmes in Myanmar.

SRI LANKA

Almost two decades of conflict between the government and the Liberation Tigers of Tamil Eelam (LTTE) has left mines in the north-east, particularly the Jaffna peninsula and the Vanni. By March 2003, the UNDP had recorded over 2,500 dangerous areas and minefields. Since the ceasefire in early 2002, restrictions on movements have been lifted, and since then, many people who had fled mine-infested areas have returned home. According to the Landmine Monitor Report 2002, there were 142 mine casualties reported in Sri Lanka that year.

Armed forces from both sides, as well as a number of humanitarian organizations, are involved in demining, which has expanded to reach new areas since the ceasefire in early 2002. Several UN agencies and NGOs are involved in mine-awareness activities, and the UNDP gathers mine data.

Sri Lanka is neither party to the Ottawa Convention nor to the CCW and its Protocols.

Medical care
With fighting suspended, fewer people were injured in 2003. The ICRC organized its third annual war-surgery seminar in Anuradhapura. More than 80 surgeons attended, over half of them civilians.

Physical rehabilitation
The ICRC estimates that there are some 15,000 amputees in Sri Lanka, with mines and other ERW there accounting for a high concentration of amputees in the north-eastern areas (the Jaffna peninsula and the Vanni). A centre run by the Friends in Need Society (FINS) produces prostheses on the Jaffna peninsula, and the NGO White Pigeon fits prostheses in the Vanni; both have traditionally used the Jaipur-foot technology. In 1999 the ICRC started assisting the FINS centre, providing it with training, materials and equipment needed to adopt ICRC-developed polypropylene technology; since then, with ICRC assistance, the FINS centre has delivered 1,247 polypropylene prostheses, at the same time as it continued producing Jaipur-foot prostheses. Between 2001 and 2002, when the lifting of travel restrictions enabled amputees in the Vanni to seek care in Jaffna, the ICRC also helped the White Pigeon centre obtain the materials it needed.

In 2003, the ICRC gave staff at the FINS centre on-the-job training and introduced treatment guidelines. About 50% of the prostheses fitted by the centre used polypropylene technology. After an evaluation in September confirmed that the ICRC had met its objective of improving the capacity and quality of patient service, the organization phased out its support to the centre, which continued to receive support from the NGO Motivation.

Physical rehabilitation assistance, 2003
- delivered: 273 prostheses; 32 orthoses; 7 wheelchairs; 24 pairs of crutches
- new patients fitted: 91 with prostheses; 4 with orthoses
- prostheses to mine victims: 145 (53% total prostheses provided)

[7] International Society for Prosthetics and Orthotics

TAJIKISTAN

Mines and ERW remain from the civil war (1992-1997) in the mountain passes of the Rasht Valley and along the border with Afghanistan. In 2000, mines were laid on the Tajik-Uzbek border in order to prevent armed incursions into Uzbekistan. In Soughd Oblast and the Tursun Zade district of Tajikistan, where people frequently crossed the border between the two countries for trade, family business and other activities, the mines have caused a number of civilian injuries and deaths. According to information collected by the Red Crescent Society of Tajikistan, some 90 people have been killed in mine incidents in Tajikistan since 2000, and a similar number injured.

In 2003, with assistance provided from other States Parties to the Ottawa Convention, the UNDP supported the Tajik authorities in creating a Tajik Mine Action Cell responsible for the coordination of mine-action activities. A survey was carried out by the Swiss Foundation for Mine Action in the Rasht Valley, on the basis of which a demining plan has been developed. The Red Crescent Society of Tajikistan has taken on the role of developing the mine-awareness plan for the national mine-action strategy 2004 to 2009.

On 23 September 1999, the President of Tajikistan signed a decree of accession to the Ottawa Convention and the CCW. National legislation that reflects the obligations of a State Party to the Ottawa Convention has been discussed and the national Tajik committee for the implementation of IHL has proposed conducting a study of the compatibility of existing legislation with the Ottawa Convention.

Physical rehabilitation

Prosthetic workshops in Dushanbe and Khojent provided artificial limbs in Tajikistan during the Soviet period, but after independence they closed because of lack of resources. The ICRC, working with the Ministry of Labour and Social Protection and the Red Crescent Society of Tajikistan (RCST), renovated, re-equipped, and the provided materials and training needed to reopen the centre in Dushanbe in 1999. The Canadian Red Cross then took on support through a delegated project. With the government and the RCST, the centre set up an outreach programme which identified patients from remote areas, transported them to the centre and provided accommodation while they were fitted. Three small satellite centres in Khojent, Kulob and Khorog repaired prostheses. By the end of 2003, the centre had fitted nearly 1,700 people with prostheses, and had begun orthosis production. About 10% of the amputees fitted at the centre were mine-injured.

In 2003, the ICRC and the Ministry of Labour and Social Protection reached an agreement on the gradual handover of the centre to the ministry over a two-year period.

Physical rehabilitation assistance, 2003

- delivered: 306 prostheses; 191 orthoses;10 wheelchairs; 395 pairs of crutches
- new patients fitted: 97 with prostheses; 123 with orthoses
- prostheses to mine victims: 28 (9% total prostheses provided)

Mine action programme

In 2001, the ICRC began supporting the Red Crescent Society of Tajikistan in launching community-based mine-action activities in coordination with the Ministry of Emergency Situations and Civil Defence. These covered the affected districts in Soughd Oblast and Tursun-Zade, and seven affected districts in the Rasht Valley.

This cooperation between the ICRC and the National Society continued in 2003. Red Crescent volunteers trained teachers, administrators, religious leaders and other community members to inform people about mine dangers and how to react to them. The volunteers worked with communities to organize discussions, distribute printed materials, air mine-awareness messages, organize contests, and put up billboards to remind people about the danger of mines. Special activities for children included distributing a comic book showing mine/ERW dangers -- to 6,000 children -- and distributing, through teachers, 8,000 copies of a game where children choose the paths they take to go home or collect firewood.

VIETNAM

Conflict in the 1960s and 1970s left Vietnam heavily contaminated with landmines and ERW. While there is no comprehensive casualty data, in 1999, a government report estimated that since 1975, mines and ERW had killed tens of thousands of people and injured even more. It will probably take decades to clear the country.

Vietnam is neither party to the Ottawa Convention nor the CCW and its Protocols.

Physical rehabilitation
There are an estimated 75,000 amputees in Vietnam. Between 1989 and 1995, the ICRC helped the Ministry of Labour, Invalids and Social Action set up production of prosthetic/orthotic components at the Ho Chi Minh City Rehabilitation Centre, and introduced polypropylene technology, increasing both the volume and quality of prostheses and orthoses manufactured.

