

Gender mainstreaming  
in landmine victim assistance  
in Eastern Burma.

*From contemporary theory to future practice.*

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Master in International Health  
September 9, 2013 - September 12, 2014

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# Gender mainstreaming in landmine victim assistance in Eastern Burma.

*From contemporary theory to future practice.*

A thesis submitted in partial fulfilment of the requirements  
for the degree of Master in International Health

by

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Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements. The thesis "Gender mainstreaming in landmine victims assistance in Eastern Burma. *From contemporary theory to future practice.*" is my own work.



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# Abbreviations

ADL	Activities of Daily Living
CRPD	Convention of the Rights of People with Disabilities
CVD	Cardiovascular disease
DM	Diabetes Mellitus
GICHD	Geneva International Centre for Humanitarian Demining
GMAP	Gender and Mine Action Programme
HRV	Human Rights Violations
IASC	Inter-Agency Standing Committee
ICBL	International Campaign to Ban Landmines
ICRC	International Committee of the Red Cross
IDP	Internally Displaced People
IMAS	International Mine Action Standard
MBT	Mine Ban Treaty
NCD	Non-communicable disease
NSAG	Non-State Armed Group
OECD	Organisation for Economic Cooperation and Development
PRSP	Poverty Reduction Strategy Paper
SCBL	Swiss Campaign to Ban Landmines
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNHCR	United Nations High Commissioner of Refugees
UXO	Unexploded Ordnance
VA	Victim Assistance
WHO	World Health Organization

# Abstract

The changing political climate in Burma (also known as Myanmar) and increased pressure from Thai authorities suggest a return of 400,000 internally displaced people, and 120,000 registered refugees, currently living in the Thai-Burma border area, to Eastern Burma. The Burmese army and several non-state armed groups have used landmines for decades and Eastern Burma is believed to be one of the most heavily contaminated areas in the world. Mapping and clearance activities were mostly rejected by the Burmese government and a premature return of displaced people, before the land is cleared from landmines and political stability is achieved, raises strong concerns about their safety. Landmine victim assistance stakeholders should be prepared for a peak in new casualties, predominantly among civilians. Additionally, loosening restrictions from the Burmese authorities may provide access to medical and rehabilitation facilities for already existing landmine victims, increasing the demand for services. This document approaches victim assistance from a gender-sensitive perspective. Gender is discussed as a cross-cutting issue and context-specific considerations or recommendations are made throughout the victim assistance pillars: laws and policy, data collection, emergency and continuous medical care, physical and functional rehabilitation, psychological and psychosocial support, and socio-economic inclusion. Men, women, boys and girls have different roles, responsibilities, and values in society which makes them uniquely affected by landmine contamination. Gender determines, among other factors, if and how a person is affected by landmines: it influences a person's right and restrictions, movement patterns and daily activities, accessibility to services and facilities, physical survival and recovery chances, psychosocial support and coping mechanisms, socio-economic chances, and vulnerability to poverty. A gender-sensitive approach enhances the effectiveness of victim assistance, to appropriately reach the entire affected population. A distinction is made between direct victims (or: survivors) and indirect victims (family or community members affected by the consequences of landmine contamination and casualties). Furthermore, this document discusses the broader health and social consequences of landmine contamination within the prolonged conflict situation in Eastern Burma. It touches upon human rights violations related to landmines, and upon public health consequences due to inaccessibility of contaminated areas (i.e. limitations of vaccination campaigns, food scarcity, and vulnerability to infectious diseases). Finally, socio-economic inclusion, whereby every community member participates in social and economic activities, is highlighted. The association between disability and poverty is discussed, and the vulnerability to adverse alternative sources of livelihood (i.e. opium cultivation).

Key words: victim assistance, gender, landmines, Burma, displaced population, refugees, amputees

Word count: 11,972

# 1. Introduction

Landmines pose a life-long threat to affected communities, leaving traces of death and disability upon detonation. As of today, people in 62 states and other areas are facing movement restrictions and inaccessibility to land, water and food sources, health care, humanitarian aid, and safe play areas for children (ICBL/CMC, 2013a). Not only the sudden loss, but also the care for disabled household and community members poses a physical, psychological, social and economic burden to affected populations. Livestock and working animals are also at risk; casualties among oxen, buffaloes, goats and elephants directly impact the livelihood of affected communities. Anti-personal landmines are indiscriminate; any person or animal can trigger the devastating mechanism, even long after war or conflict has ended. The ‘invisible weapons’ form a barrier to development and (re)construction. Contaminated areas are often not or insufficiently marked; poverty, forced labour and restriction to water and food sources leave people no other choice than to endanger themselves, their families and their animals with every step they make on contaminated land.

Although reliable figures from conflict areas are difficult to obtain, Burma (also known as Myanmar) is believed to be one of the world’s most heavily contaminated countries, making up the global top-three together with Afghanistan and Colombia (ICBL/CMC, 2013). Both government and insurgent forces controlling the areas bordering Thailand have been using landmines throughout one of the longest conflicts in history. A total number of 3,349 casualties were reported in Burma from 1999 to 2012 (ICBL/CMC, 2013). The actual number is expected to be much higher as data collection has long been restricted by the Burmese government. Victims of landmines have been denied access to rehabilitation or other assistance for decades. Mine action initiatives, including mapping and clearance, have long been refused by the Burmese government, leaving vast areas of land contaminated. After consecutive military regimes, the political climate is changing with a quasi-civilian government installed in 2011: a national ceasefire is currently signed between the government military and ethnic forces while peace negotiations are ongoing (GC/DCA, 2011). There are still many steps to take on a road that is marked by mistrust for broken ceasefire and other agreements throughout history, but there is hope that Burma will allow unrestricted support to landmine victims in the future. Hundreds of thousands of refugees and internally displaced people are expected to return to their homeland in the months or years ahead. Among them are people with disabilities due to landmine accidents, others carry the burden of lost spouses or children, but all of them face the threat of remaining landmines in their home country. Many national and international parties fear a steep increase of casualties when people move through and resettle in areas that are not marked, nor cleared. Additionally there is a great lack of medical facilities to adequately respond to landmine accidents, and long term rehabilitation facilities are extremely limited. Strong advocacy for legal frameworks, the instalment and enforcement of policy and laws, accurate data collection, and facility and capacity building are desperately needed. These are crucial elements to anticipate to both the likeliness of new casualties and to answer to the needs of the thousands of people living with the life-long consequences of prior landmine accidents. Movement patterns, cultural beliefs, social structures, division of labour, and biomedical factors determine if, how and when people are at risk to become subject to landmines, as well as how best to

live with the consequences. Mine action program designers and fieldworkers acknowledge that men and women, boys and girls are differently affected by landmines and that all will benefit from a gender sensitive approach (SCBL, 2008). Gender refers to the social attributions, expectations, value and relations of men, women, boys and girls in a given society (IASC, 2006). This document aims to apply a gender-sensitive victim assistance approach within the context of Eastern Burma. It will touch upon the broader context of human rights violations in which landmine use is taking place, before discussing gender considerations throughout the pillars of victim assistance: laws and policy, data collection, emergency and continuing health care, physical and functional rehabilitation, psychological and psychosocial care, and socio-economic inclusion. Whereas landmine survivors (or: direct victims) are traditionally the main focus of donors and victim assistance (VA) implementers, i.e. because output and outcome are relatively easy to measure, this document aims to highlight the impact of landmines and VA on indirect victims as well. A gender-sensitive approach could be particularly beneficial for indirect victims: the people who live with the loss or disabilities of family or community members, although the complexity of issues that affect indirect victims, numerous influential factors, and less visibility make it more difficult to clearly identify and measure the impact of support to this target group. Landmine casualties among children will not be specifically discussed in this document; a thorough investigation which the topic deserves goes beyond the scope of this document.

## 2. Context- Eastern Burma

Karen, Karenni, Shan, and Mon ethnic groups live in or originate from landmine contaminated areas along the Thai-Burma border, in this document referred to as Eastern Burma. Kachin state in the north, bordering China, is also contaminated but faces different political and humanitarian issues. The states in Eastern Burma are often collectively discussed in the literature whereas Kachin is mostly excluded, and for that reason not considered in this document. Despite great differences between the ethnic groups and their subgroups, specific details will only be highlighted when particularly relevant.

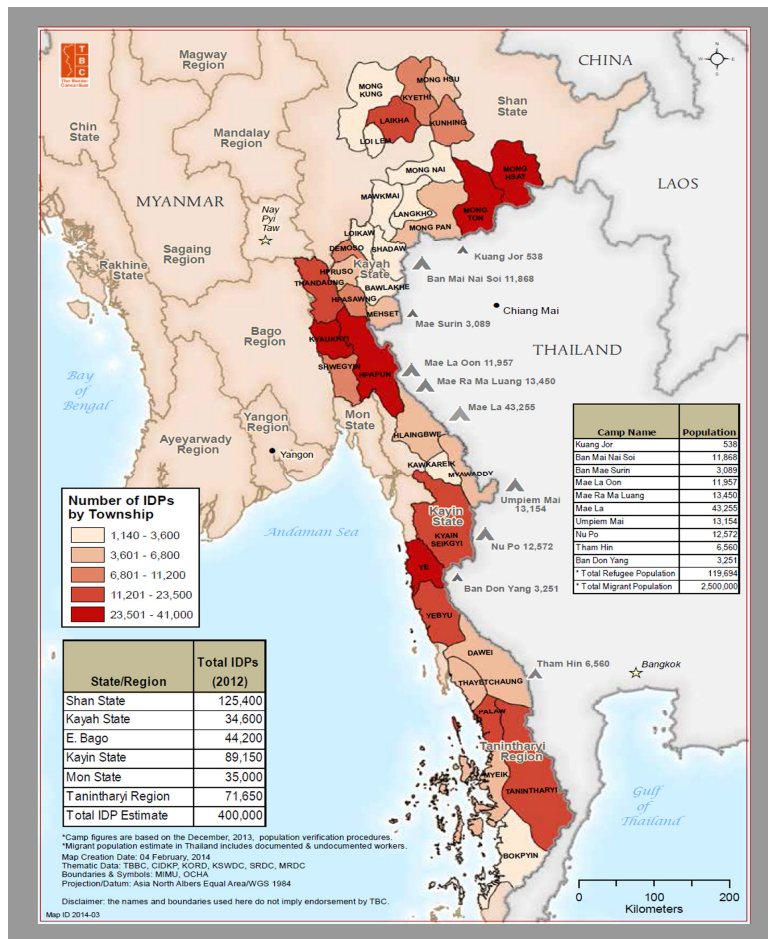
### 2.1 Conflict background

Upon independence from British rule, the 'Panglong agreement' was signed in 1947 promising autonomy to some of the many ethnic nationalities in Burma. The assassination of general Aung followed just months later and subsequently ruling military regimes never lived up to the agreement. Ethnic non-state armed groups (NSAGs) have since been fighting for equality and autonomy rights contesting the central government, which in turn has tried to 'divide and rule' the minorities. The counter-insurgency 'Four Cuts Strategy' was applied since the 1960s, intending to cut off opposition groups from food, financial resources, recruits and information. It is believed that large numbers of displaced people are a direct result of that strategy (Barron *et al.*, 2007).

