



HEALTH, HUMANITARIAN CARE AND HUMAN RIGHTS IN BURMA

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

World Health Organisation Constitution (Preamble)

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ABBREVIATIONS

ASEAN	Association of South East Asian Nations
BADP	Border Areas Development Programme
BBC	British Broadcasting Corporation
BSPP	Burma Socialist Programme Party
DKBO	Democratic Karen Buddhist Organisation
ICRC	International Committee of the Red Cross
KIO	Kachin Independence Organisation
KNU	Karen National Union
KNPP	Karenni National Progressive Party
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MRC	Myanmar Red Cross
MSF	Medecins Sans Frontieres
MTA	Mong Tai Army
NGO	Non-Governmental Organisation
NLD	National League for Democracy
SLORC	State Law and Order Restoration Council
UN	United Nations
UNDP	United Nations Development Programme
UNDCP	United Nations International Drug Control Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNPFA	United Nations Population Fund
USDA	Union Solidarity and Development Association
UWSP	United Wa State Party
WHO	World Health Organisation

1. OVERVIEW

Censorship has long hidden a multitude of grave issues in Burma (Myanmar¹). After decades of governmental secrecy and isolation, Burma was dramatically thrust into the world headlines during the shortlived democracy uprising in the summer of 1988. But while international concern and pressure has since continued to mount over the country's long-standing political crisis, the health and humanitarian consequences of over 40 years of political malaise and ethnic conflict have largely been neglected. Indeed, in many parts of the country, they remain totally unaddressed.

Although not a Rwanda or Somalia, modern-day Burma has one of the poorest health records and lowest standards of living in the developing world. At independence in 1948, the country was regarded as one of the most fertile and potentially prosperous lands in Asia. By the time of the democracy uprising, however, Burma had collapsed to become one of the world's ten poorest nations. With an average per capita income of just US\$ 250 per annum, Burma today is categorised with Least Developed Country (LDC) status at the United Nations (UN).

Health statistics can be notoriously unreliable in Burma and, by selective quoting, very different pictures of the national health situation can be painted. With so little data available, health problems can be overestimated as well as underestimated. But amongst a plethora of urgent health issues, the following problems stand out as the legacies of decades of social and political neglect:

- Burma currently has one of the highest rates of both infant and maternal mortality in Asia;
- only one third of the country has access to clean water or proper sanitation;
- nearly half of all children of primary school-age are malnourished;
- with only one doctor for every 12,500 citizens, the national system of health care does not extend to even half the country;
- health education is woefully inadequate, and only 25 per cent of all children complete the five basic years of primary school;
- Burma is the world's largest producer of illicit opium and heroin;
- HIV/AIDS is increasing at an alarming rate, with estimates of HIV-carriers increasing from near zero to 500,000 over the past six years;
- Burma has over one million refugees or internally-displaced peoples as a result

¹ Burma was renamed "Myanmar" by the State Law and Order Restoration Council (SLORC) government in 1989 as part of a national policy to change or re-transliterate many place names and titles. However, although recognised at the United Nations, the new term "Myanmar" is still rejected by most democratic and ethnic opposition parties.

of war;

- Burma also has over one million citizens forcibly resettled by the government, amongst whom health and living conditions are also often poor;
- finally, it is treatable or preventable illnesses linked to poor socio-economic status, such as intestinal infestations, pneumonia, dengue haemorrhagic fever, tuberculosis, malnutrition, malaria and illicit abortions, which are perennially the greatest causes of unnecessary death and ill-suffering in Burma.

Not surprisingly, then, virtually all international agencies attempting to establish operations inside Burma since 1988 have chosen health and education programmes as their first point of entry. For far too long, Burma's health and humanitarian crises have been allowed to continue, virtually unacknowledged and unreported, under a stifling blanket of governmental censorship and inaction. Indeed, so alarmed were they by the results of new field-surveys that in 1992 officials of the UN Children's Fund (UNICEF) considered calling for an urgent campaign of international humanitarian relief to alleviate what they described as "Myanmar's Silent Emergency":

For a long time the state of Myanmar's children was perhaps one of the country's best kept secrets. Decades of self-imposed isolation, fabricated statistics and the absence of social research and journalistic inquiry had created a false image of social developments....In fact, neither the outside world nor even the authorities inside Myanmar have an accurate or complete appreciation of the very serious conditions in the social sectors.²

However, while there can be little argument over humanitarian need, there remains considerable caution amongst many medical practitioners in Burma over allowing the issue of health to become used as another battleground by different actors and institutions during the present political impasse. Under the military State Law and Order Restoration Council (SLORC), which assumed power in 1988, Burma has entered its third critical period of political and economic transition since independence in 1948. But although the first non-governmental organisations (NGOs) have been allowed to return under the SLORC's "open-door" economic policy³, the political repression has largely continued. In particular, the result

² UNICEF, *Possibilities for a United Nations Peace and Development Initiative for Myanmar* (Draft for Consultation, 16 March 1992), p.1.

³ During 1995, at least 15 NGOs had programmes or representatives in the country, most of which had entered Burma since 1994. Not all had Memorandums of Understanding and some later left or were rejected by the SLORC, but amongst NGOs reportedly represented in the country during the year were: Action Internationale Contre la Faim, Association Francois-Xavier Bagnoud, Australian Red Cross, Bridge Asia Japan, Care International, Groupe de Recherche et d'Echanges Technologiques, International Committee of the Red Cross,

of the 1990 general election, in which the opposition National League for Democracy (NLD) won a landslide victory, has never been accepted by the SLORC. Over the past eight years, thousands of democracy supporters and NLD activists, including the party's leader Daw Aung San Suu Kyi, have been arrested or detained.⁴

In such a polarised atmosphere, the universal importance of health, human, social and economic rights frequently becomes lost amidst arguments over political or security priorities. Opposition groups, especially, have expressed grave doubts over the effectiveness and equity of any new health programmes introduced under the SLORC. Without the rights and institutions of a democratic or civil society, they argue, any health impact will be necessarily limited and only related to projects that the military government approves. Moreover such health projects will not address the many human rights abuses, including forced labour, forced relocations or summary arrests and imprisonment, which themselves have an extremely detrimental impact on health. According to Dr Thaung Htun, health spokesperson for the exile National Coalition Government Union of Burma: "The humanitarian crisis in Burma today is a direct outcome of 33 years of military misrule. How can any humanitarian problems be tackled without first addressing the root problems which are political?"⁵

By contrast, there are also many doctors and community leaders who trust that health and development programmes will constitute the first real social and political bonds to start rebuilding long-divided societies after so many years of suffering and conflict. This view is most prevalent in ethnic minority regions of the country where cease-fires have recently been achieved by the SLORC with over a dozen armed ethnic opposition groups. According to this argument, it is the spirit of peace and social regeneration in the war-zones which will eventually break the political deadlock in Rangoon.

Despite such conciliatory words, however, the tasks of social and political reconstruction now facing Burma are enormous. The evidence is stark. At a time of serious poverty and economic uncertainty for the majority of Burmese citizens, the entire health system is in a state of breakdown; corruption and inefficiency are rife; censorship is pervasive; draconian political restrictions are enforced on all medical practitioners; health information is scarce and often inaccurate; and large areas of the country remain inaccessible.

International Federation of the Red Cross and Red Crescent Societies, Medecin du Monde, Medecins Sans Frontieres (France and Netherlands), Population Services International, Save the Children (UK), World Concern and World Vision.

⁴ The political events since 1988 have been examined more fully in ARTICLE 19, *State of Fear: Censorship in Burma* (London, 1991), ARTICLE 19, *Paradise Lost? The Suppression of Environmental Rights and Freedom of Expression in Burma* (1994), and ARTICLE 19, *Censorship Prevails: Political Deadlock and Economic Transition in Burma* (1995).

⁵ Interview, 23 May 1995.

Indeed at the very moment when the first international NGOs and aid agencies were still tentatively returning to Burma, in June 1995 the International Committee of the Red Cross (ICRC) took the extraordinary decision to pull out of Burma altogether in protest at the lack of governmental co-operation (see 6.3).

In this report, therefore, ARTICLE 19 will highlight the crucial issues of health and human rights in a society under censorship at a time of historic transition and international debate over the social and political crisis in Burma. Since few studies have ever been published on the national health system in Burma, the first half of the report will examine the underlying issues of health rights and human rights against the backdrop of the country's long-running political malaise. The second half will then look at three areas of specific health concern: humanitarian emergency, AIDS and narcotics, and the health treatment of women. Each topic raises fundamental issues over the rights of all citizens to freedom of expression, to freedom of research and information, and the right to know.

In ARTICLE 19's view, these most fundamental of human rights are absolutely central to the provision and enjoyment of essential health care - as well as the protection of universal health rights - in any society in the world.

2. HEALTH RIGHTS AND HUMAN RIGHTS: THE EXPERIENCE OF BURMA

Burma today presents an acute example of the vital link between health rights and human rights. Amongst international development organisations, analysis and research into this fundamental inter-dependence are, in many respects, still evolving: many of the ethical issues raised by modern science or public health law and practice are extremely complex. Nevertheless, although not always explicitly stated, the primacy of the basic "right to health" as a human right has long been enshrined in a number of international treaties and conventions.

Pre-eminent amongst such agreements is Article 25 of the Universal Declaration of Human Rights which states:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

In addition, Article 3 of the Universal Declaration further guarantees "the right to life, liberty and security of person", while Article 5 pledges that "no one shall be subjected to torture, or

to cruel, inhuman or degrading treatment or punishment".⁶

Based upon such fundamental tenets of human rights' principle, over the years a number of other treaties and conventions have been adopted by different international bodies in recognition of the obligations on all governments to achieve universal standards. Some agreements relate to specific human rights abuses, notably the 1987 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Other health guarantees, by contrast, are contained in treaties that are intended to protect disadvantaged or particular population groups. The "right to health", for example, is invoked in the 1969 Convention on the Elimination of All Forms of Racial Discrimination (Article 5), the 1981 Convention on the Elimination of All Forms of Discrimination Against Women (Articles 11 and 12), and the 1989 Convention on the Rights of the Child (Article 24).

In practice, however, for doctors and other health practitioners actually working in the field, recent research has suggested that medical and ethical concerns over health and human rights violations generally fall into two main categories.⁷ The first is the grievous impact that many human rights abuses have on health, including such gross violations as torture, extrajudicial executions, rape, forcible resettlement or forced labour.⁸ Whether administering to victims or addressing the humanitarian impact of war, health practitioners are frequently main witnesses to the suffering and thrust into the front-line of care.

The second key area of health concern is equally critical: the impact that government policies and public health programmes or practices themselves have on health and human rights. Implicit in such a broad definition of health rights is recognition that the fundamental issue of health care can no longer be isolated from human rights or the general conditions and state of society. This far-reaching social basis to both health rights and human rights was most clearly stated in the historic Alma-Ata Declaration of the World Health Organisation (WHO) and UNICEF, which was adopted at the International Conference on Primary Health Care in 1978:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose

⁶ These universal rights to life or health are further guaranteed in both the International Covenant on Civil and Political Rights (e.g., Article 6.1) and the International Covenant on Economic, Social and Cultural Rights (Article 12.1).

⁷ See, Jonathon M. Mann *et alia*, "Health and Human Rights", in *Health and Human Rights*, Vol.1, No.1, Fall 1994, pp.6-23; and Virginia A. Leary, "The Right to Health in International Human Rights Law", in *Ibid.*, pp.24-56.

⁸ *Ibid.*, p.17.

realisation requires the action of many other social and economic sectors in addition to the health sector.

In recent years the World Bank, too, has also targeted the impact of poverty on the health of developing countries and required governments to "pursue sound macroeconomic policies that emphasise reduction of poverty" as a "central" means to achieving "good health".⁹

In line with such arguments, it is today taken as axiomatic by a growing number of international development agencies that the proper assessment, development and implementation of equitable health programmes in response to the humanitarian and social needs of the community is a central responsibility of any government. By contrast, the failure to provide accessible health care, the discrimination against women or minority ethnic and religious groups, the ill-treatment of prison inmates, or negligence in providing adequate health programmes in vital medical areas, such as maternal welfare or HIV/AIDS, can all constitute the most fundamental violations of human rights.

One of the most crucial factors behind this broadening of health definitions is the increased emphasis placed on the preventive aspects of health care rather than medical treatment itself, a trend also advocated by the World Bank.¹⁰ According to WHO estimates, for example, half a million women die around the world every year from avoidable pregnancy-related causes, of whom 90 per cent live in developing countries.¹¹ Similarly, as Medecins Sans Frontieres (MSF) has pointed out, the great majority of deaths occurring in children under five each year are "avoidable mortality", i.e. deaths due to illnesses such as malaria, diarrhoea, measles, malnutrition or respiratory infections, which can generally be prevented or inexpensively treated.¹²

For this reason, the Plan of Action adopted by the 1990 World Summit of Children targeted the "health, nutrition and education of women" as the main method of reducing the shockingly high rates of both maternal and infant mortality in many parts of the developing world. Indeed, access to information and the right to know, which are guaranteed in Article 19 of the Universal Declaration of Human Rights, constitute the very basis of preventive

⁹ The World Bank, *World Development Report 1993* (Oxford University Press, 1993), p.6.

¹⁰ Ibid, pp.6-7.

¹¹ ARTICLE 19, *The Right to Know: Human Rights and Access to Reproductive Health Information* (London and University of Pennsylvania Press, 1995), p.88.

¹² Medecins Sans Frontieres, *Populations in Danger 1995* (MSF, London, 1995), p.118. Many Burmese doctors would question whether malaria, which shows considerable drug resistance, is truly preventable or treatable. Virulent strains of falciparum malaria are endemic in Burma's borderland areas. Nevertheless, in contrast to most of its neighbours, negligible progress has been made in combating an often fatal sickness which modern treatments and medicine can greatly control.

health care.¹³ Communities and citizens, for example, need basic information to make informed choices over everyday health issues, such as birth spacing, as well as to understand the very real health risks of illnesses such as HIV/AIDS or cholera.

At the same time, for the supply of such information to be truly effective, the essential provision of public access to health care is not enough. The right of public participation must also be guaranteed in an accountable system of health management, where independent data collection and efficient monitoring of health programmes or practices are permitted as democratic rights. This is a problem not only confined to Burma. Over the years, as a recent investigation by ARTICLE 19 into reproductive health pointed out, many governments around the world have been able to "manipulate, suppress or fail to provide information", which has resulted in the ill-health or deaths of millions of citizens.¹⁴

Starvation, disease, poverty, genocide and other gross human rights abuses arising out of armed conflict are perhaps the most extreme health emergencies that, all too frequently, have been concealed by censorship. But from the pandemic spread of HIV/AIDS and resurgence of tuberculosis in the past 15 years to reproductive health and other such perennial health problems as drug abuse, cholera and malaria, there are still a host of other grave health issues that continue to go under-reported and threaten the state of global health. And yet, despite this bleak picture, many physicians are confident that a growing majority of health problems - and, most certainly, virtually all infectious or parasitic diseases - are either controllable or can be prevented altogether by a combination of education, access to information, diagnostic capacity, the availability of modern medicines and treatment, and the financing of relevant health programmes.¹⁵

Tragically, although Burma represents an outstanding example of the need to respect human rights in order to protect health rights, substantive debate on human rights and health problems facing Burmese citizens has scarcely begun. Burma today is suffering the consequences of nearly five decades of armed conflict and over 30 years of military rule. It is also a land where well over half the population has no access to any system of regular or public health care and where preventable diseases or illnesses, such as malaria, HIV/AIDS and tuberculosis, are not only rife but, in some cases, are still spreading.

Many of the gravest issues affecting the health of Burmese citizens can be put down to the consequences of armed conflict. Since 1988, such inhumane practices as torture, extrajudicial executions and "scorched earth" tactics have all been documented by international human rights organisations and gained considerable notoriety abroad (see 6.1).

¹³ Quote article?

¹⁴ ARTICLE 19, *The Right to Know*, p.72.

¹⁵ MSF, *Populations in Danger 1995*, p.121.

In this context, it therefore needs to be stressed that armed opposition groups have also, over the years, been responsible for many gross violations of human rights that have had a negative impact on health and inhibited the development of more equitable systems of public medical care.

In recent years, however, the sufferings of the Burmese peoples have undoubtedly been compounded by the volatile consequences of the government's social and economic reforms. For while the SLORC's "market-oriented" economic policies of the "open door" have clearly brought about a new degree of prosperity for certain sectors of the community (especially traders and families of the ruling elite), a growing number of health problems have been observed by medical practitioners in many different regions of the country. Many doctors, for example, believe that, in several parts of Burma, the continuingly high incidence of such serious health problems as malnutrition, malaria, diarrhoea and various water-borne diseases over the past few years can be directly attributed to the government's policies of civilian resettlement or "forced relocations". Indeed, since the SLORC assumed power in 1988, over one million citizens are estimated to have been forcibly relocated in the countryside or moved from downtown urban areas to satellite new towns around Rangoon and the other main conurbations (see 6.2 below). In some rural areas, rates of over 50 per cent malnutrition (mostly moderate) have been recorded by health workers amongst children under five. Along with poor sanitation and inadequate health infrastructures, such basic health neglect is a major, though unreported, factor behind the unacceptably high rates of infant mortality in many communities.

On the national scale, UNICEF has also recorded a recent rise in malnutrition amongst children under three from 32.4 to 36.6 per cent during 1990-91, and in 1991 raised the estimated prevalency figure for past or chronic malnutrition amongst school beginners from 29.1 to 40.50 per cent.¹⁶ The consequences of such poverty and nutritional neglect can also be detected in the nationally high rates of Vitamin A and iodine deficiency, which lead to poor physical and cognitive development. For example, UNICEF considers a goitre prevalency rate (cause by lack of iodine) of more than five per cent a "public health threat", but amongst schoolchildren in the Chin State a shocking figure of 65 per cent has been recorded.¹⁷

However, perhaps the most extreme examples of urgent new health problems in Burma today can be seen in the boom-town mining-communities of the Kachin and Shan States, where hundreds of thousands of citizens from all over the country have rushed in the past few years in the hope of striking it rich. Here in the malaria-infested jade mine region at

¹⁶ UNICEF, *Children and Women in Myanmar: A Situation Analysis 1995* (Rangoon, 1995), pp.27 and 31.

¹⁷ Ibid.

Hpakhan or the ruby mines at Mongshu, some doctors have made private fortunes providing personal health care for those who can pay, but for most citizens there is little health provision at all. For many years, foreign journalists and international health organisations have been barred from all such sensitive regions of the country. But recent travellers report that intravenous drug use, prostitution and the closely-attendant spread of HIV/AIDS are all flourishing to a deadly backdrop of ignorance and social crisis that desperately reflects the changing pressures and patterns in modern life.

In contrast to this picture of neglect, since assuming power in 1988 the SLORC has belatedly shown some awareness of the responsibilities of government for the protection of health rights in Burma. Prior to 1988, Burma was one of the world's most reticent signatories to international agreements and conventions. However, in one of many ambivalent steps taken by the ruling generals, since 1989 the SLORC government has begun to sign a broad array of different international conventions. Prominent amongst this list are the 1949 Geneva Conventions, the Convention on the Rights of the Child, the World Declaration for Nutrition, the Vienna Convention for the Protection of the Ozone Layer and the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, all of which contain important provisions relating to health and humanitarian issues. In addition, the SLORC has for the first time entered Burma into number of multi-lateral agreements that include important health provisions with different international agencies or countries, including the UN International Drug Control Programme (UNDCP), UN High Commissioner for Refugees (UNHCR), China, Thailand and Bangladesh.

Domestically, too, the SLORC has appeared to show greater interest in addressing certain health issues than the defunct Burma Socialist Programme Party (BSPP) government of the country's ageing military dictator, Gen. Ne Win, whom it succeeded in 1988. A number of basic health rights had already been officially guaranteed under the BSPP's 1974 constitution, including the "right to medical treatment" (Article 149), the "right to rest and recreation" (Article 150), the right to "enjoy benefits for injury due to occupational accidents or when disabled or sick or old" (Article 151), and "equal rights for women" (Article 154). And although the BSPP's constitution was suspended in 1988, both the duties of government and the rights of the people to both information and participation appear to have been further guaranteed in the 104 basic principles that have been drafted, to date, for Burma's new constitution at the SLORC-convened National Convention. Principle 18 (a) and (b) declares: "The State shall earnestly strive to improve the education and health of the people; the State shall enact necessary law to enable the national people to participate in matters of education

and health of the people."¹⁸

The actual timetable for introducing Burma's new constitution remains contentious. In November 1995, the NLD officially withdrew from the Convention in protest at the many political restrictions and the lack of "freedom of discussion"; the Convention, Aung San Suu Kyi said, did not represent "the will of the people".¹⁹

Nevertheless, although the political process may be deadlocked, the SLORC has simultaneously tried to introduce a number of initiatives in social and economic reform. In the health field, a National Health Committee has been set up under the SLORC secretary-one, Lt-Gen. Khin Nyunt, to co-ordinate activities between the different government ministries and health departments. In the language of their deliberations, the influence of different UN agencies is often clear. The cornerstone of current health policy is Burma's National Health Plan 1993-96, which is based upon the goals of the WHO's "Health For All by the year 2,000"; and to support these objectives, a number of specialist programmes have been set up, including the National Population Policy (1992), National Health Policy (1993), National Programme of Action for the Survival, Protection and Development of Myanmar's Children in the 1990s (1993) and the National Plan of Action for Food and Nutrition (1994). Important targets in the National Programme of Action for children, for example, are halving the rates of both infant and maternal mortality, improving the rates of immunisation to 90 per cent of all infants, and providing "access to information about and preventive measures against HIV/AIDS to all at-risk groups".²⁰ In another significant development, NGO and community-based approaches to health have also been proposed (see 3).

And yet, despite the expression of such lofty ideals, many medical practitioners contend that the overall health and humanitarian situation has actually gone from bad to worse over the past few years. The ICRC's withdrawal from Burma in June 1995 is perhaps the most glaring example of international concern over the humanitarian attitudes of government in Rangoon. All Western governmental aid was also cut off to Burma in 1988 in protest at the brutal manner of the SLORC's assumption of power. Then in May 1992, in response to human rights' concerns that aid was not reaching to the people, the Governing Council of the UN Development Programme (UNDP) took the extraordinary decision to halt new funding for its Burma's Country Programme for one year until a complete review had

¹⁸ Further constitutional recommendations are the provision of health care by the State for mothers, children, orphans, the families of fallen army servicemen, and the aged or disabled, as well as the expansion of both the private and public medical sectors.

¹⁹ *Reuters*, 29 November 1995; see also, ARTICLE 19, *Censorship Prevails*, pp.25-9.

²⁰ *National Programme of Action for the Survival, Protection and Development of Myanmar's Children in the 1990s* (Rangoon, 1993), p.6.

ensured that future projects were targeted towards the "grass-roots level" in a "sustainable manner".²¹

But undoubtedly the most serious humanitarian questions have been raised by the continuing work of the UN Human Rights Commission and the UN Special Rapporteur on Human Rights. In a series of published investigations since 1992, the Special Rapporteur has documented a disturbing background of gross human rights abuses that have all helped contribute to the poor health environment in the country, despite the recent spread of cease-fires with armed ethnic opposition groups. For example, while welcoming the release of Aung San Suu Kyi in July 1995, in his most recent statement to the UN General Assembly, the Special Rapporteur, Prof. Yozo Yokota of Japan, cited continuing evidence of summary executions, arbitrary detentions, torture, rape, forced relocations, forced labour for government development projects and forced portage, in which conscripted citizens are compelled to work in "appalling living conditions".²² Such worries were further reflected in December 1995 when the UN General Assembly, in a wide-ranging list of humanitarian concerns, urged the SLORC, by unanimous resolution, to "ensure full respect for human rights and fundamental freedoms" as well as to "put an end to violations of the right to life and integrity of the human being".

