Willy Egset and Suzanne Hammad

Landmine Victims in Jordan

A Needs Assessment Study

Fafo

Willy Egset and Suzanne Hammad

Landmine Victims in Jordan
A Needs Assessment Study

Fafo-paper 1999:3

© Fafo Institute for Applied Social Science 1999
ISSN 0804-5135

Contents

Abbreviations 4

Executive Summary 5

1 Introduction 8
2 The study 8
3 Jordanian mine victims – overview and description 9
4 Victims' Assistance and the Jordanian Health Care Infrastructure 17
5 National policies and programs 24
6 Conclusion 29

References 30

Abbreviations

APL	Anti-Personnel Landmines
CBR	Community-based Rehabilitation
GUVS	General Union for Voluntary Societies
ICRC	International Committee for the Red Cross
KHMC	King Hussein Medical Centre
LMs	Landmines
LMVs	Landmine Victims
MOE	Ministry of Education
MOH	Ministry of Health
MOHE	Ministry of Higher Education
MOL	Ministry of Labour
MOSD	Ministry of Social Development
NHF	Noor Al-Hussein Foundation
NGO	Non-governmental Organisation
QAF	Queen Alia Fund
RMS	Royal Medical Services
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief & Works Agency for Palestinian Refugees in the Near East.
WHO	World Health Organisation

Executive Summary

The main conclusions of the study are:

Numbers and distribution

- There are no routines for central registration of landmine accidents in the *civilian* part of the Jordanian health system. Similarly, most Jordanian hospitals either do not specifically classify mine victims or only have begun doing so in recent years.
- According to *military* health authorities there have been *a total of 452 victims from 1968 through 1998,* casualties and fatalities included. Sixty-two percent (280) of casualties and fatalities were military personnel, the remaining 38 percent (172) were civilians. More than one-half of military victims during this period were from the Corps of Engineers – the unit responsible for de-mining.
- Local fieldwork largely verifies these military figures, although some underreporting is likely. Rough estimates indicate that the total number of mine victims in Jordan since 1968 probably does not exceed 700, and with 900 victims at the very highest.
- There are great differences in the regional distribution of victims. In the southern border territories, landmine accidents constitute a marginal and declining problem. However, there are several accidents every year in the north and centre-north, and the number has, in fact, increased somewhat through the 1990s.
- The most typical groups of civilian land mine victims are farmers, shepherds and hunters, children, and picnickers. Physical injuries inflicted by landmines vary greatly; about one-third of survivors suffer loss of one or more limbs.
- Although mine fields are marked and generally well-known, in exposed areas fencing and warnings could be upgraded. As for the newly cleared areas, the population should be made aware that these are not safe until declared so by the authorities, and signalling should be maintained until then

Victims' assistance

- Jordanian health officials and others in Jordan do not consider landmine victims a group needing attention or services other than those offered to other groups of patients with similar types of injuries. Hence, no existing institutions, programs or organisations in Jordan today deal particularly or predominantly with victims of landmines – with the exception of the local branch of the Landmine Survivors Network currently being established.

- Jordan has had considerable success with its policy of providing general health services to its population through the 1980s and 90s. Nevertheless, the services offered by the public system could be improved upon in regard to the more multifaceted and often long-term needs of amputees and other groups of the disabled.
- There is need for further development of regional prosthetic care and rehabilitation services. For these services, patients today usually must travel to Amman.
- Advanced, long-term physical rehabilitation, as well as psycho-social counselling are particular areas that could be strengthened.
- There is a general need for more well-qualified personnel on the various fields of prosthetic and rehabilitation care.

Policy issues

- *Organisational issues*, including provision of care, implementation and coverage of insurance schemes, awareness, and local outreach of services comprise one area where there is scope for improvement.
- Formal entitlements to free public insurance for the poor, needy disabled, and other vulnerable groups could be more efficiently enforced.
- Recent official initiatives taken to promote central co-ordination among various players in the health system should be sustained in addition to state enforcement of progressive disability legislation introduced in the early 1990s.

Recommendations

Following the findings of our study and consultations with local experts, Fafo recommends the following:

1) Due to the limited scope of the mine victim problem in Jordan compared to other sources of disabilities, it is recommended

   a) to focus on low-cost actions to increase the efficiency of existing institutional arrangements, and

   b) to strengthen the general apparatus of curative health services to injured people and to rehabilitation services to the disabled in general, and

   c) to ensure that the mine victims are properly catered for within the (improved) structure and that the number of new victims is reduced as much as possible through *focused* awareness campaigns and proper signalling of mined areas.

2) International support to Jordan could be directed into all three action areas, mainly through institution building support and training. Monetary support could be directed towards improving the overall rehabilitation services benefiting mine victims. International support should be provided in a manner which helps Jordan to improve co-ordination and central planning.

3) The following examples of low-cost improvements of existing structures could be considered:

a) Jordanian authorities could improve co-ordination of follow-up of mine victims by giving a central co-ordination role to one institution under the auspices of the Ministry of Social Development, and by strengthening the referral system in the most affected areas.

b) Jordanian authorities could consider consolidating information concerning civil and military victims in central registers in the Ministry of Health or Ministry of Social Development.

c) Jordanian authorities could ensure better health and rehabilitation service access for poor victims by specifying that such services are provided for free to all mine victims as part of the actual regulations in Jordan's disability law. Furthermore, it should be specified that military facilities are made available in appropriate cases. It is important to make this information known in areas most affected by land mines.

d) The rehabilitation services to mine victims could be improved upon by exchange of competence between the civil and the military treatment centres and co-operation between, and joint training of, their staff.

e) Jordanian authorities could consider strengthening public awareness activities and civil protection schemes in the most exposed areas, and ensuring that de-mined areas are properly verified and declared mine-free.

4) The following example of international support to Jordan could be considered:

a) Support in the field of professional training in prosthetics and rehabilitation, including international exchange of professionals.

b) Support to the two central institutions (civil and military) providing services to mine victims, within the area of prosthetics and rehabilitation

c) Support upgrading out-reach capacities in the most affected areas and a regional centre for prosthetic and rehabilitation services in the north.

d) Cost coverage to locally-targeted awareness campaigns.

1 Introduction

Commissioned by the Norwegian Foreign Ministry, Fafo has conducted a study (November 1998 – Mid-January 1999) on the scope of the problem of landmine victims in Jordan, and the assistance provided to landmine victims by relevant actors. As one of few countries in the region Jordan in 1998 decided to sign the international Mine Ban Treaty of 1997. The convention prohibits the use, production and stockpiling of anti-personnel landmines, and requires ratifying states to abolish such mines within a maximum period of ten years. Jordan has some 250,000 landmines (including both anti-tank and anti-personnel mines) along its borders with Israel and Syria, many of which in fertile areas in the Jordan Valley and northern territories. While removal of the landmines themselves is the most fundamental objective of the mine-treaty, it draws attention to the victims of landmines as well, expressing in its preamble that signatories wish "to do their utmost in providing assistance for the care and rehabilitation, including the social and economic reintegration of mine victims".[1] Following a multilateral Expert Meeting on de-mining in Amman in July 1998, these humanitarian aspects were discussed by Norwegian representatives with Jordanian counterparts, revealing that available information was scarce regarding both the actual number of landmine victims in the population, and the assistance offered to them.

Fafo was invited by the Norwegian Foreign Ministry in October 1998 to prepare a study on the above mentioned humanitarian aspects of Jordan's endorsement of the international landmine treaty. More specifically, on the basis of the agreed upon Terms of References, the study addresses the following main questions:

- What is the scope of the problem – how many and what types of victims are there, and what is the distribution of these in time and geographic space?
- What are the principal existing programs and agencies dealing with victims assistance in Jordan?
- What are the relevant capacities of these actors and institutions and to what extent are their activities co-ordinated within the overall healthcare system?

2 The study

The study began with a joint assessment mission in Amman including representatives from Israel and the Canadian International Development Agency. A series of meetings were held with various governmental and non-governmental agencies over a 10-day period, from November 12 through 22, 1998. The meetings provided an excellent background for further explorations of the issues at hand, contributing substantially to our understanding of both the issues and the institutional environment in which the issues should be analysed. The

[1] "Convention on the Prohibition of the use, stockpiling, production and transfer of antipersonnel mines and on their destruction: Preamble"

meetings included key governmental ministries as well as central national and international NGOs.