Developing communication technology played an important role in the disclosure of large scale human rights violations. The government army (also called Tadmaw) is now known for its brutal regime. Men and boys are randomly recruited, forced labour like porter service is extensively used, and rape of women and girls by Tadmaw soldiers of any rank is believed to be used as a strategic weapon aiming at social disruption, humiliation, and demoralization. Homemade and factory produced landmines have been used by both government and ethnic forces since at least 6 decades placed around military settlements, strategic areas and places of economic interest, along roads, pathways, bridges, borders, and around villages (GC/DCA, 2011).

International pressure and increasing civil unrest brought the government in 2003 to the introduction of the 'Roadmap to Discipline-flourishing Democracy'. The first of seven steps leading to democracy was to reassemble the National Convention; every proposal to increase ethnic states' autonomy was therein rejected (Arnott, n.d.). Despite denial of the Panglong agreement and ongoing inequalities for ethnic minorities in Burma, the political climate is changing. In 2011 the installed quasi-civil government signed ceasefire agreements with 14 of 16 major ethnic groups and seeks consolidation into a national accord; political dialogues are promised to start soon (The Irrawaddy, 2014). National and international humanitarian initiatives are increasingly considered and some are being granted (conditionally) permission. Since the government relinquished their demand for ethnic nationalities to transform all existing military structures and to join the forces under control by the government, the peace negotiations made further progress (BBC, 2014).





**Figure 1: Internally displaced people in Eastern Burma, per township**  
**Source: The Border Consortium Programme Report July-Dec. 2013**

## 2.2 Displaced population

Currently there are an estimated 400,000 internally displaced persons (IDPs) in Eastern Burma (TBC, 2013). The refugee camps along the Thai-Burma border have hosted people since 1984 and currently count 120,000 registered and unregistered refugees (UNHCR, 2014). Recent situation assessments in the refugee camps and in future return areas raised concerns among the refugee population and humanitarian actors. Although United Nations High Commissioner of Refugees (UNHCR) stresses security and dignity to be preconditions for a voluntary return, many refugees worry about their safety and living conditions after repatriation (The Irrawaddy, 2013; Bangkok Post, 2014). The agreement of July 2014 between Thailand's National Council for Peace and Order who took power after a coup in May 2014, and the commander-in-chief of Burma's military to repatriate thousands of refugees living in the Thai border areas (Burma News International, 2014) seems to contradict the UNHCR statement that "there will be no active promotion of return until landmine areas are identified, openly marked and cleared" (Irinnews, 2013). Generations have grown up in the refugee camps and although they may have received mine risk education and will have been confronted with the consequences of landmines, many of them (especially children) have not directly been living in contaminated areas. Little is known about the extent of landmine contamination as mapping and demining initiatives have long been refused by the Burmese government. It is a major concern that the number of casualties will steeply increase when returning refugees start to farm possibly lethal ground. An additional increase of civilian over military casualties is expected when combatants return to farming, and when increased population density creates larger walking distances to collect water and wood.

## 3. Methodology

### 3.1 Aim and objectives

The aim of this document is to add to the effectiveness of landmine victim assistance in Eastern Burma. The objectives are:

- to explain why and how victim assistance programs could benefit from a gender sensitive approach
- to apply a gender-sensitive victim assistance framework to the context of Eastern Burma with a special focus on currently displaced ethnic minorities, expectedly returning in the near future

### 3.2 Methodology

A desk review with a focus on gender-sensitive landmine victim assistance was carried out, and the context of Eastern Burma was used as a case-study. Publicly available online sources were consulted, with the following search terms, individual or in combination, in full or truncated: landmine(s), victim(s), assistance, gender, rehabilitation, mine action, conflict, refugee(s), IDP(s), displaced population, ethnic, minorities, health, amputation(s), amputee(s), disability, disabilities, inclusion, psychological, war, trauma, violence, casualties, prosthetic(s), prostheses, orthotics, rape, public health, suicide, human rights, Karen, Karenni, Shan, Mon. Studies, guidelines, policy documents, and background information from personal experience in the area were collected and reviewed with use of the search engine 'Google', and the data bases of 'Pubmed', 'Sciencedirect', 'Source', 'Reliefweb', 'UN Mine Action Gateway', and 'MIMU' (Myanmar Information Management Unit). Material was selected according to relevance to the topic and validity, using triangulation on data and methodology. Limitations regarding publishing date were not applied but recent information was preferred because of recent and current changes in the area discussed in chapter 1 and 2. Information provided by governmental sources was regarded with reserve as it may not include or reflect specific details of ethnic minorities and areas controlled by ethnic forces. Eastern Burma has been isolated for many decades and there is still a great lack of information. Acknowledging that the used sources may not completely and objectively reflect reality, the information is regarded as currently the best available.

**3.3 Conceptual framework**

According to the United Nations, mine action consists of 5 pillars: stockpile destruction, demining, mine risk education, victim assistance, and advocacy. It strives to reduce the human, social, economic and environmental impact of landmine contamination. This document focuses on the victim assistance pillar, covering 6 elements: laws and policy, data collection, emergency and continuing medical care, physical and functional rehabilitation, psychological and psychosocial support and socio-economic inclusion (figure 2). The United Nations checklist for gender mainstreaming was used to discuss victim assistance elements from a gender-sensitive perspective (see appendix).



**Figure 2: Mine action pillars and victim assistance elements**  
Source: UN, 2010

**3.4 Ethical considerations**

Landmines are a politically sensitive issue holding links with several conflict related topics. The Burmese government is, despite progressing political reforms, reluctant for information to become public. Prudence not to disclose information on anyone’s personal account is crucial when writing about a country which has a long history of imprisonment and human rights abuses against persons revealing adverse information or an opinion undesirable to the ruling authorities. Specific details, however important, are for that reason sometimes deliberately left out or, when appropriate, generalized. Ethnic Burmese refugees and internally displaced people are the group of focus for this document; it strives for objectivity but not for a balanced view point taking into account considerations of the Burmese government and military forces.

## 4. Gender-sensitive victim assistance

The Mine Ban Treaty (MBT) as the principal framework calling upon mine action, addresses the need for victim assistance (VA) by stating in its preamble that States parties “in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programs” (<http://www.apminebanconvention.org/>). Various guidelines and action plans, including documents composed for related conventions (i.e. Convention on Cluster Munitions and protocol V to the Convention on Certain Conventional Weapons) aim to unify stakeholders in their approach and to support the implementation of VA (GICHD, 2011, chapter 1). The ‘Strategic Framework for Victim Assistance’ or Maputo Strategy (1999) was followed by the Nairobi Action Plan (2004) and the Cartagena Action Plan (2009), calling for on-the-ground action and goal setting. The current (draft) Maputo Action Plan stresses that “victim assistance should be integrated into broader national policies, plans and legal frameworks related to disability, health, education, employment, development and poverty reduction” (Maputo Summit, 2014). The definition of ‘landmine victims’ was adopted at the Nairobi Summit in 2004: “those who either individually or collectively have suffered physical or psychological injury, economic loss or substantial impairment of their fundamental rights through acts or omissions related to mine utilisation” (Nairobi Summit, 2004). Responding to the barrier that landmines pose for the entire affected population to develop, VA aims not only to improve the living conditions of individuals, but also intends to support development through socio-economic empowerment of the affected population. A distinction can be made between direct and indirect victims. 85-90% of direct landmine victims are men but among the indirect victims are their wives, mothers, children, etc. (Calza Bini and Massleberg, 2011). Women and children often face a multiple burden: they have to take up the responsibility of income generation in addition to caretaking. A landmine accident may set off a chain of events for both direct and indirect victims: catastrophic health care expenses, economic deprivation, school drop-out and limited future chances (Wyper, 2012).

The ultimate goal of VA is ‘full and effective participation and inclusion in society’ of landmine victims (GICHD, 2011, chapter 2). Men, women, boys and girls hold different roles in society and are uniquely impacted. VA should take gender into account in order to effectively reach all victims. Gender, together with other factors, determines:

- if and how a person’s rights are respected or protected (chapter 6)
- where, why, how and when people are exposed to landmines (chapter 7)
- if medical facilities are accessible and how appropriate the available services are (chapter 8)
- how rehabilitation affect the quality of life of female and male victims (chapter 9)
- how affected men and women cope with psychosocial consequences (chapter 10)
- which opportunities and restrictions apply to socioeconomic participation of men and women (chapter 11)