The Special Fund for the Disabled (SFD) took over this support in 1995 when the ICRC ended its presence in the country. The support was then redirected to the provision of prostheses for destitute amputees. This category includes veterans of the former opposition South Vietnamese army or their families, often poor, who were classed as civilians and therefore not eligible for the free prosthetic services provided to veterans. In 2001 the SFD introduced polypropylene technology in orthopaedic centres in Can Tho, Qui Nonh, Da Nang, Than Hoa and Vinh, and later to Kontum. The Vietnam Red Cross network has been increasingly involved in the identification, transport and monitoring of destitute amputees to be referred to government orthopaedic centres of Da Nang, Can Tho, Qui Nonh and Vinh.

Between 1988, when the ICRC first became involved with amputees in Vietnam, and 2003, more than 32,147 prostheses were produced in ICRC/SFD-sponsored centres (17,138 of which went to destitute amputees). Over half of the amputees assisted by the programme were mine-injured.

In 2003, the number of prostheses produced in the SFD-sponsored centres increased and an implementation rate of 98% was achieved, and more staff training helped improve skills. Red Cross volunteers from 13 provincial branches made follow-up visits the disabled served by the programme.

SFD assistance, 2003
- produced: 3,399 prostheses in 7 SFD-assisted workshops
- newly registered and fitted: 2,659 patients
- support for the manufacture of: 4,234 prostheses (844 at the Ho Chi Minh City centre)
- distributed: 542 wheelchairs for disabled people to 18 Red Cross provincial branches

Europe

ALBANIA

During the 1998-1999 crisis in Kosovo, some 120 kilometres of the border with Albania were mined; some areas were also left with unexploded cluster bomblets. Unmapped and unrecorded, mines were laid in fields, forests, pastures and on common travel routes in the north of the country. Here they endangered the lives and restricted the economic activities of over 100,000 civilians in more than 30 extremely poor, rural communities in the districts of Tropoja, Has, and Kukes. Looting and explosions of arms depots during riots in 1997 had left other ERW contamination elsewhere around the country. The mine/ERW accident rate was highest in 1999, when 191 people were injured or killed; by the end of 2003 over 240 people had been killed or injured since 1997-8. About one quarter of the victims were children, and about half of the accidents recorded occurred while victims were farming, herding, or going to school; 90 of the survivors had lower limbs amputated. As a result of mine-action activities, casualties have significantly declined to one or two injuries a year.

Clearance has begun and it is expected to take one or two years more. The Albanian Mine Action Executive was formed in 1999 and is responsible for collecting data on mine injury. It is developing a national mine-action programme.

Albania signed the Ottawa Convention in 1998 and ratified it in 2000, and is reported to have completed destruction of its stockpiles of antipersonnel mines in 2002.

Medical care
The ICRC coordinated with other organizations to help mine/ERW victims receive specialized medical care in Albania, Slovenia, Germany and Malta.

Physical rehabilitation
The National Prosthetics Centre in Tirana received a year's supply of components for the production of prostheses. Together with representatives of the centre, the Albanian Red Cross, and the Albanian Mine Action Executive, the ICRC conducted visits to mine-contaminated northern Albania to establish the treatment needs of mine victims. It also conducted an assessment of the centre's physical rehabilitation programme to determine what form future support should take and to prepare an exit strategy.

Physical rehabilitation assistance, 2003
- delivered: 145 prostheses; 127 orthoses; 12 prs crutches
- new patients fitted: 16 with prostheses; 24 with orthoses
- prostheses/orthoses to mine victims: 37 (18% of total prostheses provided)

Mine action programme
The ICRC and the Albanian Red Cross have worked together to improve awareness of ERW since 1997, and launched a comprehensive mine/ERW-action programme in 1999.

In 2003, the programme continued. It facilitated communication between communities, organizations involved in clearance, and other actors in order to help direct mine action to areas where it was most needed. It also continued to alert people to mine risks: over 15,000 people (including over 9,700 children) were reached during presentations conducted in mine-contaminated areas. A mobile exhibition on mines was organized with a section specifically for children, and mine-awareness materials including children's games were distributed in schools near border areas.

ARMENIA AND AZERBAIJAN

Beginning in the late 1980s and lasting until the ceasefire in 1994, the Nagorny Karabakh conflict left anti-personnel and anti-tank mines and other ERW scattered over much of the region. In Azerbaijan, the Azerbaijan National Agency for Mine Action is responsible for surveying and marking mined areas, clearance, and mine/ERW-awareness activities. In 1999, the Mine-Awareness Working Group was created in Nagorny Karabakh, responsible for mine/ERW-data collection and the dissemination of information collected. In Armenia, the national Mine Action Centre is responsible for mine action, including demining and mine/ERW-awareness activities. Demining is ongoing, but will take several more years to complete.

Neither Armenia nor Azerbaijan has ratified the Ottawa Convention or the CCW and its Protocols.

Medical care
The ICRC kept stocks of drugs and surgical materials so that it could assist health facilities in the event of an emergency, and provided specialized training for surgeons.

Physical rehabilitation
While the capacity of Azerbaijan's rehabilitation services was reduced after the collapse of the Soviet Union, the Nagorny Karabakh conflict increased the demand for prostheses. A survey conducted jointly by the government and the ICRC in 1996 estimated that there were about 2,000 amputees in Azerbaijan.

In 2003, the ICRC continued to assist Azerbaijan's Ministry of Labour and Social Affairs in extending physical rehabilitation services -- which had been centralized in Baku -- to Nakhichevan and Ganja. It partly funded the construction of a centre in Ganja, which opened in February 2003, and provided both this centre and the one in Nakhichevan with machines, tools and components to produce prostheses and orthoses. The ICRC continued to monitor the new centre's work from its regional prosthetic/orthotic centre in Tiblisi, where it also arranged for an orthopaedic technician from Nakhichevan to receive further training.

Physical rehabilitation assistance, 2003
- supported: 2 centres
- delivered: 38 prostheses; 273 orthoses
- new patients fitted: 21 with prostheses; 180 with orthoses
- prostheses to mine victims: 2 (5% of total prostheses provided)

Mine action programme
Many communities, touched by the Nagorny Karabakh conflict, remained unsafe as a result of both mines and ERW, lacking playgrounds where children could play without risk of death or injury. With funding from the Norwegian Red Cross, the ICRC initiated a pilot project -- "Safe Play Areas" -- to build or rebuild sports areas and playgrounds, and supply equipment suitable for disabled children, in 20 affected villages in Nagorny Karabakh.

Between 1999 and 2002, the ICRC, working in close cooperation with the Mine-Awareness Working Group, ran a mine-awareness programme in Nagorny Karabakh. This included a school programme, community-based mine/ERW-awareness initiatives, and a public education campaign, all of which continued through the civil defence and education services.

With the creation of the Azerbaijan National Agency for Mine Action in 1999, the ICRC handed over the mine-awareness programme that it had been implementing since 1996. Mine-awareness activities continue in the affected areas as part of the ongoing response provided by the Agency.

BOSNIA AND HERZEGOVINA

Conflict between 1992 and 1995 left mines and ERW heavily scattered around much of Bosnia and Herzegovina, concentrated in the former front-line areas that criss-crossed urban and rural areas. By the end of 2003, they had killed or injured over 4,800 people; rates had decreased significantly since their peak at the end of the conflict, down from over 600 in 1996 to 54 in 2003. While the heavy ERW infestation led to many children being injured in the first few years when there were high casualty rates, by 2003 most injuries were among adult males engaging in high-risk activities like farming and woodcutting.