In the face, however, of such a growing body of international evidence and condemnation, the SLORC has continued to reject all criticisms and deny any wrong-doing. At the heart of the SLORC's defence is an entirely different definition of the concept of human rights in both Asia and the developing world. Such a definition, which appears largely borrowed from China, gives far greater priority to the collective economic and social well-being of all citizens in general than the particular health or human rights of individuals. Speaking at the University for Development of National Races in February 1995, Senior General Than Shwe, the SLORC chairman, described human rights and the living standards of the Burmese peoples at near primal levels:

It is regarded that food, clothing and shelter needs are the most basic human rights for mankind to survive. It can be said that once the basic human rights of the people are met, there is no difficulty to fulfil other human rights.²³

Such arguments have also been advanced by SLORC officials in the international community. According to U Aung Aye, leader of the Myanmar delegation, who made an intervention at

²¹ See, UNDP, *Summary Report: UNDP Assistance to Myanmar (as per GC decision 93/21)* (Rangoon, May 1995).

²² UN General Assembly, *Situation of Human Rights in Myanmar: Note by the Secretary-General* (New York, A/50/568, 16 October 1995), p.17.

²³ *The New Light of Myanmar*, 11 February 1995.

the 51st session of the UN Commission on Human Rights in March 1994:

Human rights cannot be enjoyed in a vacuum....Our concept of justice is not only justice in its legal sense but also social, economic and political justice.

However, while few observers would disagree with the close inter-relationship between development rights and human rights in the modern political world, to date the SLORC has steadfastly refused to investigate any specific reports of health rights or human rights abuses, despite the repeated criticisms of the UN General Assembly. In its most recent reply to the UN Special Rapporteur on Human Rights, the SLORC simply dismissed all such allegations as "unfounded, emanating from anti-government sources and terrorist groups, with the aim of discrediting the Government as well as the Armed Forces of Myanmar".²⁴

It would thus appear that, although all sides in Burma are agreed on the historic need for social and political reform, for the moment freedom of expression and the important linkage between health rights and human rights are not even on the government agenda.

3. THE HEALTH SYSTEM IN BURMA

As in the education and other state sectors, there has long been a yawning gap between the reality and rhetoric over the provision of national health care in Burma. Few independent studies have ever been permitted and, until the recent ethnic cease-fire movement, large areas of the country had remained strictly off-limits to international observers for decades. Even today, vast areas remain either officially forbidden or are inaccessible to outside agencies, especially in the ethnic minority states.

Health analysts have, therefore, been largely dependent on official government reports and statistics which, ever since Gen. Ne Win first seized power in 1962, have continued to depict a medical system that is in a state of constant progress and expansion. On paper at least, a comprehensive health system was built up during the BSPP era, with large hospitals, dispensaries and a variety of specialist health centres, as well as a system of local co-operatives²⁵, in the main towns of all of Burma's 14 states and divisions. Smaller hospitals and facilities were also developed, including maternal and child health centres, under the supervision of a qualified Medical Officer in each of the country's 319 local townships. Privately, however, government doctors admit that effective central outreach never extended

²⁴ UN General Assembly, *Situation of Human Rights in Myanmar*, p.31.

²⁵ Organised under the Ministry of Co-operatives, local co-operative societies in the townships were initially used for the sale of rice, cooking oil, medicines and other rationed goods. After 1972, many were also encouraged to open clinics and employ doctors under a semi-subsidised, fee-paying system that evolved.

to much more than a third of the country. In part, this was due to governmental neglect and the perennial lack of resources, but it was also due, in large part, to the insurgencies. Even today, for example, it is still possible to find nurses and other health workers drawing government salaries in military garrison towns, who have never travelled into the countryside to take up their positions.²⁶

Since 1988, in response to the SLORC's moves towards a "market-oriented" system of economic management, a number of new initiatives and approaches have been mooted by government servants in the Ministry of Health. Many of these would appear to mark a distinct break with the past. Emphasis, for example, is now officially given to the role of "community organisations", the return of foreign NGOs to Burma, and increased co-operation with different UN agencies.²⁷

However, as opposition groups point out, many of the structural mechanisms and working practises from the BSPP era have been maintained. The BSPP's third "People's Health Plan" of 1986-90, for example, continued uninterrupted by the momentous events of Burma's "democracy summer" in 1988, and in 1991 was replaced by a series of new "National Health Plans", which are following virtually the same goals. An updated and rather more relevant National Health Policy was promulgated in 1993 but, as in other walks of national life, doctors complain that military control over the top echelons of decision-making remains absolute. In consequence, the Health Ministry, which is headed by Vice-Admiral Than Nyunt, remains highly bureaucratic and slow to respond to the needs of the people. Indeed, much of the energy and influence behind recent changes comes not from the Ministry but from the National Health Committee, a powerful inter-ministerial grouping which is chaired by Lt-Gen. Khin Nyunt, the SLORC secretary-one and head of the Military Intelligence Service. As an indication of the narrow concentration of power, Khin Nyunt, who is regarded as a progressive within the SLORC on development issues, also chairs the government's Education, Foreign Affairs, Tourism and Border Areas Development committees. Like Vice-Admiral Than Nyunt, however, Khin Nyunt (whose wife is a doctor) is believed to have no formal medical experience or training.

Despite a legacy of such inertia and political control, there can be little doubt that the growing involvement of international health workers in Burma since 1988 has given a certain

²⁶ This report does not specifically examine the provision of health care by armed opposition groups in the large areas of territory they control around Burma's borderlands. Many run their own health programmes but, in comparison to overall needs, such projects must be considered very small (see 6.3).

²⁷ Union of Myanmar, *National Health Plan (1993-96)* (Ministry of Health, Rangoon, 1993), p.2.

boost to the recognition of serious health problems in the country. This has come about both by the continuing work of different UN agencies, which remained after 1988, as well as the arrival of the first international NGOs after 1991. In particular, following the SLORC's accession to UN protocols on the Rights of the Child and the Geneva Conventions, the language appearing in official health reports has begun to fit more closely with international norms. However, it should be emphasised that the important ideals which are expressed in such reports come nowhere near describing the reality of human suffering or lack of adequate medical provision that exists in Burma today. As the country emerges from Ne Win's idiosyncratic era of one-party rule, every aspect of health and humanitarian care is in crisis.

Many of Burma's health problems are long-standing and can be dated back to previous governments. But medical workers in the field generally concur that, despite the publicity given to recent initiatives by UN agencies and foreign NGOs (especially about AIDS), for the majority of Burmese citizens the overall health situation has deteriorated since 1988 as the existing state system has begun to unravel.

In many respects, Burma today displays the classic characteristics of "strong societies" but a "weak state", where the authorities are unable to achieve - or countenance - effective action across all social and ethnic sectors.²⁸ In government-controlled areas, there are, in fact, four different - although increasingly overlapping - systems of health provision: public, private, traditional (or indigenous) and military. But it is the public sector, upon which most citizens depend and which had, in theory, been freely available to all, that has come under the greatest pressures since 1988 and which is losing patients most rapidly to the other sectors.

The political pressures in the state sector are examined below (see 5), but health workers point to two major areas of failure which permeate every region of the country: chronic underfunding, and a neglect of education and the preventive aspects of health care. Many of the most obvious failings can be seen in government hospitals. As one international health worker privately put it: "Unless you have money, public hospitals are the next step to the grave." Burma still has many excellent doctors and nurses and there are many everyday examples of philanthropy. Many honest and hard-working practitioners are also very sensitive to criticisms about health issues over which they feel they have no control. Nevertheless, after years of underfunding and poor management, corruption has become endemic in the public health system, with patients often required to pay bribes or fees every step of the way - sometimes from the hospital gateman to even getting a bed. Essential medicines, too, are always in short supply, and for many years even those medicines which do arrive in the clinics and surgeries have been routinely, but illegally, sold off to black market

²⁸ See e.g., Joel Migdal, *Strong Societies and Weak States* (Princeton, ?).

or privately-run pharmacies that can be found in streets around many main hospitals. Although treatment is technically free, patients have then been privately required to buy back all medicines (and even cotton wool) that are needed for operations. In private, many hospital staff have freely admitted their involvement in such illegal sales; it is unpopular, for example, to be posted to work in hospital blood-banks since there is no access to medicines that can be sold. But in their defence, public health workers argue that their families simply can not manage to survive without raising extra sources of income. Doctors, for example, who are at the top of the public pay scale, have average salaries of just 1,500 kyats (US\$ 15) per month.²⁹

As a result, over the years there has been a constant exodus of qualified doctors from the public sector - either abroad or, more recently, into private practice in Burma itself. Throughout the country, despite a general expansion in primary health care over the past decade, huge gaps and constant interruptions in medical provision are occurring, making it difficult to sustain community health programmes. According to UNICEF, of Burma's 13,392 qualified doctors in 1993, only 4,998 were recorded in public service; the remaining 8,394 were working as general practitioners in the private (or co-operative³⁰) sector; significantly, too, an estimated 80 per cent of government doctors also run private clinics, sometimes even during duty hours.³¹ There is also a serious understaffing of other medical personnel, including midwives and nurses, and the former BSPP's Community Health Worker programme, which, over the years, had given rudimentary training to over 30,000 volunteers, has recently been discontinued.³²

As Burma's 45 million population continues to rapidly grow, these changing demands and working practices have led to a very disparate level in the quality of health provision around the country. In January 1995, in a rare admission of problems, health officials

²⁹ Financial statistics are difficult in Burma. The official exchange rate of US\$ 1 = 6 kyats is unrealistic and in no way compares with the market rate of \$1 = 100 kyats that is used in the streets; see, World Bank, *Myanmar: Policies for Sustaining Economic Reform* (New York, 16 October 1995), pp.18-23, 27-32.

³⁰ Since 1988, the BSPP's co-operative health clinics have, in effect, moved into the private market but continue to be competitive by importing or receiving subsidised medicines which they sell at cheaper prices.

³¹ UNICEF, *Children and Women in Myanmar*, p.50.

³² In 1995 Burma had just 7,033 public and 2,671 private nurses, 8,724 midwives, 1,682 Lady Health Visitors and 1,327 Health Assistants, most of whom were working at the community level; see, Union of Myanmar, *Review of the Financial, Economic and Social Conditions for 1994/95* (Ministry of National Planning and Economic Development, Rangoon, 1995), p.196. Under another volunteer scheme begun in 1978, there were also an estimated 20,000 auxiliary midwives.

privately reported that 500 government health posts were vacant.³³ But, as always, it is in the ethnic minority states that the lack of public health care is most apparent. During 1995, for example, a third of the 150 positions for doctors in the Rakhine State were reportedly unfilled. Resignations are technically difficult, but in ethnic minority areas many non-local physicians either do not turn up or simply apply for transfer on their first day of arrival rather than remain in what are widely regarded as hardship postings with few career prospects. Indeed, so serious are recent shortages of doctors that in January 1995 the SLORC introduced regulations compelling all medical graduates to work in the state system for a minimum of three years before requests to resign or travel abroad will be considered. This, however, has not stopped the exodus.

Against this background, the second health sector in Burma - the private - is booming and, almost by default, has begun to provide an increasingly broad quality of health care. Because of the lack of resources in the public sector, in recent years many citizens have automatically turned to the private sector first, where many doctors have established reputations or are moonlighting from their state jobs. Indeed, many government doctors simply refer patients to their private clinics if they want speedy treatment - and they are able to pay. In Burma's convulsive economy, the charges can be astronomical; in the private sector, for example, a hysterectomy operation can cost 30,000 kyats - or twice the official annual wages of most state workers. None the less, there is a new class of rising rich in Burma, especially traders or those with access to foreign exchange, who are able to afford such prices, and this has been evidenced by a recent fashion for expensive "poly-clinics" with private rooms and air-conditioning, which are popular with successful businessmen and entrepreneurs. With 1996 also being promoted as Burma's "Year of the Tourist", private physicians have similarly begun to target the very real health concerns of foreigners, and in October 1995 the first 24-hour international clinic was opened in Rangoon by the Singapore-based AEA medical centre chain.

Health concerns over the methods of private doctors (where properly qualified) are, in general, more to do with the equity and ethics of treatment (see 4). Patients enjoy absolutely no health rights protection, but standards remain relatively high. This is also largely the case with the third main sector in Burma: the traditional or indigenous, which also works in the private market. There has long been a consensus that traditional practices, including homeopathic and Chinese herbal medicines, have a worthy place in the overall scheme of treatments available in Burma. The Health Ministry, for example, has a Department of Traditional Medicine³⁴, and over the years UNICEF has run training programmes to try and

³³ *Bangkok Post*, 30 January 1995.

³⁴ In addition to Traditional Medicine, there are four other main departments under the

equip traditional birth attendants (known as *lethe*) with additional skills and knowledge, especially about hygiene and nutrition.

However, since 1988 many doctors have become concerned about the numbers of untrained "quacks", operating on the fringes of modern medicine, who are using the failures in the national health system to take advantage of the sick and needy. In Burma today, virtually any one can set up as a private or independent health practitioner. As a result, across the country there are thousands (by some estimates, at least one to each of Burma's 60,000 villages) of self-appointed medics or conmen masquerading as private medical experts, who are giving injections and every kind of fake or inappropriate treatment. On some occasions, they are preferred by local custom or belief, but more often than not their main selling point is their easy availability and deceptive "PR" when compared to public or properly-qualified private doctors.

The tragedy, as many hospitals in Burma have recorded, is that patients suffering from emergency sicknesses or illnesses, such as snake-bites or cerebral malaria, are often only brought in after valuable life-saving time has already been wasted on such imposters by impoverished families who have only wasted their money. Many such practitioners have picked up tit-bits of health terminology during military service or training as community health volunteers, and they are thus able to persuade their gullible victims. In vast rural areas of Burma, however, there is no system of reporting or health information available to address such very basic issues. Moreover even where deaths have occurred through obvious maltreatment, many physicians complain that there is no will within the existing health system to investigate such blatant health right abuses, even though machineries reportedly exist.

By contrast, the final health sector in Burma, the military, has remained largely impervious to the social upheavals of the past decade. Military hospitals are well-supplied with medicines and are generally provided with modern equipment. In addition to two large Defence Services hospitals in Rangoon, there are also military hospitals in Mandalay, Maymyo, Meiktila and other important regional towns, which in the last few years have been equipped with computerised blood-testing and other expensive machinery. For many years, an estimated 50 newly-graduated doctors have been conscripted annually for a three-year period of service with the *Tatmadaw*, often in dangerous front-line areas. However there are also a few aspiring doctors who openly volunteer for appointments to military hospitals, since not only are general working conditions more favourable but there are also greater career possibilities for research and specialism. Brig. Kyaw Win, for example, who was formally Ne

Ministry: Health, Medical Education, Medical Research and Medical Statistics.

Win's personal physician, was widely regarded as one of Asia's top malariologists before he recently fell out of senior military favour and was posted as Ambassador to Canada. In addition, under the SLORC a Defence Services Medical College has also been established in Rangoon, where many sons and daughters of military officers have gained admission. As a result, doctors in the public health system privately complain that, just as in the former BSPP era, senior officers are becoming ever more institutionalised and hidden away from the daily health sufferings of most ordinary citizens.

Nevertheless, even the military sector has its own spending limits, and soldiers in the ranks privately allege that health provision is not evenly spread and does not always extend to their families. Malaria, for example, continues to inflict a steady casualty rate (including several dozen fatalities annually) amongst young soldiers stationed in the war-zones, and although they are supposed to be supplied with prophylaxis medicines, both health education and testing facilities in the field are often extremely poor.

In summary, then, all four sectors within the national health system are faced with a host of critical problems in an era of social uncertainty and political transition, which most doctors and health workers are only too anxious to address. Many doctors, for example, believe it is virtually impossible to properly tackle such everyday health problems as malaria, AIDS or tuberculosis while so many different medical regimes and practices exist. Drug resistance and infection can be quickly spread.

Very belatedly, the need for new strategies and effective integration between the different sectors was also recognised by the Health Ministry in the 1993 National Health Policy when it pledged to augment "the role of co-operative, joint ventures, private sectors and non-governmental organisations in delivery of health care in view of the changing economic system" (Clause 5). In another overdue recognition of need, it was also planned to expand national health services for the first time to the border areas, following the spread of the ethnic cease-fire movement (see 6).

Thus finally in September 1994, recognising the worsening constraints within the existing system, the SLORC took the first steps towards abolishing the system of theoretically free health care that had existed in Burma under successive governments since independence. In its place, a new "cost-sharing system" was announced for the country's 717 state-run hospitals, 1,424 rural health centres, 306 dispensaries and 353 maternal and child health centres so that the public sector could raise local income and co-ordinate more effectively with the burgeoning private market. "The community financing or community cost-sharing is just a precursor of health insurance and social security schemes of the United States and

European countries," one senior health official boasted.³⁵ In essence, the scheme consisted of a list of 23 items and medicines that can be sold by the local health authorities to raise revenues to subsidise other treatments and running costs.

Typically, however, the new system has yet to be properly explained or reported in the state-controlled media to either health workers or the general public. As a result, different pricings and practices have been introduced in different hospitals in different parts of the country, causing many doctors to overprescribe drugs which may be unsuitable but are plentiful at the expense of more apposite but unavailable cures. The concept of charges also appears to becoming mandatory, with an appendicitis operation, for example, now costing over 5,000 kyats in many hospitals after all the necessary medicines and materials have been purchased, leaving many families with the bleak choice between the possible death of a loved one or bankruptcy. Equally serious, once again this emphasis on revenue and costing within the health system continues to push doctors in the more lucrative direction of treatment and the curative aspects of medicine rather than education or preventive health care, which is undoubtedly the cheapest but most vital reform that is desperately needed in Burma today. In their defence, many physicians believe that the Burmese peoples must also be mobilised to value the importance of health education after decades of governmental indifference and neglect.

Whether such essential reforms can be initiated in the present state of political deadlock and crisis, however, remains far from clear.

4. HEALTH IN A SOCIETY UNDER CENSORSHIP

Burma today has one of the toughest systems of state censorship and media control of any country in the world. Since 1988, an independent publishing industry that concentrates on business affairs has been allowed to develop, and various new journals occasionally comment on social or health issues. In the past eighteen months, for example, the popular magazines *Thintbawa* and *Kyi-pwa-yay* have both run articles mentioning the topic of AIDS, which were passed by the censors. Any criticism of the authorities, however, is strictly forbidden under a complex array of draconian censorship laws, and virtually all health education and reporting remains the sole prerogative of the government, which tightly controls all television, radio and daily newspapers.³⁶

³⁵ *Bangkok Post*, 30 January 1995.

³⁶ See, ARTICLE 19, *State of Fear*, and ARTICLE 19, *Censorship Prevails*. Despite being allowed to write on some social topics, the January 1996 issue of *Thintbawa* was again heavily censored when over 50 out of 160 pages on the subject of education were torn out by the

In the state media, although health is a common topic, no comment is ever permitted which might imply any health neglect or failings by the authorities. The *New Light of Myanmar*, in particular, often carries agency reports from international organisations such as the WHO or UNDP, but these are rarely re-edited to illustrate the actual health conditions in Burma.³⁷ Instead, local health news largely consists of lists of prominent military, governmental and, on occasion, foreign health figures who have attended various hospital openings, graduation classes or seminars.

For a reader unfamiliar with Burma, such reports - backed up by the copious use of statistics - can give the impression of an effective system of countrywide response and co-ordination. For example, when plague broke out in India during 1994, the SLORC responded with a high-profile national awareness campaign which was heavily promoted in the state media; guard duty was stepped up at all official entry points from India and attempts were made to control the local rat population.³⁸

There should be no doubt, too, that there are many public doctors and health officials, who try to react as best they can to any medical emergency within the limitations of the present public system. On 20 May 1995, for example, Dr Mya Than Nwe from the Medical Research Department spoke on state radio about health education after an outbreak of bacterial encephalitis in parts of the Magwe Division and Rakhine State.

However many local health workers and opposition groups complain that the occasional prominence given to such headline stories can flatter to deceive over the real state of national health provision. Year-in year-out, the great majority of other local health issues continue unreported and unrecorded in any informative way. Equally prohibitive, not only is it very difficult for Burmese health workers or journalists to travel and carry out research under current censorship and security laws, but it is virtually impossible to independently publicise their findings, even where they become aware of serious health problems.

After over three decades of military-dominated rule, in the state-controlled press there is little sensitivity to immediate or local issues, and for many years health conditions in vast areas of the country have been neglected, especially in ethnic minority regions where local language publications have been restricted.³⁹ In recent years UNICEF has produced various health materials, such as *Facts for Life*, in several minority languages, but distribution is

censors.

³⁷ See e.g., *New Light of Myanmar*, 19 November 1993, for an article taken from *World Health* on the global fight against tuberculosis.

³⁸ *New Light of Myanmar*, 2 October 1994. Though little publicised, there are still occasional outbreaks of plague - usually bubonic - in the central dry zone region of Burma. A Health Ministry official privately admitted 528 cases and three deaths in one such epidemic in 1992.

³⁹ ARTICLE 19, *Censorship Prevails*, pp.35-8.

limited, and local communities and writers face many obstacles before they can publish any materials themselves. At the national level, too, health education is grossly under-resourced and many staff are unmotivated. As a result, citizens across the country are ill-informed and have little access to essential health information on a broad array of vital issues - from the high incidence of malaria in border regions to such everyday medical problems as malnutrition, snake-bites, back-street abortions and intestinal illnesses (including both dysentery and cholera), which are common health threats today. Some health problems, such as malnutrition, are neglected because they are an embarrassment, but others, such as cholera, are very sensitive to the government. In particular, all countries around the world have faced serious cultural and educational challenges in confronting the issue of AIDS/HIV, but in Burma, despite the obvious spawning ground of local conditions, government officials were tragically late. By the time the SLORC woke up to the looming scale of the problem, hundreds of thousands of citizens may already have been infected (see 7).

The damaging effects, then, of years of press censorship and health neglect in Burma are manifold and intrude into every health field. But, in general, the mechanisms and practices of censorship can be divided into two main categories: direct censorship by the authorities, and the insidious - and equally debilitating - consequences of the pervasive atmosphere of fear that has been highlighted by Aung San Suu Kyi. "It is not power that corrupts but fear," she once wrote. "Fear of losing power corrupts those who wield it and fear of the scourge of power corrupts those who are subject to it."⁴⁰ Indeed Burma, in many respects, presents a classic case not simply of what the act of censorship deliberately represses or excludes but of how an endemic culture of censorship and restrictions on freedom of expression can prevent vital issues even being reported at all.

An obvious but longstanding problem within the health system of Burma is the often low take-up rate of public services, even where they have been provided. But as UN agencies have increasingly found, although traditional beliefs are sometimes responsible, it is frequently due simply to a lack of education and understanding of what is available.⁴¹

The resultant lack of both individual and community awareness in dealing with many common, but serious, health problems in Burma is often astonishing. All aspects of reproductive health, narcotics and the recent spread of AIDS/HIV perhaps stand out as areas where successive governments in Burma have failed in their health responsibilities. The list, however, extends much further. For example, in a country where malaria has long been a major cause of infant mortality, many villagers still believe that infection results from such

⁴⁰ *Times Literary Supplement*, 12 July 1991.

⁴¹ UNICEF, *Children and Women in Myanmar*, p.51.

improbable methods as eating bananas. The treatment of such global health hazards as tuberculosis, which is re-emergent in Burma, is similarly jeopardised by ignorance and the high drop-out rate of sufferers before completing essential courses of treatment; health workers, too, must take their share of the blame.⁴² Equally striking, international agencies are beginning to discover that long years of emphasis on construction to rectify Burma's woefully inadequate sanitation and clean water systems has proven ineffective without community participation or health education back-up. As UNICEF recently warned: "Little attention was given to the knowledge, attitudes and practices of beneficiaries."⁴³

Another much neglected area of health care is the plight and treatment (save for *Tatmadaw* veterans) of Burma's large population of disabled, who have been perennially underfunded and overlooked. This neglect extends not just to government but to many fellow citizens as well. For example, although it has been estimated that anywhere between 3.5 and 5 per cent of the population is blind or in other ways disabled, there are only six schools in the country for a maximum of 400 children.⁴⁴ As a result, a culture has developed in many communities where parents simply keep their children at home. The alternatives are bleak. As one physician remarked: "For many people, to become blind in Burma is virtually to become a beggar."