While the series of meetings was highly productive in terms of a general understanding of the situation, they left several questions unanswered, including that concerning the precise extent of the problem. A better understanding of the regional and local significance of the landmine problem was particularly needed.

Fafo continued its research on two main tracks; further investigations into the *scope* of the problem, and continued inquiries into the institutional environment dealing with the mine-victims. The scope of the problem was investigated in terms of the distribution of victims in time and space, and along personal variables such as age, civil versus military, and circumstances of accidents. Data were obtained from existing registers, as well as through collection on the local, institutional level. As will be explained below, we made a broad selection of hospitals in areas proximate to minefields to be visited and interviewed on a wide range of questions concerning their staff's experiences with mine victims. With generous assistance from the Norwegian Embassy, we were provided with the necessary permits from the Ministry of Health, which also apprised Health Directors in all the relevant districts of our impending visits. In all the selected governorates, Health Directors were consulted and interviewed prior to our visits to the hospitals, and as knowledgeable professionals, with long experience in their respective districts, they proved to be valuable sources of information. At the hospitals we met with hospital directors or leading physicians. The quality of the information depended on registration routines at the individual hospital, routines which varied considerably.

Our findings will be presented in the following order: Chapter three discusses the "scope" of the problem of humanitarian victims of landmines in Jordan, in terms of numbers as well as descriptions of the victims along the above mentioned dimensions. Chapter four opens with a brief general description of the Jordanian health system, and then describes in more detail those aspects most relevant to the treatment of landmine victims. Included in this part is a "case-study", which is intended to offer a more holistic description of the problem of landmines as experienced in a village in a heavily mined area on the border to Israel and Syria. Chapter five deals with the broader issues of national policies and programs for the disabled in Jordan.

3 Jordanian mine victims – overview and description

While the individual victim is, of course, of equal concern from a humanitarian point of view, numbers do make a difference from a policy perspective. An accurate estimation of the actual number of victims on an annual as well as an aggregate basis is of fundamental interest to considerations of possible practical measures towards alleviating the problem, including preventive as well as curative measures. Hence, we were interested in the following indicators concerning the humanitarian injuries caused by landmines in Jordan:

1. Numbers of victims:
    a) Approximate total number of victims since most mines were placed in 1967–68.
    b) Annual number of victims
    c) Types of injuries

2. Distributions:
    a) The distribution of civilian versus military victims
    b) The regional localisation of victims

3) Circumstances surrounding accidents
    a) In what situations do accidents occur?
    b) Are the areas marked and commonly known as being mined?
    c) Institutional referral systems of patients among relevant institutions

3.1 Sources of data

In our investigations into the numbers of landmine victims we have relied on three main sources of data: military statistics, primary hospital data, and civil defence statistics. In addition, we have discussed the problem with individuals from a wide range of official agencies and NGOs, who have contributed vitally to our understanding of the issues at hand.

While *civilian* health authorities did not have routines in place for registration of mine victims, their military counterparts did. Major General Goussous (Director of Royal Medical Services) and Dr. Abbadi (Director of Fields Operations) at King Hussein Medical Centre, a military institution under the Royal Medical Services (the military branch of the health services), indicated a total of *about four hundred victims* since 1968. According to Dr. Abbadi, the military keeps detailed records as an assessment and planning tool in managing costs and the provision of care for the hospitalisation, rehabilitation and compensation of landmine victims.

The full register of Land Mine Victim (LMV) statistics since 1967 through 1998 was later made accessible to Fafo for further examinations, arranged by Dr. Abbadi, from the Jordanian Armed Forces' War Operations Directorate. Because mine accidents are considered "judicial cases" in which the police are always involved and to whom all hospitals are obliged to report, we were told that these figures would be the most reliable to be found.

In addition to the figures obtained from the Royal Medical Services, the Jordanian Civil Defence Headquarters was approached for numbers of civilian casualties of landmine accidents throughout the Kingdom. The Civil Defence generously facilitated our research and provided us with quantitative and qualitative data concerning landmine accidents in which they had been involved from 1979 until present.

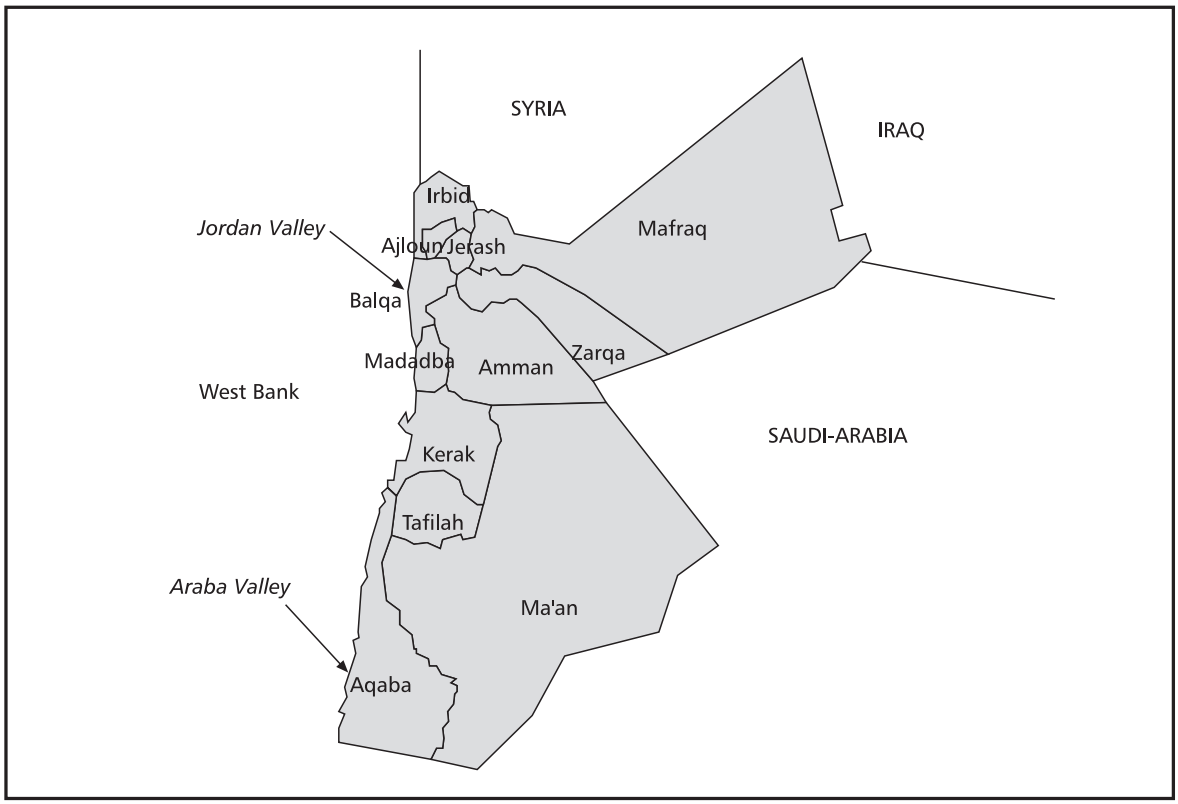
Finally, the International Committee of the Red Cross should be mentioned, as an agency active on the landmine issue in Jordan for several years, among other things in the area of awareness raising. They willingly shared with us their information, including a rich set of newspaper articles from Jordanian newspapers that were useful in sketching some of the characteristics, geographical locations and circumstances of LMVs.

3.1.1 Collecting primary data

In order to ascertain statistics provided to us, as well as to obtain a better understanding of the institutional mechanisms and capacities existing outside of Amman, Fafo made it a priority to collect data at the local hospital level. The services available to landmine victims were investigated, in addition to the particular circumstances their accidents. We were also interested in investigating the role, specific activities, and level of co-operation of leading NGOs working in the area of disability with governmental provision of service at the local level.

