Theo Verhoeff – ICRC – VA 28.01.2002

Thank you Madames Co-Chairs,

Ladies and gentlemen.

I am pleased and honoured to address this forum. My name is Theo Verhoeff and I am in charge of the Physical Rehabilitation Programmes conducted by the International Committee of the Red Cross, the ICRC.

This presentation deals with Afghanistan and covers 4 subjects: (1) the enhanced risks on mine incidents; (2) the health services being called upon; (3) the physical rehabilitation / social economic reintegration of the patient and (4) suggestions based on lessons learned.

1. Enhanced risks.

As the ICRC noted in its 1996 study "Afghanistan: The Deadly Legacy, in Figures", the epidemic of landmine injuries is exacerbated during the return of refugees or displaced populations. This is exactly what we are seeing today in regions such as Taloqan - Kunduz where people who fled the latest front-line are now returning to their villages. The surgical personnel in the two reference hospitals in the region are reporting continuing admissions of new victims wounded by mines, unexploded munitions, and cluster bomb sub munitions. We are still gathering more precise statistical evidence from all regions in the country.

2. Health services being called upon.

The epidemic of landmine injuries creates a challenge for the entire health system. Good management of mine injured and of war casualties depends on the adequate functioning of the health system chain. From first aid in district clinics, to evacuation/transport of the patient, to surgery, to physical rehabilitation and fitting with orthopaedic appliances. All this, so that the patient has a chance on the final rehabilitation goal: socio-economic reintegration.

In certain areas of the country first aid posts and clinics exist and continued to function; the ICRC supported 6 of them, reaching 16 at one point during the year. The system for the evacuation of the wounded is very precarious; no regular ambulance service exists, the roads are often inexistent or are in poor condition. Sometimes the wounded have to be transported by donkey or pack mule.

Afghanistan's main referral hospitals have worked rather well. Close to 10 years' investment in surgical training and in hospital management have born positive results. Many Afghan surgeons have operated the war wounded according to ICRC protocols. More than 25 hospitals were regularly supplied with surgical material by ICRC Afghan staff during this last period. Blood transfusion services never stopped working.

However, many challenges remain and much remains to be done:

? the country's infrastructure -- roads and bridges -- needs to be rebuilt, not only to facilitate the timely evacuation and transport of the wounded and the sick, but also to promote a more general regeneration of commerce and economic life
? the infrastructure of many clinics and hospitals is old and shabby
? ambulance services must be established
? hospital equipment must be renewed
? the supply of medicines and medical material must continue through outside agencies until the new Ministry of Public Health can reorganise its own supply circuits
? the functioning of the hospital blood transfusion system and the Kabul Central Blood Bank must be rationalised.

3. Physical Rehabilitation / Socio-economic Reintegration.

The 6 ICRC orthopaedic workshops in Kabul, Mazar I Sharif, Herat, Jalalabad, Gulbahar and Faizabad employ mostly disabled Afghan personnel. Also here, 13 years investment in continued training of national staff has been very important. Patients continued to be fitted during the few months of ICRC expatriate absence late last year. A total of 3'985 artificial limbs were provided to amputees during the year 2001. Three out every four patients was a mine victim and one out of every four patients was a newly registered patient.

The workshops not only fit amputees but serve increasingly also other patients with poliomyelitis, spinal injuries, cerebral palsy and congenital or acquired deformities. This is due to the large needs and the almost complete absence of assistance for these disabled in the country. 6'305

braces were provided to these patients during 2001.

Important additional activities were developed the last years aimed at the final goal of socio-economic reintegration of the disabled. Assistance now include also micro credits, primary education, vocational training and job-referral services. Close to a thousand patients benefited from these services during 2001.

Summarising, since 1988, a total of over 47'000 disabled individuals have been treated one or more times in one of these 6 workshops with physiotherapy and with the provision of an orthopaedic appliance.

4. Suggestions / Lessons learned.

Firstly, the ICRC insists that the co-ordination of humanitarian assistance to the war victims and people of Afghanistan can only be accomplished in situ, i.e. in the country, amongst all the humanitarian actors present, and in close collaboration with our Afghan colleagues, an essential condition for the efficiency of humanitarian action. I believe similar co-ordination is already done in countries like Cambodia and Angola.

Secondly, the harmonisation of technology for providing artificial limbs over the country is important to prevent duplication and waste. In this respect, the experience of Cambodia, another country with a widespread

landmine problem, can be useful. Six organisations in Cambodia (Handicap International, Veterans International, Cambodia Trust, American Red Cross, Cambodia School for Prosthetics and Orthotics and the ICRC) fit amputees across the country and share the same efficient, low-cost technology.. An amputee can have a prosthesis repaired or replaced in any of the workshops, no matter where the original artificial limb was fitted, because they all use the same basic technology.

Thirdly, disabled must have easier access to rehabilitation services. The prosthetic needs seem to be reasonably covered by the already existing workshops. However, there is a need for especially physiotherapy, rehabilitation of non-amputees and for prosthetic repairs, also through a further decentralisation of services. Parallel, programmes aimed at socio-economic reintegration of the disabled must be generalised.

Last but not least, a disabled person, whether in Afghanistan or elsewhere, is disabled for life and needs physical rehabilitation services for the rest of his/her life. A long term view and a long term commitment is required of donors, agencies and of authorities. Afghanistan has huge numbers of physically disabled. Fundamental for a sustainable development in the field of physical rehabilitation is the promotion of the development of a national rehabilitation policy; of training programmes for national rehabilitation staff and of corresponding governmental recognition plus a career structure.

Concluding, the ICRC welcomes the interest of other organisations in this field and hopes that constructive co-ordination and harmonisation of techniques and technology will be possible.

Thank you for your attention.

Geneva, 29 January 2002