Of similar concern are the country's many leprosy sufferers. Burma is currently one of the world's six main centres for leprosy, with over 40,000 registered patients in 1993. Some recent advances have been made in treatment, and an improved multi-drug therapy was introduced into Burma in 1992. However conditions in many of the "leper villages" vary widely, and there were widespread reports of considerable hardship and suffering during the compulsory relocation of one community near Rangoon to a very under-prepared site at Ngasu (Hlegu township) for reasons which have yet to be explained after the SLORC assumed power. None of these issues, however, is raised or substantively investigated in the press.

The lack of national awareness, then, of most of the above health problems can largely be attributed to a combination of apparent governmental indifference, poor education and press inertia. Regrettably, the absence of reporting on many other health problems is often the result of quite deliberate censorship. Undoubtedly the most blatant area of health censorship

⁴² In one recent survey of TB patients in an urban community, less than 10 per cent finished one year of treatment, of whom three-quarters dropped out within four months.

⁴³ UNICEF, *Children and Women in Myanmar*, p.61. There are still many communities in Burma where germs and diarrhoea are not associated with polluted water or human excreta and, as a result, untreated water from rivers or shallow wells is still sometimes preferred to deep tube-wells and boiled water.

⁴⁴ *Ibid.*, p.65.

concerns war-reporting and humanitarian issues. For many years, the military government in Burma has strictly suppressed all news of casualties or health information which relates to human rights questions, such as forced labour or the treatment of prisoners (see 6 below). However, human rights abuses aside, many medical practitioners do not believe that military officers have any particular motive in suppressing health news - except largely one of pride. In this, doctors must also take their share of the blame for failing to report problems. As one health official privately explained: "The *Tatmadaw* rules the country just like the Burmese kings. They had a saying: 'Make a big problem a small problem, and make a small problem disappear.' Everyone is fearful of criticism and no one wants to admit mistakes."

Evidence of such fear of failure and criticism can be seen in many quarters today. One example occurred during an epidemic outbreak of cholera in several townships in the Rangoon Division in early 1993 which, according to foreign diplomats, was never officially publicised nor were poster campaigns encouraged since it was feared they would give visitors a bad health impression. Foreign journalists and aid workers, too, often face bureaucratic delays or straight refusals in response to requests to visit certain areas or hospitals. Indeed, at some hospitals foreign visitors have been denied permission to visit wards and, instead, have to wait in rooms where patients are brought to them for interviews that can be publicly monitored by officials. Despite the overwhelming good-will of foreign visitors, the authorities, it would appear, are extremely nervous about any negative comments or publicity.

However, perhaps the most consistent evidence of the censorship and misreporting on health issues in Burma today is in the publication of official statistics. The apparent readiness of government in Burma to make cavalier use of social statistics was graphically illustrated to the world in 1987 when, in order to achieve the criteria for Burma's acceptance into Least Developed Country status at the UN, the previous national literacy rate of 78.6 per cent (for which Burma had twice won UNESCO prizes) was dropped to just 18.7 per cent.⁴⁵

Since 1988, the same doubts over government statistics have continued. One of the most controversial is the true figure for military spending and its ratio against expenditure on education and health. For example, opposition estimates of over 40 per cent of the national budget being swallowed up by defence spending contrast with official government figures which, for many years, have stayed at around 20 per cent. There simply is no access to reliable data to reconcile such very different amounts. But even on the basis of this lower figure, Prof. Khin Maung Kyi, a Burmese economist at the National University of Singapore, has demonstrated that, using the criteria of the UN's Human Development Report, Burma -

⁴⁵ ARTICLE 19, *State of Fear*, p.27. The true figure probably remains over 70 per cent (with considerable ethnic variations), and it is this higher estimate that most international agencies use today.

although it has no external enemies - has the highest military spending as a percentage of government expenditure out of a comparable grouping of regional countries that includes Indonesia, Thailand, Bangladesh and Malaysia.⁴⁶ Equally stark, at around 152 per cent in 1992, Burma, despite its poverty, has by far the greatest imbalance of military expenditure against health and education spending, with projections that it could rise to 200 per cent in 1996.⁴⁷

None the less, if many aspects of government and military spending remain shrouded in mystery, there can be little doubt that increasing international scrutiny of Burma's social data over the past few years has brought about a new sensitivity over the recycling of questionable information. Some attempts to address this issue have been obvious propaganda. A recent trilogy of articles in the *New Light of Myanmar*, for example, on "Indices of Progress in Myanmar" were studded with graphs showing improvements in the health sector at almost Olympian levels, ostensibly so as to demonstrate "that the takeover by the SLORC was aimed at the common good of the country".⁴⁸

Other defences of the government, however, have been more carefully argued. For example, Dr Aung Tun Thet, a former Health Ministry currently working with UNICEF, has tried to illustrate that, although by most international political and economic indicators Burma "is usually classified" with countries "in crisis" such as Afghanistan, Angola, Iraq, Mozambique, Sudan and Zaire, by a more appropriate examination of different health and educational indicators, Burma under the SLORC (Nawata) is actually some way ahead in terms of general social progress.⁴⁹ Significantly, Dr Thet also argued that, although in the past there had been "a tendency to hide the actual situation by producing dubious figures", since 1990 the SLORC had given "explicit directives to ensure the production of accurate social statistics".⁵⁰

Apparent recognition of this need to improve basic health data came with the announcement of the 1993-96 National Health Plan, when the reliability of national health information was for the first time officially questioned after a workshop by government

⁴⁶ Prof. Khin Maung Kyi, *Burmese Gleam: Will it Endure and Glow or Flicker and Die? A Prognosis of Recent Economic Changes in Burma* (discussion paper, Washington, October 1995), pp.10-11.

⁴⁷ Ibid. The comparative figures in Thailand and Indonesia, for example, are 59 and 5.1 per cent respectively.

⁴⁸ *New Light of Myanmar*, 29, 30 and 31 August 1995. According to the paper, this report was prepared for the American oil company UNOCAL by a consultancy firm, International Security Management, Inc.

⁴⁹ Dr Aung Tun Thet, "Nawata's Performance in the Social Sectors: The Untold Story" (conference paper, Burma Studies Colloquium, North Illinois University, October 1994), p.1.

⁵⁰ Ibid., p.8.

health workers:

Monitoring and Evaluation were identified early...as weak spots in the management system.....The participants identified the information from the peripheral health units as being incomplete, inaccurate, patchy and unreliable for monitoring and planning purposes.⁵¹

Since this time, a number of failings in the health and educational sectors have begun to be discreetly voiced in government reports. For example, the massive underachievement in the Burmese education system and the fact that the majority of children do not even complete primary school have recently been admitted on several occasions. For this reason, primary health care and the aim of achieving universal access to basic education have been publicly heralded as main goals of Burma's National Programme of Action for the Survival, Protection and Development of Myanmar's Children in the 1990s.

Critics of the SLORC, however, have been quick to allege that government officials are simply becoming more adept at regurgitating UN development language. Indeed, it is in the background papers and reports of the UN agencies themselves (notably UNICEF and UNDP) that the underlying health problems are most explicitly stated. To date, substantive steps on most health issues by the government have been extremely few.

For the moment, then, huge doubts must remain over the quality of basic health information on which current health planning and expenditure are officially based. As with all health statistics in Burma, there are always wide regional and ethnic disparities. The most striking example is the much-quoted infant mortality rate (IMR), which is used by international health and development agencies as a main indicator for national standards of health. In the early 1970s, this figure was set at around 47 per thousand live births (for children under one), at which level it remained apparently unchallenged by UNICEF, the WHO and other international agencies until 1992 when it was dramatically doubled by the Ministry of Health to 94. At the same time, the official under five mortality rate was similarly doubled to 147 per 1,000 live births, which is the fourth highest figure amongst the 14 countries in the UN's East Asia and Pacific Region.

These much higher figures have since been used as the basis for continued international concern over UNICEF's "silent emergency"⁵² and the return of foreign health and development agencies to Burma. In its defence for this extraordinary jump, the Central Statistical Organisation of the Ministry of National Planning and Economic Development, which has responsibility for collating all such social and health data, has claimed that earlier

⁵¹ Ministry of Health, *Union of Myanmar: National Health Plan (1993-96)*, p.10.

⁵² See n.2.

reports were based largely upon urban statistics. But one public health worker actually involved in the new survey has privately told ARTICLE 19, "We could no longer hide the truth."

None the less, despite the importance of such admissions, many doctors warn that even the reliability of these adjusted figures should be treated with great caution. There are many variations in local estimates, with some much higher and lower figures reflecting both the paucity of governmental outreach and the very different health conditions in different parts of the country. For example, doctors working with MSF (France) have unofficially estimated the IMF at around 200 per 1,000 live births in war-torn ethnic Karen regions along the Thai-Burma border, while the figure in upland areas of the eastern Shan State has been put as high as 300 per 1,000 live births.⁵³ Similarly, although there are many other serious health problems, in some of the new-towns around Rangoon the IMF has actually been calculated by local health workers at below the new national average - at closer to 65.

Finally, it needs to be stressed that, in any examination into the consequences of censorship, simple concentration on data collection and the reliability of statistics can be very misleading in judging the overall state of health efficacy or emergency in any country. After recent tours of Burma, a number of international health and development workers have privately argued that, in some areas, the health infrastructures are so poor or non-existent that any official statistics produced by the government are nearly meaningless since they do not reflect the real conditions of health in the community. In many rural areas, for example, cholera and dysentery epidemics, which take hundreds of lives, still go unreported, especially in ethnic minority areas and the war-zones. Explained one foreign aid official who asked to remain anonymous:

It's all very well for health officials to use statistical projections to declare a state of emergency over the spread of AIDS - and they may well be right. But for many families and communities it will still be malaria, conflict or malnutrition and poverty brought on by everyday social injustices and hardship that will continue to take the greatest toll of life. However there is no sense of governmental or international urgency over issues like these.

Indeed, many local health workers already feel that the tendency of international donor agencies to focus on the high-profile issue of AIDS/HIV (which is generally regarded as a safe, non-political subject) could marginalise even further vulnerable groups and other long-standing health problems in the country. "Nowadays people will train in AIDS but nobody

⁵³ Doug Porter, *Wheeling and Dealing: HIV/AIDS and Development on the Shan State Borders* (Background paper supported by UNDP, Rangoon Institute of Economics and Australian National University, October 1994), p.29.

wants to work in a leper colony or work with the blind or handicapped," one physician complained. "Doctors will only work where they know there are good salaries and funds."

Of equal concern to many Burmese doctors, in official government reports there is no relation between statistics and the quality of health care that is actually provided. One veteran official in the Burmese health system privately made a long list of criticisms:

The way health statistics have been used in official reports is unethical and misleading. The survey questions asked to produce such data never reveal the true picture. There is no proper monitoring or feed-back. For example, there is always a lot of statistical concentration or publicity about the opening of new clinics or hospitals, but it is never asked or disclosed whether there has been a better rate of diagnosis, more doctors employed or patients seen, a better rate of treatment, a better rate of patient satisfaction or an improvement in the general standards of health in the community. This is what we should be aiming at, but no one dares openly talk or write about it.

Another much neglected issue is the way in which the government is able to use its absolute control over health provision and the media for political purposes. For many years publicity and the provision of health care have been used as political weapons, and this is a trend which has accelerated under the SLORC. For example, after decades of neglect in most ethnic minority regions, the sudden prospect of hospitals, doctors, foreign aid agencies and medical supplies have been promised in areas where the SLORC has an agenda for change; meanwhile other areas remain neglected. But the one message constantly reinforced in the state media is that the military government is the only institution in the country which can enable such beneficial developments to happen - and, by implication, should be the only conduit for international aid and funds.

This, however, is a process which many opposition groups believe is more likely to empower the SLORC than the actual people it is intended to help. There can be no doubt that Burma's health problems will only be solved by an integrated approach in which public institutions, including the Health Ministry, must play a central role. But for the moment there are vast areas of the country where international aid workers still have no access to the community to judge the political realities or social infrastructures for themselves.

Thus, finally, perhaps the most overlooked area of censorship and health care are the health rights of citizens themselves, especially the right to information. In a health system where corruption is widespread and private practice now booming, many citizens have become increasingly victim to a pernicious combination of governmental censorship and exploitation by unscrupulous doctors who do not hesitate to conceal information as well. Explained one physician:

The problem is often not so much one of censorship in itself, but a complete lack of information or fora for citizens to discuss health issues which they need to know about in their daily lives. This means that they are totally vulnerable, not only to preventable illnesses or diseases such as malaria, HIV or cholera, but also to doctors in whom they put their trust. Many doctors will always direct them in the direction of the private sector where they can make lots of money through treatments and drugs. The patients, however, are unable to judge the diagnosis, context or quality of any treatment they receive.

Although there are many incidents of individual generosity, examples of misdiagnosis and poor treatment are rife. Undoubtedly the most widespread and disturbing is in the sale and mis-handling of medicines by both doctors and middlemen who make their livings out of the trade. The state-owned Burma Pharmaceutical Industry is, in fact, one of the few governmental institutions that has historically enjoyed a high reputation for quality in the country, but production is generally limited and most medicines are always in short supply. As a result, in the days of the BSPP a thriving cross-border trade in black market medicines developed, which was estimated to account for over 50 per cent of all drugs on sale in the country.⁵⁴

Under the SLORC's market-oriented economic system, parts of the border trade are now technically legal. However the same problems in both commercial distribution and sales have persisted with exactly the same negative implications for patients. No law is enforced on the prescription or labelling of medicines; on sale in the market there are many fakes, out-of-date medicines or drugs still bearing instructions in only Chinese, Thai or Indian languages, which few medical practitioners - let alone Burmese citizens - can read. Moreover such unsound medical practices are not confined only to the private sector, which accounts for the bulk of this trade. One recent survey in a public health centre monitored dispensing practices according to WHO standards and found them "far from rational" with a labelling rate of prescription instructions at an astonishing "0 per cent".

Such discoveries place UN and other international agencies, who are increasingly finding examples of malpractice, in a difficult moral dilemma. In a system where little objective or investigative reporting has ever been allowed, foreign organisations can be quickly seen as trouble-makers, causing embarrassment or arousing resentment amongst government officials and local doctors alike. As a result, the need for publicity to spread

⁵⁴ In the 1980s, the BPI share of the market was estimated at around 25 per cent, other drug imports by the government at 17 per cent, and medicines distributed by UNICEF or other foreign aid agencies at 4-5 per cent; see, Milton Roemer, *Primary Health Care in Burma's National Health System* (USAID, Rangoon, 1986), p.52.

awareness is often tempered by self-censorship and tact to be allowed to continue working and to try and produce longterm results.

However one area where immediate action is needed is over the national over-use and abuse of intravenous treatments, especially drips and vitamin injections. Initially, such treatments were started by doctors as another means of selling more medicines and earning extra income, but they have since become extraordinarily popular throughout the country. Chinese-brand injections, especially B-Complex or B-12-1,000, are commonplace and have become almost expected by patients as a means of boosting health and energy levels during illness. Standards of hygiene, however, leave a lot to be desired in even public health centres where new or sterilised needles are always in short supply, but the fashion for giving vitamin injections is also endemic amongst the many unregistered practitioners working throughout the country.

In the Kachin State, for example, quacks - who use unsterilised needles - claim to be able to give a three-year protection by injection against malaria. What is actually in these injections has not been surveyed (some quacks reportedly make their own cocktails by adding opium or heroin). But many of the patients coming forward for such back-street injections are heroin addicts, amongst whom alarmingly high rates of HIV-infection are now being detected (see 7).

Like many health issues in Burma, the scale of this problem has yet to be properly researched. It could be a local problem that is tied to the life-style and culture of intravenous drug-users in northeast Burma. Other medical experts are not so sure and believe that many other citizens may have been unwittingly infected. "A time bomb" was the private verdict of one government doctor. However, without an urgent campaign of health awareness and publicity which reaches into every community, it is difficult to see how even such a basic health problem as vitamin injections or the consistent treatment of such serious illnesses as malaria or AIDS can be properly addressed. As a first step, the right to freedom of expression and research must also be restored to Burma's long-suffering health workers and physicians.

5. POLITICAL RESTRICTIONS ON MEDICAL PRACTITIONERS

Doctors and other health workers have traditionally formed one of the most respected sectors in Burmese society. In the parliamentary era of the 1950s, although there were many failings within the national health system, hospitals and physicians in Burma enjoyed international renown. The door remained open to the international community, and many ethnic Indian doctors also continued to work in both the private and public sectors in Burma. Foreign diplomats and patients, for example, would travel from Thailand and other neighbouring

countries for specialist treatment in Rangoon.

Medical practitioners date the general decline in specialist standards to the military's seizure of power in 1962 and the beginning of 26 years of isolation under Gen. Ne Win's *Burmese Way to Socialism*. As the political repression mounted, all industries were nationalised and most foreigners expelled, resulting in a steady exodus of qualified doctors began which has continued until today. Currently, several thousand doctors from Burma are believed to be working in different countries abroad, including 500 in the United Kingdom alone.

Most emigrant doctors admit to having left for either financial or political reasons which, until very recently, strictly precluded their return.⁵⁵ However many also point to their frustration at the fall in medical training standards that followed the nationalisation of all schools and colleges in 1964. In particular, the Chair of English was abolished at Rangoon University in 1966 and English demoted to a minor subject in schools. This proved a major handicap to medical students required to study scientific subjects and texts. With funds always scarce, translations never kept pace with demand, and the publication of essential materials was furthered hampered by constant bureaucracy and censorship delays.

Finally, this damaging discrimination against English was ended in 1980 when one of Ne Win's own daughters reportedly failed entrance tests to begin post-graduate studies in medicine abroad. The damage, however, had already been done to a whole generation of students. Although some excellent medical staff have remained in the country, there is a general consensus that educational standards have never quite caught up. Certainly, there were never enough doctors or nurses trained to match the expansion in health care that was attempted under the BSPP.

Since 1988, like other public servants, the social and political pressures on medical practitioners have greatly intensified. Young doctors and medical students were highly active in the democracy protests of 1988. A number of undergraduates from Rangoon Institute of Medicine No.2, for example, were in the firing line when troops opened fire on demonstrators outside the American embassy on 19 September, the day after the SLORC assumed power, in scenes which were caught on camera and horrified the world. Eyewitnesses claim that, elsewhere in the city, nurses and medical personnel, including one carrying a Red Cross flag, were shot at by the security forces when they went to try and help some of the wounded

⁵⁵ Until 1993, the SLORC enforced a regulation, encoded in the 1982 Citizenship Law, that citizens who leave Burma and take foreign citizenship were barred from returning. Since the lifting of this ban, increasing numbers of exile doctors have revisited their country, although none is known to have re-established residence. For a visit by a delegation of 23 US-based doctors, see, *AP*, 20 December 1993.

victims.⁵⁶ In the aftermath of such brutality, a number of well-known doctors and medical students joined the several thousand democracy activists who fled into territory controlled by armed ethnic opposition groups following the SLORC's assumption of power. Prominent amongst this group were Dr Naing Aung and Dr Thaung Htun, who are leading figures in the All Burma Students Democratic Front (ABSDF) which runs health programmes and is still militarily active in a few border regions today.

In government-controlled areas, meanwhile, the political pressures on medical practitioners have been relentless. Like all universities and colleges of higher education, Burma's four main institutes of medicine were closed by the government for much of 1988-91, causing yet another massive backlog in the number of qualifying health personnel. By early 1991, huge gaps had begun to appear in staff positions in many of the country's hospitals and clinics. Then in another intensification of pressures on public servants, in April 1991 all government doctors were barred from engaging in politics under SLORC decree No.1/91 and required to fill in forms answering 33 detailed questions on their political views, including about the *Tatmadaw*, insurgent groups and Aung San Suu Kyi as well as the CIA and BBC. Subsequently, hundreds more doctors and medical staff were reported to have been sacked on the basis of their answers, bringing to 15,000 the number of civil servants that Lt-Gen. Khin Nyunt announced had been sacked or disciplined since the SLORC came to power.⁵⁷

However, perhaps the most extraordinary crackdown on doctors and other public health workers occurred the following year after another outbreak of student demonstrations at Rangoon University in December 1991 in celebration at the award of the Nobel Peace Prize to Aung San Suu Kyi. In 1992, the SLORC began ordering all of Burma's public doctors to attend MIS-run "re-education" classes at the former BSPP training camp at Phaungyui. Nearly 3,000 - or a quarter of the country's doctors - attended the first six courses during 1992-93 where, dressed in military uniforms, they were required to attend classes aimed at providing "doctors with nationalism", "acceptance" of the *Tatmadaw*'s leading role, "management of public health affairs" and the "observance of discipline".⁵⁸ Yet again, the political behaviour and attitudes of health workers were closely monitored and, following the completion of these courses, colleagues reported that a number of doctors and other health officials were abruptly

⁵⁶ See e.g., *Burma: Dying for Democracy* (Channel Four TV, UK, 15 March 1989); and, Physicians for Human Rights, *Health and Human Rights in Burma (Myanmar)* (Boston, 1991), pp.8-9.

⁵⁷ Rangoon Home Service, 4 October 1991; Article 19, *State of Fear*, pp.61-2. Doctors also complain that, where more than one family member is working in public service, another form of punishment is the compulsory transfer of husbands, wives or other close relatives to different regions of the country.

⁵⁸ *New Light of Myanmar*, 27 May 1993.

dismissed.

Thus, after seven years of such constant scrutiny and observation, many doctors admit that the twin pressures of political censorship and poor working conditions and wages have left even the most committed of the country's public health workers a very demoralised force. As in other walks of civil servant life, a common saying amongst health workers runs: "Malote - Mashote - Mapyote: no work - no problems - no sackings." Moreover, while there is no real evidence that doctors are ever strictly harrassed in the process of carrying out their work, there is a deep-felt view that, like other intellectuals, writers and academics, they are immediately targeted because of their status if they dare to express dissidence or publicly state their political views. Explained one doctor, "It's O.K. as long as you just do your job and keep away from politics. But if you are a doctor and do get involved, then you are in immediate danger."

The evidence would appear to support such claims. Doctors have been prominent amongst opposition figures arrested or imprisoned by the SLORC since 1988. Dr Zaw Min, for example, who was active in the 1988 protests at Rangoon University and Rangoon General Hospital, was arrested in July 1989 and subsequently sentenced to 20 years' imprisonment with hard labour (since reduced to 10) under section 5(j) of the 1950 Emergency Provisions Act for illegally organising workers and distributing anti-government literature that was deemed to be seditious. Like another physician who was also arrested, Dr Maw Zin from Paukkhaung, he was suspected of involvement with the outlawed Communist Party of Burma.

The main security pressures, however, have been focused on medical supporters of the National League for Democracy. In an apparent act of revenge, Dr Tin Myo Win, an NLD central committee member and surgeon at Rangoon General Hospital, was arrested in August 1989 on vague security charges for what many fellow professionals believe was his active support for the democracy movement during the 1988 protests. Dr Win was eventually released in 1992 but, despite the NLD's landslide victory in the 1990 election, many more NLD supporters, including several important medical figures, have continued to be arrested. On 30 April 1991, for example, two respected physicians, Dr Zaw Myint Maung, MP-elect for Amarapura-1, and Dr Zaw Myint, MP-elect for Henzada-2, were both sentenced to 25 years' imprisonment on imprecise sedition charges of planning to "set up an illegal government".

More recently in October 1993, Dr Aung Khin Sint, also an NLD MP-elect and medical writer, and Dr Ma Thida, a writer and surgeon at the Muslim Free Hospital in Rangoon, were both sentenced to 20 years' imprisonment under a cocktail of different charges, including the 1950 Emergency Provisions Act, the 1962 Printers and Publishers

Registration Law and the 1908 Unlawful Associations Act, for writing or distributing "illegal" literature in support of the NLD that was circulated during the SLORC's National Convention in Rangoon.⁵⁹ After months of pressure by the UN Special Rapporteur for Human Rights, Dr Aung Khin Sint was unexpectedly released in February 1995, but Ma Thida, who is reported to have been suffering from tuberculosis, remains in detention amidst growing concerns about her health (see 6.3).