In our analyses of LMVs' needs vis-à-vis existing capacities we adopted a broad approach, which included examination of the treatment offered from emergency care through rehabilitation and reintegration into society. The issue of adequate treatment requires a perspective in which the *links* between institutions, programs and policies must be taken into consideration. Therefore, the questionnaires prepared for the various institutions reflected our concern not only with each institution's capacities, but also with its

Figure 1 Jordan with governorates



NB: International borders are indications, and not necessarily accurate.

relations to other institutions and services, as well as accessibility for the relevant group of patients.

Since mines in Jordan, with some minor exceptions, are located in mapped and marked minefields, and since emergency cases would normally be treated in the nearest general hospital, the local hospitals proximate to the minefields would hold the most reliable information on numbers of victims. Jordan's major minefields are located in the Araba Valley, in the Jordan Valley, and in the northern border territories towards Syria. While Jordan has some 75 hospitals in all, more than one-half of them (42) are private and a majority of them are in Amman. Seven hospitals are military. Based on a list provided by the Ministry of Health stating the exact locations of all public, private and military hospitals, we selected 14 public hospitals to be visited in the relevant border governorates. Except for a few specialised institutions, the 14 hospitals include *all public hospitals* in the seven border governorates of Irbid, Mafrak, Balqa, Ajlun, Jerash, Kerak, and Aqaba, leaving only Tafila[2] and the four "inland" governorates uncovered. Hospital visits were preceded by interviews with the Directors of each governorate's Regional Health Directorate, who also facilitated our work at the local level.

As for private hospitals, the overwhelming majority of these are in Amman, as mentioned, and thus not of primary concern to us. Few of them are general hospitals dealing with emergency care, and many of them have been recently established, both of which make them less likely to hold the kind of information we were seeking. Still, we decided to include a smaller selection of private hospitals. Of the four private hospitals in the north, we included the most relevant and oldest one in Irbid. In the south, where hospitals in general are more sparse, we included one in the border area of Kerak.

With the exception of the King Hussein Medical Centre in Amman, and one in Aqaba that is also open to civilians, we did not visit the military hospitals. In consideration of the close contact between these hospitals and the military authorities, and the well-established landmine accident monitoring routines of the latter, we do not think that significant quantitative information would be lost by exempting these from our fieldwork. Yet, on the issue of interaction with civilian sector institutions, their understanding might have differed from that of the civilian side.

Most hospitals lacked reliable recording and registration systems. Registration tended to be manual and older archives were often located outside the hospital, making the retrieval of information difficult. With regard to data on LMVs in particular, we were informed that patients of landmine accidents were not specifically classified as such. Despite these constraints, we were provided with data of varying quality from all the hospitals visited. The more exact records were based on information from existing in-patient records up to a maximum of 10 years back, or amputation operations following LM accidents. Several hospitals provided us with estimates based on the personal recollection of their staff's experiences with landmine accidents. Despite the possible errors involved in the latter source of information, they served our purpose of understanding the scope of the problem in these districts.

[2] Tafila only recently became a border-governorate after an administrative reorganisation (not included in the map above), and landmine victims from Tafila have been received by the hospitals in either Kerak or Aqaba, according to health officials in Kerak.

3.3 Results: Numbers, distributions and types of injuries

As mentioned above, the most *exact* figures on landmine accidents and victims were held by the War Operations Directorate of the Jordanian Armed Forces, and relayed to us by the Royal Medical Services. Estimates of the figures' reliability are discussed below, suffice it here to say that the data are most certainly of the best quality available, and sufficiently accurate to allow for meaningful break-down as presented in the following.

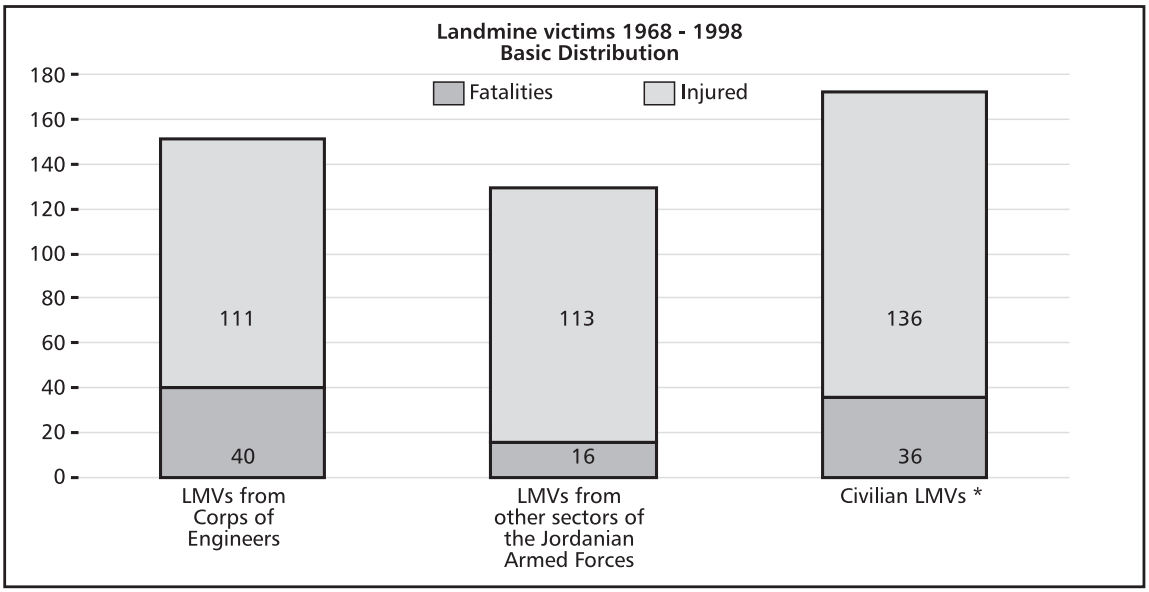
Table 1 Landmine victims 1968 –1998, basic breakdown, RMS figures

	LMVs from Corps of Engineers	LMV from other sectors of the Jordanian Armed Forces	Civilian LMVs *	Total
Fatalities	40	16	36	92
Injured	111	113	136	360
Total	**151**	**129**	**172**	**452**

*) Includes a minor, unspecified number of injuries of other explosives.

As can be seen in Table 1 above, military sources report a *total of 452 victims from 1968 through 1998,* casualties and fatalities included. Sixty-two percent (280) of these were military personnel, and the remaining 38 percent (172) were civilians. Noticeably, more than one-half (54 percent) of the military victims and one-third (34 percent) of the total number of victims were conscripts of the Corps of Engineers, which is the unit responsible for de-mining and, previously, for mining. The numbers are illustrated in Figure 2 below.

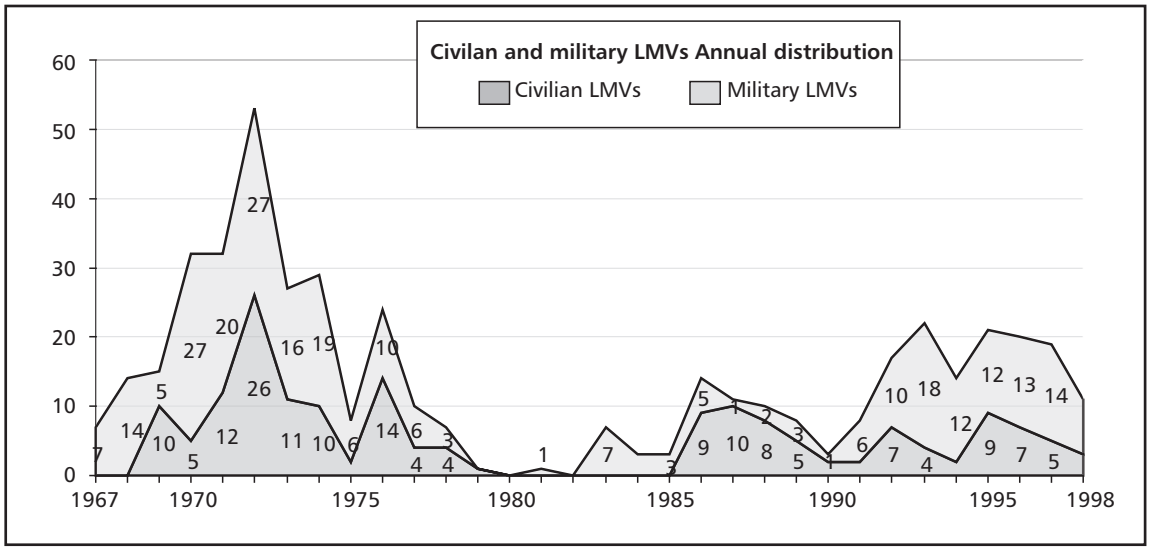
Figure 2 Basic distribution: Civilians and military, casualties and fatalities