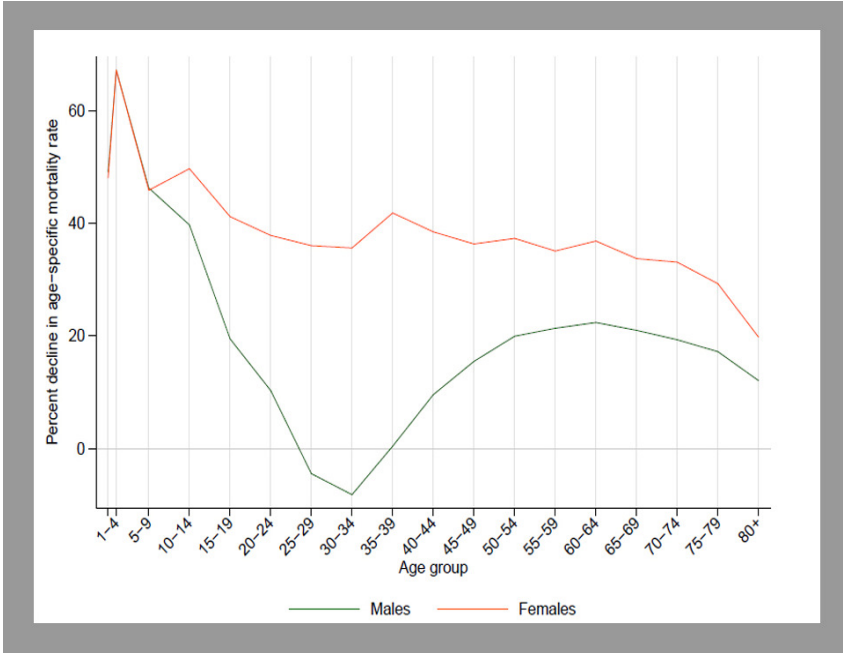
'The Strategy of the United Nations on Mine Action 2013-2018' refers to gender in all of the 4 strategic objectives and calls for a promotion of "gender mainstreaming and the implementation of the Gender Guidelines for Mine Action Programmes" (UNIACGMA, 2012, p.13). Gender mainstreaming is the process of creating knowledge, awareness and responsibility to address gender differences throughout the design, implementation, monitoring, and evaluation of programmes (SCBL, 2008). The Gender and Mine Action Programme (GMAP) emanated from the Swiss Campaign to Ban Landmines (SCBL), encourages and supports gender mainstreaming in policies, programming and operations, complementing the efforts of collaborating mine action stakeholders. The Geneva International Centre for Humanitarian Demining (GICHD) requested a gender review of the International Mine Action Standard (IMAS) in 2008. Despite growing attention, there is still a gap to bridge between understandings and frameworks, and the transformation of these into action. The latest Monitor Report, evaluating the proceeding of promises and responsibilities under the MBT, highlights "ensuring that all victims, along with other people with similar need, have equal access to age and gender appropriate services" as one of the 3 main challenges (ICBL/CMC, 2013).



# 5. Landmines in Eastern Burma

Mullany *et al.* (2007) argue that forcibly displaced people in Eastern Burma are 4 times more likely to have a family member subject to landmine accident than other people in the same area. Landmine use and its casualties are part of a chain of human rights violations and consequences. A thorough exploration goes beyond the scope of this document, but it is important to acknowledge the broader context. ‘Deliberate attacks of villages, confiscation of land and assets, large-scale forced relocation, torture, extrajudicial execution, rape and other sexual violence against women and girls, and the use of child soldiers’ are among on the long list of allegations collected through interviews with civilians, combatants and escaped detainees from Eastern Burma (HRW/KHRG, 2011). Convict porters are systematically used by government forces to carry military supplies, to function as human shields, and for ‘human minesweeping’. For this purpose, also known as ‘atrocitiy demining’, people are forced to walk ahead of columns or patrols to detect and remove or to detonate landmines. The numerous recalled occasions of landmine casualties have merely the same end: injured porters are left behind to be found back dead, or are shot on the spot since they are not able to fulfil their task anymore (HRW/KHRG, 2011).

The demographics of Eastern Burma are characteristic of a chronic low-intensity conflict zone: high birth rates, high death rates, and a relative absence of young men (Guha-Sapir and D’Aoust, 2010; Avalon, 2012). A male/female ratio of 89/100 suggests conflict-related life-loss (Parmar, 2014). Figure 3 shows that Burmese men aged mid-20 to mid-30 experienced increased mortality rates between 1990 and 2010 (IHME, 2013).



**Figure 3: Percent decline in age-specific mortality rate by sex from 1990-2010 in Burma**  
**Source: Institute for Health Metrics and Evaluation**

Recent studies confirm findings of prior surveys associating adverse health outcomes with human rights violations (HRV); the most frequently experienced violations in Eastern Burma are food destruction or theft, forced displacement, and forced labour (table 1) (Lee *et al.*, 2006; Mullany *et al.*, 2007). Although landmine injuries could be regarded as a violation of human rights, depriving people from access to food, water, and healthcare, Mullany *et al.* (2007) approach it from a health outcome perspective. Confounding factors were not explicitly explored so associations may not be regarded as causalities; nevertheless they describe increased odds of reported landmine injuries within households that experienced HRV in the year prior to the survey compared to households that did not experience HRV (table 2):

<b>Type of HRV</b>	<b>Odds ratio (95% CI)</b>
Food destruction or theft	4.55 (1.23 - 16.91)
Forced displacement	3.89 (1.01 - 15.0)
Forced labour	2.62 (0.71 - 9.61)

<b>Number of HRV</b>	<b>Odds ratio (95% CI)</b>
0	1.00
1	3.61 (0.47 - 27.5)
2 or more	19.79 (2.59 - 151.2)

**Tables 1 and 2: reported landmine injuries associated with experienced human rights violations**  
**Source: Mullany, 2007**

The latest reports from Human Rights Watch, Karen Human Rights Group, Amnesty International and others consistently mention ongoing violations of human rights but also note that the intensity of the fighting has decreased (KHRG, 2014; HRW, 2013; AI, 2012). United Nations (UN) point out international humanitarian law violations and the Security Council Resolutions has called for investigation and ending of it. The culture of impunity however is reinforced since the military is independent from the civilian government and it not obliged to answer to questions from the government or international community (GJC, 2012).

Tadmadaw soldiers’ impunity is in particular demonstrated in the systematic rape of women and (sometimes extremely young) girls. Women are being raped when they refuse to hand over a son for recruitment, or in the absence of a spouse due to forced labour, or due to landmine or fight related death (SHRF/SWAN, 2002). Raping is strongly linked to displacement: it takes place while women necessarily have to collect water and wood in areas afar due to landmines and displacement, or during the process of (forced) migration when typically spouses and children are held under gunshot being forced to watch. Raping during forced labour has been reported, during incarceration in military camps, or while farming (Apple and Martin, 2003). Gang-rape, assault related injuries leading to death, and killings of women and girls by government soldiers are documented. Families are disrupted as women frequently flee after being raped or out of fear for it. Without providing any further details, Cardozo *et al.* mention in their study (2004) not only 3% of the women, but also 3% of the men among

the studied Karenni refugee population to be raped. The majority of incidents are suspected to remain unreported due to shame, cultural norms, and stigma which may prevent men even more than women from reporting (WLB, 2014).

### 5.1 Types of landmines and injuries

Anti-personnel mines can be divided in 2 categories (ICRC, 2005):

- **Blast mines** are mostly buried in the ground and destroy limbs upon detonation with pressure waves travelling faster than the speed of sound; they intend to maim rather than to kill.
- **Fragmentation mines** are mostly detonated by a trip-wire; hundreds of fragments are fired off into the target's body and often involve more than one victim due to its large fire range.

Landmine injuries are classically divided in 3 patterns (Coupland, 1997):

- **Type 1:** severe injury of legs, perineum and genitalia after foot contact with an AP-mine, mostly resulting in one or more traumatic amputations of variable anatomical level
- **Type 2:** severe fragmentation wounds potentially affecting any body part, commonly including head, chest and abdomen; resulting from triggering a fragmentation mine
- **Type 3:** severe wounds on hands, arms, neck and face, caused by accidental detonation while handling a mine (placing/clearing/playing), mostly resulting in upper limb amputation(s) and severe eye damage

The location of penetrated debris and the extent of bone and soft tissue destruction depend on the type of mine, the distance to it, and the victim's body composition. Women and children with smaller bodies face greater risk of damage to vital organs and genitals with type 1 and type 2 injuries. Men are more often than women subject to type 3 injuries related to either deliberate or forced handling of mines: they are most likely to plant or remove NSAG mines and to be used by government forces as human mine sweepers.

Besides the physical and psychological burden of a lost or disabled family member and the omnipresent threat for individuals, landmine contamination carries numerous public health consequences. Diarrhoea and water-borne diseases i.e. result from limited access to safe drinking water and improved sanitation (respectively 27% and 51% in vulnerable communities). Open defecation too close to the living areas, in order to avoid unsafe ground, leads to hygiene-related diseases. Vaccination campaigns and distribution of vitamins and minerals are restricted by both the government and by the presence of landmines. Physical, educational and medical infrastructure and resources have been denied or destroyed throughout the ethnic areas, allowing multi-resistant malaria and tuberculosis to develop from absent or improperly administered treatment (TBC, 2013).



<i>Indicator</i>	<i>Burma*</i>	<i>Thailand*</i>	<i>Eastern Burma** (95% CI)</i>
Infant mortality rate per 1,000 live births	41	11	77 (56-98)
Under -5 mortality rate per 1,000 live births	52	13	139 (107-171)
Maternal mortality ratio per 100,000 live births	200	26	711 (150-1272)
Life expectancy at birth	64 (M) 68 (F)	71 (M) 79 (F)	
Government expenditure on health per capita (in US\$)	4	289	
Government expenditure on health as % of the total government expenditure	1.5	15.3	
Private expenditure on health as % of the total expenditures on health	84.1	22.3	
Out-of-pocket expenditure as % of total private expenditure on health	93.7	55.8	
Number of hospitals (per 10,000 pop.)	0.6	1.8	
Number of hospital beds (per 10,000 pop.)	6	21	

**Table 3: Selected health indicators for Burma, Thailand and Eastern Burma**

**Source \* WHO Health Statistics 2014**

**Source \*\* Parmar 2014**

Widespread food insecurity is highlighted throughout several assessments; acute malnutrition rates up to 41.2% are reported and 59.1% of all premature deaths in Eastern Burma are believed to be caused by preventable diseases (BPHWT, 2010; Beyrer and Lee, 2008). The aforementioned 3 major HRVs all affect food security: either directly (destruction or theft) or indirectly (forced displacement and forced labour make it impossible for people to farm their land). Additionally, landmine contamination causes farm land to be (partially) inaccessible, resulting in food scarcity and malnutrition. Poor health interacts with poverty through a vicious circle: illnesses make people less capable to work and generate income, thus sufficient and necessary resources are less affordable, leading to worsening health conditions, i.e. from increased susceptibility to infectious diseases. Differences in health indicators (table 3) between Eastern Burma and the national statistics are not solely on the account of landmine contamination, but it is considered to be an important contributing factor.