However, undoubtedly the clearest evidence of the political harassment of a medical practitioner has been the experience of Dr Khin Zaw Win (also known as Kelvin), a qualified dentist and former UNICEF worker who attended the UN conference on the Rights of the Child in China in 1992. Subsequently, he embarked on a masters programme at the University of Singapore and continued to make contact with international health officials. Briefly back in Burma, he was arrested at Mingaladon Airport on 4 July 1994 and sentenced to 15 years' imprisonment for "spreading false news" under the 1950 Emergency Provisions Act (5e), Section 17/1 of the Unlawful Associations Act and Section 5 of the 1923 Official Secrets Act as well as various currency and customs offences. In an apparent act of vilification, colleagues believe that the latter charges were merely intended to discredit him. The real reason for his arrest was his academic research into Burmese politics and his well-known contacts with foreigners, including the UN's Special Rapporteur on Human Rights to whom the *New Light of Myanmar* alleged he had helped send "fabricated news" in 1992.⁶⁰

Khin Zaw Win's real crime, it thus appears, was to try to speak out. In an earlier conference paper distributed in Australia, he had written in poignant terms of the consequences of political deadlock and the need for peaceful reform: "Understandably, there are now signs of ideological fatigue, a vacuum so to speak. The censorship that has prevailed at all levels during the last three decades has been terribly effective."⁶¹

Sadly, the use of such defamatory charges against prominent individuals accused of expressing anti-government opinions is not unusual. Perhaps the most extraordinary example also occurred in the medical field in 1989 when U Win Tin, vice-chairman of Burma's Writers Association and central committee member of the NLD, was arrested on trumped up charges of being involved in an illegal abortion. His link to the case was extremely tenuous; a young man whose partner had recently undergone an abortion apparently stopped by his house. Nevertheless, at his trial in October 1989 he and another NLD colleague, U Ngwe Hlaing, were sentenced under section 216 of the Penal Code to three years' hard labour for

⁵⁹ For trial details, see, ARTICLE 19, *Censorship Prevails*, pp.8-9 and 28.

⁶⁰ *New Light of Myanmar*, 23 August 1994.

⁶¹ Dr Khin Zaw Win, *The State, Order and Prospects for Change in Burma* (The Centre for the Study of Australia-Asia Relations, Griffith University, 3-4 December 1992), p.2.

allegedly "harbouring an offender".⁶² Abortion is illegal in Burma, but prosecutions are rarely brought. However while the young couple and doctor involved in the abortion case have since been released, Win Tin remains in jail and is believed to have received a further 11 year sentence under the 1950 Emergency Provisions Act. Now 65 years-old, he is known to be in poor health after over six years without adequate medical treatment and is suffering from chronic spondylitis for which he has to wear a neck brace.

Finally, one of the most overlooked health issues for medical practitioners in Burma today is the right to organise and right to freedom of association. Independent trade union activity, which had briefly revived during the 1988 protests, was immediately banned following the SLORC's assumption of power. In its place, doctors and other health workers who want to involve themselves in voluntary medical associations are largely restricted to three organisations, all of which - although described as "NGOs" - have close links to the Health Ministry and government. This creates particular problems for foreign NGOs and UN agencies working in Burma which are being required, in response to international concerns, to try and work with truly representative NGOs in the community, for it is in the direction of these government-backed NGOs (or GRINGOs) as well as SLORC township authorities that international organisations are being prompted by the government to look for local partners (see 9).

After years of political repression and malaise, the question of indigenous NGOs in Burma remains a difficult one. The Burmese peoples, despite their recent poverty, have traditionally been extremely generous in making donations for public health care, but this has largely been for buildings or sanitation projects which have subsequently become incorporated into governmental health infrastructures. For a variety of political and cultural reasons, indigenous NGOs, which deal with local or specialist issues (such as disabilities, drug addiction or ethnic nationality questions), have either been forbidden or have never really become established - and this has long applied in armed opposition territory as well.

Founded in 1949, Burma's oldest NGO, the Myanmar Medical Association (MMA), currently has over 6,000 members with 50 branches at the township or state/divisional levels. Consisting of physicians within both the public and private sectors, the MMA was pulled into the government's orbit during the time of the BSPP when senior officials in the Ministry of Health took up key leadership posts in the MMA's governing hierarchy. However, although the MMA continues to publish its own journal and run occasional workshops and programmes (including an AIDS prevention project with World Vision in Kawthaung), many

⁶² Amnesty International, *Myanmar (Burma): Prisoners of Conscience: A Chronicle of Events since September 1988* (London, 1989), pp.56-7.

health workers feel that the MMA has yet to re-establish its own independence during the post-1988 era under SLORC government.

For the moment, this has largely left the non-governmental health field to Burma's two other main "NGOs", the Myanmar Red Cross (MRC) and the Myanmar Maternal and Child Welfare Association (MMCWA), both of which are even more closely linked to the government and Ministry of Health. With over 180,000 volunteer members, the MRC is supported by public donations and government funds and is, in theory, supposed to have branches in each of the country's 319 townships. Here it is mostly responsible for disaster preparedness and first aid to complement public services. Similarly, the MMCWA is in the process of trying to establish branches in townships throughout the country. As it continues to expand in size, one of its main tasks will be to work with local Township Medical Officers, under the Ministry of Health, to manage many of the country's Maternal and Child Health Centres.

That there are many committed doctors and health workers in both organisations is not in question. Doubts, however, have been frequently raised over their neutrality and responsibilities in the current political environment. For example, despite over four decades of armed conflict, there is no evidence of the MRC ever operating as a neutral, humanitarian agency amongst civilian communities in armed opposition areas, while, more recently, the MRC has become involved in the controversial repatriation of several hundred student refugees from Thailand in 1989 and over 190,000 Muslim refugees from Bangladesh during 1994-95 (see 6). Indeed, opposition groups allege that Military Intelligence officers and informers are routinely placed within the MRC's ranks, causing many communities - especially ethnic minorities - to view the MRC as another branch of government.

Likewise, even the treatment of children is not free from political argument, and many medical practitioners question the MMCWA's NGO status: for example, although a doctor, its joint general-secretary is the wife of the SLORC secretary-one, Lt-Gen. Khin Nyunt; the president is the wife of Col. Pe Thein, the former health minister; and the vice-president is the sister of the late Dr Maung Maung, a leading BSPP functionary and, originally, one of Ne Win's chosen successors.

Equally concerning, at a time of historic social and economic change, many citizens believe that the obvious favouritism shown by the SLORC towards the MMA, MRC and MMCWA is inhibiting the development of other NGOs, which more accurately reflect the aspirations of the people and are independently based in the community. Experience the world over has demonstrated that, in the longterm, the existence of such institutions is fundamental to the building of civil society and concomitant to sustainable development and political reform.

As with the SLORC's timetable for reform, the whole NGO question remains extremely unclear, but since the 1992 decision of the UNDP's Governing Council to reorientate its programmes in Burma at the "grass-roots" level (see p.?), foreign NGOs and other UN agencies have been urging that effective health care must be based upon real participation in the local communities. This important ideal, however, would appear contradicted by events inside Burma. For not only has the SLORC continued to reject the 1990 election result in which the NLD won a clear mandate from the Burmese peoples, but NLD members have been sacked or barred from many public offices and functions. In many townships this even includes Parents and Teachers Associations, where educational issues of vital importance to the community are discussed. Opposition groups thus claim that the provision of all aid, whether humanitarian or educational, is still politically dominated by the government.

In the ethnic minority war-zones, too, the issue of NGOs and community participation has become very controversial. Here central government outreach has long been resisted; but, in agreeing to cease-fires, many armed opposition groups have been telling their supporters that co-economic development, the legalisation of indigenous NGOs, and the construction of a new system of public health care are all activities which can help cement the peace. By contrast, the SLORC has been reluctant to authorise the go-ahead of any new projects in which locally-based community or opposition groups are actively involved. Instead, international aid agencies are required to negotiate first through the SLORC and respective government ministries over any access that they might be allowed at the community level.

The result is widespread dissatisfaction over the quality of health care that has been provided so far, despite constant publicity over health building programmes in the state-controlled media. The SLORC, for example, claimed to have constructed over 30 hospitals and 66 dispensaries under its Border Areas Development Programme between 1989 and 1993 alone.⁶³ But explained Kyauk Nyi Lai, secretary-general of the United Wa State Party, which signed a cease-fire with the SLORC in 1989: "The SLORC claims it helps the Wa but, for example, when it builds a hospital, there is neither a bed or a single doctor. And when I ask the Burmese why they do that, they answer 'we have our own problems.'"⁶⁴

Fundamental problems therefore lie ahead over the rights to freedom of association, participation and expression if local community groups in Burma are to be allowed to take control of their own health destinies. Many community groups are willing to accept this important task. In addition to opposition groups, there are also many Buddhist, Christian or

⁶³ Ministry of the Development of Border Areas and National Races, *Measures Taken for Development of Border Areas and National Races (4)* (Rangoon, 1993), pp.45-6.

⁶⁴ *The Sunday Post* (Bangkok), 2 April 1995.

Muslim organisations that are keen to expand the scope of their community work in response to the needs of their people. Over the years, for example, several Christian-based groups have been permitted to undertake educational projects in fields as diverse as AIDS awareness to running kindergarten classes. Under existing legislation, however, religious organisations are barred from straying outside a strictly religious mandate, and existing programmes remain technically under evangelical auspices. Furthermore, despite a great deal of UN and foreign interest, the SLORC appears very undecided over whether to allow any of these groups to become local partners to international aid organisations, despite their popular bases within the community.

For the present, then, it is only the MMA, MRC and MMCWA, all of which maintain national structures, that are the main NGOs operating in the non-governmental health field. To address this issue, in January 1996 the NLD unfolded a humanitarian policy whereby international agencies, such as the UNDP, should work in close co-operation with the NLD as the only national organisation in Burma that had been democratically shown to represent the will of the people. In this way, by following the primary objectives of the UNDP's Human Development Initiative⁶⁵, the NLD considered that humanitarian aid could be more ethically targeted by democracy supporters at the poorest and most disadvantaged members of society.

By contrast, many doctors in Burma believe that the next organisation to receive the same preferential treatment as the MRC and MMCWA is the government-backed Union Solidarity and Development Association (USDA), a mass party formed in late 1993 after the SLORC's attempt to form a successor party to the BSPP failed to gain popular support. With an estimated 2,000,000 members, the USDA is now organised throughout the country and frequently mobilised to demonstrate community backing for all the government's plans. Indeed, international health workers report that USDA representatives already sit in, as a matter of course, on some planning meetings and health seminars in the townships.

6. CONFLICT AND HUMANITARIAN CRISIS

Burma today is confronted by a host of complex humanitarian issues that are related to the question of both health and human rights. Many are long-standing problems that can be dated back to Burma's independence in 1948. However, for present-day purposes, they can largely be classified into three broad categories: death and other physical sufferings which have occurred during the conduct of war; refugee protection and the internal displacement of

⁶⁵ For an analysis of this UNDP style of operation which is intended to have impact at the community and village level, see, *UNDP'S Myanmar Human Development Initiative: An Assessment*, prepared for UNDP by Agrodev Canada Inc. (Ontario, January 1995).

civilians; and, finally, the treatment of prisoners and detainees. All these grave health issues have long been veiled under a cloak of censorship which has precluded desperately-needed solutions.

6.1 The Backdrop Of War

Undoubtedly the most neglected area of medical care in Burma is the health crisis that exists in many rural areas as a result of over four decades of armed conflict. Virtually all areas of the country have been affected at some stage. There are still communities, for example, in the Delta and Pegu Yoma regions of Lower Burma that are suffering from impoverishment and malnutrition as a result of displacement during fighting over 20 years ago. Since the late 1970s, however, the humanitarian crisis has been most deeply felt in Burma's ethnic minority borderlands, where the human and economic cost has been devastating. Ethnic minority peoples constitute an estimated third of the 45 million population and, even today, there are over 20 different ethnic nationalist forces still under arms.

Despite their terrible impact, until 1988 civilian casualties and the state of civil war in Burma were scarcely mentioned in the state-controlled press. When armed opposition groups were referred to, it was usually as "bandits", "opium smugglers" or "racist saboteurs". The one exception was on Armed Forces Day in March each year when the government would usually admit to the deaths of some 500 troops in the preceding twelve months as opposed to an average 2,500 "insurgents". Opposition forces, by contrast, have estimated the death rate - including civilian victims - at around 10,000 fatalities each year, with large annual fluctuations depending on the intensity of the fighting.⁶⁶ Certainly, the documented casualty rates amongst several ethnic minority groups have been appalling. In northeast Burma, for example, the Kachin Independence Organisation recorded the deaths of 33,336 civilians in the years 1961-86 alone, while an unpublished UN survey undertaken in 1991 in Tachilek district in the Shan State revealed a ratio of 1,430 females to 1,000 males, indicating the high mortality rate for ethnic minority men in the fighting.⁶⁷

Such rare estimates, however, do not give an adequate picture of the degree of human suffering. In ethnic minority areas, many local cultures and communities have been destroyed; and across the country there are countless disabled, widowed or orphaned. Equally disturbing, while Gen. Ne Win's xenophobic *Burmese Way to Socialism* held sway, no independent observation of the humanitarian situation was permitted at all. Neutral observers, including

⁶⁶ For a discussion, see, Martin Smith, *Burma: Insurgency and the Politics of Ethnicity* (Zed Books, London and New Jersey, 1991), p.100-1.

⁶⁷ Martin Smith, *Ethnic Groups in Burma: Development, Democracy and Human Rights* (Anti-Slavery International, London, 1994), pp.40, 62.

the International Committee of the Red Cross, were strictly barred from the war-zones, and no reference was ever made to such important international protocols as the 1949 Geneva Conventions on the Protection of the Victims of War or the 1987 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, under which universal standards in humanitarian protection are guaranteed during the conduct of war.

As a result, an uncritical culture of human rights abuses has developed in Burma in which the summary arrest, torture or extrajudicial execution of civilians has become commonplace, and humane treatment is rarely afforded to combattant prisoners captured by either side. Indeed, over the years vast areas of the country have been declared virtual "free-fire" zones under a draconian counter-insurgency programme, known as the "Four Cuts", which was developed by *Tatmadaw* commanders in the 1960s to try and separate insurgent groups from civilian supporters.⁶⁸ All such practices, it should be stressed, are in complete violation of the Geneva Conventions under which governments or parties to a conflict are obliged to provide humanitarian relief and health care to both civilian victims and prisoners.⁶⁹

Since 1988, this obsessive secrecy about some of Asia's least-reported wars has begun to dissipate. In part, this has been in response to an upsurge in international media interest that resulted after an estimated 10,000 students and other democracy activists fled from Rangoon and other urban areas into territory controlled by armed ethnic minority forces following the SLORC's assumption of power. In particular, fierce battles were frequently witnessed by foreign journalists along the Thai and Chinese borders between 1988 and 1992. At the same time, as growing numbers of refugees fled the fighting, serious international concern was also raised for the first time over the humanitarian plight of the civilian victims of the war by organisations such as Amnesty International and Human Rights Watch/Asia.⁷⁰

However, changing international awareness over the scale of Burma's humanitarian disaster can also be attributed to an important shift in government policy under the SLORC. This followed the unexpected collapse, due to ethnic mutinies, of the country's largest insurgent force, the Communist Party of Burma, in 1989. The first evidence of this change came in January 1990 when Gen. Saw Maung, the former SLORC chairman, publicly admitted that the real death toll in over 40 years of armed conflict "would reach as high as millions".⁷¹ Since this landmark statement, the SLORC has offered peace talks - with the

⁶⁸ See e.g., Smith, *Burma: Insurgency*, pp.258-62.

⁶⁹ See e.g., Jean-Philippe Lavoyer, "Refugees and Internally Displaced Persons: International Humanitarian Law and the Role of the ICRC", in *International Review of the Red Cross*, March-April 1995, pp.164-5.

⁷⁰ See e.g., Amnesty International, *Myanmar: "No law at all": Human rights violations under military rule* (London, 1992) pp.17-29.

⁷¹ *Working People's Daily*, 10 January 1990.

added enticement of development aid - to all of Burma's armed opposition ethnic forces for the first time since 1963.

Political issues, it needs to be stressed, are not being discussed, and all cease-fires, to date, have been purely military while the SLORC proceeds with its National Convention process in Rangoon.⁷² Similarly, the social cornerstone of the SLORC's new ethnic policy is the Border Areas Development Programme (BADP) which, although it technically co-ordinates projects between the Health Ministry and other government departments, has remained under direct military control. This has led to some very different perceptions over what is actually being achieved. For example, since the BADP's establishment in 1989, the SLORC claims to have invested over US\$ 400 million (2,842 million kyats⁷³) on development initiatives in ethnic minority regions, while opposition groups claim that most of this expenditure has been simply on buildings and roads, with precious little on health projects where there is local involvement or participation in decision-making. Moreover, the SLORC is continuing to restrict all contacts between international aid agencies and ethnic minority forces, which actually control many of these lands (see p.?).

None the less, after a slow beginning, the peace process has begun to gather momentum and allowed the first UN and other international visitors to travel to several war-torn areas of the country in decades. Currently, 17 of the 20 largest armed opposition groups in Burma, with over 50,000 troops under arms, have cease-fires with the SLORC.⁷⁴ Of equal importance, in line with its policy of signing international protocols, the SLORC has finally acceded to the Geneva Conventions on the Protection of the Victims of War. Previously, Burma was one of just four countries not to have signed.

Thus, with the recent cease-fire of the Mong Tai Army (MTA) of Khun Sa in January

⁷² ARTICLE 19, *Censorship Prevails*, pp.24-9.

⁷³ *Statement by Ambassador U Pe Thein, Representative of the Union of Myanmar on Agenda Item 112 (c), Human Rights Situations and Reports of Special Rapporteurs* (UN General Assembly Third Committee, 30 November 1995), p.5; n.b., at the real market rate, 2,842 million kyats is worth only US \$28 million.

⁷⁴ United Wa State Party, Myanmar National Democratic Alliance Army (Kokang), National Democracy Alliance Army (eastern Shan), New Democratic Army (Maru-Lashi), Shan State Army, Palaung State Liberation Party, Kachin Defence Army, Pao National Organisation, Kachin Independence Organisation, Shan State Nationalities Liberation Organisation, Karenni Nationalities People's Liberation Front, Kayan New Land Party, Kayan Home Guard, Democratic Karen Buddhist Organisation, Karenni National Progressive Party, New Mon State Party and Mong Tai Army. Those yet to agree cease-fires are the Karen National Union, National Socialist Council of Nagaland and Rohingya Solidarity Alliance. Smaller insurgent forces which are still active include the Chin National Front, National Unity Party of Arakan and the ABSDF.

1996, the situation is extremely delicately poised. As fighting comes to a halt, opposition groups and community leaders are hoping that, for the first time in decades, the establishment of peace will allow serious attention to be paid to the many health and humanitarian issues raised by the war, including the welfare of refugees, the indiscriminate use of mine warfare, and the conscription of children or underage soldiers.⁷⁵

Tragically, however, continuing injuries or military-related deaths are still being reported in different regions of the country, even where military truces have been agreed. On 21 March 1995, for example, a cease-fire was signed by the Karenni National Progressive Party (KNPP) in Loikaw, the Kayah State capital, in which the SLORC reportedly agreed to stop using local civilians for forced labour or portering. However, just three months later, seven badly wounded porters were rushed by local medics to hospital in neighbouring Thailand after being ordered to walk ahead of government troops through a KNPP minefield. As local clashes over trade and territory escalated, few observers were surprised when full-scale fighting broke out again in January 1996.

Disturbingly, too, there has been no let-up in reports of gross human rights abuses where formal cease-fires have yet to be agreed. In November 1995, for example, the UN Special Rapporteur on Human Rights presented evidence to the UN General Assembly of "torture, arbitrary killings, rapes" and other "atrocious acts" in which, he believed, the main victims were ethnic minorities, women, peasants and "other peaceful civilians who do not have enough money to avoid mistreatment by bribing".⁷⁶ Documentation of such allegations was provided by the Special Rapporteur from the Karen State in the south to the Chin State in the country's far north. Such charges, however, are never publicly investigated or replied to inside Burma.

Of equal concern to ARTICLE 19 during recent fighting is the negative impact that governmental censorship has been having on the conduct of the war. Indeed, many ethnic minority leaders believe that governmental misuse of the media could ultimately jeopardise the success of the entire peace process. The health implications are enormous. After decades of conflict, the humanitarian situation is critical in many borderland areas, and across the country millions of displaced citizens are, at last, hoping for the chance to return and develop their homelands. However, other than the occasional announcement of meetings, substantive

⁷⁵ Smith, *Ethnic Groups in Burma*, pp.116-121. The use of underage soldiers is especially common amongst ethnic minority forces, notably the Wa, Karen, Karenni and MTA of Khun Sa.

⁷⁶ *Statement of Mr. Yozo Yokota, Special Rapporteur of the Commission on Human Rights on the Situation of Human Rights in Myanmar to the Fiftieth Session of the General Assembly* (27 November 1995), p.9. For a more detailed report, see, UN General Assembly, *Situation of Human Rights in Myanmar*.

details of the peace discussions are not being revealed nor are their security implications for the local people. Moreover, while all sides accept the need for caution, opposition groups allege that the government's manipulation of the media over the past three years has been leading to further destitution and loss of life at the very moment when other military officials are publicly advocating peace.

Such fears were dramatically brought into focus in early 1995 by the SLORC's actions in the aftermath of a mutiny by several hundred Buddhist soldiers from the Karen National Union (KNU) in southeast Burma. Following months of growing acrimony, the dissident troops finally revolted against the KNU's predominantly Christian leadership in December 1994 under the guidance of Sayadaw U Thuzana, a local Buddhist abbot.⁷⁷ However, even though it had already entered the first stages of peace talks with the KNU, the SLORC's response was to lend immediate support to the mutineers, providing them with food and weaponry to establish a new armed force, the Democratic Karen Buddhist Organisation (DKBO). Then, using the DKBO militia as cover, the *Tatmadaw* unilaterally broke off the cease-fire offer to the KNU to launch a full-scale offensive, overrunning the KNU's headquarters at Mannerplaw.

Tragically, as so often in Burma's troubled past, the main victims have once again been innocent civilians. Taking advantage of the KNU's confusion, new "Four Cuts" operations were launched during 1995 in Karen-inhabited areas of Kyaukkyi, Nyaunglebin, Toungoo and Tavoy, well away from the DKBO mutiny, with government troops reportedly burning down villages, conscripting porters and extrajudicially executing a number of villagers.⁷⁸ Sadly, too, although over 5,000 Buddhist refugees did eventually return into areas where the DKBO is active, many more families fled the Burmese army advance, bringing the total number of Karen refugees in Thailand to well past the 70,000 mark.

As has long been usual, day-to-day conditions in the war-zones have gone unreported in the state-controlled media throughout all these developments. But in spreading confusion and fear, Karen community leaders are certain that the role of the press has been critical. In the *New Light of Myanmar*, a 33-part series of articles was run in early 1995, entitled "Whither KNU?", denigrating the Karen nationalist movement with a carefully-woven mixture of fact and fiction. Most KNU soldiers and Karens are, in fact, Buddhists, but the main thrust of these articles was to accuse the KNU's president, Bo Mya, and Christian zealots within the KNU movement of plotting anti-Buddhist discrimination and atrocities. To

⁷⁷ The grievances of the Buddhist mutineers were serious, including anti-Buddhist discrimination as well as gross human rights abuses by a group of KNU officers in the Paan area who were reportedly responsible for extrajudicial executions and the forced labour of civilians.

⁷⁸ See e.g., *The Nation* (Bangkok), 19 October 1995.

ensure that these allegations reached the widest possible audience, many of these reports were also carried on state radio (including the *Tatmadaw's* newly-inaugurated Myawaddy station), and in June 1995 they were reproduced in book form in both Burmese and English-language versions.