Annual distribution

Figure 3 below shows a substantial variations in the *annual distribution of victims*. The high numbers found in the late 1960s and early 1970s are not surprising, considering the serious political unrest troubling Jordan at the time, with armed groups struggling for control and influence in various parts of the country. The number of victims reached its peak with as many as 53 reported victims in 1972, and declined thereafter as central control was re-

Figure 3 Annual distribution, military and civilian LMVs



Source: War Operations Directorate, Jordanian Armed Forces, obtained from Royal Medical Services, via Dr. Mohammed Abbadi, Director of Field Operations.

established. The conflict continued to result in casualties after regular clashes had ceased, because rivalling groups had placed unmarked and unmapped mines to protect their areas. But, uncontrolled mining has not been extensive and we have no indications that these type of mines have been significant with respect to accidents occurring after the 1970s. During the 1980s, numbers were low, with several years of no or very few victims on either the military or the civilian side. We have no certain knowledge of reasons for the rise of civilian victims during the second half of the 1980s. However, this might be related to improved reporting procedures. On the other hand, individual accidents produce substantial effects in the statistics, so that changes in annual numbers may be coincidental. The increased occurrence in the 1980s might also be related to dislocation of mines due to earth erosion, bringing mines outside of marked fields. Reportedly, heavy rains during 1991 and 1992 produced this effect, bringing mines outside of the marked fields, especially in hilly terrain, and contributing to the increased number of victims since.

During a visit to the village of Mukhaibe in the north, which is described in more detail in a later chapter, another factor mentioned by locals contributing to an increase in land mine accidents in the 1990s was deterioration of fences and warning signs surrounding the mine fields. In the same village, it appeared that fences and warning signs had been removed altogether from cleared areas although they had not been declared safe. Thus, villagers had begun to use the areas, sometimes with fatal consequences.

These causes for increased civilian casualties during the later 1980s also apply to an increase in the number of military victims in the 1990s. In addition, military personnel have been the victims of mine-clearing accidents, of which there have been at least 29 since systematic mine clearing started in 1992.

Types of injuries

Military statistics also specify the *types of injuries* incurred by mine accidents, as seen in Table 2 below. Of the 360 surviving victims, less than one-third (111) have lost limbs as a result of the accident. It is unknown to us whether this number includes those who have undergone amputations after the accidents. As the number of mine victims with severe disabilities amounts to between 150 and 330 (if the group of "multiple body injuries" is included) it is clear that mine accidents are not a major reason for disability in the Jordanian population. While the total number of disabled in Jordan is highly disputed, a Fafo survey estimates the proportion of the population suffering from "severe disability" at 3.5 percent (including illness). This amounts to some 145,000 severely disabled in the population as a whole, at 4.13 million in the latest census (Fafo 1998:183, 52). Hence, landmine victims constitute between 0.10 and 0.23 percent of the total number of severely disabled. That is, if all victims are still alive, which is unlikely.

Table 2 Types of injuries

Types of injuries resulting from LM accidents	Civilian LMVs	Military LMVs	Total
Death	36	56	92
Loss of limbs (including feet, 1 leg or both, fingers, 1 arm or both)	37	74	111
Severe injuries	14	1	15
Multiple body injuries (e.g. legs, feet, facial, broken bones)	65	107	172
Head and/or back injuries	2	1	3
Eye injury and/or blindness	2	20	22
Hearing impairment and/or loss of hearing	0	5	5
Simple or no injuries	11	15	26
Economic losses	1	0	1
Type of injury not indicated	4	6	10
Total	**172**	**285 ***	**457**

* Higher than the total number of military LMVs because some cases are included in more than one category.

Source: War Operations Directorate, Jordanian Armed Forces, obtained from Royal Medical Services, via Dr. Mohammed Abbadi, Director of Field Operations.

Are military figures reliable? Yes, to a high extent they are

Field visits to the hospitals and regional directorates of our selected border-proximate governorates and districts both enriched and substantiated these aggregate numbers through interviews with regional health officials and locals, both health workers, NGO activists and to a lesser extent ordinary villagers and landmine victims themselves.

Keeping in mind the weaknesses of the hospital data, our field work findings largely support the military figures, and added knowledge of important patterns. Yet, there is most probably a certain degree of underreporting in the military figures, particularly of civilian LMVs, although the exact number and attributes of missing cases are almost impossible to estimate. The military depend on *reports* for their statistics, and in the chain of reporting there are potential sources of error. If victims are not brought into contact with any official institution in connection with the accident, they will not be registered. Possible examples

could include persons found dead by relatives, or smugglers with minor injuries. Through the thirty-year period in question here, it is likely that a certain number of cases have escaped the registration procedures.

While field work could not produce exact and detailed data, it gave us a firm understanding of the scope of the problem in the various regions, that could be compared to the military figures. In each of the covered regions, we received data of two basic types: First, hospital *records* with exact specifications for the number of mine victims. Unfortunately, this type of data was rare, and if available usually only for the 1990s. Second, *recollections* of the number of mine victims for recent and more distant years based on the personal knowledge of experienced doctors and managerial staff, including their estimates of past trends back to the 1970s. When combining all the records and estimates and projecting annual trends back to 1968 for all regions, the total number of victims amounts to a maximum of 900, that is about twice of that provided by the RMS. This number is certainly overstated, however, mainly because of duplications of reported cases arising from the fact that some victims are registered at more than one hospital. Especially the more complex cases would often be transferred from receiving hospitals to the leading regional hospital. Furthermore, the backwards extrapolation of trends is extremely uncertain, based on the personal memory and impressions of health workers. Finally, most of the hospitals visited have not existed for the entire period in question, so that "their" cases were earlier captured by other hospitals. In conclusion, taking into consideration the possible sources of errors in these estimates as well as in the military figures, it is reasonable to believe that the actual number is somewhere between the registered 452 cases and the maximum estimate of 900, that is at about 650 to 700 victims since 1968.

Regional distribution: Most Significant in the North and Centre-North

There are substantial regional differences in the distribution of landmine victims. In the *southern governorates* of Aqaba, Tafila, and Kerak the number of victims is very small and declining, with victims last year only in Aqaba (2 –3), and with only 3 victims over the past twenty years reported in Kerak. The minefields in these regions are located in very sparsely populated desert area, not under pressure of expansion of agriculture or housing. Initial mine-clearing has been made in areas that are more exposed to tourism, industry or other activities, thus contributing to further reduce the number of accidents.

In the *north and centre-north*, on the other hand, the problem of landmines is still significant, most notably in Irbid and Balqa, and to a lesser extent in Mafrak. These governorates with rich agricultural lands at the borders toward Israel and Syria claim nearly all of Jordan's landmine victims for the recent years.[3] Mines are generally considered a problem in these areas. They present a direct danger to the population, especially to children unwittingly entering the fields, and others who for various reasons take the mined land into use. Land mines also have strongly adverse effects on agricultural development, due to the large tracts of land infested with mines, and damages inflicted on farmers' livestock. The fertile land, combined with population pressure, offer strong incentives for people – and

[3] This is supported by data from the Civil Defence, that reports 33 LMVs in Irbid and Mafrak since 1979, and 21 in Balqa in the same period, which is *55 of the total of 56* victims reported by the Civil Defence in the period of 1979-99.

animals – to utilise the areas. While the local population seems to be well aware of the mine fields and their dangers, deteriorating fences and warning signs allow for more activities across the fields. For example, herds may wander in, forcing shepherds to enter the area to get them out. Other groups at risk include children not old enough to read signs and comprehend the dangers involved, or poor people taking the risk to collect fruits or berries. In the village of Mukhaibe we also encountered the problem that *cleared* areas not yet declared safe, have had their fences and warning signs removed and subsequently taken into use by the villagers. Although this is not permitted, prohibition is leniently enforced, and accidents have occurred.