In May 2003, the Inter-Entity Mine-Awareness Management Team was officially transformed into a commission of the National Society. This was an important development for what had originally been a structure created by the ICRC to carry out mine-awareness activities, and was a prerequisite for handing over complete responsibility for mine-risk education to the National Society by the end of 2004.

Bosnia and Herzegovina ratified the Ottawa Convention in 1998, and completed the destruction of its stockpiles of anti-personnel mines in November 1999.

Mine action programme
In 2003, the ICRC continued to provide financial support to the Red Cross Society of Bosnia and Herzegovina and maintained mine-action activities for children and adults. These focused especially on adult males such as farmers and woodcutters. Reminders on mine/ERW risks were passed to over 110,000 people through presentations connected to sports and cultural activities. Children were also reminded of risks through quiz competitions in primary schools around the country which involved some 63,000 pupils. Both the National Society and the ICRC continued to participate actively in meetings of national bodies responsible for national mine-action planning and strategy development, coordinated by the national Mine Action Centre.

CROATIA

Mines and ERW were left in well over half the country's counties during the conflict in the early 1990s. Left near former front lines and in other strategic locations, they have killed or injured well over 1,000 people. Although there are now much reduced casualty rates, accidents do still occur -- one person was killed and nine injured in 2003 -- especially among people who take risks knowingly, compelled by need to plant crops, tend livestock, or gather wood. In addition to causing injuries, mine/ERW contamination continues to hinder economic recovery and community development.

In December 2000, Croatia adopted a national mine-action programme with the object of clearing the country of mines by 2010. In 2001, the parliament adopted the law on the Croatian Red Cross (CRC), making the CRC the State's auxiliary in implementing mine-awareness activities.

Since ratifying the Ottawa Convention in 1998, Croatia is reported to have destroyed its stockpiles of anti-personnel landmines.

Mine action programme
In 1996, the ICRC and the CRC launched a mine/ERW-awareness programme and mobilized Red Cross branches to engage in mine action. Presentations, information sessions and other activities were used to alert the public to mine/ERW dangers in 14 out of 21 mine-affected counties.

By 2003, most people knew about mine risks and the challenge was to keep them alert to the risks. Efforts focused on high-risk groups like returnees, hunters, farmers, fishermen, and children. The CRC raised funds to build 15 safe playgrounds in communities still contaminated with mines/ERW, increased its use of the media to pass reminders of mine risks, sponsored a play on mine/ERW risks which was attended by 2,400 children, and focused on helping communities gear their initiatives towards high-risk groups. It also organized workshops and meetings to train local Red Cross staff and mine-awareness instructors and discuss community initiatives. Along with the Croatian Mine Victims Association, the ICRC supported the Croatia Mine Action Centre workshop in identifying mine victims' needs and helped prepare the national strategy on assistance to mine victims. The CRC continued to assume greater ownership of the mine-awareness programme, taking over financial responsibility for training instructors and conducting activities.

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

As a result of the internal conflict of 2001, ERW were left scattered in the country, particularly in regions that had been subjected to bombardments. Most affected were the northern areas around Tetovo and Kumanovo, and the outskirts of Skopje. There were five mine casualties in 2003, and contamination continued to be an obstacle to the return and economic reintegration of refugees and the displaced.

In 2001, the United Nations opened a Mine Action Office (UNMAO) in Skopje. The ICRC collected data on accidents and shared them with UNMAO to ensure that mine-clearance teams were assigned tasks according to communities' actual needs. Progress has been achieved in clearing mines and in enhancing knowledge of the danger of mines through activities and community initiatives designed to raise awareness of this danger.

The former Yugoslav Republic of Macedonia ratified the Ottawa Convention in 1998. Destruction of the stockpile of anti-personnel mines began in 2002 and was completed in 2003.

Mine action programme
In August 2001, the ICRC trained 20 community volunteers to carry out mine-risk education in affected communities, and supported the volunteer network of the Macedonian Red Cross in informing internally displaced people of the dangers posed by mines/ERW.

Community discussions and accident data showed that children were the most at risk. Sharko, a sheep dog well known to children through folklore, was first used in a leaflet to alert them to the danger of playing with ERWs, and then continued, through television spots and a theatre performance, to remind children of the safe behaviour to adopt.

Materials such as posters and leaflets were designed with the groups at risk, including children, and tested in the field by trained mine/ERW-awareness community volunteers and volunteers from the Macedonian Red Cross.

In 2003 the ICRC and the Macedonian Red Cross continued to run the programme together until they handed it over in June to the national body trained by UNMAO. By this time, the programme had alerted over 3,500 people to mine/ERW risks through 270 presentations in mine-affected communities and cen-

tres for the displaced, and had given mine/ERW-awareness training to new police recruits - of various ethnic origins -- in the Tetovo and Kumanovo regions.

GEORGIA

As a result of fighting between Georgia and its breakaway region of Abkhazia between 1992 and 1993, parts of Abkhazia and western Georgia are affected by landmines and other ERW. ERW contaminate fields, orchards and industrial areas. They restrict some economic activities, particularly in Abkhazia; Ochamchira and Gali are the regions most affected. People displaced by fighting in Abkhazia and now living in western Georgia are also at risk as they often travel through mined areas to return to their homes in Abkhazia.

The HALO Trust began mine-clearance work in Georgia and, together with the local authorities, set up the Abkhaz Mine Action Centre in 1999 to coordinate mine-action activities. Working throughout Abkhazia, ICRC field staff are often given information about the location of mines or ERW, which they pass to the HALO Trust for follow up. The Abkhaz Committee of the International Campaign to Ban Landmines is involved in the collection of mine/ERW-accident data, while the Association of Invalids with Spinal Injuries maintains the victim database. The mine/ERW-accident rate reported by the HALO Trust in Abkhazia is now very low: less than one per month.

Georgia has not ratified the Ottawa Convention. It is party to the Convention on Certain Conventional Weapons and its original Protocol II, but has not ratified Amended Protocol II.

Medical care
In western Georgia, the breakdown of the economy has left the medical system without the resources to provide services for the war-wounded, and many people cannot afford the medical care they need. Hospitals in Abkhazia have similar problems, and the availability of drugs and medical equipment is limited by restrictions on goods entering the territory.

In 2003, the ICRC provided surgical hospitals in western Georgia and Abkhazia with equipment, appropriate medicines and surgical materials. At the Zugdidi regional referral hospital and four facilities in Abkhazia, the ICRC continued to supply the hospital blood banks with reagents, tests and blood bags enabling them to screen blood for infectious diseases. In November, it signed an agreement with the health authorities on starting a centralized blood transfusion programme at the Sukhumi hospital (renovated by the ICRC) to serve the whole of Abkhazia.