The attempt to foster the Karen split took an even more serious turn when the refugee population in Thailand also appeared to be targetted. Pamphlets and letters were circulated, in the name of the DKBO, in villages and refugee camps along the Thai-Burma border, ordering all Buddhists to return and threatening reprisals against any families who did not immediately relocate to a resettlement area around U Thuzana's headquarters at Myaing Gyi Ngu. "Those who still remain in the refugee camps will be considered as anti-Buddhist KNU and will be destroyed," warned one widely-circulated letter.⁷⁹

These threats were then followed by a series of cross-border raids that are still continuing by DKBO units on official refugee camps inside the Thai border, in which at least 25 Karens or Thai nationals (reportedly including three border police) have been killed and dozens of refugees kidnapped.⁸⁰ In the process, three camps have been destroyed and several former KNU officials captured, including 71 year-old ex-Brig-Gen. Tu Roo who was murdered on the spot when he proved too ill to walk. Warnings and accusations have also been made by the DKBO against foreign aid workers, which were bizarrely echoed in the *New Light of Myanmar* when it accused Jack Dunford, a respected British charity worker who chairs the Burma Border Consortium co-ordinating international relief, of being a "spy" responsible for engineering "an alliance" between the KNU and the MTA of Khun Sa.⁸¹

And yet, despite frequent eyewitness reports of close collaboration between DKBO troops and government forces, the SLORC has continued to deny any involvement other than to "provide security" for local inhabitants and the breakaway Buddhist army.⁸² Indeed, in a formal reply to the UN Special Rapporteur in July 1995, the SLORC Foreign Ministry claimed that, since the government "should not be held responsible for alleged human rights violations" beyond its control, "the Government of Myanmar is unable to comprehend your

⁷⁹ Amnesty International, *Myanmar: "No Place to Hide": Killings, abductions and other abuses against ethnic Karen villagers and refugees* (London, 1995), p.10.

⁸⁰ See e.g., Amnesty International, *Myanmar: "No Place to Hide"*, pp.10-21; Human Rights Watch/Asia, *Burma: Abuses Linked to the Fall of Mannerplaw* (New York, 1995), pp.16-18.

⁸¹ A Resident of Kayin State, *Whither KNU?* (Myawaddy Press, Rangoon, 1995), p.57.

⁸² See, UN General Assembly, *Situation of Human Rights in Myanmar*, pp.17-20, 29. Some attempts at hiding Burmese army presence have been very unsubtle. For example, after the fall of Mannerplaw a large boundary sign, "SLORC Tactical Command 661", was clearly visible from the Thai border. A few days later, the sign was replaced with "DKBO" in large letters; for picture, see *Burma Issues*, July 1995, p.7.

concern about the current situation along the Thai/Myanmar border".⁸³ DKBO officers, however, were not so circumspect in the one interview they gave to Thai journalists at the border. "We have attacked and razed the camps. If we did not do so, then the refugees would not return home," explained a Capt. Tu Na. "All will have to return."⁸⁴

All such actions are in complete contravention of Common Article 3 of the Geneva Conventions which the SLORC signed amidst much international fanfare in 1992. Not only does this fundamental bedrock of international humanitarian law guarantee health care for the sick and the wounded, but it expressly forbids torture, murder or the taking of hostages, stating that "persons taking no active part in the hostilities, including members of armed forces who have laid down their arms," shall "in all circumstances be treated humanely". Moreover, although armed opposition forces are technically not able to sign, Article 3 clearly binds all parties - including groups such as the DKBO or KNU - to the humanitarian obligations of internal conflict.⁸⁵

Somewhat surprisingly, then, at the end of a year of such conflict and suffering, the SLORC chose this moment to re-open the offer of peace, and in October 1995 government delegations began a series of meetings with KNU leaders, including Bo Mya. As in the other war-zones, there were undoubtedly leaders on both sides who wanted to try and bring an end to so many years of inconclusive fighting, but local refugees and inhabitants still watched the situation with great caution.

If any further reminder was needed of the continuing dangers, during December and January the DKBO attacks on the refugee camps were resumed. On 2 December, three refugees, Ka Ka Per, Ka Lar and a middle-aged schoolteacher, Saw Wah, were shot and killed at a funeral service in Shoklo refugee camp. Then, in January the attacks were turned against foreign aid workers. "Where are the foreign doctors?" demanded DKBO guerrillas in a night-time raid on Shoklo.⁸⁶ Dr Francois Nosten and an Australian colleague, who run a world-famous and WHO-backed malaria research programme (see 6.2 below), narrowly escaped by hiding for the night in a bunker but Nosten's malaria clinic and a nearby MSF hospital were looted of both medicines and equipment. Having failed in this attempt, the DKBO promptly offered a US \$400 reward for help in the capture of any foreign aid worker.

The Thai response was to step up security and plan to close yet another camp, moving all 9,405 inhabitants of Shoklo further from the border. Thus far from finding sanctuary abroad, for these victims of war more upset has been imposed upon already badly-disrupted

⁸³ UN General Assembly, *Situation of Human Rights in Myanmar*, p.20.

⁸⁴ *The Nation* (Bangkok), 1 May 1995.

⁸⁵ Human Rights Watch/Asia, *Burma: Abuses Linked to the Fall of Mannerplaw*, pp.4-6.

⁸⁶ Ron Moreau, "Doctors Under Fire", *Newsweek*, 19 February 1996.

lives.

get in DKBO radio

6.2 Refugees and the Internal Displacement of Civilians

Civilian displacement has long been one of the least recognised social and health problems in Burma, but millions of citizens have undergone this bitter experience during the past 48 years. In general, persons that are currently displaced can be divided into three main groups: internally-displaced civilians in the war-zones; civilians relocated under government resettlement programmes; and refugees (or other migrants⁸⁷) in neighbouring countries.

Considerable difficulties remain in bringing effective health care to all three groups; all sectors of Burmese society are in a state of enormous social flux. Nevertheless, each category has been the subject of increasing international concern over the past few years - and not simply over violations of human rights. Experience the world over has warned that displaced peoples are especially at risk from such serious health problems as malnutrition, malaria, cholera, dysentery and even narcotics and AIDS, all of which have the most damaging impact on the health of the nation. Although marginalised, the health status of these most vulnerable groups can not be divorced from the health problems of the rest of society.

Undoubtedly the most neglected social group are the internally-displaced peoples in the war-zones. Estimates vary widely over the numbers affected, but community leaders believe that they number well over one million citizens today, especially ethnic minority Karens, Karennis, Mons, Kachins, Shans, Palaungs and Was. Many are living in remote forests and mountains in the borderland areas, but there are also large concentrations of displaced peoples around ethnic minority towns as well as numerous villagers who have been forcibly relocated into "strategy villages" during government counter-insurgency operations. In the northern Shan State, for example, community leaders estimate that as much as half the local population has either moved into the towns, been internally displaced or fled to the border since fighting first erupted in the 1960s. In the northern Wa region alone, there are currently estimated to be 70,000 inhabitants in 32 camps in areas controlled by the United Wa State Party along the China border. Similarly in the Kachin State to the north, the Kachin

⁸⁷ The distinction between refugees, who are recognised under international definitions, and/or migrants is often very difficult in the case of Burma. During the past three decades, vast numbers of Burmese citizens have crossed into neighbouring countries due to political and ethnic conflict as well as the resultant poverty and suffering. Many have kept well away from local authorities or refugee camps and since found work (mostly illegal but sometimes also legal) in an exodus which has accelerated since 1988. But while international agencies, such as the UNHCR, strictly reject refugee status where there is a perceived economic motive, most such exiles interviewed by ARTICLE 19 see themselves as victims of Burma's long-running political and ethnic troubles.

Independence Organisation (KIO) has calculated that, despite its 1994 cease-fire, there are still over 60,000 displaced persons in the hills, a further 10,727 refugees in camps along the China border, as well as over 60,000 villagers in relocation villages under *Tatmadaw* control.⁸⁸

For the moment, all such groups remain beyond the reach of effective international health care or aid. The UK-based NGO, Health Unlimited, has recently begun the first ever child immunisation project in KIO-controlled areas of the Kachin State, and, like MSF, Aide Medicale Internationale? and several other Western NGOs, has in the past been involved in small health projects in the Thai border region. But the great majority of Burma's displaced peoples are having to be self-reliant and live by their own resources, despite the announcement of the SLORC's Border Areas Development Programme. The little investment, to date, has been on infrastructure and buildings, with few health-training or educational programmes. Moreover there remain vast areas where government authorities have never had any access.

For their part, armed opposition groups are sometimes able to provide emergency food or shelter, depending on their strengths and capabilities. Over the years, for example, ethnic minority parties such as the KIO and KNU have trained many local health workers, but away from military camps medical provision is minimal and there are only a handful of qualified doctors. As a result, in large areas many serious health problems have long remained untreated - and, indeed, may have become even more complicated due to the different medicines and practices of treatment. Community health workers report that, in most areas, malaria is usually the major health problem, but illnesses such as tuberculosis, tetanus, typhoid, diarrhoea, pneumonia, hepatitis and cholera are also a constant threat. In addition, in northeast Burma there is now increasing concern about heroin addiction and the recent spread in HIV/AIDS.

These grim health conditions, however, are rarely reported. Every year thousands of civilians and villagers die in Burma's borderland areas during health emergencies or epidemics that attract only occasional attention in the outside world. In August 1993, for example, Chinese doctors crossed into UWSP-controlled areas of the eastern Shan State after an outbreak of cholera in two displaced persons' camps. Here they diagnosed and treated over 940 cases. In the same period, Karen villagers in southeast Burma and Palaung villagers in the northern Shan State were not so fortunate. Dozens of deaths were unofficially reported in a number of localised outbreaks of sickness which, though undiagnosed, were attributed by

⁸⁸ See e.g., KIO, *Collective Endeavour: A Report on Reconstruction Activities in Kachin State* (October 1995), p.2.

local community leaders to cholera.

Although less severe, many of the same basic health problems often afflict the second displaced population in Burma: civilians relocated under government resettlement programmes. Resettlement policies have existed in Burma since the 1950s, and in 1985 the development of several new relocation areas was begun by the former BSPP government around Rangoon. However the scope and scale of these relocations have accelerated rapidly under the SLORC which, opposition groups allege, has used such programmes as a form of social control after many workers in down-town urban areas took part in the 1988 democracy protests. By 1990, Habitat (the UN Centre for Human Settlements) estimated that 1.5 million or 4 per cent of Burma's population at that time had been affected by displacement at different times in the past, including 16 per cent of the urban population. Of this number, over 250,000 citizens have been moved to the satellite new-towns of Hlaingthayar and Shwepyithar near Rangoon since 1988.

Conditions vary widely at many of these new settlements, and while there has some demand (and land speculation) for housing at a few of the better-located sites, in other areas living conditions have been extremely poor, especially in the early stages of resettlement. Not only are such illnesses as dengue fever or diarrhoea often common due to the inadequate drainage and sanitary facilities, but no thought has been given to the social and health implications of the break-up of so many long-standing communities, which were already a low-income sector within Burmese society. The socio-economic and health implications are completely inter-linked. Poor housing conditions and forcible relocation away from the main job centres have all contributed to the high levels of unemployment, poverty, malnutrition, separation of families, and increases in illegal abortions and sexually-transmitted diseases.

Since many of these factors can be attributed to resettlement policy, the disturbing health conditions in many relocation areas provide another major dilemma to international aid agencies considering setting up programmes inside Burma. To date, it has precisely been in some of the resettlement sites that governmental health authorities have been willing to allow foreign organisations to work. Considerable delays continue on receiving permission or Memoranda of Understanding to begin. But in 1992, while other agencies were still hesitating, the first two international NGOs to return to Burma, MSF (Netherlands) and World Vision, considered the health conditions serious enough to warrant their immediate institution of a whole array of different health studies and programmes in the Rangoon satellite towns of Hlaingthayar and Shwepyithar (MSF Netherlands) and Dawpon, Hlaingthayar and South Dagon as well as one in Mandalay (World Vision). Particular concentration has been given to nutrition, health education, AIDS awareness and the health of women and children in the first

NGO health projects begun in Burma in decades.⁸⁹

Similar controversy surrounds the treatment of the third displaced persons group: the country's huge population of refugees or exiles currently living abroad. Burma today has one of the largest, though least recognised, refugee crises in Asia. Officially, in January 1996 there were 93,252 refugees (mostly Karens, Karennis and Mons) in Thailand, some 50,000 Muslim refugees in Bangladesh (following the repatriation of over 190,000 refugees in 1994-95), as well as an estimated 50,000 refugees in India and China.

These figures, however, are the tip of the ice-berg and do not reflect the longterm exodus of many other citizens over the years. Much of the alarm is being felt in neighbouring Thailand, where a recent governmental study put the total number of refugees or illegal migrants from Burma at over 350,000; not surprisingly, Thai officials believe such huge numbers adversely affect the country's "national security" as well as social and economic environment.⁹⁰ However, although subsistence food and medical aid is provided for refugees in the official camps⁹¹, the urgent health problems of the majority of this largely transient population are not being addressed in any systematic way. In August 1995, for example, Sora-at Klinpratum, the Thai deputy-minister of Public Health, announced that an estimated 60 per cent of all malaria cases being treated in Thailand were "illegal immigrants", most of whom came from Burma or Cambodia.⁹² Equally serious, the AIDS pandemic in south-east Asia now poses an even greater threat, with health officials recently reporting that over 200 AIDS sufferers from Burma were being treated in public hospitals in Thailand's Mae Hong Son province alone (see 7 below).⁹³

Most of this exile population, however, remain silent for fear of arrest. This was graphically illustrated in January 1996 when 54 Burmese citizens were badly burnt when a truck smuggling 100 illegal migrants across Thailand caught fire. After hospital treatment for up to 70 per cent burns, all were arrested. Another young Burmese woman, held in a police cell in Ranong, described the dilemma many such refugees and emigrants face:

⁸⁹ See e.g., Frances McConville, *A Rapid Participatory Assessment of the Health Needs of Women and Their Children in an Urban Poor Area of Myanmar* (World Vision UK, April-June 1995).

⁹⁰ See e.g., *Bangkok Post*, 22 January 1995.

⁹¹ Since 1984, under an agreement with the Thai Ministry of Interior, international NGOs have been providing relief aid to the refugees, presently under the aegis of the Burmese Border Consortium (BBC). Malaria and respiratory diseases are the major health problems, but supplementary feeding programmes have also been run by MSF (France) and the Consortium to support vulnerable groups, including underweight children, pregnant women and tuberculosis patients, as well as deal with such persistent health problems as beri beri.

⁹² *The Nation* (Bangkok), 16 August 1995.

⁹³ *Bangkok Post*, 26 February 1995.

I don't want to go back home. Life is hard there. I have nothing to eat and no means of living. In Burma they are building a railway line linking the coastal towns. Hundreds of thousands of us were conscripted to build the railway and had to work hard. It is better to stay in Thailand.⁹⁴

For the moment, then, the main focus of international concern is over the humanitarian treatment and future repatriation of all refugees, an issue which is likely to gain increasing momentum with the recent Karenni, Mon and Mong Tai Army cease-fires. To its international credit, the Thai government has had, for many years, a largely tolerant attitude to the vast numbers of refugees from Burma taking shelter within its borders, but there are growing indications that official thinking is beginning to change. In part, this is due to the sheer numbers of refugees, but also because of a longterm plan by the Thai government to normalise relations with Rangoon and the SLORC, which it wants to become a member of ASEAN. In 1995, as a first step, the SLORC signed ASEAN's "Treaty of Amity and Cooperation"; and, significantly, despite the DKBO attacks across the border, Thailand's new policy of "constructive engagement" has survived.

As a result, exiles from Burma are coming under increasing pressures from different Thai authorities. Already many Mon, Karenni and Karen refugees have been removed into remote border areas (sometimes in response to DKBO attacks), despite the many health and humanitarian hardships this has entailed. Meanwhile, in the past three years, thousands of Burmese migrants have been arrested who have been found living illegally or working outside the camps.⁹⁵ In one notorious example, a severely-handicapped Mon refugee, Maung Kyan, who had lost his eyesight and both his arms in a landmine explosion, was arrested in April 1995 after travelling to Bangkok for essential medical treatment. He was then held with his family in the Immigration Detention Centre for over two months before being released (after an international campaign for his liberty) into the "Safe-Area" camp near Ratchaburi, which was initially set up in 1992 by the Ministry of Interior for exile Burmese students.⁹⁶

The prospect of such publicity, however, or modern health care is not available to the many refugees and exiles now facing repatriation back to Burma. Huge uncertainties remain over the whole repatriation process. To date, while granting "persons of concern" status to over 2,000 Burmese students in Bangkok, the UN High Commissioner for Refugees

⁹⁴ *The Nation*, 8 January 1995.

⁹⁵ See e.g., Human Rights Watch/Asia, *The Mon: Persecuted in Burma, Forced out of Thailand* (New York, 1994) and *Abuses against Burmese Refugees in Thailand* (1992); Amnesty International, *Thailand: Concerns about Treatment of Burmese Refugees* (London, 1991).

⁹⁶ *The Nation*, 19 June 1995.

(UNHCR) has not been involved in the humanitarian plight of refugees at the Burma border - although it did, in April 1995, request the Thai National Security Council to allow an international monitoring presence to be set up following the DKBO's attacks on refugee camps.⁹⁷ The Mon National Relief Committee (MNRC), too, has expressed concerns over the future provision of health and development aid - as well as protection from human rights abuses - in what it recognises will be a historically important undertaking.⁹⁸ A particular grievance is over the cease-fire agreement with the New Mon State Party in which returning refugees and internally-displaced civilians have been specifically precluded by the SLORC from receiving cross-border NGO assistance during the resettlement period; this was scheduled to end by 30 April 1996. Any further supplies or aid, both Thai and SLORC officials have insisted, must come from the government side.

Thus in November 1995, in response to such concerns, the UNHCR sent a delegation to Rangoon to discuss establishing a monitoring presence inside the Burmese border to ensure a "safe and dignified" return of the Mon refugees.⁹⁹ But many refugees remain unconvinced. Regrettably, the experiences of refugee populations around Burma's borders has not given certain grounds for optimism. In September 1994, for example, thousands of Chin refugees living in Mizoram in northeast India were suddenly rounded up by local police and handed over to the SLORC authorities who, according to local reports, promptly arrested many of them. In China, too, over 30,000 refugees are still estimated to be living in borderland communities, and in 1995 the KIO eventually tried to begin a resettlement programme for 10,000 refugees all on its own.

As a repatriation model, however, most international attention has remained focused on the desperate situation of Muslim refugees living along the Bangladesh border. In 1991-92, Burma's Rakhine State was the scene of one of the greatest refugee exoduses in modern times for the second time in 14 years, when over 260,000 Muslim refugees (sometimes known as Rohingyas) fled into Bangladesh amidst widespread reports of human rights abuses by the local military and *Na Sa Ka* border police. According to eyewitness testimony, forced labour, forced relocations, torture and extrajudicial executions were widespread.¹⁰⁰ Just as in 1978, news disinformation in the government press played a crucial role, and the SLORC variously blamed the exodus on "scare-mongering" by small groups of *Mujahid* extremists or illegal Bengali immigrants. "The Rohingya problem is no more than the problem of

⁹⁷ *AFP*, 26 April 1995.

⁹⁸ MNRC, *Regarding the Repatriation Program of Mon Refugees*, 31 August 1995.

⁹⁹ *The Nation*, 17 November 1995.

¹⁰⁰ See e.g., Human Rights Watch/Asia, *Burma: Rape, Forced Labor and Religious Persecution in Northern Arakan* (New York, 1992).

unregistered illegal immigrants," claimed the *Working People's Daily* in January 1992.

Following international pressure, the SLORC appeared to relent and a repatriation programme was eventually arranged under UNHCR auspices in a Memorandum of Understanding in November 1993. In 1994 the first repatriations began and, according to the UNHCR, its initial US \$34 million programme has since changed from one of "repatriation" to largely one of resettlement and "reintegration" within two short years.¹⁰¹ By January 1996, over 194,000 refugees had officially returned, leaving a further 50,000 refugees in Bangladesh, who could largely be fitted into two categories: refugees identified with opposition groups or individuals, separated from their families, whom the SLORC wanted to check more closely.

Disagreements, however, between international agencies and observers have continued to follow every stage of the repatriation process, especially over the level of protection afforded to a minority group who, after all, claim to have been driven twice from their homes within 15 years. In this respect, the level of information supplied to the refugees and the access of neutral observers to the resettlement procedures are critical.

Initial concerns centred on the voluntary basis of repatriations. Not for the first time, the analysis by UN agencies in Burma has differed markedly from international NGOs working in the same field. The US Committee for Refugees, Refugees International and MSF, for example, have all produced condemnatory reports indicating that not only were refugees pressurised by the Bangladeshi authorities - including by food deprivation and beatings - to leave their 20 make-shift camps, but they were not adequately informed of their rights to reject *refoulement* under international humanitarian law¹⁰². Indeed, while appreciating the UNHCR's dilemma, MSF was so concerned of the impending repatriations that it conducted its own "awareness survey", which showed that 65 per cent of the families questioned did not know of their right to refuse repatriation.¹⁰³ Of special concern to MSF was a change in UNHCR policy in July 1994, from one of individual interviews and "information sessions" for refugees to mass "voluntary" registrations for repatriation; this brought about a dramatic change in the willingness rate for return from 23 per cent in one camp survey to around 95 per cent overall.¹⁰⁴ Not surprisingly, if such methods were allowed to pass unchallenged, MSF

¹⁰¹ UNHCR, *Return to Myanmar: Repatriating Refugees from Bangladesh*, Information Bulletin, June 1995.

¹⁰² US Committee for Refugees, *The Return of the Rohingya Refugees to Burma: Voluntary Repatriation or Refoulement* (Washington, 1995); Refugees International,?; MSF, *MSF's concerns on the repatriation of Rohingya refugees from Bangladesh to Burma* (Amsterdam/Paris 1995).

¹⁰³ Ibid., p.4.

¹⁰⁴ Ibid., p.3; UNHCR, *Return to Myanmar*, p.3.

feared that they could set a precedent for similar mass repatriations as solutions to other refugee emergencies around the world.

Other criticisms have also followed the treatment of refugees upon their return. A particular question is whether the refugees much-documented fears of persecution have been properly addressed without substantive evidence of political reform in Burma. Article 33 of the 1951 Convention relating to the Status of Refugees expressly forbids the returning of refugees to territories where their lives or freedom could be endangered. For its part, the UNHCR, with the presence of 25 international officers inside Burma, claims to be satisfied with the SLORC's guarantees of safety.¹⁰⁵

Opposition groups, however, have not been reassured. Not only have the returnees been resettled in remote border areas, but they have been issued with temporary identity cards that do not grant full citizenship rights. Moreover foreign journalists and health workers have been barred from independently visiting the region. Indeed, recent travellers report that security surveillance is intensive, returnees are not allowed to make long journeys without official permission, and in many areas UN and international NGO workers are not allowed to travel without a military escort. Equally concerning, the practice of forced labour, which was a major reason for the exodus in the first place, continues to be widespread - a fact acknowledged by the UNHCR, which has made the unusual claim to have reduced "the burden for both the local population and returnees" to a maximum of four days of work a month per family after intervening with the authorities.¹⁰⁶ get in about EU and WHO

The extraordinary involvement of the UNHCR in negotiating over the frequency of the government's use of an inhumane labour practice, which has been repeatedly condemned by the UN General Assembly, the International Labour Organisation and other world bodies, does much to exemplify the difficulties international aid agencies face in ensuring the most basic of health and humanitarian protection for the citizens of Burma. Even more remarkably, as evidence of the labyrinthine way in which government is managed in Burma, in 1995 SLORC officials, though publicly denying that forced labour existed, privately told the UN Special Rapporteur on Human Rights that a "Secret Directive" had been issued to "discourage" its further use.¹⁰⁷ No clear evidence, however, has yet been found to support this claim - other than instructions to local government authorities that, where due, pay should be given.