3.4 Conclusion: not exceeding 700 victims

According to military figures, Jordan has had a total of 452 victims from 1968 through 1998, 62 percent of which are military personnel. Local data collection lend support to the number, but suggest some underreporting. According to our estimates the total number of landmine victims in the period indicated probably does not exceed 700 with a 900 victims as a an absolute maximum. Mine victims thus constitute a marginal portion of Jordan's community of disabled. Still, the problem of mine victims is significant in border areas in the north and centre-north.

4 Victims' Assistance and the Jordanian Health Care Infrastructure

Landmine victims belongs to a category of patients with needs on many levels within the health care system. Their possibilities for rehabilitation and reintegration into social and economic life rely on a number of factors within and outside of the health system. No particular institutions or organisations exist in Jordan that deal exclusively or even predominantly with mine victims.[4] In meetings with us, government agencies, including the Ministry of Health, and central NGOs all expressed their commitment to non-preferential treatment. The focus of this chapter therefore will be on the general ability of the Jordanian health system (including NGOs) to cater to the needs of mine victims as one group of disabled among others, through the network of local health centres, as well as through more specialised institutions. We will also discuss some of the most important actors in the NGO sector.

4.1 Local health care

According to a WHO country report on Jordan, the "main goal of Jordan's health strategy has been to provide adequate health coverage to all" (WHO 1998:14). This strategy has led to a broad distribution of limited government resources, with an aim to offer fundamental

[4] An exception is the Washington-based Landmine Survivors Network (LSN) which is in the process of establishing a Jordanian branch. The organisation primarily deals with awareness and peer support networks.

services in "relatively less-affluent non-urban areas" (ibid.) through a network of local and regional health centres. The objective has been that none of Jordan's 1,100 villages, large or small, shall be without some form of health services, an objective that today is more or less fulfilled with a network of 326 primary health centres, 274 secondary health centres, 316 maternal child health centres, 42 comprehensive health centres, and 203 dental clinics (ibid.). Surveys confirm that physical access to some sort of health services is generally good, 67 percent of the population having access to either a physician, a health centre or a hospital within ten minutes walking distance (Fafo 1998:186). Undoubtedly, the local outreach of basic services has contributed immensely to the improvements found in general health indicators in Jordan over the recent decades. Their services seem to be rather inexpensive even for those not covered by insurance, but medicines and other accessories are costly, and sometimes not covered by insurance. Medicines, we were told, are sometimes in short supply in the villages.

However, the health centres play a rather marginal role vis-à-vis patients with more complex needs such as mine victims. While Comprehensive Centres are quite well-equipped and staffed with several doctors, nurses, and sometimes specialists, the other types of centres are rather basic, in both respects. Most health centres are not in a position to offer more advanced services to mine victims, neither at the emergency stage, nor prosthetic or rehabilitation services. Health centres refer patients with special needs– including prosthetic care and rehabilitation – to the main hospital(s) in the governorate and not directly to the national institutions. For the prosthesis itself, and for maintenance and training, patients are referred to the more advanced regional hospitals in the regional centres where such exist, although they often end up going to Amman for these services. The general tendency that patients prefer central (regional or national) institutions to locals even when local services *are* adequate, on the assumption that better expertise is found at higher levels, seems to be strong in Jordan, contributing to increase pressure on central institutions.

An important institution which supplements and adds to the services of the health centres, is that of the *Civil Defence*. The Civil Defence has an extensive network of units across the country which is available on notice 24 hours a day to deal with serious accidents. Although its medical expertise is limited, it offers first aid and transport for victims to the nearest appropriate health facility. Transport is particularly important since ambulances are not always easily available from health centres or local hospitals. The relationship between the Civil Defence and the MOH and its health centres is often cited as an example of successful cross-institutional co-operation.

Though not established for providing the more advanced services usually required by mine victims, the national outreach and the personal knowledge of local conditions and people represented by the local health centres and their staff must be considered vital assets in Jordan's potential ability to cater to the disabled in their own local communities. This could be further improved with increased knowledge of and training in emergency care, as well as community based programs for disabled, which has been initiated by some NGOs.

4.2 Prosthetics and rehabilitation

As noted above, a large group of mine victims suffer a loss of one or more of their limbs, and many others have severe physical injuries. The availability of prosthetic care and physical

rehabilitation is thus of crucial relevance to the physical and social well-being of mine victims. Prosthetic care includes not only the physical prosthesis itself. On the contrary, health personnel stress that the prosthesis itself is of little use, and can even be counter-productive, unless the prosthesis is properly *fitted* by qualified personnel, adequate *training* given to the patient, and *follow-up* care and maintenance provided. As a reminder of the futility of a narrow focus on equipment, it was reported to us that many amputees do not use their prosthesis because they feel uncomfortable with them, which is common when proper training and care have not been provided.

When discussing secondary and tertiary health care, Jordan's health development strategy mentioned above should be kept in mind. Resources being scarce, a policy that has favoured development of basic services nation-wide can hardly sustain more advanced services at an equally satisfactory level at the same time, at least not within the public domain which is our concern here. Hence, there is a limited local outreach of physiotherapy and rehabilitation services, and prosthetics more specifically. Minor physiotherapy centres do exist at several of the regional hospitals, including the Princess Basma Hospital and Ramtha Hospital in Irbid, at Mafrak Hospital, and at Salt Hospital in Balqa. Other hospitals report irregular access to physiotherapists. But, the staff at the hospitals with physiotherapy centres unequivocally described the standards and capacities of these local and regional centres as inadequate. The Princess Basma Hospital is an advanced and recently upgraded regional referral hospital receiving the majority of landmine victims in the north. Even there, the hospital management described its physiotherapy centre as "unsuitable" due to its limited space in a badly ventilated underground location, with outdated equipment and insufficiently trained personnel[5]. It should be noted too, that psycho-social support, including counselling on rights and psychological assistance, are rarely offered as part of rehabilitation care in Jordan.

In practise, therefore, more complex cases – which would almost always include severely injured mine victims – are transferred to the national institutions in Amman, if possible, since this involves higher costs for the patient. While some transfers are made to the Jordan University Hospital, the most important national institutions for prosthetics and rehabilitation services are the public al-Bashir Hospital and the King Hussein Medical Centre, under the Royal Medical Services, which are described below.

4.4.1 Al-Bashir Hospital

Al-Bashir Hospital is the largest civilian hospital in Jordan with 874 beds, a staff of 3,000, and more than 400,000 patients served annually, including some patients from other countries in the region. According to its Director, it masters all modern methods, except for open-heart surgery which is only undertaken at King Hussein Medical Centre. Al-Bashir's rehabilitation unit served 5,700 patients in 1997, and its prosthetic centre is the primary provider of such services to civilians in the country. There are 11 rehabilitation specialists working at the centre, including physiotherapists and occupational therapists. No mine victims had been received at the hospital during 1997, and although he did not have specific data on the number of such patients for earlier years, the Director believed it to be in the area of 0 to 2 annually.

[5] The Health Director of Irbid governorate gave a similar description of this centre. He further noted that the MOH realised the need for a centre in the north and had plans underway to establish one, pending available funding.

The rehabilitation centre does not have social workers or psychologists, although there are some social workers in its administration. As a referral hospital for all of Jordan and with a very high number of patients, al-Bashir operates on the margins of its capacity. Thus, there are waiting lists to receive treatment, and its facilities and equipment are worn-down. According to its Director, the hospital's equipment is generally old-fashioned, mentioning as an example that the patient files are not computerised, which was felt to be an important problem. Although they had been given some used computers from a private company, they did not have the appropriate programs to register patient records. Similarly, while the hospital was able to send 8 rehabilitation workers on training at an advanced centre in Ljubliana last year, an urgent need for training in new methods to keep its personnel and methods abreast of time was reported.

