

The aftermath of war: in the minefields of Mozambique

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There's a wealth of amputation
Waiting in the ground...

— Bruce Cockburn, "The Mines of Mozambique"¹

I have always taken pleasure and pride in doing things differently, taking the path least travelled and forging new ways. However, in the landmine-littered countryside of Mozambique, such actions could literally result in death or dismemberment. The "wealth of amputation" decried by Canadian singer Bruce Cockburn in his song "The Mines of Mozambique" was the reason why I travelled to that country. During my residency in Physical Medicine and Rehabilitation, I spent 3 months in rural Mozambique interviewing, examining and evaluating the functional, social and economic status of individuals who had had an amputation, with the specific goals of determining access to prosthetic services and identifying the obstacles faced in obtaining health care, prostheses and rehabilitation.

Although Mozambique was ranked 166th in the 1998 United Nations Human Development Report² in which Canada was listed first, it was once a highly industrialized country, a major tourist destination for Rhodesians and South Africans, and one of the first countries in southeast Africa to win independence from its European colonists. What followed independence was 17 years of civil war with atrocities such as the kidnapping of children who were then pressed into the service of the rebel armies, burning of villages, mass destruction of infrastructure, hospitals and schools, and widespread indiscriminate use of landmines. Now, despite 8 years of peace, Mozambicans continue to risk life and limb as they venture out in search of water, firewood and access to their farmland.

During my 3-month study, I interviewed over 160 people who had survived amputations. In Canada the majority of amputations are the result of vascular or infectious causes, however, 99% of the population I surveyed had lost limbs to trauma. Landmine injuries were the most common cause, followed by bullet wounds and train accidents. Many individuals had had limbs severed with a machete or by mortars. In many of the villages, our team of researchers was approached by men who had suffered penile amputations by rebel fighters' machetes. Furthermore, most injuries oc-



Children and civilians are often victims of landmines. Mario Chambale (pictured here) suffered a left transtibial amputation after stepping on a landmine when he was 12 years old. The author (right) examines his wood and rubber prosthesis during interviews. Mario was training to be a traditional healer in his community of Magude.

curred far from hospital, requiring days of transport. Thus, once viable limbs required amputation due to serious infection by the time the survivors reached medical care.

We met children who had severe physical trauma from landmine injuries that had occurred after the war, typically while they played in fields around their villages. One teenage boy had lost both legs above the knees and is now transported in a *capulana* (Mozambican sarong) carried on the backs of relatives.

Sixty-two percent of the people I interviewed had received one or more prostheses. A lack of affordable transportation to the rehabilitation centre and a lack of information were the major obstacles for those individuals who did not receive rehabilitation. Most of the people who had a prosthesis used it daily, even when the components had broken or had become worn through years of use. Only 22% of individuals who had a prosthesis had salaried employment, compared with 91% of people who had not had an amputation.

Yet, despite years of trauma and tragedy, the optimism and energy of the people we met prevailed. Neighbours who fought on different sides now work together to re-

build. I found few individuals, no matter how physically impaired, who were dependent on another person. Over 90% of those I interviewed expressed hope for the future. No disabled person felt rejected by community or family, as is often reported in studies of people with amputations in developing countries. One 14-year-old boy with an above-knee amputation told us that when he returned home from receiving his prosthesis, his classmates would force him to go out and climb trees with them. Some who had not made it to a rehabilitation centre, typically for lack of affordable transportation, constructed their own ingenious devices.

When I returned with 2 of my fellow researchers to Canada, the media wanted details of the tragedies, descriptions of what the landmine injuries were like and how devastated the country was. Colleagues and friends wanted to know how my experience had changed me and whether it would change the way I practise medicine. These were difficult questions to answer. Although the personal accounts and physical scars of the Mozambicans I interviewed and examined were horrific, I felt that I would be doing them an injustice by victimizing them further, promoting the image of a bleak, grief-stricken Africa. With most media images from Africa depicting masses of people in desperate circumstances, images that I find we have grown immune to, I felt obliged to emphasize the positive. Each individual story was unique: tales of community, heroism and survival against all odds. The woman who lost both legs when she was running to escape rebel fighters, and ran over mines that her family

had set to protect her village, now manages her family and farm from her knees wearing bright orange plastic kneecap protectors. A soldier who had lost both legs in a landmine explosion is active in an organization for disabled soldiers, runs a community store and farms. The girl whose arm was hacked off with a machete and handed back to her is now training to become a traditional medicine woman.

These strong people could teach us lessons about the power of people to endure and forgive. The healing process of a country is a long, slow one, not the stuff of headlines, much like rehabilitation medicine itself. I feel privileged to have been able to witness this.

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