¹⁰⁵ In June 1995, the UNHCR did nevertheless report that 45 refugees who had returned were being held in detention. UNHCR, *Return to Myanmar*, p.4.

¹⁰⁶ Ibid., p.6.

¹⁰⁷ *Statement of Mr Yozo Yokota, Special Rapporteur of the Commission on Human Rights*, p.8.

None the less as a test-case, the work of the UNHCR in trying to "anchor" Muslim returnees back in their Rakhine State homes has given a rare international glimpse of health conditions in at least one ethnic minority region of the country. In rural areas of Maungdaw and Buthidaung, for example, the UNHCR has uncovered a ratio of only one doctor to nearly 100,000 local inhabitants, as compared to one doctor to 1,600 refugees in the camps in Bangladesh and one doctor to 12,500 citizens within Burma nationally.¹⁰⁸ Equally stark, 90 per cent of local residents are illiterate and only 15 per cent of children in the returnee areas actually attend government schools, which are underfunded and generally poorly run.

In response, the UNHCR has begun a wide-ranging "reintegration" programme that focuses on health, water, sanitation, education, transportation and community service projects. In keeping with the UNDP's guidelines that programmes in Burma should be run at the "grass-roots" level, some of these projects are being run in conjunction with the Myanmar Red Cross (community services) and others (water and sanitation) with the World Food Programme and the French NGO, Action Internationale Contre la Faim. In the process, over 400 village wells or ponds are being built and 41 schools renovated. There are also UNHCR budgetary plans for a further \$US 23.9 million expenditure during 1996-97.

Nevertheless, while there can be no doubt that the intercession of emergency relief and medical aid is doing much to sustain displaced peoples in a time of great need, the UNHCR's close involvement with the government's chosen authorities and agencies raises serious questions over the community-based approach that is required in sustaining such projects. Returnees, for example, privately complain about the lack of locally-trained medical staff who speak their language or understand their customs (especially regarding Muslim women). Equally controversial is the SLORC's hand-picked appointment of all local officials and headmen.

Thus present programmes are proceeding on the basis of expediency and humanitarian need, with an emphasis on QUIPS (Quick Impact Projects). But, as in other areas of Burma, for sustainable development and health initiatives to really take root, social and educational reforms are also essential in which the democratic rights of participation and decision-making are also restored to the local people.

6.3 The Health Treatment of Prisoners and Detainees

The final area of grave health concern under international humanitarian law is the treatment of prisoners and detainees in Burma. In the war-zones, reports of the summary arrest, torture or extrajudicial executions of both villagers and suspected insurgents have long been

¹⁰⁸ UNHCR, *Return to Myanmar*, p.7.

commonplace (see 6.1 above). However, over the years there have also been continuing allegations of serious health and human rights violations against detainees in prison. Amnesty International, for example, has identified 20 detention centres across the country where "brutal interrogation" has taken place.¹⁰⁹ The methods of torture that have been documented include various forms of water torture, electric shock treatment and beatings, all of which are universally condemned under different international instruments. Another persistent complaint has been the lack of adequate medical provision for political prisoners and obstructions against families sending in medicines or essential supplies.

After the SLORC assumed power in 1988, such allegations initially multiplied when several thousand students and democracy activists were arrested in a succession of security clampdowns by the authorities. Former detainees interviewed by ARTICLE 19, many of whom were still suffering from ill-health, have widely reported the use of such inhumane but systematic abuses as food or sleep deprivation followed by beatings and the denial of adequate medical care. In the course of such ill-treatment, health problems such as bronchitis, pneumonia or heart conditions have often become chronic, and at least 15 political prisoners are known to have died. Since independent observers are denied access, the exact circumstances of most of these deaths are still unclear, but prominent amongst the list of fatalities are Maung Thawka (U Ba Thaw), chairman of Burma Writers Association, U Maung Ko, the NLD workers' leader, U Oo Tha Tun, a parliamentary candidate and Rakhine historian, and three leaders of the left-wing People's Progressive Party, U Khin Sein, U Nyo Win and U Khin Maung Myint.¹¹⁰

In a change of public presentation since April 1992 when Gen. Than Shwe replaced Gen. Saw Maung as SLORC chairman, the existence of "political prisoners" in Burma has occasionally been admitted, and over 2,000 detainees have been released under SLORC Declaration 11/92. In addition, since November 1993 the UN Special Rapporteur on Human Rights has been permitted occasional access to a number of political prisoners in Insein jail, including the student leader, Min Ko Naing, and the NLD figures, ex-Gen. Tin Oo and Dr Aung Khin Sint, both of whom have since been released.

Other prisons and prisoners, however, have remained strictly off-limits to outside visitors, despite repeated requests for access by both the UN Special Rapporteur on Human Rights and the International Committee of the Red Cross. A particular concern is the health treatment of prisoners who are compelled to work as porters in the war-zones or on government construction sites. Across the country, chain-gangs of labourers are an everyday sight. But in the past few years large numbers of prison labourers are reported to have died in

¹⁰⁹ Amnesty International, *Myanmar: 'No law at all'*, p.13.

¹¹⁰ For a description of conditions in several prisons, see, *Ibid.*, pp.14-16, 24.

working conditions of great hardship, especially in the ethnic minority borderlands where medical treatment is minimal and malaria, dysentery and other potentially fatal diseases are endemic. "There are many prisoners that are dying," a Christian pastor told Amnesty International in 1992 after witnessing prison chain-gangs working on the Myitkyina-Sumprabum-Putao highway in the Kachin State.¹¹¹ Many more prisoners were also killed during heavy fighting with the KNU around Mannerplaw in early 1992, having been conscripted as front-line porters from jails all over the country. More recently, the All Burma Students Democratic Front has claimed that over 100 prison inmates died in one year from hunger and lack of proper medical care at the Boke Pyin labour camp in southern Burma.¹¹²

Thus, finally, in June 1995, the ICRC, which is charged under the Geneva Conventions with visiting prisoners of war and other detainees, took the extraordinary decision to pull out of Burma in protest at the SLORC's continued refusal to accept three key "customary procedures" that the ICRC insists upon: the right to interview prisoners without witnesses, to see all prisoners and prisons in any part of the country, and to visit any prisoner repeatedly. "To have some credibility we cannot go just once, we need to follow up visits every few months," one official explained who declined to be identified. "We also have to see those prisoners in private, without security officials present."¹¹³ As a result, the ICRC office (opened in 1986) was closed down; an artificial limb programme for war victims has been handed over to the Health Ministry and Myanmar Red Cross; and training classes in the Geneva Conventions for military officers stopped altogether.

Therefore, with the ICRC's withdrawal, there is now even more concern in Burma over the treatment of prisoners and detainees, which were sadly brought into focus by a crackdown that began on political prisoners in Insein jail in November 1995. This reportedly led the wives of 36 prisoners to write to the Ministry for Home Affairs complaining of a deterioration in the health of their husbands after a new punishment regime, including the denial of medical attention and meetings with relatives, was introduced after the group were supposed to have been found in possession of anti-government literature and materials. Five NLD supporters appeared to be singled out, U Win Tin, vice-chairman of Burma's Writers Association, U Saw Naing Naing, MP-elect for Pazundaung, U Myo Myint Nyein, a magazine editor, Monywa Tin Shwe, a lawyer, and Dr Myint Way. According to NLD sources, food and drink had been restricted and the prisoners moved to military dog cells, where they had to sleep on the floor without blankets. In February 1996, the NLD also reported that the five men were facing further anti-government charges: their alleged "crime",

¹¹¹ Ibid., p.20.

¹¹² ABSDF press release, 22 January 1996.

¹¹³ *Reuters*, 19 June 1995.

it appeared, was to have tried to smuggle out news to the UN Special Rapporteur on Human Rights about the appalling conditions in prison.

Given the past deaths of prisoners, there are widespread anxieties over their health. In particular, 65 year-old Win Tin, one of the NLD's founding theoreticians, is known to suffer from chronic spondylitis and, having been originally jailed on spurious charges of involvement in an abortion, colleagues fear his imprisonment is now being extended indefinitely (see 5). Similar fears have been expressed over the condition of another detained writer, 29 year-old Dr Ma Thida, who had been working at the Muslim Free Hospital in Rangoon. Serving a 20-year jail sentence under a variety of censorship laws, she has been suffering from tuberculosis as well as suspected endometritis? (see *ibid*).

In ARTICLE 19's view, it is thus absolutely imperative that both the ICRC and Special Rapporteur on Human Rights should be given permission to return to Burma as soon as possible and begin prison inspections, with access to all prisoners, under the usual terms and conditions of their universally-accepted mandates.

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7. AIDS AND NARCOTICS

In recent years, perhaps no health issue in Burma has been the source of greater international concern than AIDS and the closely-attendant problem of narcotics, but no health issue has suffered more from the dearth of accurate field research and knowledge. Epidemic crises in both fields have been allowed to develop to a fatal backdrop of censorship, ignorance, insurgency, governmental inaction and international speculation in which fact has often turned out to be stranger than fiction. Decades of health neglect have left a heavy toll. Not only is Burma today the world's largest producer of illicit opium and heroin, but with only 9,885 identified cases of HIV-infection (and 550 of AIDS) in 1995 as compared with WHO estimates of up to 500,000 HIV-carriers, there is no other country in the world with such a disturbing gap between projections and corroborated figures.¹¹⁴

In combatting AIDS, it is, ofcourse, only too easy to be wise after the event. But as ARTICLE 19 pointed out in 1991, in Burma there were long a number of high-risk factors which made the country an entirely predictable spawning ground for the rapid spread of the disease.¹¹⁵ In particular, Burma stands out as a country where economic, political and migrational factors have dangerously exacerbated underlying social and health problems. In the global struggle against AIDS, no country can stand isolated.

¹¹⁴ See e.g., *AFP*, 21 September 1995; UNICEF, *Children and Women in Myanmar*, p.42.

¹¹⁵ ARTICLE 19, *State of Fear*, p.12.

The first key factor has been widespread drug abuse throughout Burma's borderland regions. Located at the cross-roads of south and south-east Asia, it was mostly intravenous drug users (IDUs) sharing needles to inject heroin from Burma's Golden Triangle region who accounted for the extraordinary explosion in the transmission of the disease in the late 1980s. Detailed evidence is lacking from Burma itself, but the pattern of this transmission has been confirmed by studies in all of its neighbours. Burma today is classified by the WHO, along with India and Thailand, as one of Asia's "HIV Top Three". In China, for example, 70 per cent of all identified cases of HIV-infection come from Ruili on Burma's border; in India, the small frontier state of Manipur constitutes 16 per cent of all recorded HIV-carriers; and in Thailand, the incidence of AIDS sky-rocketed dramatically throughout the country in the early 1990s from the border provinces of Chiang Rai, Chiang Mai and Mae Hong Son.¹¹⁶ In Mae Hong Son province alone, public health officials last year recorded a rate of 18.5 per cent HIV-infection in a random survey of ten villages near the Burma border.¹¹⁷

The second key factor behind the rapid spread in HIV/AIDS has been equally predictable: the illicit sex trade with Thailand. As Burma's economic crisis continues, for the past few years tens of thousands of impoverished young women or girls from Burma have been annually travelling backwards and forwards to Thailand, where many have entered - or been lured - into prostitution in the myriad bars, brothels and massage parlours that exist in all main towns. The scale of this secretive trade is massive, with as many as 40,000 Burmese women, many of whom are ethnic minorities, estimated to be working in Thailand at any one time.¹¹⁸ The physical and health risks are legion. Recent medical studies, for example, have suggested that the probability of HIV-infection is up to ten times greater when the AIDS virus is passed on in conjunction with other sexually transmitted diseases.¹¹⁹ Such information, however, is not available to the young women from Burma, who not only do not speak the Thai language but often work in the poorest classes of brothels where they have to serve up to ten clients every night - frequently without condom protection. In Burma, too, sex education, condom use and the treatment of sexually-transmitted diseases are even more scarce, leaving women extremely vulnerable to infection (see "Women and Health" below).

The fatal inevitability of this situation has not been lost on Thai health workers. Indeed when 17 out of 19 ethnic Shan teenage prostitutes, none of whom had any knowledge of AIDS, tested HIV-positive after a brothel-raid in Chiang Rai, Mechai Viravaidya, a

¹¹⁶ *Reuters*, 1 June 1994, 25 February 1995.

¹¹⁷ *Bangkok Post*, 26 February 1995.

¹¹⁸ See e.g., Smith, *Ethnic Groups*, p.114; Human Rights Watch/Asia, *A Modern Form of Slavery: Trafficking of Burmese Women and Girls into Brothels in Thailand* (New York, 1993).

¹¹⁹ UNICEF, *Children and Women in Myanmar*, p.42.

minister in the Prime Minister's Office, urgently warned: "Our neighbours are coming over the border and taking the virus back. This is not just a health issue, it's a social issue. We are fighting a lot of ignorance and vested interests."¹²⁰

However, if it was the deadly combination of intravenous drug-use and the international sex trade which first caused HIV/AIDS to make such a rapid impact, there are also a number of equally salient factors inside Burma itself that have ensured its continuing spread. Pre-eminent amongst such problems are the lack of relevant health information and education, the shortage of condoms and blood-testing equipment, unhygienic injecting practices, frequent job migration by miners, truckers, seamen and other social sectors, and, finally, conservative social structures that make AIDS such a difficult issue to confront. Equally important, it was largely amongst ethnic minority or other disadvantaged peoples in remote border regions that the AIDS epidemic first developed.¹²¹ As a result, after decades of political neglect, central government authorities were quite incapable of identifying the health issue of AIDS or effectively responding. There were no democratic institutions or local systems of health management and, indeed, there appeared to be no cognizance at all that the health concerns of minority peoples, many of whom had been living in or around war-zones, have a direct impact on the well-being of the nation. Like narcotics and prostitution, sensitive issues such as ethnic minority politics have never featured in any informative way in the state-controlled media.

Far too belatedly, governmental reaction has quickened. The first case of HIV-infection was identified in Burma in 1988. But when the scale of the crisis was finally confirmed by the results of the first sero-sentinel surveillances during 1992-93, according to one international specialist in the sociology of health behaviour, it was "already present at high epidemic levels throughout geographically disparate parts of the country".¹²² The reliability and ethics of even these first surveys have since been questioned by senior health practitioners; it is believed, for example, that, amongst risk groups, doctors selected individuals whom they suspected were already HIV-infected in several parts of the country rather than testing genuine samples of particular social groups. The results, nevertheless, were startling: amongst intravenous drug-users, over 90 per cent in the Kachin State and over 80 per cent in Mandalay tested HIV-positive while, amongst pregnant women, 12 per cent tested positive in the busy trading town of Tachilek and 6 per cent in Kawthaung on the Thai border,

¹²⁰ *Burma Alert*, June 1991.

¹²¹ Gerry V Stimson PhD, *Drug Injecting and the Spread of HIV Infection in South-East Asia* (to be published in proceedings of 2nd AIDS IMPACT Conference, Brighton, UK, July 1994), pp.12-13.

¹²² Stimson, *Drug Injecting and the Spread of HIV*, p.12.

where around 20 per cent of males with sexually-transmitted diseases also proved positive.¹²³

Such alarming figures inevitably necessitated an important shift in official attitudes. After several years of denying that there was any risk of HIV-infection in Burma (until 1991, cartoons in the state-controlled media depicted AIDS as a "foreigners' disease"¹²⁴), a number of AIDS awareness and prevention campaigns have been initiated. Throughout this process, an important supporting role has been played by various UN agencies. As early as 1989 a national AIDS committee was established under the Minister of Health, but it took until 1991-92 for the Ministry of Health to formulate its first National AIDS Control and Prevention Plan when, with financial backing from the UNDP and WHO, a number of projects were agreed, including the introduction of the sentinel surveillance tests, blood screening and counselling. Since this time, the UNDCP has commissioned its first studies on the close link between intravenous drug use and the spread of HIV-infection in Burma, while UNICEF has helped develop a national project on the "Control of HIV/AIDS through Reproductive Health" in conjunction with the Ministry of Health and its three chosen NGOs: the MRC, MMCWA and MMA. By mid-1995, this programme was underway in 25 townships especially targetted for the high risk of HIV-infection.

In another important change of policy, despite initial reluctance by the SLORC, several of the first international NGOs to be allowed to return to Burma have been given permission to start AIDS awareness programmes in selected government-controlled regions of the country. In the past two years, Medecins du Monde has worked at drug rehabilitation centres and sponsored workshops for trainers on health education in AIDS, World Vision has set up an educational programme in AIDS awareness (in partnership with the MMA) in the border-town of Kawthaung, while the Association Francois-Xavier Bagnoud has developed a project to help poor Burmese women, including sufferers who are HIV-positive, to reintegrate back into society after a life of prostitution in both Burma and Thailand. Although very much in their pilot stages, the presence of such foreign aid organisations in Burma and their collaboration with governmental authorities or local health workers would have been unthinkable just a few years ago.

At the national level, too, the SLORC has given apparent priority to the health risks of HIV/AIDS. By the end of 1995, an estimated 80 per cent of public doctors and medical officers were reported to have undergone basic training programmes in AIDS prevention and diagnosis. Attempts have also been made to get the same message over to the general public, and AIDS awareness posters are freely on view in most urban areas today. In broaching this subject, some important taboos have had to be tackled. In 1991 UNICEF, for example,

¹²³ Source: Department of Health, Rangoon.

¹²⁴ See e.g., *Working People's Daily*, 30 July 1991.

produced a one-hour film for Burmese television, "Poisonous Love", in which a young man contracts HIV from a prostitute and then infects his wife and, possibly, newborn child. However, it reportedly took UNICEF a further year to persuade the authorities to broadcast the film, since government censors were adamant that a scene showing condoms was offensive in a Buddhist country and must therefore be cut. Eventually, it took a direct appeal to one of the ruling generals to gain permission: Lt-Gen. Khin Nyunt, the SLORC secretary-one. "Khin Nyunt's wife is a physician, thank goodness," one Western health worker told the *New York Times*. "Otherwise, it might never have gotten on the air."¹²⁵

Since this time, although conservative in language, the dangers of AIDS and possible methods of transmission (with the exception of homosexuality?) have been regularly reported in the state-controlled media. Equally important, such commentaries generally reflect the realities of Burmese custom and health in a public manner which is very new. Reported the *New Light of Myanmar* on 20 October 1994: "Because only 17 per cent of the population has access to contraceptives, sexually active men and women are at risk, particularly if they have different sexual partners over time."

And yet, despite these first moments of health *glasnost*, SLORC officials have remained exceedingly sensitive to any international criticisms of their handling of the AIDS crisis. Adverse comments in the foreign media have met with stinging rebuttals. For example, when the *Bangkok Post* of 16 September 1994 painted a grim picture of the plight of AIDS patients in the Contagious Diseases Hospital in Rangoon, the response was immediate. Both Vice-Admiral Than Nyunt, the Minister of Health, and Dr Hla Myint, director-general of the Department of Health, launched strong defences of the government's work in the *New Light of Myanmar*, accusing the international press of "exaggerating for political purposes".¹²⁶

Government doctors, too, have expressed frustration at the opprobrium which they feel has been attached to their work because of international rejection of the SLORC. Although usually privately expressed, such views reached a broader audience during an AIDS conference in Chiang Mai, Thailand, in 1995 which the SLORC had allowed a medical delegation to attend. Matters came to a head when John Dwyer, an Australian immunologist, warned of his belief that the Burmese government was making every possible mistake in

¹²⁵ *New York Times*, 11 March 1994.

¹²⁶ *New Light of Myanmar*, 27 September and 11 October 1994. Although few Burmese citizens have access to international newspapers such as the *Bangkok Post*, these reports are often picked up and rebroadcast in the Burmese language by other media in the region, including the Voice of America and BBC. The BBC has also run its own series of Burmese-language programmes on the subject of AIDS, which proved popular in the country. Since August 1995?, however, the BBC has been jammed.

dealing with the epidemic. In reply, Dr Bo Kywe, a former doctor in the military who was conscripted and deputy director of Burma's National AIDS Programme, told a press conference that Dywer was "absolutely incorrect": "People like him who are walking on the international stage have to highlight some points; a lot of people are walking in this way."¹²⁷ Dr Kywe, however, did acknowledge that the AIDS crisis was not under control in Burma: "We won't be either optimistic or pessimistic, but we are trying to do our best."¹²⁸

The polarity of views expressed in such exchanges only serves to highlight the difficulties in finding common ground to address health issues in a country as riven by political conflict as Burma. Without the institutions of democratic and accountable government, even the fundamental health issue of AIDS can become a deeply political question. Not all health workers are convinced that international boycotts and pressure on the SLORC are the best solution for such a global emergency as AIDS. "One of the critical problems facing Burma now is its political isolation," argued Danial Tarantola, AIDS programme director of the Francois-Xavier Bagnoud Centre for Health and Human Rights at the Harvard School of Public Health. "By applying political pressure on the few, the world is penalising the many."¹²⁹

The critical question, then, is whether the health programmes now being instituted under the SLORC will be enough to ward off the continuing spread of the disease from its high plateau. Certainly, random surveys have recently indicated a high awareness of the existence of AIDS in government-controlled areas, although not necessarily every aspect of transmission or cause.

However, despite the recent changes, there remain vast areas and sectors of society where any impact has been minimal. Many health workers fear that for many citizens it is already a case of "too little, too late". Moreover the belated national profile given to the dangers of HIV-infection are in no way matched by the availability or efficacy of treatment. Outside the main conurbations, blood screening is still minimal and, according to government and WHO officials, even the proportion of blood samples screened nationally can "not be verified".¹³⁰ Indeed, if predictions are correct, as the numbers of AIDS sufferers begin to rise over the next decade, the crisis in HIV/AIDS will be moving from one of simple "awareness and prevention" programmes to the treatment and human rights' protection of patients.

¹²⁷ *The Nation*, 21 September 1995.

¹²⁸ *Ibid.*

¹²⁹ *Reuters*, 30 July 1993.

¹³⁰ Min Thwe and Bo Kywe, National AIDS Programme, D.J. Goodwin, WHO, *HIV Surveillance in Myanmar, 1985-95* (III International Conference on AIDS in Asia and the Pacific, Chiang Mai, September 1995), p.4.

Already such locally-endemic health problems as tuberculosis, drug addiction, hepatitis and malnutrition are believed to be taking several years off the average life expectancy of HIV-infected persons in Burma when compared with sufferers in the West. Experience in border areas of northern Thailand, for example, has warned that the lives of babies born to HIV-infected mothers are likely to be especially at risk.

In turn, the medical problems of a future generation of AIDS sufferers raise a plethora of health issues over the rights to treatment, privacy and health information in communities which are most adversely affected. Already health data suggests that the impact of AIDS is likely to be patchy, affecting not only the younger generation with worrying implications for families where the main breadwinners are stricken by illness, but also ethnic minority communities in remote border regions where the disease may now be endemic. In particular, hill peoples such as the Akha in the southern Shan State, where heroin addiction is rife and many young women have been working in prostitution in Thailand, stand in danger of decimation.

In the view of ARTICLE 19, for any of these problems to be addressed the one unifying factor will be restoration of the right to freedom of expression and opinion. Freedom of expression is the only universal guarantee by which the quality of research can be improved and the rights of local communities to information and participation in health issues that so drastically affect them can be protected. But as UNICEF has warned, "No comprehensive national education and communication programme yet exists."¹³¹ The enormous gap between WHO projections and the officially identified number of HIV-carriers in Burma is only the most obvious gap in essential knowledge. It is also important to credit that the SLORC and Ministry of Health have allowed certain foreign specialists to work on this emergency, but those who have been given permission to enter Burma have swiftly become aware of the difficulties in establishing reliable information and data. According to Doug Porter, who conducted research in 1994 supported by the UNDP, Rangoon Institute of Economics and the Australian National University: Before undertaking the research, none of the team was sanguine about the difficulties to be encountered, but none anticipated the realities. Field research activities were in practice severely restricted and abbreviated in terms of their overall duration; the localities visited (e.g. the central Wa region was not visited); representativeness (e.g., hill-top Wa villages were not accessed); and in terms of the veracity of information gathered..... Furthermore, planned research activities often had to give way to the exigencies of military and security interests in the area, including everyday military surveillance, itinerant banditry, *Tatmadaw* operational activities, and instability in some of

¹³¹ UNICEF, *Children and Women in Myanmar*, p.42.

the militia-controlled areas.¹³²

Disturbingly, as international experience has revealed in the battle against AIDS, little substantive impact can be made on the spread of HIV/AIDS as long as the underlying social and political conditions remain unchanged. The rapid migration of workers in Burma, especially such social sectors as labourers or women in the sex trade, has become a major factor.¹³³ But perhaps the most difficult to address remains the increasing practice of heroin abuse, which has long been a serious, although much neglected, health problem in its own right.