4.4.2 King Hussein Medical Centre

The second main institution for rehabilitation and prosthetic care in Jordan is the military King Hussein Medical Centre (KHMC), with its attached Farah Rehabilitation Centre. The KHMC is the most prestigious comprehensive hospital in the country, and with its advanced methods and facilities it attracts patients from all over the Middle East. Primarily, however, the hospital attends to Jordanians with a military insurance (see 5.1 below). While the KHMC was established in 1972, the Farah rehabilitation centre, which is now an integrated part of the hospital, opened in 1982, and the prosthetic centre in 1992. In spite of the hospital's prominent status, its Director, Major General Yousef Goussous, maintained that the prosthetic services offered at his hospital were sub-standard. It was mentioned, among other things, that the prosthetic centre itself was located at a distance away from the medical premises, and that the tools and equipment for preparation and maintenance of prostheses were partly outdated. Even more needed, he said, was training and professional update of the staff. Not only is their own competence not regularly updated, but there is also a problem of recruitment which may soon become acute, since no prosthetic technicians are currently being trained (see 5.4 below).

It is evident that the rehabilitation and prosthetic services offered at KHMC are quite ahead of those of the public sector, reflecting the generally more advanced status of the military sector. Illustratively, al-Bashir tries to transfer its most complex cases to the KHMC. Civil-to-military transferrals are not straightforward, and the principles on which such transferrals are made are not easily verified. Still, relations between the two hospitals, and the two sectors, are more open than one might have expected. On the military side, it was claimed that a number of patients without military insurance had already been received, and that more could be accepted if resources were increased. They maintained, as a principle, that it is an important task for the Jordanian Army to serve the civilian sector, including in the field of health. As yet, however, it is not easy for civilian patients to get treatment at KHMC, whatever reasons for or nature of their injuries. But, the fact that there *are* established contacts and possibilities of mutual transferrals, and no apparent animosity between the two sectors, bode well for further development of their mutual relations if so desired.

4.4.3 NGOs

According to UNICEF's Situation Analysis on Children and Women 1997 (UNICEF 1997), institutional care and rehabilitation services in Jordan meet only a tiny proportion of the total need. Limited state resources coupled with strong kinship support structures in Jordanian society, have encouraged a move towards a community-based approach to care, rehabilitation and reintegration of the disabled. This is the approach presently adopted by most of the larger NGOs (in co-operation with international organisations and the Ministry of Social Development (MOSD)) in their disability programs, which have also had an orientation towards the poor, and towards remote communities where state services are less available.

The NGO sector in Jordan is sizeable and plays a significant role in the field of social development as a whole. The General Union for Voluntary Societies (GUVS) claims 700 member organisations, as many as 120 registered within the field of disability alone. While we were only able to learn about the work of a few of the larger NGOs, the majority are small and with limited capacities. None of them work specifically with landmine victims, but some of the NGOs contribute substantially in important areas related to disability otherwise not covered by state services.

Among the most active NGOs in the field of disability is the *Projects Management Section*, which is a branch of HRH Prince Raad's Office. Established in 1995, it has initiated a variety of programs, including specialised sports centres in Amman, Aqaba and Kerak, and distributed donated equipment such as hearing aids and wheelchairs. Its most significant initiative is the Community-Based Rehabilitation (CBR) Program for the Southern Governorates – which addresses health, educational, and rehabilitation needs of the disabled in the region. A survey has been implemented to support their program, seeking to identify all disabled persons in the south and their needs – such as equipment, training or job creation. The Programme arranges for home visits to train families of disabled persons in basic skills. Awareness-raising programs are conducted in the communities, together with training of volunteers. As part of the CBR program an early diagnosis centre has been established in co-operation with the MOH to serve the Southern governorates, as one of only two in the country. Likewise, plans are underway to open the first prosthetics centre in the South to serve amputees. A similar program based in the North, run by ADRA and funded by UNICEF, is also supported by the HRH's office.

While a large and presumably important NGO such as the Red Crescent Society was less active on the local level than expected, two other important and relevant NGOs should be mentioned, namely the Noor Al-Hussein Foundation (NHF) and the Queen Alia Fund (QAF). Under the patronages of HRH Queen Noor and HRH Princess Basma respectively, these are two of the largest NGOs in Jordan in the areas of social development and disability. The NHF stresses the role of the local communities themselves, developing local leadership and offering support in the identification of needs and implementation of local projects. Their disability activities focus on early detection and development of parenting skills on the one hand, and empowerment of disabled persons within their communities on the other. Important components of the latter type include vocational training and micro-credit schemes – currently established by the NHF in 20 villages throughout the country.

The Queen Alia Fund's involvement in social development is also wide, supported by its 50 centres across the country. The QAF has a department that deals specifically with disability, and is represented in the National Council for the Affairs of the Disabled (see 5.2.1 below). Its activities has included, among other things, a national survey on disability, public awareness-raising activities, training of professionals and families of disabled, early detection and intervention programs, and special education centres for people with physical and hearing impairments.

The issue of co-ordination among NGOs themselves and with the public sector proved to be a concern among many of the organisations. While the GUVS seems to play a minor role in this respect, independent steps towards increased co-operation have been taken among organisations working in similar fields. An example is offered by an outreach network established by the al-Hussein Society for the Physically Challenged, the Holy Land Institute for the Deaf, the Swedish Centre for Mentally Handicapped, Nazik Al-Hariri Society for the Mentally Handicapped, and the Scandinavian Ladies of Amman Association. Their team assesses, educates and dispenses medical aids and equipment to those in need across the country, including refugee camps and several outlying villages and towns of the rural areas. It also provides physiotherapy and occupational therapy services to disabled children, and instructs their families and community volunteers to continue treatment.

4.5 A local view: the village of Mukhaibe on the border to Israel and Syria

As indicated in chapter 3, the landmine problem appears to be most serious in the northern areas of Jordan. Especially at the northern strip bordering Syria and Israel, where less attention has been paid to the problem, than in the Jordan Valley, where actual de-mining has taken place since 1993 with international assistance. This was confirmed to us by both the ICRC and NHF, the latter having received reports of problems with landmines from several of the villages in the north.

On invitation of Noor al-Hussein Foundation we selected the village of Mukhaibe, on the border to Israel and Syria under the Golan Heights as a "case-study" of the local situation in the north. Mukhaibe it is the first in Jordan to approach the authorities for assistance to alleviate the humanitarian impact of landmines. Human and economic losses suffered by landmines have been identified by its Village Council as a main obstacle to its development and welfare.

Village profile: the problem of landmines in context

Mukhaibe village is located in Irbid governorate within the Bani Kinana district. It is divided into Upper and Lower Mukhaibe, with a combined population of 5,400. Mukhaibe is home to some of the poorer communities in the North. The livelihood of most villagers depends on shepherding, farming, chicken farms, and government employment – although the latter is rather limited due to the centralisation of these institutions in Irbid city, about 40 km away. Upper Mukhaibe has additional revenues from tourists and picnickers using its facilities, as it is a spa area with rich greenery. While serving as an economic advantage, running water leads to land movements which dislocate mines and increases the risk of accidents.

Several other factors put the Mukhaibe communities at risk of landmine accidents. Due to population growth, residential areas have expanded into previous mine fields which had been cleared, but not declared absolutely safe by the military. Still, warning signs and fences had been removed and insufficient restrictions were placed upon villagers from taking the areas into use. Some serious accidents had subsequently taken place in the areas.

Warning signs signalling the mine fields were small, and not supported by symbols that the illiterate and children could easily understand. Fences aimed at restricting access to minefields were in some places insufficiently maintained, making it possible for animals and children to slip through. Apparently, some of the local population defied the dangers and had taken the actual mine fields into use, and we could ourselves see shepherds herding sheep inside the fields. According to local representatives, the military has been unwilling to spend money on upgrading signage, since the mines are to be removed anyway.

Impact and victims

The landmines surrounding Mukhaibe have caused injury to the people, their animals, and their general economic development. The village has had 12 victims from the village over the past thirty years, which is perhaps fewer than one might have expected from its extremely exposed location. Victims were mainly shepherds following their animals into minefields, women collecting herbs from mined areas, or children straying into the fields. An unknown number of outsiders, usually picnickers, had also been injured in the areas.

Despite the relatively small number of victims, the situation of the survivors illustrate some of the weaknesses of the health system faced by individuals with modest personal resources. An example is the limited capacity of village health centres to deal with serious accidents: the two health centres in Upper and Lower Mukhaibe are served by 1 doctor and do not have the facilities nor expertise to provide the necessary treatment. The nearest hospital is in Irbid city, 40 km away. Since there are no ambulances in the village, emergency cases must be taken to Irbid in taxi – requested from the nearby town of Um Qais.