## 6. Laws and policy

There is great political gender inequality in Burma: 37 out of 38 minister government posts are filled by men and the military dominates most political branches. All 12 members of the Union Level Peace Team, concerned with the design and implementation of ceasefire policies, are men. Only 2 out of 52 persons in the related Working Committee are women. The Myanmar Peace Center, established in 2012, does not employ women in the strategic running and the importance of including women in peace negotiations is neglected in their mission statement (Hedström, 2013; Belak, 2002). The Myanmar Mine Action Center falls under the Myanmar Peace Center and has the role to “act as a regulatory, planning, coordination and quality management body” and to “serve as the focal point for all humanitarian mine action activities within the country” (<http://myanmarpeace.org/> accessed 20 July 2014). The Myanmar National Mine Action Standards have been drafted and adopted and require adherence by international humanitarian mine action operators in Myanmar. There is a great risk that the absence of women in policy development will be reflected by a strongly male-oriented, gender blind approach to VA.

Disability issues fall under the responsibility of the Ministry of Welfare, Relief and Resettlement. Burma ratified the Convention of the Rights of People with Disabilities (CRPD) in 2011. CRPD “provides a framework to address the needs of survivors and to ensure the full realization of their human rights and respect for their inherent dignity” (UNHR, 2008). Although not representing the total group of (indirect) landmine victims (see chapter 3), through its signature Burma promised the “full and effective participation and inclusion in society” of persons with disabilities (UN, 2006). A “Rights of Disabled Persons Law” was drafted for submission to the parliament. Minister U Kyaw Tin (2014) announced at the 7<sup>th</sup> session of the CRPD “[...] to make the right real for persons with disabilities, a National Action Plan for Disabilities (2014-2024) is being developed for implementation with the participation of persons with disabilities.” With that he refers to the Incheon Strategy of the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) to which Burma is a member. Among the 10 goals in this strategy for the 2013-2022 decade, goal 6 specifically focuses on gender: “Ensure gender equality and women’s empowerment” (UNESCAP, 2012). The Burmese Ministry of Health mentions in the objectives of the current 5-year plan: “to ensure quality health care for citizens by improving quality of curative services as a priority measure and strengthen measures for disability prevention and rehabilitation” and: “expanding health care coverage in rural, peri-urban and border areas” (MoH, 2013).

Burma is not a States Party to the Mine Ban Treaty (MBT) but international pressure increases on the Burmese government to sign it; with its signature the government would be held accountable for implementation of mine action programs. NSAGs cannot sign a convention, but several groups signed a ‘Deed of Commitment’ to ban anti-personnel mines with the Swiss non-governmental organization ‘Geneva Call’ (GC/DCA, 2011). The MBT and CRPD legal frameworks originate from different contexts and have their own respective focus, but they overlap and complement each other in the area of victim assistance. They “share the goal of promoting the full inclusion of survivors and other persons with

disability within society” (ICBL/CMC, 2011, p.3) including gender as a cross-cutting topic. Signing international treaties or conventions does not automatically guarantee that the Burmese government will fulfil the connected commitments. Burma accessed the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in 1997 after it already accessed the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (1992), the Convention on the Rights of the Child (1991), and in earlier times the Convention concerning Forced or Compulsory Labour (1955) but widespread violations to all of these agreements are still ongoing. For none of the conventions was the optional protocol signed, which would enable inquiry or complaints procedures regarding convention violations.

## 7. Data collection

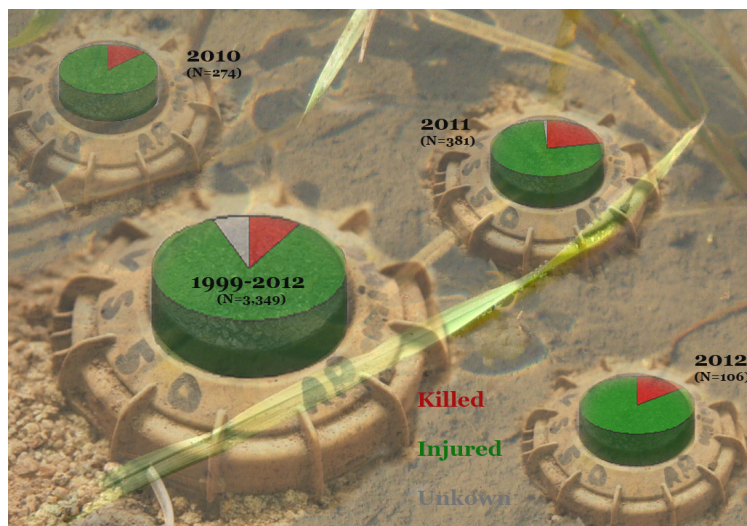
Burma has long been isolated from the international community and the situation in Eastern Burma has equally been unknown to the Central Burmese population. Results from the April 2014 national census, expected to be released later this year, may fill some information gaps that have resulted from restricted access to minority areas by the government and ongoing violence. Cooperating community based organizations have increasingly made data available from surveys carried out by health workers over recent years. Although data are incomplete and bias is likely, the information is of great importance and is generally used to plan and prioritize activities (TBC, 2013; GC/DCA, 2011).

There is a unanimous understanding of the need for accurate data in order to deliver effective landmine victim assistance (VA). All accessible sources should be consulted for the purpose of complete and accurate data collection throughout the planning, execution and evaluation of VA, to enhance a benefit for all, and to allocate resources effectively and efficiently. In order to respond to the different needs of women, men, girls and boys, data should be disaggregated by sex and age, and should contain accident related activity to understand where, why, how, and when accidents happen to different people. Despite their importance, data from conflict areas are hard to obtain. Although some mapping activity in Eastern Burma has been permitted in recent years, it is not known how many mines are still present. National data do not reflect local disparities and the reliability of data collected by health workers is uncertain. In addition, victims may be reluctant to provide details fearing repercussion or in the cultural belief that injuries or death are a moral punishment. On the other hand, data collection systems have improved over the last years in terms of disaggregation and correction of duplications (ICBL/CMC 2013a).

### 7.1 Available data

The International Campaign to Ban Landmines (ICBL) annually publishes the Landmine Monitor Report, containing global and country-specific data to monitor the world-wide landmine problem and the MBT implementation proceeding. Landmine Monitor report is a compendium of all available data and is therefore regarded as the most comprehensive source. Despite ICBL's rigorous approach, data about type and degree of injuries are lacking.

The following statistics are based on information from community based organizations, ICBL Monitor reports, and publicly available research data. Fluctuating figures reflect temporary changes like ceasefires, increased fighting or (forced) movement. Although Hougen *et al.* (2000) and McDiarmid (1995) argue that death rates from landmine accidents are structurally underestimated, 9.5% of the total of 3,349 reported casualties in Burma between 1999 and 2013 were reported as lethal. 84.5% of the incidents led to injuries while the outcome of 6.0% is documented as 'unknown' (figure 4) (ICBL/CMC 2013).



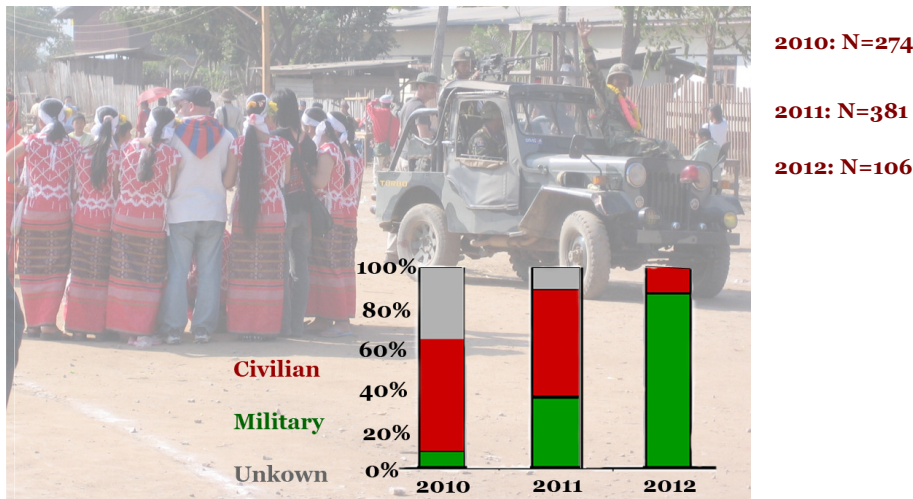
**Figure 4: Reported casualties by outcome (% of total year casualties)**

**Source: Landmine Monitor Reports 2011, 2012, 2013**

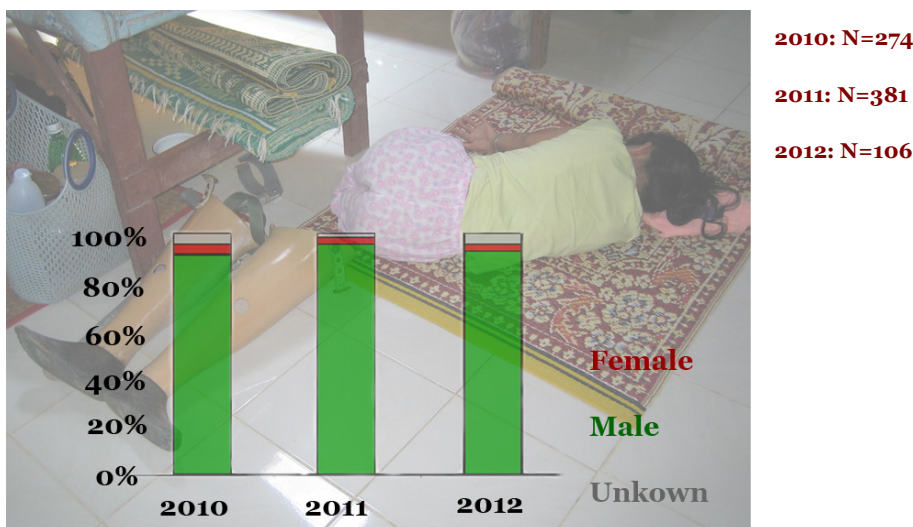
Note that these figures only include the reported cases. The suspected high numbers of incidences among porters and human minesweepers have never been officially reported (see chapter 5) and records of casualties among Burmese military are not publicly available (ICBL/CMC, 2013a; HRW/KHRG, 2011).

Civilians globally make up 78% of landmine casualties; in Eastern Burma the division between military and civilians among the ethnic population is often vague. Many IDPs find refuge in NSAG controlled areas and entire villages function as makeshift NSAG military bases. People may fulfil several social roles i.e. one can both be farmer and combatant. Furthermore, victims may not reveal their true status during data collection. A possible explanation for the incline in military casualties in 2012 (figure 5) could be decreased fear for repercussions when revealing military status, due to ceasefire agreements.