As always in Burma, there is a considerable gulf between official descriptions of the narcotics trade and the grim reality itself. Burma is a state party to the 1961 Single Convention on Narcotics Drugs and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. In 1993, a new Narcotics Drugs and Psychotropic Substances Law was also promulgated by the SLORC, replacing 1974 legislation from the BSPP era and prohibiting all drug use, possession or trafficking. At the same time, since 1989 the SLORC has for the first time officially entered Burma into a programme of sub-regional cooperation, supported by the UNDCP, with China, Thailand, Laos, Cambodia and Vietnam as well as through bilateral agreements with both India and Bangladesh?. These ties have been reflected in the increasing use of developmental and crop-substitution language in official government reports. Nevertheless, senior SLORC officers and the state-controlled media continue to depict Burma's narcotics problem as essentially a "war" of interdiction, always being waged successfully by the *Tatmadaw*, in the most propagandist terms. "Which country in the world has sacrificed the lives of over 190 soldiers with additional 350 wounded in the combat against drug traffickers in a matter of only four weeks?" the SLORC foreign minister, U Ohn Gyaw, asked the UN General Assembly on 11 October 1994.

In such a politically-censored environment, neither the size nor full horror of Burma's drugs' problems are publicly revealed. For decades the illicit opium trade in Burma has remained hidden by secrecy and danger; the twin problems of armed opposition and narcotics are inextricably interlinked. But while Burma's political deadlock continues, all the main elements in the trade have remained impervious to change: the impoverished hill farmers who

¹³² Porter, *Wheeling and Dealing*, p.93.

¹³³ For example, when World Vision conducted research to begin its AIDS programme in Kawthaung, 31 commercial sex workers were interviewed; two years later, all such workers had disappeared by either moving or going "underground". See, World Vision, *Report on Review of the AIDS Awareness, Education and Prevention Project in Kawthaung* (MMA and World Vision, Rangoon, May 1995), p.12. See also, Southeast Asian Information Network, *Out of Control: The HIV/AIDS Epidemic in Burma* (Chiang Mai, 1995). pp.6-12.

grow the opium poppies; the armed opposition groups, local militia and traders who transport or refine the raw opium into heroin; the corruption and indifference of government officials; and, finally, the international syndicates who transport the finished product onto the world markets. Indeed, according to the US State Department, despite the spread of cease-fires in the war-zones, Burma's annual opium harvest has more than doubled since the SLORC assumed power in 1988 to more than 2,000 tons per annum.¹³⁴ An astonishing 60 per cent of the heroin for sale on the streets of the USA today is estimated to originate from Burma.¹³⁵

However, while world attention continues to focus on the misleading search for a few "Mr Bigs", the alarming health consequences for the Burmese peoples have been dangerously overlooked. From the exile Kuomintang, Communist Party of Burma and SLORC to local ethnic minority or militia leaders such as Lo Hsing-han and Khun Sa, there has long been a simplistic tradition of blaming the trade on different protagonists in Burma.¹³⁶ For their part, SLORC officials continue to blame the trade on the colonial era of the British, who left Burma in 1948.¹³⁷ The sad truth is that the international narcotics trade has long spawned its own corruption.

In the midst of such arguments, the health and human rights of the local inhabitants are forgotten. In the 1980s, for example, Burma's Shan State was the scene of a grave but indiscriminate abuse of health rights when, largely unresearched and unreported, over 60,000 acres of highland forest and dozens of ethnic minority villages were sprayed from the air with the US-supplied 2,4-D, a compound used in the production of Agent Orange, without any warning to the local people. Food and water supplies were contaminated, and a variety of health disorders were reported by villages who migrated towards the Thai border. In fact, little of the wealth associated with the narcotics' trade ever reaches the impoverished inhabitants of northeast Burma, except for a small class of entrepreneurs who have flourished under the SLORC's "open-door" economic policy. Indeed, during the crop-spraying period, opium production actually went up; for hill-farmers there is simply no other cash crop.¹³⁸

After so many years of conflict, the plight of many communities in the main poppy-growing areas is now desperate. This has been evidenced by an upsurge in intravenous drug use over the past decade as more and more opium is locally refined into heroin. Coinciding

¹³⁴ See e.g., *The Nation*, 13 March 1992.

¹³⁵ U.S. Department of State, *International Narcotics Control Strategy Report* (Washington, March 1996).

¹³⁶ Smith, *Burma: Insurgency*, pp.314-15.

¹³⁷ *Drugs Suppression in Myanmar: Tatmadaw Role in Combating the Scourge of Illicit Drugs* (mimeograph, Rangoon, July 1996), p.1.

¹³⁸ For an investigation, see, United States General Accounting Office, *Drug Control: Enforcement Efforts in Burma are not Effective* (USGAO, Washington, 1989).

with the advent of AIDS/HIV, this changing pattern of drug abuse could not have occurred at a worse time. Whether through undiagnosed cases of AIDS, drug overdoses, meningitis, tuberculosis, septicaemia, hepatitis or other related health problems, the few qualified practitioners still working in the area have reported an alarming loss of life. Indeed, in many areas, community leaders privately say that it is hard to find a single family without at least one addict.

So alarmed was one armed opposition group, the Kachin Independence Organisation (KIO), by the explosion in drug abuse - and what it correctly predicted to be AIDS - in the late 1980s that it unilaterally passed its own legislation and began a drug eradication programme of its own. The campaign began in horrifying circumstances. Having recorded 328 drug-related deaths in the jade mining town of Hpakhan between November 1989 and April 1990, 54 drug dealers and offenders were publicly executed by the KIO in August 1990 in scenes which were video-taped and widely circulated. "We firmly believe to have no other alternative than the use of the death penalty in individual cases of continued violation of our drug laws," defended a KIO official at one international seminar.¹³⁹

However, from its initial strongholds in the Shan and Kachin States, the practice of intravenous drug use has now spread across the country and can be found (is common?) in both Mandalay and Rangoon. As a further indicator of health neglect, heroin is easily available in prisons, where many drug offenders at some stage end up¹⁴⁰; and it remains particularly cheap and commonplace in the jade mining regions of the Kachin State and the ruby mines of the Shan State, which have long been wild and lawless places. From such epicentres, HIV/AIDS is continuing to spread amongst intravenous drug users, as was belatedly confirmed by the 1992 sentinel surveillance tests in which 62.8 per cent of all IDUs tested nationally were HIV-positive, one of the highest sectoral figures ever recorded in the

¹³⁹ Col. Zau Seng, *Establishing Anti-Drug Policies in a Liberated Zone of Burma* (Statement of KIO to International Symposium: Illicit Drugs and Global Geopolitics, Paris, December 1992), p.7.

¹⁴⁰ According to one survey, 70 per cent of 500 prisoners in Lashio jail were convicted under narcotics' legislation, while 790 of the 4,000 prisoners in Mandalay jail were drug offenders, some 70 per cent of whom were IDUs; see, *HIV Infection and Injecting Drug Use in the Union of Myanmar: A report to the United Nations International Drug Control Programme by Professor Gerry V Stimson* (Final Report, 9 February 1994), pp.16-17. There is also particular concern over the health treatment of drug offenders, including those who are HIV-positive. In many prison hospitals (which are often regarded a good place to be admitted from a cell), drug offenders constitute a large percentage of the patients, including around 40 per cent in Mandalay. In the past, prisoners have also formed one of the main sources for donated blood, but no data is available on current practices or screening.

world. By the following March, this figure had grown to 74.3 per cent.¹⁴¹

Although occasionally alluded to in Burma's new business press, none of these serious health issues is ever reflected in the state-controlled media. There are undoubtedly officials on the government side, just as there are amongst democratic and ethnic nationalist parties, who are anxious to begin largescale drug eradication and rehabilitation programmes. In most major towns, government-sponsored drug treatment programmes have long existed. In the last four years, the UNDCP has also initiated pilot crop-substitution programmes in the Shan State. But in taking the kind of essential actions that are needed against the heroin trade, sheer survival and political expediency still predominate. Simply too much money is being made - and not just by corrupt officials or armed opposition groups, notably the UWSP and MTA of Khun Sa, which control most of the poppy-growing areas and opium trade. It is one of the most open secrets in Burma today that much of the large sums made through narcotics is being laundered through official trade and other new business projects that are currently underway in Mandalay, Rangoon and the other main conurbations.

Into this vacuum, many community groups, especially those based around local Christian churches, have instituted their own narcotics and AIDS awareness programmes in the towns. Several armed opposition groups also advocate anti-narcotic policies. US Drug Enforcement Agency officials, for example, privately admit the noticeable success of the KIO in halting poppy cultivation, while the USWP has publicly called for direct international assistance which bi-passes the SLORC.¹⁴² This is a step, however, few international health or development agencies are prepared to countenance for fear of jeopardising their relations with Rangoon. The sad truth remains that, until political reform and stability are ensured, many of the most vulnerable or affected groups will remain beyond effective outreach.

The drug culture in Burma today survives amidst a woeful tide of misery, ignorance and superstition. In rural areas of the Kachin State, for example, rumours spread in 1993 that the blood of children could cure AIDS sufferers, and there were reports (which appear to be unsubstantiated) of teams of male and female addicts luring children away with sweets, before using chloroform to sedate their victims and syringes to extract blood from their arms.

Even the particular AIDS explosion that occurred in Burma can be put down to such extremely ill-informed behaviour: the popular fashion amongst IDUs of visiting "shooting galleries" where dealers inject groups of addicts with unsterilised, self-made equipment (such as needles attached to eye-droppers or polythene tubes) that is then repeatedly used. Tragically, in these areas many quacks and even medical practitioners also give repeat

¹⁴¹ Ibid., pp.4-6.

¹⁴² See e.g., Ta Saw Lu, *The Bondage of Opium: The Agony of the Wa People* (UWSP Foreign Affairs Department, 1993).

injections in such unhygienic conditions. As a result, international AIDS specialists are now convinced that such unsanitary practices, combined with the already high prevalence of the disease amongst a mobile social group, accounts for the extraordinarily fast spread of HIV-infection in northeast Burma. For example, according to a rare survey of 73 drug addicts from Hpakhan, 91 per cent were HIV-positive, of whom 47 per cent had only used drugs "for six months or less" and only 16 per cent had been using drugs "for more than two years"; moreover, although most were sexually active, 80 per cent had never heard of condoms.¹⁴³

Built upon such bedrocks of ignorance, it is difficult to see how existing legislation or programmes can cope with the twin perils of drug addiction and AIDS. Even the total drug output in Burma is the subject of great controversy. Although producing no alternate figures, SLORC officials have consistently accused Western anti-narcotic agencies of exaggerating Burma's opium harvest, a claim some armed opposition groups would support. But even the widely quoted figure of over 2,000 tons per annum in the West is largely based upon satellite imagery and sample field-surveys, and it must therefore be seen, at best, as guesstimates.

Similarly, although over 50,000 addicts are recorded to have officially registered since rehabilitation programmes began at public drug treatment centres in 1974, there are no reliable estimates of the real number of drug addicts today. The KIO, for example, estimates that there are 33,500 opium and heroin addicts in the Kachin State alone.¹⁴⁴ Many medical practitioners believe that, given the lack of resources, drug treatment centres are well-organised and represent one of the best public services. Relapses, however, are common; centres are often far from patients' homes; and current legislation, which requires addicts to voluntarily register or face jail terms of up to five years, simply forces many addicts to go underground. Equally urgent, while the government has apparently felt able to make the important step of switching from a policy of silence or indifference on the question of contraception to one of advocating condom use, sweeping changes are still needed to pharmaceutical legislation which outlaws the non-medical possession of syringes and needles.

In conclusion, therefore, given this terrible background of AIDS and drug abuse, many Burmese citizens are beginning to seriously question why still no effective action is being taken against Burma's enormous trade in illicit opium, which for several years has been the world's largest. Exactly the same question is being amongst international narcotics agencies and, as a sign of such concerns, in November 1995 a Presidential Decision Directive was signed by President Clinton with-holding US aid (including to the International Monetary Fund and World Bank) from countries such as Burma where US officials did not believe

¹⁴³ Stimson, *HIV Infection and Injecting Drug Use*, pp.8,11.

¹⁴⁴ Col. Zau Seng, *Establishing Anti-Drug Policies in a Liberated Zone*, p.9.

governments were "co-operating" to stop the flow of heroin.¹⁴⁵

Less than two months later, in one of the dramatic switches which makes the drugs trade so difficult for outsiders to follow, the SLORC agreed a cease-fire/surrender with the 15,000-strong MTA of Khun Sa, which had previously been denounced in the state-controlled media as the main trafficking force. Government troops were allowed to enter MTA positions, and two doctors were sent up from Rangoon to his Homong headquarters to personally care for Khun Sa. The official US attitude was one of outrage; already under indictment in the US for heroin trafficking, a US\$ 2 million reward was offered for information leading to his capture.

Nevertheless, with the MTA truce, the central government has achieved its first apparent peace in northeast Burma in decades. Cease-fires have also been sustained since 1989 with the other key nationalist forces involved in the narcotics trade, notably the UWSP and Myanmar National Defence Alliance Army which control the prize poppy fields in the Wa and Kokang sub-states. The KIO, too, which agreed a cease-fire in 1994, continues to apply its own eradication and rehabilitation programmes.

The situation, then, might never have been more opportune to address the underlying political issues and poverty which have long underpinned ethnic conflict and the opium trade. After so many years of warfare, no side believes political and developmental solutions will be either quick or easy, but there has never been a better moment to try. At the moment, however, the drugs trade still continues in conditions of great secrecy and doubt. For while orders have reportedly gone out to stop heroin refining in MTA areas along the Thai border, over the past eight months the *Tatmadaw* has also taken control of the important drug-trafficking town of Mongko on the Chinese border after clashes between rival Kokangese cease-fire militia which went absolutely unreported. Here opposition sources in the drugs trade estimate 10 per cent of all heroin-refining in the Shan State takes place.

Health workers and community groups, nevertheless, are expecting substantive action. According to a local survey of heroin abuse and AIDS in northeast Burma, which was recently circulated in private to international donors:

The younger generation, in particular, is in danger of near extermination if something is not done to control a wider spread of AIDS. It is with this hope that we make an appeal to humanitarian groups everywhere all over the world.

UNICEF 49 - the existing National Drug Law is not strictly enforced.

¹⁴⁵ AP, 18 December 1995.

WOMEN AND HEALTH

Despite their respected role in society, women from all ethnic groups in Burma have become extremely vulnerable to the devastating impact of the country's long-running social and political malaise. This is not always apparent to foreign visitors. Unlike several other parts of Asia, women in Burma take visibly active part in a great variety of public affairs, especially in commerce, education, health and agriculture. As a result, the particular health and discrimination problems, which many women have to suffer daily, are often overlooked. By the same token, the prominence of Daw Aung San Suu Kyi as a national leader is very much an exception in the male-dominated world of Burmese politics. Gender discrimination, however, severely restricts the right of women to express their legitimate interests in social and political affairs. Although constituting an estimated 40 per cent of the workforce, few women have ever been allowed to rise to top governmental positions.¹⁴⁶

In the past few years, a number of international agencies have begun to uncover evidence of such discrimination or health neglect (notably UNICEF and NGOs working with refugee populations along Burma's borders), but this view has never been publicly accepted by any Burmese government. Although a signatory to the UN Convention on the Political Rights of Women, Burma has not ratified the Convention on the Elimination of All Forms of Discrimination Against Women, nor is there any official agency to advance or protect the status of women. Under the SLORC, all reports of health or human rights abuses against women continue to be rejected by military spokesmen in blanket fashion. In October 1995, for example, the SLORC responded to the UN Special Rapporteur on Human Rights, who had provided a summary of serious human rights violations against women, by citing the existence of "equal rights" and five key laws which, it argued, would prevent any such abuses occurring: the Suppression of Prostitution Act (1949), the Myanmar Buddhist Women's Special Marriage and Succession Act (1954), the Myanmar Maternal and Child Welfare Association Law, the Nursing and Maternity Law, and the Penal Code. Claimed the SLORC: Women in Myanmar are not only protected by such laws and provisions, they are also

protected by Myanmar traditions and customs, as well as customary law,
religious beliefs and practices. Women's rights constitute human rights and

¹⁴⁶ In 1991-92, for example, there were 60,708 females in higher education as opposed to 45,948 males. Women teachers also outnumber men by two to one, but few women have been promoted to top posts in the education system; see, M. Smith, "Burma (Myanmar)", in World University Service, *Academic Freedom 3: Education and Human Rights* (Zed Books, London, 1995), p.105. Similar discrimination against women exists in the health sector, where women are also in the majority if all jobs, including nurses, are included.

Myanmar women fully enjoy fundamental rights.¹⁴⁷

Contradicting such assertions, since 1988 a disturbing pattern of grave human rights abuses and humanitarian neglect, in which women have often been particular victims, has been documented in virtually all of Burma's 14 states and divisions. Many of the most serious allegations, including those of summary arrest, rape or extrajudicial execution, have concerned the activities of government soldiers on military operations in ethnic minority regions of the country where *Tatmadaw* officers have extraordinary powers of arrest and command.¹⁴⁸

Another grievance, in many parts of the country, has been the forcible conscription of women, including girls, pregnant women and the elderly, into compulsory labour duties on government construction projects or even as porters in the war-zones. Such forced labour by women is in complete contravention of Article 11 of the ILO's 1930 Convention No.29 Concerning Forced or Compulsory Labour, ratified by Burma in 1955, which confines compulsory labour to "able-bodied" males between 18 and 45. In Burma, however, the numbers of women who have been forced to work on such projects in the past few years are massive. This has major health and humanitarian implications for the whole of Burmese society, since not only does forced labour, in itself, have an extremely detrimental impact on the health of women and their children, but it is in the course of such forced labour duties that many of the worst human rights violations against women, including rape or threats to life, have occurred. In 1991, for example, ARTICLE 19 reported the deaths of two Karen highschool girls, Naw Aye Hla (aged 17) and Ne Law Win (aged 16), who, conscripted as porters, were compelled to walk through a minefield in the hills near Papun.¹⁴⁹ More recently, the underground Burmese Women Union, which was formed in 1995 by democracy activists in the Thai border region, presented a 30-page dossier of women's sufferings during forced labour to the Fourth UN Conference on Women in Beijing. "Sometimes we didn't go because we were tired, but they came at night and dragged us from our house," one woman complained. "My children were screaming and crying, but I just had to leave them there."¹⁵⁰

Not surprisingly, then, it has been reports of extreme human rights violations such as these which have attracted most international concern since the SLORC came to power. The detention of Aung San Suu Kyi, the 1991 Nobel Peace prize winner, has also served to focus

¹⁴⁷ UN General Assembly, *Situation of Human Rights in Myanmar*, p.30.

¹⁴⁸ See e.g., Amnesty International, *Myanmar: The climate of fear continues, members of ethnic minorities and political prisoners still targeted* (London, 1993), pp.18-21; Human Rights Watch/Asia, *Burma: Rape, Forced Labour and Religious Persecution in Northern Arakan*, pp.6-11; Smith, *Ethnic Groups in Burma*, pp.110-116.

¹⁴⁹ ARTICLE 19, *State of Fear*, p.59.

¹⁵⁰ Burmese Women Union, *The Plight of Burmese Women* (Bangkok, 1995) p.17.

attention on the important role of women in the democracy movement. Suu Kyi herself was finally released in July 1995 after six years under house arrest without trial, but many other women have also been detained over the past seven years. Prominent amongst women political prisoners still held today are the writer, Daw San San Nwe, her daughter, Ma Myat Mo Mo Tun, and Dr Ma Thida. Like Dr Khin Zaw Win, San San Nwe and her daughter were accused in 1994 of anti-government activities and having sent "fabricated news" to the UN Special Rapporteur on Human Rights, receiving ten and seven year sentences respectively, while Ma Thida, who is serving a 20-year sentence, was arrested with the MP-elect, Dr Aung Khin Sint, in a clampdown on NLD supporters the previous year (see 6.3).health?

However in the view of ARTICLE 19, such ill-treatment of women - whether through forced labour, forced relocations or imprisonment - is only indicative of a greater neglect that has developed at the heart of Burmese society during the long years of conflict in which the basic health and human rights of women have long been denied. Every day women in Burma are suffering ill health or dying through causes that should be entirely preventable. In Burma's present state of political crisis, however, such issues receive little or no publicity at all.

As in other sectors of the medical system, the general standards of health care available to women are extremely variable, depending much on class, poverty and region of the country. But at a time of deep social upheaval, many health workers believe that large numbers of women have to bear a "double burden", which is particularly injurious to their health, as both workers and the main carers for the welfare of their families. Although rarely documented, such hardships are at their most obvious in ethnic minority regions where constant relocations and the heavy loss of men in the fighting has left many women having to bring up families alone. In just one border region of the eastern Shan State, for example, the United Wa State Party, which made a cease-fire with the SLORC in 1989, claims that over 12,000 Wa soldiers were killed and many more disabled in 22 years of armed conflict, leaving innumerable widows and orphans without support in an area which, even today, remains beyond the reach of most outside agencies.¹⁵¹

A similar burden of social hardship for women, including poverty and poor access to health care, also exists in many of the relocation sites and satellite new-towns which have been built up across Burma under the SLORC (see 6.2.). These problems have been little studied, but in 1992 one UNICEF consultant warned:

The forced displacement of an already vulnerable group of low-income population, who have suffered from chronic poverty, to an area with extremely poor sanitation and living conditions with little or no job opportunities gives rise to

¹⁵¹ Ta Saw Lu, *The Bondage of Opium*, pp.2-3.

a sequence of socio-economic problems, such as unemployment, abandoned wives and children, induced abortion, increased exposure to STDs/AIDS and malnutrition, which need to be addressed promptly.¹⁵²

Equally disturbing, even where the health evidence is outstanding, the government authorities have remained painfully slow to react. One of the most obvious examples of the longterm neglect of health and women's issues, is the poor provision of sanitation and clean water supplies. Not only are contaminated water or unsanitary conditions a main source for the spread of some of the most prevalent illnesses in Burma, such as hepatitis and intestinal parasitic diseases, but women and their children have traditionally performed the burdensome task of collecting the water. However, according to the government's own figures, by 1990 only 32.1 per cent of the country was estimated to have access to proper sanitation or clean water.¹⁵³ Considerable infrastructural problems remain in any rapid upgrading of facilities. But, somewhat remarkably, despite the massive sums available for expenditure on the armed forces, in the official Programme of Action for the protection of Burma's children the government claimed that any "extension of these services is precariously dependent on the limited support of UNICEF and other agencies."¹⁵⁴

Another major handicap are the poor levels of educational provision that available to many women. In rural areas, especially, it is girls rather than boys who are kept home from school to perform domestic chores or help with the farming, and this has long been reflected in the lower literacy rates for women in a country where only one in four children are estimated to finish primary school. Government figures, for example, generally show a 15 per cent disparity between national literacy rates for men and women, but in ethnic minority areas, where children also have to struggle to learn Burmese as a second language, the gap is even wider, with estimates by community leaders of 80 per cent illiteracy amongst women in some border regions. Indeed, in remote mountain areas across the country, many girls never even attend school. But, as a growing body of international evidence has shown, the education of women is often the key to the health of the whole community. According to UNICEF, for example, "investments in women's education" have resulted in a broad array of social breakthroughs in other parts of the developing world, including falls in infant mortality, improvements in the general nutritional status of families, increased educational achievement

¹⁵² J. Boyden, *Myanmar Children in Especially Difficult Circumstances* (UNICEF, Rangoon, 1992), p.32.