On the rehabilitation side, none of the victims we met with had prostheses, although they all had had limbs removed. The lack of prostheses was explained by distance from the nearest rehabilitation centre, and travel and prosthetic costs, as most victims were uninsured. Bureaucratic procedures and lack of knowledge of rights and available services contributed further to prevent individuals from obtaining public assistance.

The detrimental impact of landmines on the village's two main sources of livelihood, animal rearing and farming, was a great concern to the village leaders. According to the Lower Mukhaibe Village Council, the total number of animals killed by landmine explosions amounted to 15 cows, 35 sheep, 61 goats, and up to 2000 chickens. Similarly, the rich soil in the area has been left largely under-utilised since mines were placed in the late 1960s, representing a considerable economic loss.

4.6 Conclusion

Jordan has a substantial health infrastructure in place, due to deliberate public policies aimed at providing adequate health services to all. Yet, "adequate" services are sometimes rudimentary, and more advanced forms of secondary and tertiary care are not easily available,

especially outside of Amman. Thus, a weakness in the system of health care services available to landmine victims, is access to prosthetic and rehabilitation services in the regions exposed to mine accidents. While a number of NGOs are active in the field of disability, contributing vitally in their fields, only of few of them have a significant national outreach, and cannot compensate for insufficient state services in the fields mentioned.

5 National policies and programs

Generally, health has been a field of priority in Jordanian public policies, and overall public spending on health compares well even with industrial countries. Yet, while there are notable strengths as well as important weaknesses in the Jordanian health system, problems remain in accessibility and efficient utilisation of existing resources. The problem applies in particular in relation to those living in remote and rural areas and with modest personal resources, a group to which civilian mine victims frequently belong. In the present chapter some aspects of this problem will be discussed. First, the Jordanian health insurance system will be described in some detail. Second, we discuss recent legislative initiatives aiming at empowerment of the disabled and greater co-ordination of services. Finally, education of key groups of health personnel is discussed.

5.1 Financial access: The Jordanian health insurance system

Except general availability, probably the single most fundamental determinant of access to and use of goods and services is *cost*. In Jordan, health services are covered in various ways by the state and through private schemes, with the private sector slightly larger than the public measured by sources of payment (World Bank 1996:12). In addition, there is a significant role played by NGOs. Most notable in terms of size is UNRWA which provides basic health services to some 400, 000 Palestinian refugees, but which refers these to public and private hospitals for further care.

While the private sector is based on individual as well as collective work-place arrangements, the public sector consists of two main programs, a civilian program organised by the Ministry of Health (MOH) and a military program organised by the Royal Medical Services (RMS). In addition, there are some smaller university-based programs. All of these both finance and provide health care on different levels. The MOH system consists primarily of the Civil Insurance Program whose nominal beneficiaries are civil servants and their dependants, as well as the poor, needy disabled and blood donors (World bank 1996: Annex 3). In addition, the MOH subsidises care and services provided to non-insured *and* also to patients covered by other schemes, such as through its network of primary health centres. The Royal Medical Services is larger than the MOH system in terms of the number of persons covered, which is estimated by the World Bank (1996:20) to include as much as 35 percent of the population. The figure reflects the fact that military insurance not only covers active or retired personnel, but also a liberally defined group of dependants.

Based on the combined formal scope of the individual programs, the World Bank (1996:16) estimates the aggregate insurance coverage at 80 percent of the population, a figure far above the 53 percent of a representative sample of the population which themselves report to belong to an insurance scheme in a recent Fafo survey (1998:189). While subsidised care and services are usually available to the uninsured, lacking insurance clearly increases costs significantly and thus reduces access to care, services, and accessories for up to one-half of the Jordanian population. This applies in particular to the more costly advanced services and equipment – including those of rehabilitation and prosthetic services. For certain services, such as pharmaceuticals, the uninsured have to pay market rates. Similarly, the actual coverage of the various schemes are varied, sometimes excluding or reducing support for certain services. For example, transportation to and from institutions for non-emergency care does not appear to be covered by public insurance, thus discouraging the utilisation of central services, especially among the less prosperous in rural areas.

The process of obtaining free insurance cards for those entitled is rather complex, probably contributing to the under-utilisation of current entitlements. For example, an adult disabled must first approach the MOSD or its regional directorates for his/her card. The MOSD will then do a case evaluation and a medical evaluation to confirm the disability and send it to Amman's Family and Children Directorate, which takes the case to the MOH, which must give a final approval and issue the insurance card. Jordanian authorities clearly recognise the deficiencies of its insurance system, and plans are underway to extend its coverage.

5.2 Empowerment and rights: The Law for the Welfare of the Disabled

Following several years of public debate and high-level advocacy *The Law for the Welfare of Disabled Persons* (MOSD 1993, Law No. 12/1993) was adopted by the Jordanian parliament in April 1993, representing a significant measure of formalisation of disability rights in Jordan. The Law is the first of its kind in the Arab region, and its provisions and entitlements are progressive by any international standard. It entitles the disabled – among other things – to health care, education, vocational training and rehabilitation, employment, sports and recreation, and participation in decision making. Further, it provides for caretaker support for poor families with disabled members, free health insurance for the "needy" and their dependants, tax exemptions on various equipment and cars imported by individuals and institutions, quotas (2 percent) of disabled among employees in both the private and public sectors, and special facilities for disabled persons in all new public buildings.

The law contains provisions of significant institutional relevance. Most notably, it places the Ministry of Social Development in a new-found co-ordinating role, noting that the MOSD "in co-operation with the other Ministries, Governmental Departments…[etc.] shall work towards the provision by these parties of their services and programs for the welfare of the disabled persons" (MOSD 1993: Article 4). Further, the MOSD "shall supervise and license all institutions and centres in the public and private sectors concerned with the rehabilitation, welfare and relief of disabled persons" (ibid.). Included among the relevant bodies covered by the law, whose respective roles and responsibilities are delineated in the text, are the Royal Medical Services which shall contribute in "its field of specialisation" on a par with the Ministry of Health and other civilian ministries and agencies. The leading

role bestowed upon the MOSD in the implementation of the law is an example both of the Ministry's increasing involvement in health policies as well as its emerging supervisory or supra-ministerial role in the political system more generally, although the exact extent of that role was not defined to us. The new and leading role of the MOSD is also evident in the composition of another notable institutional innovation, namely the *National Council for the Welfare of Disabled Persons*, to be described below, in which the MOSD holds the presidency, vice-chairmanship and secretary.

Meetings with local professionals indicate that the general awareness of the law and its generous entitlements, as well as official enforcement, could be improved. Steps have been made in that direction, the most important of which is the establishment of the above mentioned National Council for the Welfare of Disabled Persons, and its specialised sub-committees. The establishment of the council was explicitly called for in Article 6 of the Law in recognition of the need for such a national body to assume responsibility for initiating and overseeing the law.

5.2.1 National Council for the Welfare of Disabled Persons

The National Council consists of nearly all government ministries, represented by their respective secretary-generals under the presidency of the Minster of Social Development. The Council also includes several representatives from the non-governmental sector, disabled persons, and the armed forces. This wide and multi-sectoral representation meets the need for co-ordinating national efforts in the area of disability called for by several of our meeting partners. The Council, with its wide authority to initiate, oversee and implement measures for the disabled, has a strong formal potential to act as the co-ordinating body.

According to Article 7 in the disability law, the Council is supposed to draft "the general policy for the welfare, rehabilitation and education of disabled persons", prepare a national plan for prevention and alleviation of disability and its effects, and lay down "internal executive and organisational instructions for the administrative, educational and rehabilitation projects and programs as required for the implementation of the Law". While the Council is yet to gain a position as strong as that envisioned by the law, it has appointed a smaller Executive Committee and specialised sub-committees which are active in various fields.

The Executive Committee is chaired by the Secretary General of the MOSD and HRH Prince Firas. With its own premises and administration, the committee meets regularly (2 or 3 times a month), and can be considered the technical arm of the Council serving as a liaison between the Council and its sub-committees. There are seven sub-committees, each with about ten members, representing concerned ministries, NGOs, and to some extent the private sector. These committees were established, some as recently as 1996, to focus on the following areas: needs-assessment, a newsletter for the National Council, setting conditions for tax exemptions, establishing a National Disability Register, community-based rehabilitation, providing standards of sign language interpreters, and co-ordination of national efforts in the field of special education.