Overall, the vast majority of reported casualties from Eastern Burma are adult men (figure 6). Women yearly make up for 3-5% of the reported casualties; less than the global 13% of all incidents in which the sex is reported (ICBL/CMC, 2010, 2011, 2012, 2013). The accuracy of casualties among children is questionable; 15 of the 17 children reported over the last 3 years were boys but it is not know if the incidents are related to the deployment of child soldiers. Boys may be considered as men when they join the army so data might be skewed as their casualties will be counted under 'men'. Child soldiers are used by both NSAG and government forces. A 2011 report states that in Karenni State every second child is a child soldier and Karen State every fourth child (GC/DCA, 2011, p.3). Children are in general less likely to survive the landmine impact than adults because ejected shrapnel penetrates deeper into their smaller bodies and is more likely to damage vital organs. Additionally, children are more likely to encounter unexploded ordnance (UXO) than landmines, because their visual attractiveness triggers the curiosity of children (Can *et al.*, 2009). A possible explanation for the low child casualty number could be the fact that Burma is predominantly contaminated by landmines instead of UXO (Bendinelli, 2009).



**Figure 5: Reported casualties by status (as % of total year casualties)**  
**Source: Landmine Monitor Reports 2011, 2012, 2013**



**Figure 6: Reported casualties by sex and age (as % of total year casualties)**  
**Source: Landmine Monitor Reports 2011, 2012, 2013**

Mullany *et al.* (2007) report exposure to violence from combatants by 1 in 50 households and exposure to death or injury from landmine explosions in 13.3 per 10,000 persons per year. Parmar *et al.* (2014) mention landmines as a cause of death among 1.6% of the studied population, while Lee *et al.* (2006) report 4%. Comparison of the figures should be done with great caution because of differences in population characteristics and size, time and location. Nevertheless, all available data show that landmines more frequently cause disability than death. The World Health Organization ‘Guidance for surveillance of injuries due to landmines and unexploded ordnance’ (WHO, 2000) offers a standardized tool to measure the impact of landmine related injury. Physicians for Human Rights offer a similar tool and add a capacity measurement of medical facilities to respond to landmine related injuries (PHR, 2000). Both leading documents, however, do not refer to gender-related differences in impact or needs between men, women, boys and girls.



## 8. Emergency and continuing medical care

Medical care to landmine victims can be divided in emergency care, aiming at survival, and continuous care, aiming at optimal recovery. Institutionalized medical facilities in Eastern Burma are scarce; mobile health workers are the main health care providers covering large areas, mostly travelling on foot. They may be targeted by government forces for (suspected) connections with insurgent groups. Village leaders and other informants pose themselves at risk by providing security information; health workers are frequently forced to relocate through landmine contaminated areas and provide assistance at night. Torture, cruel treatment of captured health workers, confiscation and destruction of medical supply and facilities are recurrently reported (BPHWT, 2010; Footer *et al.*, 2014). Permanent structures for this reason hardly exist and availability of medical care highly depends on the safety situation and the season (i.e. rivers may be impassable during rainy season).

### 8.1 Emergency assistance

Men mostly detonate landmines during farming or military activities whereas accidents with women happen i.e. during water or firewood collection. Men are therefore more likely to receive emergency care from accompanying persons, like comrades or other farmers, than women who often perform their tasks alone or accompanied by their children. 52% of landmine victims “died either immediately or during transportation to the nearest hospital” according to Hougen *et al.* (2000). Studies from other areas confirm higher death rates among female victims (42%) than men (29%) but figures for Eastern Burma were not found. Treatment delay strongly influences the chance of dying from blood loss or from complications (Glanou and Baldan, 2010; Trimble and Clasper, 2001; Coupland, 1997). Iron deficiency anaemia to which particularly women and children are predisposed, adds to their vulnerability (TMI/UNICEF, n.d.). Wound contamination and bacterial infections caused by projectile particles of footwear, soil and mine fragments, complicate wound healing and often make multiple surgery necessary. Home-made landmines, frequently used by NSAGs, contain any available material like glass, bamboo, wood, metal, plastic, human and animal faeces (Trimble and Clasper, 2001; Silva *et al.*, 2012). Another predictor of death in landmine accidents, even after reaching medical facilities, is sustained hypotension (Nelson, 2006). Murrad *et al.* (2012) argue that “sub-facial packing plus compression plus hypothermia prevention [...] proved effectual: 84% of extremity injury patients with severe in-field haemorrhage were normotensive on admission”.

Treatment delay is mostly caused by safety and infrastructure restrictions rather than by gender-based treatment prioritization as seen in other countries (HI, 2013). It may take days or in some areas up to weeks to reach a health care facility. Mobile medical teams like the ‘Back Pack Health Workers Team’, ‘Free Burma Rangers’ or ‘Trauma Management Program health workers’ may reach the casualty scene instead and provide care on the spot; field surgery is then common practice. Generally, 75% of landmine victims undergoing amputation surgery need blood transfusion and blast injury patients need more blood than fragment injury patients (Giannou and Baldan, 2010). This poses a risk for both the victims and medical personnel: the little available material supply limit medics to protect themselves from heavily bleeding patients and they may be the only available blood donating source

for the patient to survive. HIV, hepatitis B and other diseases may spread when blood is needed but adequate blood quality control measures are absent.

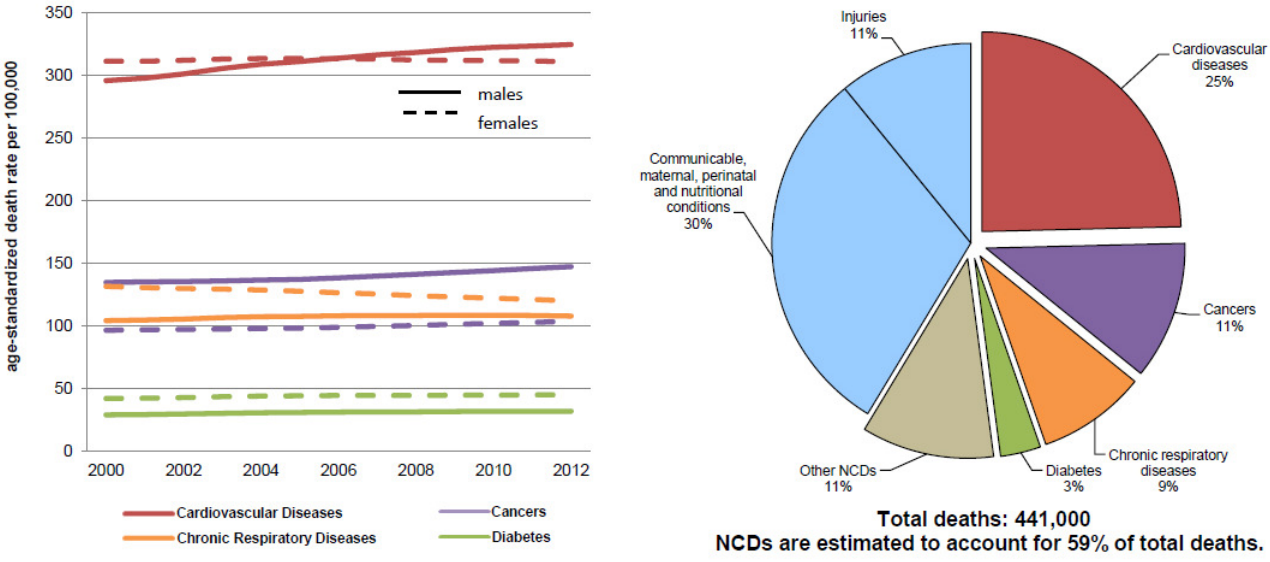
Training lay-persons in basic trauma life support skills and shortening in-field response time have shown to bring down mortality rates (Callese, 2014, Murad *et al.*, 2012, Richard *et al.*, 2009) which are highest during the pre-hospital phase (Murad *et al.*, 2012; Husum *et al.*, 2003; Jahunlu *et al.*, 2002). Community-based first aid training such as the 'Village First Helper Program' of the Karen Department of Health and Welfare can be of great importance (<http://kdhw.org/programs-activities/mobile-health-clinic/village-health-worker-program/> accessed 20 July 2014). Emergency assistance training may also be included in mine risk education programmes, which should be gender-sensitive in order to effectively target all community members: the different roles and capacities of men, women, boys and girls should be taken into account when accommodating the time, place, group composition, and method (i.e. taking into account literacy, recognisability of visual aids, and affiliation with teaching tools) (Jones *et al.*, 2013).

## **8.2 Related health conditions**

Severity of injury, availability of emergency care, travel time and physical response are determining factors in the outcome for landmine survivors. Pre-injury health conditions should not be neglected since they may influence wound healing processes, coping mechanisms, and long-term disability. HIV, hepatitis, tuberculosis and malaria are highly prevalent in Eastern Burma but in many cases people are not aware of having those diseases (TBC, 2013). These conditions affect the immune system and thus a person's ability to survive major trauma. The same applies to diabetes mellitus (DM). DM-type 2 deserves special attention in the light of amputee care because of the strong impact on wound healing processes (Anderson and Hamm, 2012). According to the 2009 STEPS survey, blood sugar levels of 85.6% of the males and 83.5% of the females in Burma had never been measured (WHO, 2011). In their study, Hu *et al.* (2012) found an association between white rice consumption and elevated risk of DM-type 2. White rice is a staple food in the very limited nutritionally varied diet among the Eastern Burmese population (Banjong *et al.*, 2003). The existence of (undiagnosed) DM-type 2 should therefore be considered throughout the amputee care. Nutritional status, related to food insecurity, and substance abuse are other influencing factors for a survivor's physiological and psychological capacities that are, depending on area and season, relevant to the situation in Eastern Burma. These topics will be discussed in the next chapters.