Hospital assistance, 2003
- hospitals supported: 7
- admissions: 7,245 patients (110 war-wounded)
- surgical operations: 1,924
- outpatient consultations: 17,087
- mine victims treated: 7

Physical rehabilitation
The ICRC continued to support the prosthetic/orthotic services in Tbilisi and Gagra. To ensure the long-term continuation of quality services for the country's 4,000 amputees, it was decided that management of the Tbilisi centre would be transferred to an independent foundation set up by staff of the centre. The Georgian Foundation for Prosthetic and Orthopaedic Rehabilitation will succeed the ICRC in managing the country's only major physical rehabilitation facility. In Abkhazia, which is particularly affected by ERW, the ICRC kept up its support to the prosthetic/orthotic centre in Gagra. The centre serves the region's 600 amputees, most of whom are war-disabled. It also covered the Gali area with an outreach programme; a specialist team regularly visited a small number of patients who were unable to get to the centre. In 2003, the Tbilisi centre continued to offer training for orthopaedic technicians from other countries, while staff working at the Gagra centre had the opportunity to attend training at a centre over the border in Sochi (Russian Federation).

Physical rehabilitation assistance, 2003
- supported: 2 centres
- delivered: 373 prosthesis; 1,082 orthoses; 20 wheelchairs; 1,231 crutches
- new patients fitted: 144 with prostheses; 364 with orthoses
- prostheses/orthoses to mine victims: 82 (21% of total prostheses)

RUSSIAN FEDERATION (CHECHNYA)

Since the mid 1990s, recurrent hostilities between the federal government and Chechen fighters has left mined areas in Chechnya, as well as in the areas of Novolak and Botlikh in Daghestan. In 2003, ICRC-supported hospitals in Chechnya treated 97 mine injuries. Relying on the experience from other contexts, the ICRC initiated mine-awareness activities in 2000 to inform people about the dangers and looked into how to support prosthetic/orthotic services.

The ICRC's physical rehabilitation programme focuses mainly on building the capacity of the Grozny Orthopaedic Centre in Chechnya, and also, but to a lesser extent, other centres in the region.

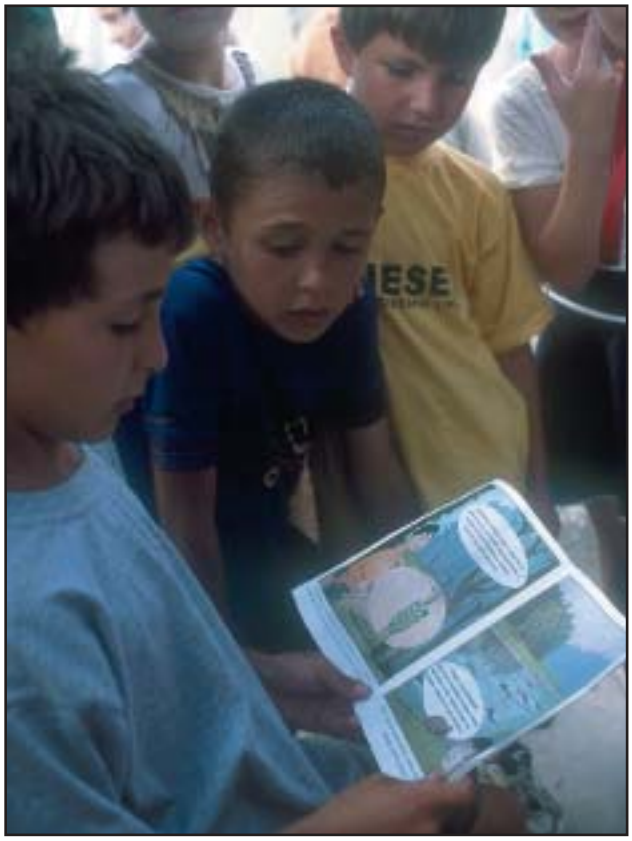
Security risks remain a major constraint for humanitarian organizations working in Chechnya. ICRC movements are therefore very limited within the republic. In view of the high security risk, the ICRC's expatriate team stays based in Nalchik (Kabardino-Balkaria) and Nazran (Ingushetia); crossborder field trips to Chechnya are limited.

The Russian Federation is not party to the Ottawa Convention. A law on ratification of Amended Protocol II of the CCW has been submitted to parliament and is awaiting a decision.

Medical care

In the northern Caucasus, health services suffer from a lack of financing, poor maintenance, outdated equipment, inadequate drug supplies and unevenly distributed resources. These problems, coupled with general poverty, and in the case of Chechnya, war damage and lack of security, made access even to basic health care difficult for the population.

The ICRC continued to supply 10 hospitals in Chechnya and one referral facility each in Ingushetia and Daghestan with medicines, surgical materials, and equipment as needed. It extended this assistance to include other departments besides surgery. Projects to upgrade the water supply and sanitation conditions were completed in two of the referral hospitals it supports (Shali and Argun), and planning started on a third one (Gudermes). Support for medical laboratories in Chechnya and the blood bank in Grozny continued, and a contingency stock of medicines and surgical kits enabled the ICRC to step in rapidly on several occasions to help out hospitals facing emergencies.



Displaced children learn about mine/ERW risks in an IDP camp in Ingushetia

The ICRC also organized a seminar in war surgery that was attended by 40 surgeons from the northern Caucasus, and arranged for eight Chechen doctors to attend specialized training in Moscow and Yaroslavl, paying for their travel and lodging.

Hospital assistance, 2003

- supported: 12 hospitals; 5 laboratories; 1 blood bank
- admissions: 63,485 patients (912 war-wounded)
- surgical operations: 18,984
- mine victims treated: 334

Physical rehabilitation

The conflict has left many people in Chechnya disabled: the ICRC estimates that there are up to 7,000 amputees in the republic. Through its surgical and orthopaedic programme, the organization provides wheelchairs and crutches to patients with disabilities.

To address longer-term needs for physical rehabilitation among Chechnya's several thousand war amputees and other disabled people, the ICRC's physical rehabilitation programme focuses mainly on building the capacity of the Grozny Orthopaedic Centre in Chechnya, which serves over 970 disabled

people, and also, but to a lesser extent, other centres in the region.

The programme has been carried out as part of a two-year cooperation agreement signed with the Russian Ministry of Labour and Social Development in October 2001. It is currently awaiting extension.

The ICRC is sponsoring the specialized training of eight Chechen staff attending a two-year training course at a centre in Sochi, and further training in St Petersburg and Makhachkala (Daghestan). It also organized a workshop in Sochi for 11 technicians from across the northern Caucasus. The ICRC also donated equipment to the centres in Grozny and Makhachkala.