Some of the most important measures that have been introduced by the National Council include a special Identification Card for the disabled entitling them to special benefits, the introduction of a community-based rehabilitation program at Mu'tah public university to serve as a national training centre, and the establishment of a National

Disability Register to serve as a comprehensive database on all disabled persons in the country. As noted by international agencies that we met with, popular and professional awareness and official enforcement of the progressive legislation adopted over the recent years continue to pose obstacles to further improvements upon the opportunities and well-being of the disabled in Jordan.

5.2.2 The National Disability Register

The idea of establishing a National Disability Register came about in recognition of the need to collect reliable and comprehensive information on the disabled population in Jordan. It is a joint endeavour led by the MOSD and MOH through one of the sub-committees of the National Council. Its purpose is primarily to establish the number of disabled persons throughout the Kingdom, with details about their disabilities. The register would serve as a running database on disabled persons in the country, providing policymakers with a tool for more accurate planning of future activities, programs and preventative measures

To date, the National Register is not functional, and the mechanism for its start-up and data collection is still in the planning phase. Reportedly, the information sheets to be filled in by MOSD regional directorates across the country has been designed, pending approval by the National Council. Once approved, the next step would be to train the data collection staff while simultaneously raising public awareness as a means to facilitate registration of all disabled persons. All those registered are entitled to the above-mentioned ID. Thus the ID would serve as an incentive to encourage disabled persons to register in order to receive their entitled benefits and exemptions. On the other hand social stigma attached to disability is still prevalent in Jordan, and this combined with the problem of local awareness of central policy initiatives pose a real risk that registration remains incomplete. This will both reduce its quality as tool for policy making as well as impair access to entitlements among the non-registered.

5.3 Reintegration into economic life: Training opportunities for disabled

Providing the disabled with skills and adequate training which corresponds to their abilities and the needs of the job market is crucial in promoting economic and social reintegration. This section focuses on the key providers of training opportunities to disabled persons in Jordan, outlining other schemes available to facilitate their post-training employment and reintegration into economic life.

As indicated above, the responsibilities for the disabled rest in many different ministries. While the MOH has the responsibility for primary health care and physical rehabilitation, the Ministry of Education (MOE) is responsible for the education of minors (below 18 years of age), and the Ministry of Higher Education (MOHE) for the education of adults. Although there is an option for vocational training in the secondary cycle under the MOE's educational system, the Ministry of Labour (MOL) is the main institution responsible for vocational training of adults. Under the MOL is established a Vocational Training Corporation, with training institutes distributed throughout the Kingdom. The facilities of the Vocational Training Corporation have recently been made available to disabled persons, following advocacy on the part of HRH Prince Raad's Office. According to this agreement, training institutes shall adapt some of their courses and introduce new

ones to suit the abilities of disabled persons. To date, there have been few disabled graduates of these institutes, as this is a new venture and the introduction of special courses is still in its planning phase.

The Ministry of Social Development has two training centres for the disabled in Jordan, and has recently introduced a new department in its ministry to assist graduates of vocational training centres in finding employment. They also try to ensure that the 2 percent employment quota called for by the disability law is implemented on the ground. This is proving to be a challenge due to the preference of employers for able-bodied employees, and there are neither official means of enforcement nor a systematic monitoring mechanism to ensure that this part of the law is implemented.

The role of local NGOs in this field cannot be overlooked: as mentioned above, several NGOs have established income-generating projects for the disabled in local communities. The CBR program of Prince Raad's Office has a larger-scale employment project which aims at employing disabled persons especially from poorer communities, such as a paper clip factory in Kerak which offers employment to the blind. The Al-Hussein Society for the Physically Challenged offers a 2-year course in television and radio repair which is recognised by the MOE.

5.4 Human Resource Development

This section examines in brief the education of personnel key in the treatment of mine victims and other amputees, notably prosthetic technicians, and rehabilitation workers such as occupational therapists and physiotherapists. It looks at the educational and training opportunities and institutions existing in Jordan to promote human resource development in the above-mentioned fields.

As for *rehabilitation physicians*, it appears that in 1997 there were only 4 such specialists educated, out of a total of 318 specialists educated that year (WHO 1998:25). There were 19 graduates in *physiotherapy* the same year (not including the RMS), all of which were educated in Amman, and none at an institute in Irbid which was set up to facilitate recruitment to the northern region. There were 7 graduates in *occupational therapy*. The RMS has its own community college for paramedical professions (including physiotherapy) under the responsibility of MOHE, which provides education and training courses for different paramedical categories at the main hospitals. The situation for *prosthetic technicians* is quite acute, since the only institution that offered a prosthetic training program (the Institute for Orthopaedic Technology previously funded by the German GTZ) recently closed down. Although exchange programs and training opportunities abroad are occasionally available to RMS and Al-Bashir, they are insufficient to meet the needs. According to the RMS, there is a possibility that a new prosthetic program will be set up at Jordan University. A more general problem concerning education of specialised personnel in Jordan, is that of brain-drain. Physiotherapists and occupational therapists are frequently recruited to Gulf countries for better salaries.

In order to improve access of disabled persons living in more remote areas to rehabilitation services, several of the NGOs mentioned above have started training programs for volunteers and parents with basic physiotherapy and occupational therapy skills within their communities. The CBR Rehabilitation Program of Prince Raad's Office has co-

sponsored an academic degree in community-based rehabilitation at Mu'tah University in Kerak, which is intended to serve as a national centre for specialised training in CBR.

6 Conclusion

According to military figures, Jordan has had a total of 452 victims from 1968 through 1998, 62 percent of which were military personnel. Cross-checking and local fieldwork lends support to the number, but suggest some underreporting. According to our estimates the total number of landmine victims during this period is not likely to exceed 700, with a 900 victims as a maximum. Mine victims thus constitute a marginal portion of Jordan's disabled community. Still, the problem of mine victims is significant in the border areas in the north and centre-north.

Jordan has a substantial health infrastructure in place, and considerable resources are devoted to health in the country. Yet, more advanced forms of secondary and tertiary care are not easily available, especially outside of Amman. A weakness in the system of health care services available to landmine victims, and other comparable patients, is access to prosthetic and rehabilitation services in the outlying regions exposed to mine accidents. NGO activities fall short of compensating for inadequate state services in these fields. It is likely that much could be achieved with marginal or no increase in total spending, as room for improvement has been found in several organisational aspects. Examples of the latter include inter-institutional and inter-sectoral co-operation, central co-ordination, education of health personnel, and health insurance arrangements. Similarly, work remains in the implementation of the commendable and progressive legislation on disability rights adopted in Jordan over the recent years.

References

Convention on the Prohibition of the use, stockpiling, production and transfer of antipersonnel mines and on their destruction. [http://www.icbl.org/frames/treaty.html]

Hanssen-Bauer, Jon, Jon Pedersen and Åge A. Tiltnes, eds. (1998), *Jordanian Society – Living Conditions in the Hashemite Society of Jordan*. Fafo-report 253. Oslo: Fafo

Law for the Welfare of Disabled Persons, Law Number (12) for the Year 1993 (English version). Amman: Ministry of Social Development

Ministry of Health (1997), *Annual Report 1996 –97*. Amman: Ministry of Health

Ministry of Higher Education (1997), *Annual Report 1996 –97*. Amman: Ministry of Higher Education

UNICEF (1997), Situation Analysis on Children and Women. Amman: UNICEF

World Bank (1996), *Hashemite Kingdom of Jordan. Health Sector Study,* Report No. 15418-JO, Human Resources Division, Country Department II, Middle East and North Africa Region, August 12.

World Health Organisation, [1998], *Hashemite Kingdom of Jordan,* Country Profile. Unpublished draft. Amman: World Health Organisation

Landmine Victims in Jordan

Fafo Institute for Applied Social Science
P.O.Box: 2947 Tøyen
N-0608 Oslo, Norway
http://www.fafo.no

Fafo-paper 1999:3
Order number 615