Other non-communicable diseases (NCD) should also be taken into account when treating landmine victims; people may be unaware of pre-morbid NCD influencing their condition. Cardiovascular diseases (CVD) are high on Burma’s burden of disease list (figure 7), with ischemic CVD comprising the largest proportion of CVD related deaths (OECD/WHO, 2012; WHO, 2014a). Smoking, a major contributing factor to CVD, is seen significantly more among Burmese men than women (44.8% vs 7.8%) as is the use of betel nut chewed with tobacco: 51.4% for men and 16.1% for women (WHO, 2011). Obtained disabilities from injuries may also predispose landmine victims to NCD related risk factors like physical inactivity, smoking or drinking habits or substance abuse, psychological distress and poverty (see chapter 10). In a studied population with peripheral artery disease Lefebre and Chevan (2011) found that the female sex predisposes a person to a more proximal level of amputation posing a disadvantage in terms of energy expenditure, balance and prosthesis handling, compared to a more distal amputation level. Better functional outcomes for people with longer residual stump are consistently found by Penn-Barwell’s meta-analysis (2011).



**Figure 7: Age-standardized death rates and proportional mortality (% of total deaths, all ages, both sexes)**  
**Source: WHO, 2014a. NCD Country Profile Myanmar**

Sundet *et al.* (2004) address post-injury malaria as a complicating factor for wound healing and prolonging hospital stay duration. 42.7% of the landmine victims in a Cambodian malaria-endemic area (similar to Eastern Burma) developed symptomatic malaria within 10 day of admittance. 36.1% of them showed wound infection compared to 10.0% of patients without malaria, prolonging the average hospital stay to 31.2 days instead of 19.4 days. Immunosuppression following traumatic injury may cause recrudescence of asymptomatic malaria (or other) infections. People may prematurely leave the medical facility due to safety constraints or for other reasons, and post-injury malaria may develop after they leave, posing life-threatening risk to the patient. Surgeons may be obliged to premature wound closure, risking severe infections. A reason for men to leave the facility could be fear for disclosure of their military activities, whereas child caring tasks may cause women to return home earlier than medically desirable. Regardless of the duration of stay, medical facilities should cater for male and female patients, the latter often accompanied by their children. Separate sanitary areas and wound dressing rooms should facilitate personal hygiene; inappropriate facilities may cause omission of the treatment of genital injuries which and lead to severe long term complications.

Mental health also influences a persons' response to landmine trauma. A review of numerous studies suggests an association between psychological distress and immune functioning, morbidity and mortality, and confirms the negative relationship between stress and wound healing (Walburn *et al.*, 2009). Not only landmine survivors but also indirect victims exhibit different coping mechanisms which may influence their quality of life in the short and long term. Differences between coping styles for men and women are culturally determined; more on this topic will follow in chapter 10.

### **8.3 Continuing health care**

Disrupted infrastructure and discontinuation of services challenge follow-up and structural health care provision. Besides long term health issues touched upon above, amputation stumps need life long care. Changing stump shape and volume cause improper fit of the prosthesis, friction, and wounds. This can have devastating consequences: not only do wounds limit the use of prosthesis, but in severe cases they may lead to the necessity of a higher level amputation or death from infections (ICRC, 2005). Despite the great lack of long-term medical data about landmine victims, some particular studies were found. Host *et al.* (2012) describe the risk of 'Marjolin's ulcer': a malignancy that can develop until decades after initial injury. For landmine survivors, severe traumatic wounds are added up to the combination of burn scars and chronic infections which were already known to be risk factors. Many undiagnosed cases of Marjolin's ulcer are suspected to exist and the resulting cancer is considered to be a long-term health problem for landmine accidents. Husum concludes from his study in 2002 that "chronic pain syndromes are a major medical problem in severely injured land mine accident survivors, including both amputees and non-amputees." Pain can increase over time due to pathophysiological processes like ischemia and infection and due to sensitization of the central and peripheral nerve systems. Neuropathic pain can strongly limit a person in daily life. Stump pain, phantom sensation, and phantom pain are most common after amputation and it can take up to years to disappear (Silva *et al.*, 2012). Hirsch *et al.* (2010) found no sex differences in experienced phantom or residual limb pain but females reported general pain more frequently and with higher intensity. A

study of Wyper (2012) suggests that victims of landmines or unexploded ordnance with pain perceive “significantly higher impact on life satisfaction, moods and feelings, self care, participation in family activities, relationships with relatives and ability to work” compared to pain-reporting persons among another disability group. Husum (2002) found economic impact as the only factor in his study that seemed to be associated with post-injury pain. Limited (medical) resources stimulate the search for alternative solutions; the results of study aiming at pain relief through poverty relief by providing livestock to facilitate livelihood, are not yet available but could bring an interesting concept for future interventions (<http://traumacare.no/resources/trauma-systems/post-injury-pain-syndrome/> accessed 10 September 2014). Livelihood activities, income, and socio-economic participation seem to strongly affect the quality of life and experienced consequences of disability (more about livelihood in chapter 11).

Regular medical follow-up should be strongly promoted to monitor health consequences and to react timely to infections, wounds or other complication. The few permanent health care facilities such as those from the Myanmar Red Cross are available for only a small group of people due to travel distance and costs, as well as the government-controlled organizational character (see figure 8). Home treatment by health workers of mobile clinics and outreach teams aims to address the accessibility and affordability barriers. Acceptance of home treatment may benefit from health workers with the same sex as the patient. Caretakers play a crucial role in the situation of landmine survivors; inclusion and instruction of caretakers are vital throughout the emergency and long-term treatment. Moreover, the caretakers’ health may be affected and should be considered as such. Income and food insecurity, malnutrition, poverty related issues, domestic violence, and the physical and psychological burden may heavily affect indirect victims and should not be neglected.

‘Save Lives, Save Limbs: Life Support for Victims of Mines, Wars and Accidents’, a handbook for medics and medical teachers,’ and ‘War Surgery: Field manual’ both published by Third World Network (Husum *et al.*, 2000 resp. 2011) and the ICRC publication ‘War Surgery: working with limited resources in armed conflict and other situations of violence’ (2010) are some of many valuable resources for the emergency treatment phase. The Burmese Border Guidelines (2007) comprehensively cover a broad range of health issues in the area to which landmine victims may be exposed. The majority of medically oriented sources may address some biomedical differences between males and females, but have minimal attention for gender and how it may affect a person’s medical needs.

## 9. Physical and functional rehabilitation

Rehabilitation is defined by WHO as “a set of measures that assist individuals, who experience or are likely to experience disability, to achieve and maintain optimum functioning in interaction with their environments” (WHO/WB 2011, p.96). CRPD article 26 refers to habilitation and rehabilitation by including physical, mental, social and vocational aspects (UN, 2006). Habilitation relates to congenitally acquired disabilities and is not further discussed in this document (WHO, 2010, Health Component, p.45). Physical rehabilitation aims to regain physical mobility while functional rehabilitation focuses on daily life activities; both are intertwined and should start as soon as possible after landmine accident.

Rehabilitation processes can take up to months or even years but in Eastern Burma timeframes are drastically shortened for reasons previously explained. Landmine victim rehabilitation mostly takes place in specialized facilities and includes the production or delivery of mobility and/or functional aids. Direct and indirect victims are targeted as both parties have to learn to adapt and live with the changed circumstances like interpersonal dependence and responsibility. However, a great part of the rehabilitation process (particularly mental and social adaptation) takes place in the daily living and working environment. The map in figure 8 shows the main locations of specialized rehabilitation centres in Eastern Burma. Currently there are additional facilities in the refugee camps in Thailand but the expectation, as discussed in paragraph 2.2, is that these settlements will eventually disappear. The Thailand-based facilities in Peng Lo and Mae Sot are more likely to remain functional because of their cross-border activities and services to the large groups of Burmese migrant workers in the areas.

Electricity is, besides logistics, supply, and education, a determining factor for prosthetic workshops to operate. It is estimated that only a quarter of people in need of rehabilitation services has access to it (GC/DCA, 2011). Advancing solar technique and non-electricity-requiring prostheses production are explored to serve remote populations (Green Empowerment, 2005). Outreach programmes are extremely beneficial but also challenging: nearly all of the local prosthetic technicians are landmine survivors themselves and the long walking distances through mountainous jungle environment with heavy materials for on-site fabrication challenges their physical capacities. Training of persons in the field to measure and cast stumps and to perform minor adaptations for proper fitting could take a large burden from the technicians and greatly increase the reached population. Gender-sensitivity should naturally be part of such initiatives.



**Figure 8: Rehabilitation facilities with prosthetics and orthotics services**  
**Source: ICBL, 2013**

## **9.1 Physical mobility**

Physical mobility is of vital importance in the context of conflict. Lost or damaged vision, often in combination with upper extremity amputation(s), puts survivors with type 3 injuries (often males, see paragraph 5.1) in a very vulnerable position. And with them their caretakers from whom they are partially or completely dependant. For type 1 and 2 survivors, in the majority of cases having lower extremity amputation(s), prostheses are the preferred device of choice. Additional support is needed as physical capacities and material deterioration may prevent prostheses to be used fulltime. Crutches are favoured over a wheelchair because they make it easier to hide or seek shelter during attack. Rough terrain additionally challenges wheelchair use, particularly in rural areas. Creative and functional solutions are often found when resources are limited: home-made prostheses and walking aids of bamboo, wood, plastic pipe or other available material are commonly seen and may be very useful. Weather conditions and terrain determine which materials and fabrication techniques are preferable for mobility devices. Equally important but often overlooked are the means of use which are usually different for men than for women. Personal mobility patterns should be assessed for the design, choice, or review of devices which should fit not only a person's leg or arm but also with the practical demands. Aesthetics should be considered and may clash with practicality. Women i.e. may prefer an artificial foot with a slipper while men are frequently seen to cut off the toes to enlarge freedom of movement in mountainous terrain. Composing a device in consultation with the user increases ownership and effectiveness. Cultural appropriateness is important to support the use i.e. a fixed shoe is undesirable because people are used to take off footwear entering a house or religious place. Practical solutions like an exchangeable foot and a knob for lower extremity prostheses could answer to the both need of a practical device and of personal dignity by an aesthetically acceptable leg. Arm amputees with lost eye sight may benefit from a stick attachable to a socket on the residual limb. Absent visual control for blind survivors challenges the use of arm prosthetics. A socket on the arm with exchangeable tools such as a sponge, toothbrush, spoon, hook, tools for agricultural use, etc may be very useful but should be extensively practiced to avoid injury. An innovative solution with magnetically adherent socket and tools offers the possibility to share and exchange devices among other arm amputees, i.e. in communal living conditions such as the 'Care Villa', a 24/7 nursing home in one of the refugee camps (WHO, 2014b). Selection, production and composition of assistive devices should be done with a gender sensitive approach: men, women, boys and girls may all have different priorities, needs and preferences.