Physical rehabilitation assistance, 2003
- delivered: 148 prostheses; 69 wheelchairs; 717 pairs of crutches
- new patients fitted: 148 with prostheses
- prostheses to mine victims: 97 (66% of total prostheses provided)

Mine action programme
Since 2000, the ICRC has worked with high-risk groups to increase their knowledge about the danger from mines in Chechnya and affected areas of Daghestan. As these areas are difficult to reach, activities first focused on the internally displaced in Ingushetia, whose frequent visits back home to villages not only put them at risk, but also give them an opportunity to spread mine-awareness messages in the affected areas that are inaccessible to ICRC staff. As the emphasis of the ICRC's northern Caucasus operation shifted to Chechnya, so did its mine-action programme.

The ICRC discussed with the authorities their role in informing the population, including returning IDPs, about the risks, as well as addressing the mine problem as a whole. Community-based activities involving village leaders and teachers served to spread messages about safe behaviour as widely as possible through appropriate information materials. A public information campaign was conducted comprising discussions with journalists, newspaper articles, and TV spots. The ICRC also supported the setting-up of a mine survivors' clubs to promote dialogue on the problems of mine victims. In Ingushetia, the ICRC worked with IDP parents to help them prepare their families for mine risks upon their return to Chechnya. In Chechnya, as in Daghestan, the ICRC addressed children in particular, for example through puppet shows, a TV series, and cartoons featuring the popular mine-awareness character Cheerdig.

In 2003, many people in Chechnya and the Novolak and Botlikh districts of neighbouring Daghestan continued to live with the risk mine or UXO accidents. Based on accident data collected from hospitals receiving its aid, the ICRC prepared mine-awareness messages for the main groups at risk, which included people who venture into forest areas - to collect firewood for example - and children.

After being trained by the Chechen Puppet Theatre, children in Grozny started using puppets to teach other children about safe behaviour, such as avoiding short cuts. In Daghestan, over 5,000 children learnt about mine danger when the puppet show "The Thousandth Jug" visited their villages. Teachers were included in the mine-awareness programme and the ICRC provided over 600 schools in Chechnya and Daghestan with teaching materials, including stationery for children to prepare their own mine-awareness posters.

Round-table discussions were held to brief journalists on what information and advice to include in newspaper articles and television broadcasts. In the affected communities, village leaders organized discussions about the significance of the messages of ICRC-produced television spots and how to apply the advice given. A café to be run by mine victims and acting as a mine awareness information centre was planned in Grozny.

SERBIA AND MONTENEGRO

Southern Serbia and Kosovo
The 1998-1999 conflict in Kosovo, the NATO bombing, and the conflict in 2000 and 2001 between Albanian armed groups and the Yugoslav Joint Security Forces have left pockets of mine-infested areas. In Southern Serbia, mines/ERW killed or injured 21 people in 2000, and incidents have been reported since; the municipalities most affected are Presevo, Bujanovic and Kursumlija. While most victims have been men, often tending livestock or gathering wood, over one third of the victims have been children. In Kosovo, mines/ERW have been detected in 130 areas in 80 villages of Kosovo. In 2003, they killed three civilians and injured 15 others.

Serbia and Montenegro acceded to the Ottawa Convention in September 2003 and, with support from the international community, has begun destroying its stockpile of anti-personnel mines.

Mine action programme

Southern Serbia
The ICRC began supporting mine action in Serbia and Montenegro in 2000. A network of volunteers was set up to help communities alert groups at risk, and to liaise with civil defence and other authorities able to clear or mark mines, or otherwise take measures to reduce risks. This involved Red Cross branches in Bujanovac, Presevo and Medvedja.

Since data on accidents showed that children were at risk, Red Cross programmes involved distributing leaflets, notebooks and posters in primary schools, and putting on a children's play about mine injury in mine-affected municipalities.

In 2003, the ICRC, Red Cross branches and other stakeholders conducted a survey that showed that people generally knew about mine/ERW dangers and how to avoid them. Media messages were therefore timed to remind about the dangers specifically to target groups at risk (like hunters) at the periods when they engaged in risky activities. Income-generating projects provided needy mine victims with materials to start small businesses (such as a barber shop, welding business) so they could better support themselves and their families.

Kosovo
In Kosovo, the ICRC began mine action in 1999. It set up community-based activities, worked with international and national authorities developing a mine-awareness training programme focusing on children, and trained 100 teachers to alert school children to the danger of mines and ERW and train other teachers to do the same.

In 2003, the ICRC handed over mine-action programmes to the Red Cross structures in Kosovo, once communication systems needed to carry out these activities had been set up. The only institution in Kosovo to work in mine-awareness, the Red Cross structures in Kosovo began planning income-generating projects for mine victims who are heads of households.

Children in war-torn areas often have nowhere safe to play

Latin America

COLOMBIA

Colombia's decades-old internal conflict intensified in 2002: there were some heavy aerial bombing operations, an increase in attacks using explosive devices, and a sharp rise in internal displacement. While there is no specific information available as to the number and exact location of ERW abandoned in rural areas; more areas are registered every year as being affected by mines, and mine casualties are on the increase. The Landmine Monitor estimates that all but a few of the country's departments are affected, and the number of casualties continues to be particularly high in Antioquia and Arauca. The government's Programme for the Prevention of Anti-personnel Mine Accidents and Victim Assistance (PAAV) is responsible for collecting mine information and for coordinating victim assistance. It reported 609 victims in 2002 and 659 victims in 2003.

The army carries out military mine clearance only and there is currently no specifically humanitarian demining in Colombia.

Colombia ratified the Ottawa Convention in 2000, and national legislation implementing the treaty came into effect on July 2002. The National Inter-ministerial Commission on Anti-personnel Mine Action (CINAMA) is responsible for the implementation of the treaty. Colombia is also a State Party to Amended Protocol II of the CCW.

In 2003, organizations such as Geneva Call, the Geneva Centre for Humanitarian Demining and the Swiss Foundation for Mine Action were working in Colombia. There was a renewal of interest amongst government circles, international organizations such as UNICEF, and NGOs involved in mine action; United Nations agencies defined a mine-action portfolio during the year, and the Organization of American States opened an office in Colombia as part of its integral mine action programme.

Medical care
While the government provides advanced medical services to populations living in conflict-affected areas, many people are unaware of their rights or have administrative difficulties when registering as beneficiaries; in some cases, health centres refuse to provide free services as stipulated by the law. Furthermore, some costs of specialized care are not covered by the health insurance system. The ICRC continued to make patients injured in violence aware of the services of the national health system, and when necessary it covered their costs of transport, housing, food, medicines, surgery, or physical rehabilitation. In 2003, the ICRC facilitated the treatment of 48 war-wounded civilians, directed 368 victims to the national health service, and supported the physical rehabilitation of 18 war-wounded people.

NICARAGUA

An estimated 135,000 mines/ERW were scattered in northern and central Nicaragua during the internal conflict in the 1980s, an estimate that concerns only those laid by government armed forces. The North Atlantic Region is the area most affected.

So far, half of all mines - both in the field and in stock - are reported to have been destroyed. Clearance is expected to be completed by 2005.

Nicaragua ratified the Ottawa Convention in 1998, and adopted legislation implementing the treaty in 1999. It is also party to the CCW and its Amended Protocol II.