¹⁵³ *National Programme of Action for the Survival, Protection and Development of Myanmar's Children in the 1990s* (Rangoon, September 1993), p.3.

¹⁵⁴ Ibid.

by children and, equally important, higher incomes and productivity in the community.¹⁵⁵

The range of basic health problems, then, that women are facing in Burma today are considerable. In essence, most are attributable to poor living conditions and the lack of access to adequate health care or education. Along with human rights abuses, these are issues which, in the long term, can only be solved by social and political reform.

Two further issues, however, stand out that are of particular relevance to women and which many medical practitioners believe must be confronted by the most immediate action now: the provision of essential reproductive health information and a halt to the continuing traffic of Burmese women into prostitution, where they are especially vulnerable to HIV-infection and the many other dangers of the sex trade.

Possibly the least acknowledged health problem in Burma is that of reproductive health, but as UNICEF recently warned: "The paucity of information on women's reproductive health in Myanmar is in itself an indication that many of their needs are unrecognised."¹⁵⁶ The most obvious indicator of such health neglect of women is Burma's estimated Maternal Mortality Rate of 140? per 100,000 live births, which is third highest in the East Asia and Pacific region.¹⁵⁷ However even these government-admitted figures are based upon hospital statistics, and there are wide regional disparities in Burma with no reliable data at all on deaths occurring in the home, where an estimated 80 per cent of all births take place.¹⁵⁸

Tragically, most of these deaths are happening in conditions of great secrecy and silence. Yet few doctors in Burma have any doubts about their causes. The vast majority are closely inter-linked by a simple lack of access to reproductive health information, contraception and birth spacing programmes.

Abortion is illegal in Burma. As a result, doctors will often attribute maternal deaths that have been caused by botched abortions to other medical causes so as to spare the women's families public embarrassment. However, by all estimates, a shocking 50 per cent of all maternal deaths - estimated by UNICEF in 1992 at 58 women every week¹⁵⁹ - are a direct result of back-street abortions that might have been avoided altogether if reproductive health information and affordable contraception had been available. Shockingly, too, most other

¹⁵⁵ UNICEF, *Children and Women in Myanmar*, p.39.

¹⁵⁶ Ibid., p.13. For a rare, independent study of women's health problems in Burma, see, Frances McConville, *A Rapid Participatory Assessment of the Health Needs of Women and their Children in an Urban Poor Area of Myanmar* (World Vision, 1995), which is based on a three month study of 200 mothers.

¹⁵⁷ UNICEF, *Children and Women in Myanmar*, p.14; *National Programme of Action*, p.2.

¹⁵⁸ Ibid., p.14.

¹⁵⁹ UNICEF, *Possibilities for a United Nations Peace and Development Initiative*, p.2.

fatalities are due to causes which would be equally preventable with adequate health advice, especially concerning common illnesses that are aggravated by pregnancy, such as malaria, hepatitis and malnutrition. For example, over 60 per cent of pregnant women in Burma - or 700,000 women annually - are estimated to suffer from iron deficiency anaemia, while iodine and other nutritional deficiencies are equally prevalent in many areas of the country.¹⁶⁰ Equally important, many doctors believe that the poor nutritional status of mothers is responsible for the high levels of pre-term or low birthweight deliveries in Burma as well as the large numbers of growth-retarded or brain-damaged babies, which leaves yet another legacy of public health care problems for future generations to address.

Very belatedly, then, official attitudes are beginning to change to the question of reproductive health information. This, however, is largely in response to the pandemic spread of AIDS, and much of the population still remains beyond the reach of any public birth spacing programmes. Health workers across the country report that, every day, women of all child-bearing ages continue to resort to all kinds of methods of abortion, ranging from the use of indigenous medicines to induce bleeding to illegal operations carried out by private doctors or the desperate use of quacks who use sticks and other crude implements to abort fetuses for as little as 200 kyats (US\$ 2). Every doctor and midwife in Burma has heart-rending stories to tell of illicit abortions that have gone terribly wrong, often resulting in the deaths of young and frightened mothers. Such incidents, however, are never reported in a conspiracy of silence which all parties prefer to keep until there is a fundamental change in public attitudes and law.

Against this bleak background, the subject of abortion largely remains taboo. But, under the prompting influence of various UN agencies, Burma is slowly moving from a position of neutrality on the question of contraception (which had always been scarce) to one of acceptance of the right to contraception and reproductive health information. For the moment, however, reproductive health education has not been introduced on a countrywide basis within the public health system. Since 1991, birth spacing programmes have been carried out in only 31 townships with the support of UN agencies and the Family Planning International Assistance.

It is now also accepted by both the Health Ministry and international agencies that women are especially vulnerable to the risks of HIV-infection due to a combination of local reasons in Burma, including unprotected intercourse with male partners who are already infected, the frequency of blood transfusions after delivery to pregnant women because of anaemia or poor perinatal care, and the many women working in prostitution in Thailand.

¹⁶⁰ UNICEF, *Children and Women in Myanmar*, pp.14-15; the goitre prevalence rate, which is caused by iodine deficiency, is officially put at 28 per cent.

Indeed, health officials estimate that women constitute at least a third of all cases of HIV-infection in Burma - or over 175,000 individuals, and this already high incidence would appear to be confirmed by all the sentinel surveillance data since 1992.¹⁶¹ As a result, the "Control of HIV/AIDS through Reproductive Health" project was begun in 1993 in joint partnership between the Ministry of Health, UNICEF and the SLORC's preferred NGOs - the MRC, MMCWA and MMA - with additional support from the WHO, UNDP and UN Population Fund (UNPFA). From six initial townships, education programmes that focus on high-risk young women and men had spread to 25 townships by 1995, with projections of expanding services to 103 of Burma's 319 townships by the end of the century. At the same time, in another important shift of policy, priority is being focused on better reproductive health training for midwives, auxiliary nurses and community volunteers who, it is intended, will act as the next generation of educators.

Such an initial burst of activity, however, should in no way deflect attention from the massive task ahead. With widespread restrictions still being imposed on the media, freedom of expression and the right to community participation, many health workers doubt how effective these efforts will be at reaching the most vulnerable and needy members of society. Indeed, since 1988 the official contraception prevalence rate is only estimated to have risen from 13 to between 17 and 22 per cent of the female population of reproductive age, still some way short of the goal set by the Health Ministry and UNPFA of 30 per cent by 1997.¹⁶²

For the moment, the reality is that the majority of women in Burma remain extremely under-informed on reproductive health matters, and such information is not supplied in any systematic way in the state-controlled media. In many areas, superstitious beliefs remain common. Many women, for example, will not take evening baths during pregnancy due to a misguided fear of water retention which, they believe, can cause the loss of their baby.

Compounding these problems, government health centres are invariably underfunded and understaffed, while the over 8,000 local midwives often have impossibly large areas to serve which can become quite inaccessible in the rainy season. As a result, although some effort has been given to the provision of antenatal care in urban areas, an estimated third of all births in Burma still take place without the presence of trained medical personnel, while many women prefer to rely on the variable quality of private medicine for personal reproductive health matters if they have access to the towns. For those who can afford it, this can mean high standards of modern health treatments, including sterilisation for women and vasectomies for men (the latter of which are illegal). But most women are forced to depend

¹⁶¹ Southeast Asian Information Network, *Out of Control*, p.11.

¹⁶² UNICEF, *Country Programme Recommendation: Myanmar* (23 March 1995), Table 1; UNICEF, *Children and Women in Myanmar*, p.16.

on the private market to purchase contraceptives, although many health workers have serious concerns over prescriptions, quality control and medical supervision. Nevertheless, four contraceptive methods are generally available in urban areas today: Depo Progesterone injections, pills, intrauterine devices and condoms, the last of which are usually only purchased by men and are unpopular with married couples since they have traditionally been associated with prostitution.

As Burma's reproductive health programmes expand, such questions as condom use, health rights and birth control will inevitably lead to more issues that require full public explanation and debate. Already there have been reports of dissension amongst Muslim communities in the Rakhine State, where the recent availability of Depo Progesterone injections (in government health programmes?) has led to rumours, largely spread by men, that the SLORC wants to sterilise all Muslim women and increase the Buddhist population as a form of social policy control. In the Rakhine State, as elsewhere in Burma, ethnic population statistics remain one of the most contentious, though least publicised, political issues of the day.

However it is over health education and contraceptive use to stop the spread of HIV/AIDS and other sexually-transmitted diseases that the most serious challenges are likely to be faced. In many respects, this problem is tightly interlinked with the final secretive health issue in Burma today: prostitution. A deeply conservative country, imbued with Buddhist traditions, the existence of prostitution is rarely publicly acknowledged in Burma itself and remains strictly illegal. Yet perhaps no health issue more clearly demonstrates the close connection between censorship, the vulnerability of uneducated women and the importance of access to essential health information to allow citizens to make informed choices about personal lifestyles and health.

The scale of indigenous prostitution in Burma is impossible to calculate. Much of the trade is extremely shadowy and mobile, with many young women - sometimes as young as 12 - frequently moving house or directly being brought to clients at night while under the control of different madames and pimps. Some are forced to enter prostitution to support their families, while others have taken up this trade while trying to eke out a living on the streets. However, by all estimates, the number of active commercial sex workers has increased dramatically in response to the social and economic upheavals in Burma since 1988. In major towns, restaurants or night-clubs often operate as thinly-disguised brothels, while in the mining boom-towns of the northeast many small brothels openly exist. Over 100 brothels, large and small, are operational in the Hpakhan jade mine area alone, where high rates of HIV-infection have been recorded amongst intravenous drug users (see 7). Elsewhere, many commercial sex workers simply move around the country as traders or work out of roadside

tea-shops and restaurants as part of the massive internal migration of peoples in the country today.¹⁶³

The levels of health ignorance expressed by many of these young women are often astonishing. Under the 1949 Prostitution Suppression Act, four training schools, with capacity for up to 600 former sex workers, have been set up in Rangoon, Mandalay, Myeik (Myait?) and Kengtung under the Department of Social Welfare.¹⁶⁴ As a result, these women were targeted for some of the first HIV-testing and AIDS awareness programmes in Burma. But of 78 residents interviewed in 1994 by UNICEF in one training school, 70 per cent had sexually-transmitted diseases and seven were HIV-positive; moreover, 98 per cent had no knowledge of AIDS or how it could be prevented.¹⁶⁵

Burmese doctors, however, believe that women who have been working in the sex industry in neighbouring Thailand run the risk of even greater exposure to HIV/AIDS and other health dangers. Here AIDS and other sexually-transmitted diseases are endemic in the sex industry. Male emigrants who frequent prostitutes in Thailand, especially seamen and labourers, are also carrying the HIV virus back to Burma, but this entire population group remains largely unidentified and inaccessible. For this reason, it is women who have often been the focus of most health education concern.

The numbers of women and girls from Burma working in prostitution in Thailand is undoubtedly large, with estimates of up to 40,000 at any one time today. Frequently advertised as AIDS-free but without adequate language skills, many are forced to work at the cheapest and most dangerous end of the market, where rates of up to 90 per cent HIV-infection have been recorded. In recent years, the appalling health conditions under which many Burmese women are working have been increasingly well documented. In some brothels a form of debt bondage exists, and beatings and over 15 deaths have been reported.¹⁶⁶

In response to such international health and human rights concerns, in 1993 the Chuan government launched a suppression policy against the sex industry, but although there are now fewer brothels the number of sex workers - whether Thai or immigrant - has not markedly decreased. Young women from Burma still form a substantial proportion of the sex workers in many borderland areas, especially in Chiang Mai and northern Thailand and in the border sea-port of Ranong (opposite Kawthaung), where much of the business is today conducted out of restaurants.

¹⁶³ Porter, *Wheeling and Dealing*, p.69.

¹⁶⁴ UNICEF, *Children and Women in Myanmar*, p.65.

¹⁶⁵ Ibid., p.38. Fifteen of the young women were below the age of 18.

¹⁶⁶ Smith, *Ethnic Groups in Burma*, 113-6; Human Rights Watch/Asia, *A Modern Form of Slavery*.

The reasons why so many women from Burma have ended up in prostitution in Thailand are many. Some have been lured, others have been forced - but the one common denominator is poverty and lack of education. The majority of the women are thought to be ethnic minorities, especially Shans, Lahus, Akhas, Karens and Mons from borderland regions where illiteracy rates amongst women are often appalling. For example, one recent survey of AIDS awareness amongst nearly 200 young people in the Shan State recorded that 72.4 per cent of women were illiterate as against only 24.5 per cent of men; moreover in impoverished rural areas female illiteracy reached 86.2 per cent.¹⁶⁷ Perhaps little wonder, then, that the bright lights of the boom-time economy of Thailand, where over 350,000 refugees and migrants from Burma are living today, appears to offer a brighter future than their own home villages. According to one survey for UNICEF, in some Shan communities ? are working in prostitution in Thailand at any one time.

In the view of ARTICLE 19, therefore,

9. THE INTERNATIONAL PERSPECTIVE

Whatever is publicly said, few international organisations - whether governmental or non-governmental - have any illusions about the underlying problems of working in Burma today. The country's political and economic difficulties are outstanding. But as Madeleine Albright, U.S. Permanent Representative to the UN, explained after a recent visit to Burma:

For years, controversy has surrounded programs conducted within Burma by United Nations agencies, including UNICEF and the UNDP. Their efforts raise a classic policy dilemma: how to help people living under despotism without helping the despots themselves.¹⁶⁸

Nevertheless, as the door to Burma slowly opens, immediately divergent views have been expressed over the relative merits of "constructive engagement" pursued by Asian neighbours and many multinational businesses in helping achieve reform and the policies of conditionality or boycotts of the SLORC that have been supported by most opposition parties, human rights groups and several governments in the West. During such arguments, the questions of health and humanitarian care for all the Burmese peoples inevitably becomes hostage to the political debate.

In many respects, the same divisions over approaches have affected many of the UN, NGO and international aid organisations which work on Burma. It is the political future and

¹⁶⁷ Porter, *Wheeling and Dealing*, p.73.

¹⁶⁸ Madeleine Albright, "Burmese Daze", *The New Republic*, 4 December 1995 and reproduced in *Burma Debate*, November/December 1995, p.19.

health of the Burmese peoples that are under discussion, but institutional self-interest is undoubtedly a powerful factor. In recent years, the arguments over international aid and development involvement in Burma have become a well-rehearsed subject¹⁶⁹, but discussions over ethics and effective actions can quickly degenerate into arguments over a hierarchy of needs. The selective use of evidence on a whole array of health and humanitarian issues - from human rights abuses or heroin production to high infant mortality rates and the spread of AIDS - can produce very different justifications for institutional actions over Burma.

All groups are looking at the same broad body of problems (and, in health matters, share many of the same views), but often come to describe these problems in very different language. Indeed, some international reports in recent years have often given the impression that there are two Burmas: one as "Asia's New Killing Fields", where gross human rights abuses are endemic, and the other as a belated model of Asian development, where international agencies working in the country achieve nothing but successes. Here self-censorship plays a critical part, not only to be allowed to continue operations in the country but also, as the experience of the ex-UNICEF worker Dr Khin Zaw Win has warned, to protect the security of employees who will be living in Burma long after they have gone.

Out of recent experiences, nevertheless, a general pattern of behaviour in the health field has evolved. Provided that various foreign exchange and non-interference qualifications are met, there is now an implicit international understanding, supported by the European Union and other world bodies, that humanitarian aid must be prioritised in the case of refugees and emergency while, in developmental terms, projects which are based at the community level are acceptable. This was highlighted in May 1992 when the UNDP's Governing Council undertook a complete reassessment of programmes in Burma to refocus future projects on the basis of "human development initiatives" at the "grass-roots level".¹⁷⁰ Since this time, in both NGO and UN language there has been much concentration on such terms as "capacity building", "community development", "community participation", "social mobilisation" and "integrated participatory planning at the village/grassroots level" in assessing the sustainability and impact of projects.¹⁷¹

The key question, however, remains whether such international programmes will achieve their goals. There can no doubt, for example, that improved clinical skills, modern

¹⁶⁹ See e.g., Harn Yawngnaw, "Engaging the Generals" and Martin Smith, "Humanitarian and Development Aid to Burma" in *Burma Debate*, July/August 1994, pp.4-9 and 16-21; World Vision, *The Role of NGOs in Burma* (Milton Keynes, 1995).

¹⁷⁰ See, UNDP, *Summary Report: UNDP Assistance to Myanmar*; Agrotech Canada, *UNDP's Myanmar Human Development Initiative*.

¹⁷¹ See e.g., *Ibid.*, pp.2-9; World Vision, *Report on Review of The AIDS Awareness*, pp.1-2.

diagnosis techniques and improved immunisation and sanitation programmes will benefit the levels of health care for those to whom it is available. Opposition groups, in contrast, contend that, while Burma's political impasse continues, present international projects are just a drop in the ocean in terms of human needs. Moreover Burma itself has many able doctors and health workers who are only too willing to take on many of these important tasks once the perennial problems of security restrictions, underfunding and poor management are addressed. Indeed, far from focusing on the "grass-roots" level, many medical practitioners believe that an important first step in any reform of the country's health system will be strengthening and upgrading the delivery capacity of the Health Ministry and public system of medical care which, in any nation in the world, is the main line in health defence and co-ordination.

Huge doubts, then, must remain about the quality or impact of international initiatives unless they are accompanied by political reform, in which the rights to freedom of expression, research and information are restored to all of Burma's peoples. In ARTICLE 19's view, all such rights, including the ability of NGOs to function, are dependent on the creation of a civil society. However as Prof. David Steinberg, a veteran Burma specialist and representative of the Asia Foundation in Korea, has recently written: "Burma today effectively has no civil society....In a sense the SLORC has been attempting to create its own civil society - one that it controls".¹⁷²

For the present, it is the SLORC alone which is determining not only which international organisations can enter the country, but where and how they can work and even what supplies or funds they can import and distribute. At the same time, many NLD supporters and ethnic cease-fire forces claim that they are being discriminated against and even blocked from making the same international and developmental contacts from inside the country. This has resulted in some very contradictory images of what is considered real community development in Burma today. For example, in an AIDS training course run in 1994 by World Vision for "community development groups" in Kawthaung, only three such "CDGs" were represented: the MMCWA, MRC and USDA, all of which are considered as semi-governmental institutions by most Burmese citizens.

Thus, far from bringing the benefits of immediate health care and grass-roots participation to the community, many opposition groups argue that it is the government which is gaining both legitimacy and empowerment out of this process. This led the NLD in January 1996 to unveil its own economic and development plans, requesting that, in future, the UNDP should consider ways of implementing projects through the NLD as the legally-elected

¹⁷² Steinberg, *Civil Society in Burma*, p.7.

government of Burma. The ball was thus back in the political court, but the underlying dilemmas still remained. As Aung San Suu Kyi herself once explained:

People's participation in social and political transformation is the central issue of our time. This can only be achieved through the establishment of societies which place human worth above power, and liberation above control. In this paradigm, development requires democracy, the genuine empowerment of the people.¹⁷³

(History has long since shown that, all too often, international agencies underestimate the political realities of Burma.)

10. RECOMMENDATIONS

Despite the background of grave neglect of health rights and human rights outlined in this report, the situation is not irredeemable. After decades of isolation, an important generational shift is now taking place in the direction of Burmese politics with social and economic consequences that remain very unpredictable. All sides, nevertheless, recognise the need for change. Whatever the international dimensions, the great majority of Burma's present problems have become self-inflicted.

Amongst the Burmese peoples today there is a great energy and desire to confront the many social, ethnic and political problems that have confronted the country since independence in 1948. Whether in the democracy protests of 1988, the NLD's 1990 election victory, the ethnic cease-fire movement, the statements of senior military officers, or the new access permitted by the central government to international organisations, over the past eight years there has been persistent acknowledgement of the need to take advantage of this historic opportunity for change. For the moment the political process may appear paralysed, but still many Burmese citizens believe that the possibility of real dialogue and national reconciliation lie tantalisingly around the corner.

In this respect, the question of health and humanitarian reform have been singled out as neutral, but critical, building blocks in the bid to modernise Burmese society and confront the many new challenges of the developing world. Structurally, the system still exists for a quick response in most government-controlled areas, but efficacy leaves much to be desired and there remain vast areas beyond any effective outreach. Indeed, in many parts of the

¹⁷³ Daw Aung San Suu Kyi, *Empowerment for a Culture of Peace and Development*, address to the World Commission on Culture and Development, Manila, 21 November 1994, delivered by Mrs Corazon Aquino.

country, the national health system is still beginning at "Year Zero".

Therefore, while welcoming the gradual steps in openness and , ARTICLE 19 believes that there is still a long way to go if such efforts are really to translate into substantive social reform to the betterment of all the Burmese peoples. In particular, in the health field, ARTICLE 19 calls upon the government:

- to invite the ICRC to return to Burma as soon as possible and allow it every access, under international standards, to the country's prisons and detainees;
- to release, immediately and unconditionally, Dr Ma Thida, Dr Khin Zaw Win, Dr Zaw Myint, Dr Zaw Myint Maung and all other medical practitioners and prisoners detained for the peaceful expression of their political beliefs;
- to reinstate all medical practitioners and health workers who have been dismissed from their jobs on the grounds of their political beliefs;
- to allow medical practitioners, academics and writers to research and report health studies in Burma free from censorship or restrictions on freedom of association and travel;
- to immediately end forced labour, forced relocations, torture, sleep or food deprivation and all other human rights abuses that violate universal humanitarian law and have a detrimental impact on the health of Burma's citizens;
- to sign and ratify the Covenant on Civil and Political Rights, the Covenant on Economic, Social and Cultural Rights and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;
- to ensure that all refugee or resettlement programmes are conducted under proper international safeguards and with independent monitoring, and that all refugees are fully informed of their rights under international humanitarian law, including the right to refuse repatriation;
- to inform all citizens fully, whether refugees, displaced peoples or other local inhabitants, about prevailing social and political conditions that are essential for their health and welfare;
- to strengthen the capacities of civil society by allowing indigenous NGOs and parties in Burma to participate in the elaboration of health policy, including research, training, networking, public education and policy discussion on all health issues;
- to undertake, as an urgent matter of respect for the health rights of all citizens, substantive educational programmes that spread awareness at both the national

and community levels about such everyday health issues as malaria, leprosy, the physically-disabled and malnutrition that drastically affect the lives of so many citizens;

- to also target the particular problems of both AIDS and drug abuse and open up both subjects to free discussion and debate, without which lasting solutions to these still burgeoning health issues will never be found;
- to sign the Convention on the Elimination of All Forms of Discrimination against Women and give particular concentration to the health rights and problems of women, especially concerning reproductive health;
- to recognise the particular health problems and discrimination faced by ethnic minority peoples by allowing the publication of locally-produced health materials and fostering the training of local health workers and doctors;
- to ensure that all medicines on sale or prescribed in Burma are properly labelled and that all citizens are adequately informed of their legitimate health rights;
- to allow international health and development organisations - whether UN, governmental or non-governmental - to conduct health and humanitarian programmes in Burma, free from day-to-day military presence or supervision;

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Censorship has long concealed a multitude of grave issues in Burma, but the country's humanitarian crisis is one of the most neglected. International covenants on the protection of health rights are being ignored, while the long-suffering peoples of Burma have no right of access to information or freedom of expression about the vital health issues that so desperately affect their daily lives. From AIDS and heroin addiction to malnutrition and the high rates of maternal mortality caused by back-street abortions, many of Burma's health problems have long flourished amidst a climate of ignorance and secrecy. It is into this complex social environment that the first foreign non-governmental health agencies are returning to Burma in decades. This report, however, examines whether any real advances can be made in medical aid and humanitarian protection until political reform is introduced and the right to freedom of expression and the enjoyment of fundamental human rights is restored after over 30 years of military rule.