## **9.2 Functional rehabilitation**

Functional rehabilitation covers all the activities of daily living (ADL); it aims to prepare both the direct and indirect victims for their return to daily life. Optimal use of remaining functions is the prime focus before adaptations explored to compensate (partially) lost abilities. Besides activities that are similar for everyone (i.e. bathing, eating, drinking, toileting, clothing, sitting, standing, walking, communicating, etc), genders-specific tasks like cooking, parenting, and livelihood activities usually differ between men and women (see chapter 11). These differences should be addressed accordingly for effective rehabilitation. Hygiene and (self) care play a major role, not only to reinforce human dignity

but also to prevent complications. Sexuality often receives little attention in the rehabilitation process despite the physical and psychosocial impact of disability in general and landmine injuries in particular (Verschuren, 2013). Genital organs i.e. may be damaged, and interpersonal relationships may become under pressure. Diminished (sense of) capacity to fulfil social roles, psychological burden, coping styles, and livelihood affecting consequences may influence behaviour. Falb (2013) found Burmese refugee women who experienced conflict victimization to be almost 6 times more likely to report past-year intimate partner victimization.

Victims and caretakers benefit most from practice with and instruction from persons whom they affiliate with. A prosthetic technician being landmine survivor him/herself adds to the understanding of his/her patients. Currently most of them are male and a better gender balance is desirable not only to serve female victims but also to neutralize the masculine culture that might influence the decision of visiting a workshop. Adaptation, training and support in ADL activities are mostly carried out by health workers in cooperation with the technicians; health worker teams are generally mostly mixed.

### **9.3 Necessary compromises**

Safety constrains, accessibility restrictions, financial limitations and social obligations make compromises unavoidable. Artificial limbs are often, out of necessity, prematurely fitted on a stump that has not yet taken definite shape. Pain, wounds and infection make weight bearing hard or impossible; improper gait provokes further physical problems i.e. with the contra-lateral leg or back. Users' education to find effective solutions and to carry out small repairs and maintenance could prevent wounds and other complications. Primary health care providers should be trained in treatment of minor issues like blisters and should be able to refer when concerning complication occur. Caretakers may necessarily fulfil this role in the absence of health workers and the rehabilitation process should prepare them for it.

Rough environment and high intensity use make regular repair and adaptations needed; distributing spare parts (stock could i.e. be administered through the village head) and locally available material could prolong the life span of an assistive device. Prostheses need to be replaced on average every 2 years for adults (children need renewals more frequently as they grow) and prosthetic feet may wear out within a year's time (Steen Jensen and Sexton, 2010).

Rehabilitation does not follow a blueprint. Each direct and each indirect landmine victim faces different challenges and opportunities. Many rehabilitation related guidelines or documents discuss technical sub-topics; WHO Community Based Rehabilitation guidelines' Health component includes rehabilitation and mobility devices but gender considerations are merely absent. WHO currently composes health-related rehabilitation guidelines, which will be a leading document supporting the implementation of the rehabilitation aspects of the CRPD (WHO, 2012). Gender considerations are unfortunately not mentioned in the concept paper; publication is expected later this year.



## 10. Psychological and psychosocial support

Psychological and psychosocial support aims at facilitating resilience. It may involve counselling with a professional or other person specifically trained to it. A study of Lim *et al.* (2013) reveals that health workers in conflict zones in Eastern Burma provide psychological support, but “their inability to fulfil patients’ expectations, by treating acute ailments, was a source of frustration”. Beliefs, practices, age and gender determine how people cope with life stressors and trauma. Coping strategies differ between individuals as well as between groups. Women generally engage more in communication with others, while men tend to use physical activity as a coping style. Injuries and disability may impact a person’s way of coping and thus their resilience which depends on the effectiveness of coping strategy. Different studies among the population in Eastern Burma report (unexpected) high levels of resilience (Lim *et al.*, 2013; Cardozo *et al.*, 2004). Barron *et al.* (2007, p.27) suggest that “survival strategies, such as camaraderie and a Buddhist concept of self-confidence (*weria*), may have accounted for the refugees’ surprising resilience”. Although 20-30% of the Karen are Christian and small numbers of people are animist, Buddhism is the predominant religion in Eastern Burma and Buddhist elements are intertwined with everyday life. Religious elements may reinforce resilience, but contrarily stigma may result as well i.e. from the belief that death and injuries are related to bad karma from prior lives. Taking responsibility for ones own actions and acceptance of fate are common life approaches in Eastern Burma; the burden of landmine casualties are sometimes regarded as ‘moral punishment’ (Hynes, n.d.).

Despite high resilience, different studies address psychological and mental health issues. Momartin *et al.* (2003) studied a population of Bosnian origin in which women tended to be displaced and separated, whereas men were more likely to be incarcerated and tortured, similar to ethnic minorities in Burma. “Threat to Life was the only factor predicting PTSD [post-traumatic stress disorder]” and “the experience of Traumatic Loss contributed to the severity of symptoms experienced and the level of functional impairment associated with PTSD.” Gender did not affect PTSD rates. Cardozo *et al.* (2004) found “high prevalence rates of depression (42%), anxiety (41%), and psychosomatic complaints” among Karenni refugees. A high number of traumatic events and previous mental illness were associated with poorer mental health outcomes. In a later study (2012) Cardozo *et al.* compared mental health outcomes of Cambodian landmine survivors with the general population and found “significantly higher prevalences of symptoms of depression, anxiety, PTSD and PTSD caseness”. The landmine victims in Burma’s neighbouring country Laos in Wyper’s study (2012) showed “no significant difference between the genders in the PIPP [perceived impact of problem profile] scores”.

Prolonged conflict and displacement may change gender roles and attitudes within a community; landmine injury can cause additional changes on household level. Men, who lost their capability to fulfil social expectations and to provide income, are seen to face depression and aggression with increased probability of domestic violence. Female survivors with disabilities risk abandonment by their husbands, or decreased likelihood of getting married (Chaganti, 2009). High risk sexual behaviour, alcohol or substance abuse, and domestic violence are frequently observed during and after



prolonged conflict (Tol, 2013; Falb, 2013; Muhwezi *et al.*, 2011). Morals and values may be distorted and should be addressed to increase the likeliness of effective coping strategies. Ezard *et al.* (2011) assessed the population in 3 refugee camps along the Thai-Burma border, and described that “alcohol use was described as a culturally acceptable and appropriate response to the stressors of displacement for men”. The Inter-Agency Standing Committee (IASC) ‘Guidelines for Gender-based Violence Interventions in Humanitarian Settings’ (2005) could be helpful documentation to address these issues.

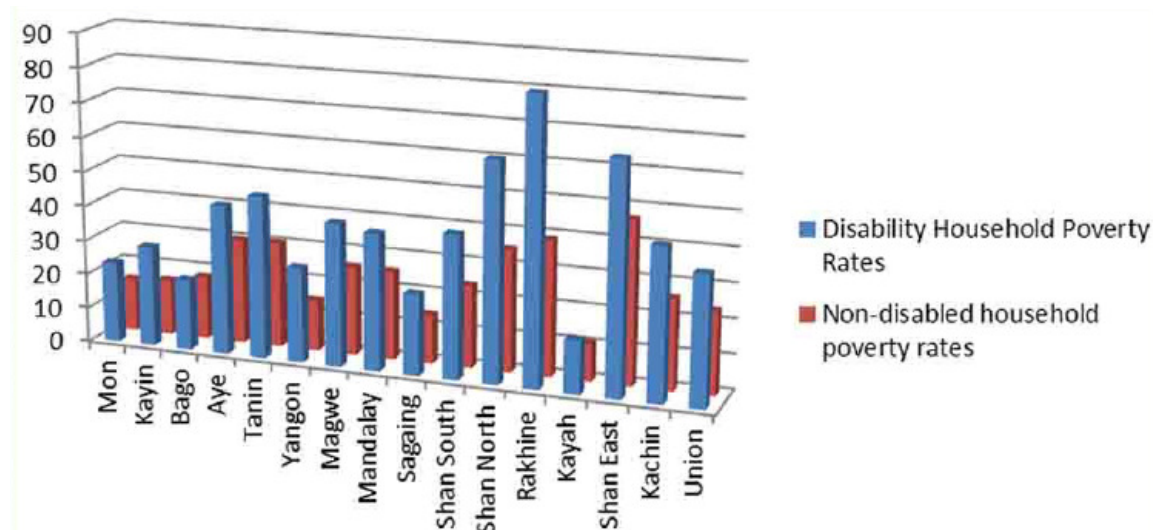
Frequent thought of suicide emerged in personal interviews, particularly among blind arm amputees. Incompatibility with the obtained limitations was paradoxically mentioned as both the ground for suicide ideation as well as the reason for low success rates: end of life wishes could not be put into action due to physical limitations and dependence from others. Literature or studies on the topic of suicide ideation among the population in Eastern Burma were not found.

Cultural sensitivity is a crucial factor for effective psychological and psychosocial support and holds a strong gender component. Social and cultural rules determine who expresses what to whom, when, where, and how. Psychosocial support should make use of socially accepted channels, build upon supportive structures and strive for empowerment. Peer-to-peer support is found to be effective: people with similarities in terms of age, gender, and social origin, and in particular those with similar experiences, support each other on the basis of those experiences (Rutherford and Macauley, 2013; Macauley, 2011). Both parties benefit from this form of support because of mutual trust and concern, experiential knowledge, credible role modelling, and social approval. Human beings have the tendency to compare and measure themselves with others; interaction with those who share a common characteristic gives a sense of normalcy (Corcoran *et al.*, 2011). Not solely physical functioning and capacities, but the attitude of both the affected person and the environment, determine the extent of disability (Shakespeare, 2013). Peer-to-peer support can therefore be beneficial for the self-image and confidence of landmine victims. Exchange of personal information between persons from opposed sex is not common in Burma. Peers or psychosocial workers are ideally of the same sex as the person they intend to support; people with older age are generally highly respected and may benefit from same age peers.

Besides effective coping mechanisms and peer support, goal formation and motivation plays an important role in distress management (Lim *et al.*, 2013). The medics from Lim’s study were able to cope with extreme levels of distress through their motivation to assist the population, and were rewarded by the respect granted to them by their communities. Landmine survivors consistently express that their greatest need is not merely medical rehabilitation, but “assistance in helping them resume their roles as productive community members and contributors to their families’ well being” (Victor *et al.*, 2003; SCBL, 2008). These roles, as discussed before, are different for men than for women and should thus be addressed accordingly.