Physical rehabilitation
Nicaragua is one of the poorest countries in Latin America. It has some 3,000 amputees and about as many other people with motor disabilities. In 1984, the ICRC began, in cooperation with the Ministry of Health, to run a prosthetic/orthotic centre in Managua -- at the time, the only centre producing prostheses and orthoses in the country. The *Centro Nacional de Producción de Ayudas Técnicas y Elementos Ortoprotésicos* (CENAPRORTO) produced over 2,900 prostheses for over 1,700 amputees before the ICRC handed it over to the Ministry of Health in 1993. The Special Fund for the Disabled (SFD) then provided some assistance and made yearly follow-up visits. When management problems were identified, an SFD prosthetist began working full time to reorganize the centre in order to improve the quality and quantity of appliances produced. Begun in 1999, the restructuring was completed in 2001: lower-limb production costs were reduced by 25%, and upper-limb costs by over 60%.

In 2003, the SFD continued to train staff from the centre, sending two Nicaraguan students to a three-year orthopaedic course in San Salvador. It also

maintained its financial and material support (donation of prostheses, wheelchairs and crutches) to enable the centre to produce more than 567 prostheses and 925 orthoses. The Nicaraguan Red Cross continued to help identify, collect information on, and transport amputees living far from the centre. The SFD also provided materials and technical advice for a local foundation (Walking Unidos) producing prostheses in Leon, and started negotiations with this foundation regarding the establishment of a second rehabilitation centre in the capital so as to better respond to needs. The centre will be a branch of Walking Unidos, and will benefit from the technical and financial support of the SFD.

Thirty percent of the amputees treated in the CENAPRORTO centre were mine victims, and an additional 15% had other kinds of war wounds.

Mine action programme
The ICRC began supporting the mine-awareness activities of the Nicaraguan Red Cross in 1998. Its child-to-child mine/ERW-awareness programme (De Niño a Niño) teaches children in schools in the North Atlantic Region. Some 30 Red Cross instructors were trained how to implement the programme, and teaching material was drawn up and translated into the Miskito language. The newly trained instructors then held group sessions on mine awareness and first aid for 120 pupils.

PERU

During the decades-long internal conflict in Peru, landmines were laid -- in the 1980s and early 1990s -- around electrical pylons in two coastal departments (Lima and Ica) and three departments in the Andean Highlands (Ayachucho, Huancavelica, Junin). According to ICRC sources, since 1992, these mines have injured more than 138 people, half of them children. Among these victims, 18 died, 48 were amputated, and 72 were badly injured. In 2003, a total of five mine incidents were reported. Furthermore, the border conflict with Ecuador in 1995 also left approximately 120,000 mines; the army conducted mine clearance in affected areas.

The national police and electrical companies completed the clearance of mines around electricity pylons at the end of 2003; monitoring was organized to ensure that there were no more mine risks around pylons.

Peru ratified the Ottawa Convention in 1998. In 2001 the government reported that it had completed the destruction of its anti-personnel mine stockpiles, and CONTRAMINAS, a public body composed of representatives from different ministries, was formed in December 2002. In July 2002, the national IHL committee (*Comisión Nacional de Estudio y Aplicación del Derecho Internacional Humanitario*, CONADIH), drafted a law to make the use of anti-personnel landmines punishable by law. In May 2002, a subgroup of the CONADIH, made up of representatives of the Ministry of Home Affairs, the Ministry of Justice, the Defensoria del Pueblo (Ombudsman), and the ICRC, proposed guidelines for a national plan to address the dangers of landmines.

In August 2003, the ICRC participated in a regional seminar on mine action organized by the Peruvian Ministry of Foreign Affairs, the Organization of American States, and Canada. The conclusions and recommendations of the seminar were included in the "Lima Declaration" which was submitted to the 5th meeting of States Parties to the Ottawa Convention, held in Bangkok in 2003.

Peru is also party to the CCW and its Amended Protocol II. In 2001 the ICRC organized a seminar on the CCW and its Protocols and other topics related to the issue of explosive remnants of war; it was attended by representatives of the government and of international organizations concerned.

Medical care
Starting in 1989, the ICRC helped cover the cost of medical or surgical care provided by the Ministry of Health to those who had been injured in armed violence, including mine accidents. After 1998, national health benefits covered most hospitalization costs, though expenses for prostheses were still not covered. Although it did not take on any new cases in 2003, the ICRC continued to help cover the cost of prostheses for those whom it had assisted in previous years.

Mine action programme
During the year, the ICRC and CONTRAMINAS organized several coordination seminars in order to work with the ministries and organizations concerned in order to develop a training plan for mine awareness in the Central Andes. The plan was finalized towards the end of the year.

Middle East and North Africa

ALGERIA

Algerian territory was mined in World War II, as well as during the conflict to end French colonial rule, and the situation of violence in recent years. According to the Landmine Monitor, Algeria estimates that more than three million mines are planted in 5,676 hectares of its territory.

Algeria ratified the Ottawa Convention in 2001. It is not party to the CCW and its Protocols.

Medical care
Since 1999, the ICRC has worked with the Algerian Red Crescent Society to strengthen its first-aid services. This involved financial, technical and material support to help the Red Crescent build a national first-aid network capable of rapid and effective action in mass casualty situations. Refresher courses were organized for National Society first-aid instructors. In addition, the ICRC helped to produce and translate first-aid manuals in conjunction with the International Federation of Red Cross and Red Crescent Societies.

The ICRC also worked with the Algerian Red Crescent to organize the first in a planned series of training sessions in group therapy techniques for post-traumatic care specialists. Similar sessions were organized for Red Crescent instructors to help them provide medical and psycho-social care in the regions worst affected by the continuing situation of violence.

Physical rehabilitation
In January 2002, a prosthetic/orthotic unit using ICRC polypropylene technology opened in Algeria's largest physical rehabilitation centre, located in the Ben Aknoun hospital in Algiers. Established to produce prostheses for the victims of mines and violence in Algeria, the unit was set up on the basis of an agreement signed in 2001 by the Algerian Ministry of Health and Population, the Algerian Red Crescent, the Polisario Front in Algeria, and the ICRC.

ICRC technical and financial support for the centre was maintained in 2003. Assistance was also given for the transport, accommodation and fitting of Algerian and Sahrawi amputees brought to the centre for treatment.

IRAQ

Explosive remnants of war are one of the most dangerous threats to physical safety now faced by the people of Iraq. Even prior to the outbreak of major hostilities in Iraq in March 2003, many parts of the country were littered with mines and other ERW -- a lethal legacy of the 1980-1988 Iran-Iraq war, the 1990-1991 Gulf war, and decades of internal violence. These conflicts left large swathes of the Iraqi countryside, and neighbouring Iran, Kuwait, Saudi Arabia, and Turkey infested with ERW.