## 11. Socio-economic inclusion

Socio-economic inclusion refers to the participation of each community member, including those with disabilities, in social and economic activities (GICHD, 2011, chapter 5): many landmine victims mention this as their greatest need. CRPD addresses this in the articles 27, 29 and 30: the right to work and employment and the right to participate in political, public, and social life (UN, 2006). Disability and death from landmines carry significant direct and indirect costs. Among the direct costs are i.e. medical expenditures, and travel expenses to medical facilities; indirect costs are i.e. lost labour productivity, and school drop-out due to insufficient financial resources or because children are needed to carry out household and caretakers' tasks (WHO/WB, 2011, chapter 2; Mitra *et al.*, 2011). Several studies address the connection between disability and poverty, but data are scattered and conclusions are mixed. Poverty among the rural population in Burma was discussed at the "Forum on Poverty" in 2011, and the importance of poverty reduction among people with disabilities was mentioned. The need for a Poverty Reduction Strategy Paper (PRSP), a national plan aiming at poverty reduction and improvement of living conditions which enables a country to apply for international debt relief measures, was highlighted. The PRSP approach "defines poverty not only as a lack of financial and material means, but also as a lack of social freedom, justice and equal opportunities" (Miller and Ziegler, 2006). Apart from a quotation of the Organisation for Economic Cooperation and Development (OECD), any reference to gender or gender inequality is absent in the extensive document about rural development and poverty alleviation in Burma (U Myint, 2011). Poverty is complex and difficult to measure. Figure 9 however gives an indication of the poverty rates in Burmese households with one or more disabled family members, compared to households without disability, in several states and districts.



**Figure 9: Poverty rates for households with and without persons with disabilities**

Source: Social Policy & Poverty Research Bulletin Feb. 2012

Throughout the disability and poverty literature, women are often described as having a double burden: the female sex and a disability (or the care for a disabled household member) put women in a marginalized position regarding economic participation. A study of Kyaw and Routray (2006) shows that Burmese female-headed households are more likely to be poor than male-headed households. Although the study was carried out in the so-called Dry Zone, but the outcome might be indicative for Eastern Burma because of the similarities in livelihood and culture.

Income is a key component to stay out of, or to escape from, the poverty-poor health-cycle. Assessing possibilities and limitations, at individual and household level, could help to support landmine victims in (adapted) continuation of their prior livelihood activities or in finding new opportunities. The majority of people in Eastern Burma is, or used to be, subsistence farmers, cultivating rice and crops or owning a small herd of livestock. Dying clothes, weaving, and basket-making are important supplementary activities and are often still possible to do with an artificial limb and/or right assistive device. Farming is possible for many leg amputees, but distance to the fields may limit them. A UNHCR 'village profiling' exercise in displacement affected areas, reveals limited market access for displaced people (14%), likely because of distance to the village centre. 54% of the people of concern had to travel more than 1 hour to the nearest market (UNHCR, 2013). Arm amputees have less distance limitation but more challenges handling tools. Additional loss of eye sight drastically narrows down occupational options drawing upon cognitive functions and verbal expression. Incapability of physical activity may be a heavy constraint for people with eye and arm injuries, often related to military activity, and learning new vocational skills may be needed for suitable livelihood activities. Financial support or other facilitation of knowledge and skills development could be a crucial element of victim assistance. Rarick and Nickerson (2006) describe Burma as a highly feminine society, according to Hofstede's dimensions of culture. The study poses an interesting contrast with the highly masculine and male-dominated political and military arena. Feminine cultures allow overlap between tasks for men and women; Barron *et al.* (2007) confirm that idea, and mention that in Eastern Burma husband and wife work together as partners, especially in farming communities. "Values such as consensus, cooperation, and harmony are rated more highly than individualism, assertiveness, or entrepreneurialism." Besides shared tasks, men generally carry out the physically heavy duties and women are responsible for household chores, feeding and clothing of dependant family members. Shifted tasks after disabling injury do not necessarily entail a complete change of responsibilities, but the double burden of both care giving and income generating by the non-injured partner should be taken into account.

When the hundreds of thousands of refugees and IDPs return to Eastern Burma, a situation of high competition can be expected. Land confiscation and mine contamination will force many people to look for alternative employment. The logging and mining sectors are rapidly expanding, but disabled landmine survivors are likely to be disadvantaged in the competition for job opportunities in those sectors. The search for alternative sources of income brings about particular challenges for displaced people in Shan state. The Shan have a long history of illicit opium cultivation; it offers a relatively secured source of income and a life line for people who may not see any other option (Barron *et al.*,

2007). Currently 92% of the opium cultivation takes place in Shan state. The use of opium is 6 times higher than in non opium-growing areas with related steep prevalence increase of HIV/AIDS and sex trafficking. Poverty and the lack of access to land are mentioned as main drivers for people to turn to the poppy fields (TNI, 2014); people with disabilities may be extra vulnerable to this source of income and/or to substance abuse. Poverty alleviation and alternative livelihood sources are necessary protection measures and should offer people more sustainable coping mechanisms to address their challenges (TNI, 2014). Physical and mental preparation of direct and indirect victims to livelihood challenges and opportunities is important to empower people and optimize resilience against the poverty-disability-cycle. Awareness of these issues among community members should not be neglected. Not only the physical impairment, but even so attitudinal aspects form barriers for landmine victims to socio-economic (re)integration. Stigma, lacking knowledge and misconceptions can be diminished by awareness raising campaigns or through positive role modelling by influential persons like village leaders. Cooperation and ownership increase the sustainability of initiatives and the chance to succeed. Projects of amputee-run farms with crops and livestock for own consumption and for local sale, based on the initiatives and long-term planning of the beneficiaries themselves, have shown to be successful (<http://cpi.org/?s=myanmar>): productivity and socioeconomic participation reinforce the sense of independence and the quality of life. Additional advantages of livelihood projects within victim assistance programmes are i.e. better monitoring and evaluation possibilities, a central location for follow-up and repairs of assistive devices, integral peer-to-peer support. The most important reason however, is to answer to the need expressed by direct and indirect landmine victims, taking gender differences into account (ICBL/CMC, 2013b).

## Conclusion

The protracted conflict in Eastern Burma influenced the roles, values and responsibilities of men, women, boys, and girls. Landmine contamination should be regarded in the broader context of conflict, involving widespread human rights violations, affecting the public health situation and limiting development. The expected return of the large and varied displaced population in the near future raises concerns of increasing landmine casualties, and the changing political climate calls for sound landmine victim assistance programmes. Gender-sensitivity is merely undervalued in the majority of available guidelines and handbooks, addressing victim assistance topics. The needs, challenges, and opportunities for women in Eastern Burma are likely to be underrepresented due to the exclusion of women in the design, implementation, and evaluation of VA programmes.

Available data on Eastern Burma are likely to be incomplete; data on disability and indirect landmine victims are merely lacking. Sex- and age-disaggregated data, representing the entire affected population, are needed to plan VA programmes and to avoid increasing inequity. Men, women, boys and girls are differently affected by landmines and may face different medical needs. A mixed medical staff may increase the acceptability of home treatment and the accessibility of medical and rehabilitation facilities for all victims. Assistive devices should be selected and adapted according to personal needs and preferences in order to facilitate the use. Facilities should cater for separate sanitation and sleeping areas, and allow implementation of all daily life activities in the treatment. The interplay between household members deserves attention in order to respond to interpersonal changes and gender-related issues. Resilience and coping styles affect the entire household and may benefit from culturally appropriate support. Appropriate attention for specific characteristics in male victims, i.e. lost ability to military engagement, could benefit all household members by decreasing chances of substance abuse, domestic violence, or other counter-productive coping styles.

Although medical recovery is traditionally the central point of landmine victim assistance, direct and indirect victims frequently indicate livelihood and income generation opportunities as their main concerns. Victim assistance implementers could enhance effectiveness by considering livelihood at the core of the VA programme; disability is likely to reinforce poverty and vice versa. However, supporting the adaptation to and exploration of alternative livelihood sources could instead increase resilience among landmine victims. The conflict-related masculine appearance is embedded in a feminine culture which offers opportunities to both men and women. With the majority of direct landmine victims being male, and the majority of indirect victims being female, both should be considered within their gender roles in victim assistance programmes.

# Appendix

## Checklist for gender mainstreaming in victim assistance

<b>Ensure that women, girls, boys and men have equal access to gender-sensitive emergency and continuing medical care for injuries sustained in mine/ERW accidents</b>	
✓	Provide transportation, where possible, to ensure better access to emergency and follow-up medical care for all survivors.
✓	Engage same-sex staff in prosthetic workshops to assist mine/ERW survivors.
✓	Ensure privacy for patients during their physical examinations and consultations.
✓	Make appropriate arrangements and supply suitable accommodation (including for guardians or chaperones) to ensure that women and children are able to obtain treatment, particularly if they must travel from their homes.
<b>Ensure that the planning and provision of services for mine/ERW survivors (including physical rehabilitation, vocational training and psychological support) are tailored to the different needs of women, girls, boys and men</b>	
✓	Collect, analyse and store sex- and age-disaggregated data on mine/ERW survivors and the impact of their injuries on their economic, social and psychological well-being.
✓	Involve male and female survivors of mine/ERW accidents in the planning, implementation and monitoring of assistance programmes.
✓	Provide access to same-sex counsellors or support groups for male and female survivors (as appropriate within the local context).
✓	Provide support services for family members taking care of mine/ERW survivors.
<b>Engage in advocacy to raise awareness of the rights of all disabled persons</b>	
✓	Support existing national programmes addressing disability-related issues, ensuring that equitable care, rehabilitation and vocational/educational opportunities are offered to all individuals, regardless of age or sex.
<b>Ensure that men and women have equal access to employment opportunities in victim assistance programmes</b>	
✓	Implement affirmative action employment and training strategies for women with disabilities.
✓	Prioritise the recruitment of male and female mine survivors in mine action programmes.
✓	Prioritise microcredit or small business loan projects for female mine survivors heading households.
✓	Ensure that victim assistance service providers furnish sex-segregated accommodation.

**Source: United Nations Gender Guidelines for Mine Action Programmes (2010)**

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