The latest conflict further increased the threats to the country's civilian population from ERW. Large ammunition stockpiles, as well as small arms and light weapons, were abandoned by the Iraqi armed forces in public sites after the collapse of the Iraqi government in May 2003. Unexploded artillery shells, grenades, cluster bombs, anti-personnel mines, and other weapons littered many areas, mostly industrial sites, but also playgrounds, schools, construction sites, and roadside refuse dumps. Children, often unaware of the dangers, were particularly at risk from accidents caused by ERW. In addition, large quantities of weapons distributed to the Iraqi civilian population in the weeks before the outbreak of the latest conflict remained in circulation. This heightened the risk of accidents and further violence in an already tense environment. In the aftermath of major hostilities, hospitals in Iraq reported a significant increase in civilian patients mutilated by mines and unexploded ordnance.

Efforts to clear explosive remnants of the war were severely impaired during the lawlessness that prevailed after the fall of the government, and by the persistent hostilities and insecurity in Iraq through 2003.

Following the October 2003 bomb attack on the ICRC's delegation in Baghdad there was a subsequent reorganization of activities which resulted in a significant decrease in mine action activities.

Iraq is not party to the Ottawa Convention or the CCW and its Protocols.

Medical care
From 1999 until the outbreak of full-scale war in Iraq in late March 2003, the ICRC improved health care for most of the population of Iraq by upgrading 10 major hospitals and 15 primary health-care centres.
In 2003, as major hostilities in Iraq became increas-

ingly likely, stocks of medical supplies were pre-positioned inside Iraq and in five logistics bases in neighbouring countries. At the onset of the fully-fledged war, the ICRC made daily visits to key urban surgical hospitals caring for the war-wounded and others with urgent needs for care, and carried out emergency repairs and other work needed to keep hospital water, sanitation, and power systems working. Water, fuel, and medical supplies, including medicines, surgical instruments, oxygen, anaesthetics, dressing materials, wheelchairs, stretchers, and bedding were delivered to scores of hospitals, some treating up to 100 war-wounded daily at the height of the conflict.
The situation deteriorated rapidly after the collapse of the Iraqi government on 9 April when a looting rampage swept the country and brought many public services to a virtual standstill. Several main hospitals were ransacked and could barely function after being stripped of everything from beds, surgical equipment, and sanitation components, to light fixtures, window glass and refrigerators. In several cases the ICRC re-equipped looted hospitals to enable them to restore medical services.

Physical rehabilitation
The ICRC has been involved in physical rehabilitation in Iraq since 1994, providing material and technical assistance for seven centres in Baghdad (3), Basra, Erbil, Najaf and Mosul, as well as to the school for prosthetics and orthotics in Baghdad. Since then, these centres have supplied nearly 20,000 prostheses and 10,000 orthoses to the physically disabled. ICRC assistance included the provision of raw materials, components for orthopaedic appliances, and staff training in the fields of patient management, physiotherapy, and centre renovation.

In 2003, the ICRC maintained this support for the seven centres where the production of prostheses and orthoses continued to be based on ICRC polypropylene technology.

Several prosthetic/orthotic centres were ransacked by looters and vandals after the fall of the Iraqi government in early April. This severely disrupted their capacity to provide fittings and care for amputees and other physically disabled people. ICRC support to re-equip the centres helped them restore these services.

Mine victims received more than half of the prostheses delivered by the centres in 2003.

Physical rehabilitation assistance, 2003
- centres supported: 7
- delivered: 925 prostheses; 670 orthoses; 416 pairs of crutches; 25 wheelchairs
- prostheses to mine victims: 470 (50% total prostheses provided)

Mine action programme
In January 2002, the ICRC signed a cooperation agreement with the Iraqi Red Crescent Society (IRCS) on a mine-action programme. The programme's aim was to raise awareness of the mine/ERW threat in affected communities in the four

Two young boys receive medical treatment for serious burns which they got from playing with ERW

southern governorates by recruiting and training a network of IRCS volunteers. The programme benefited from the ICRC's extensive knowledge of the country and its needs, acquired throughout its uninterrupted presence in the country since the start of the Iran-Iraq war in 1980.

As the likelihood of full-scale war loomed in Iraq in early 2003, the ICRC appointed experienced staff to launch an emergency mine-action programme in Iraq expanding to additional 11 governorates. More than 400 IRCS volunteers in 15 governorates were trained to carry out mine/ERW field surveys and to alert the population in the contaminated area. This network was managed by IRCS mine-action programme coordinator and 15 IRCS branch officers. ICRC information leaflets and posters on preventive measures were widely distributed by IRCS staff and volunteers, and radio spots highlighting the issue were prepared for local and national stations broadcasting in and to Iraq.

From May onwards the ICRC worked closely with the IRCS to identify newly contaminated sites, collect data on victims, and initiate an awareness-raising campaign in the worst-affected regions. Working with the limits imposed by the precarious security situation, priority was assigned to regions affected by the heaviest fighting. Contaminated sites included industrial areas, playgrounds, schools, civilian houses, and makeshift rubbish dumps in urban residential areas. Information gathered was relayed to the Coalition forces/occupying powers that were urged to address this issue immediately.

By the end of 2003, IRCS volunteers had visited some 2,000 communities, and almost all of the communities visited had appointed a contact person to serve as the focal point regarding mine/ERW-related issues.

For nearly a decade, the ICRC has supported the production of most of the artificial limbs available for Iraqi amputees; since 1999 it has provided over 6,000 prostheses to mine/ERW victims in Iraq.

The ICRC was the only international humanitarian organization that kept working in central, southern and northern regions of Iraq throughout the most intensive phase of the war and the period of lawlessness that swept the country following the downfall of the Iraqi government. ICRC assistance to hospitals helped key facilities restore or maintain emergency health services for the wounded, who included many ERW victims.

The ICRC and the Iraqi Red Crescent have established a mine-action network covering 2,000 villages in all but three of the country's 18 governorates.

ISRAEL, THE OCCUPIED AND THE AUTONOMOUS TERRITORIES

Explosive remnants of war continue to pose a threat to the civilian populations of Gaza and the West Bank as a result of persistent armed violence in these territories. For several years, the Palestine Red Crescent Society (PRCS) has run a small-scale mine-awareness programme.

Medical care
In 2003, the ICRC provided training and material support for emergency services provided by the PRCS in Gaza and the West Bank. In conjunction with the Palestinian health authorities, it organized a series of eight seminars on war surgery for nurses and paramedical staff. It also helped coordinate the movement of ambulances and medical supplies to hospitals and health centres.

Mine action programme
In June 2002, the ICRC began to support and complement the PRCS mine-action programme, conducting training workshops for PRCS staff and volunteers in Gaza and the West Bank, and helping organize the construction of safe playgrounds for children in Jenin.

In 2003, some 60 trained PRCS volunteers were working in mine action, and the ICRC provided them with information, materials and distinctive uniforms, and offered further training.

JORDAN

Mines were laid along Jordan's western and northern borders during the 1967 war. Information on mine/ERW casualties in Jordan is available from medical facilities and groups concerned with the mine threat, but there has been no systematic data collection. A national demining programme started in 1993 and since then many of the priority areas have been cleared, but in 2003 several thousand hectares were still contaminated. The military forces, the sole authority responsible for demining, also carry out some mine-awareness activities. The National Demining and Rehabilitation Committee (NDRC) is responsible for integrating all aspects of mine action, and the Jordan National Red Crescent Society is a member of the committee. Official sources report that

there have been over 600 mine casualties since the end of the 1967 war. A few landmine accidents occur each year, and there was a noticeable increase in ERW incidents after the war in Iraq. Adult males and school children were the groups most at risk.

Jordan ratified the Ottawa Convention in 1998, and in 2003 reported that it had completed the destruction of its stockpiles of anti-personnel mines. It is party to the CCW and its Amended Protocol II.

Medical care
In cooperation with the Jordan National Red Crescent Society and the Palestine Red Crescent Society, the ICRC continued to coordinate an ambulance service transferring people in need of medical care, or in some cases mortal remains, between Jordan and the West Bank. Acting as a neutral intermediary, the ICRC facilitated the transfers by ensuring that the authorities concerned kept administrative delays and security constraints for ambulance crossings to a minimum.

Mine action programme
The ICRC and the Jordan National Red Crescent Society have cooperated regarding mine-awareness activities since 1995. This cooperation was instrumental in Jordan's decision to sign the Ottawa Convention.

In 2003, ICRC provided financial, training, and technical support for the mine-action activities of the Jordan National Red Crescent Society. Trained National Society volunteers supported the development of mine action both in Iraq (helping train Iraqi Red Crescent volunteers) and in camps for Iraqis fleeing over the border. One trained volunteer also gave presentations on explosive remnants of war to 120 officers and staff from the Civil Defence Directorate.

LEBANON

Decades of conflict have left Lebanon littered with anti-personnel landmines and ERW: in 2002, the Lebanese army reported finding more than 2,000 mined areas, particularly concentrated in southern Lebanon along the former front lines near the border with Israel. Parts of the Bekaa valley, Mount Lebanon, and some parts of northern Lebanon are also contaminated.

Mine/ERW-related accidents increased sharply after Israel ended its 22-year occupation of areas of southern Lebanon in May 2000, and previously off-limits former military installations and other zones became accessible. Though figures are not precise or comprehensive, estimates put casualties at over 2,500, some 650 of which occurred in southern Lebanon. Most victims have been adult males, often farmers or herders; about 5% were children.

The Landmine Resource Centre of the University of Balamand in Beirut collects data on injuries. Demining is monitored by the UN Mine Action Centre in Tyr. In 2002, the army reported demining 1.7 million square metres of land.

Lebanon is not party to the Ottawa Convention or the CCW and its Protocols.

Medical care
In 2003, the ICRC and the International Federation of Red Cross and Red Crescent Societies together helped fund first-aid training for the Lebanese Red Cross Society (LRCS), and purchased materials for ambulances. The ICRC also furnished medical supplies to Palestinian hospitals in Beirut, the Bekaa Valley, and in southern and northern Lebanon.

Physical rehabilitation
In 1982, the ICRC set up, and then ran, physical rehabilitation centres in Beit Chabab and Sidon which were handed over to private organizations in 1995, although they have continued to receive ICRC technical and material support.

Throughout 2003, Palestinian amputees unable to receive prostheses through the Lebanese healthcare system remained dependent on ICRC support to receive prosthetic/orthotic appliances.

Physical rehabilitation assistance, 2003
- delivered: 58 prostheses; 57 orthoses
- new patients fitted: 13 with prostheses; 19 with orthoses
- prostheses/orthoses to mine victims: 3 (5% total prostheses provided)

Mine action programme
Involved in mine action in Lebanon since 1998, the ICRC worked with the Lebanese Red Cross in 2000 to launched an emergency mine-awareness programme after the Israeli withdrawal. This included training LRCS staff in mine-affected areas, distributing brochures to raise awareness of mine/ERW risks, and organizing presentations for thousands of adults, as well as for children in summer camps. In 2001, under the coordination of the National Demining Office, the ICRC and the LRCS launched an integrated community-based programme to link communi-

ties, mine-clearance agencies, local authorities, and organizations assisting mine victims.

In 2003, the ICRC continued to offer training and technical support as the LRCS further developed mine action countrywide, organizing training workshops for new volunteers. Both the ICRC and the LRCS participated in regular meetings and training organized by the National Demining Office.

YEMEN

Large areas of Yemen are still infested by mines left from the numerous conflicts and armed clashes that have afflicted the country over the past four decades. A Landmine Impact Survey conducted in 2000 found a total of 592 communities affected by mines/ERWs: some 36,000 people lived in 14 communities deemed to be highly affected, and 791,400 people in the other 578 communities considered to be moderately or lightly affected. Landmines/ERW limit the land available for farming and grazing. Over the past 10 years there have been a total of 5,000 mine/ERW casualties: 200 casualties in the past two years. A large number of the casualties were women and children.

Yemen started its mine-action programme in 1998. The National Mine Action Committee, established in 1998 as a policy steering body, is responsible for national mine-action strategy. The Yemen Executive Mine Action Centre (YEMAC), established in 1999, is in charge of implementing and coordinating mine action all over the country. The United Nations Development Programme (UNDP) supports mine action in Yemen and works to strengthen national capacities in that domain.

Seven national mine-clearance units are operating and mine clearance is ongoing. So far, six out of the 14 highly mine-affected communities have been cleared. With respect to demining, the objective of the mine-action programme for the second phase (2003-2006) is to survey and clear 45,700,000 square metres of common-use agricultural land.

Yemen ratified the Ottawa Convention in 1998 and reported destroying the last of its anti-personnel mine stockpiles in 2002. It is not party to the CCW.

Physical rehabilitation

There are, by official estimates, over 1,000 amputees in Yemen. Most of them were disabled by war wounds, either mine wounds or other kinds of war wounds that did not get proper treatment. The government-run National Artificial Limbs and Physiotherapy Centre in Sana'a provides most of the artificial limbs fitted in Yemen. In an effort to improve access to these appliances, the government is working decentralize prosthetic/orthotic and physiotherapy services by opening several new centres to serve populations in remote areas. In Al Mukalla, a centre was opened in late 2002 to serve amputees and other disabled people from the remote Hadramout governorate. There are no professional prosthetic/orthotic training facilities in Yemen.

ICRC polypropylene-based techniques for the production of artificial limbs were introduced in Yemen in 2001 at the main limb-fitting centre in Sana'a. On-the-job training was given to prosthetic/orthotic technicians. In February 2003, two ICRC prosthetic/orthotic technicians introduced, in conjunction with the Ministry of Health, a similar programme at a newly established State-run facility in Al Mukalla, and monitored progress at the Sana'a centre.

Physical rehabilitation assistance, 2003

- delivered: 479 prostheses; 2,073 orthoses
- new patients fitted: 54 with prostheses; 321 with orthoses
- prostheses/orthoses to mine victims: 0