

THE GATHERING STORM

**INFECTIOUS DISEASES AND
HUMAN RIGHTS IN BURMA**
JULY 2007



HUMAN RIGHTS CENTER, UNIVERSITY OF CALIFORNIA, BERKELEY
CENTER FOR PUBLIC HEALTH AND HUMAN RIGHTS
JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH



**Human Rights Center
University of California, Berkeley**

The Human Rights Center investigates war crimes and serious violations of human rights worldwide. Using empirical research methods, our projects give voice to victims of mass violence and support efforts to bring those responsible to justice. As a member of the campus community, we offer interdisciplinary courses, training seminars, and fellowships to prepare the next generation of human rights researchers and advocates.

**Center for Public Health and Human Rights
Johns Hopkins Bloomberg School of Public Health**

The Center for Public Health and Human Rights investigates the impact of human rights abrogation on the health of populations and develops rights-based approaches to public health challenges. We endeavor to bring the tools of population-based sciences to bear on complex health and rights interactions. The Center includes public health professionals, researchers, health workers, and advocates, dedicated to improving health and promoting social justice through education, research, and advocacy in accordance with the International Declaration of Health Rights. We recognize the role that repressive laws and social discord play in the health of populations and work to implement evidence-based approaches in the development of public health interventions. It is our mission to conduct research and translate it into practical policy alternatives that can foster health and dignity.

Photographs by Nic Dunlop.

The Gathering Storm

Infectious Diseases and Human Rights in Burma

July 2007

Eric Stover
Voravit Suwanvanichkij
Andrew Moss
David Tuller
Thomas J. Lee
Emily Whichard
Rachel Shigekane
Chris Beyrer
David Scott Mathieson

Human Rights Center
University of California, Berkeley

&

Center for Public Health and Human Rights
Johns Hopkins Bloomberg School of Public Health

Contents

- Map of Burma v**

- Acronyms..... vii**

- 1. Executive Summary 1**

- 2. Introduction..... 11**
 - Limitations 12
 - Governance, Human Rights, and Infectious Diseases..... 13

- 3. Background 17**
 - Militarization..... 17
 - The Union Solidarity and Development Association 19
 - Counter-Insurgency and the “Four Cuts” Policy 20
 - Armed Conflict and Health..... 21
 - Forced Labor 21
 - Political Prisoners and Child Soldiers 22
 - Censorship and Freedom of Association 22
 - Education 23
 - The Courts and Political Reform..... 24
 - The Economy 25
 - The Drug Trade..... 27
 - Opium Eradication and Human Rights..... 30
 - The United Nations 31
 - The Future..... 31

- 4. The Politics of Foreign Aid 33**
 - Humanitarian Aid and Human Rights 34
 - The Challenges and Obstacles of Humanitarian Aid 37
 - The Global Fund 38
 - Médecins Sans Frontières (MSF-France) 42
 - Government Restrictions on International Organizations 42
 - International Committee of the Red Cross 43
 - Other International Relief Organizations..... 45
 - The Three Diseases Fund..... 46
 - Guiding Principles for the Provision of Humanitarian Assistance 49
 - Conclusion 50

5. Burma.....	53
HIV/AIDS.....	57
Malaria.....	64
Tuberculosis.....	68
Lymphatic Filariasis.....	70
Avian Influenza.....	72
Conclusion.....	74
6. China-Burma Border Region.....	77
Background.....	77
Drugs.....	80
Infectious Diseases.....	81
<i>HIV/AIDS</i>	81
<i>Malaria</i>	86
Conclusion.....	91
7. Thai-Burma Border Region.....	93
Background.....	94
Ethnic Groups.....	96
Drugs.....	97
Violations of Human Rights and International Humanitarian Law.....	98
Migration.....	100
Health Indicators.....	100
Infectious Diseases.....	104
<i>HIV/AIDS</i>	104
<i>Tuberculosis</i>	107
<i>Malaria</i>	109
<i>Filariasis</i>	112
<i>Other Infectious Diseases</i>	114
Conclusion.....	115
8. Bangladesh-Burma Border Region.....	119
Introduction.....	120
Arakan State and Southeastern Bangladesh: A Long and Complex History.....	122
The Border Region.....	125
HIV/AIDS.....	128
Malaria.....	130
Tuberculosis.....	131
Polio.....	132
Conclusion.....	133

9. Indo-Burma Border Region.....	135
Indo-Burma Relationship.....	136
Ethnic Groups and Human Rights Abuses	139
Local Ethnic Health Organizations	143
Drugs	144
Infectious Diseases	146
<i>HIV/AIDS</i>	<i>146</i>
<i>Tuberculosis</i>	<i>150</i>
<i>Malaria</i>	<i>151</i>
Conclusion	153
10. Conclusions and Recommendations	155
Authors and Acknowledgements	163
Acknowledgements	164
Appendix:	165
Guidelines for UN Agencies, International Organizations and NGO/INGOs on Cooperation Programme in Myanmar	165

Map of Burma



© Karen Human Rights Group (KHRG) 2007

Scale: 1 to 800,000

Acronyms

3D Fund	Three Diseases Fund
AFP	<i>Agence France-Presse</i>
AIDS	Acquired Immune Deficiency Syndrome
ALP	Arakan Liberation Party
ANC	Antenatal care
ARHP	Asia Regional HIV/AIDS Project
ART	Antiretroviral therapy
ASEAN	Association of South East Asian Nations
ASP	Additional Safeguard Policy (Global Fund)
ATS	Amphetamine-type stimulants
AUSAID	Australian Agency for International Development
AZG	<i>Artsen Zonder Grenzen (Médecins Sans Frontières–Holland)</i>
BBC	British Broadcasting Corporation
BCP	Burma Communist Party
BIMSTEC	Bangladesh, India, Myanmar, Sri Lanka and Thailand Economic Cooperation
BPHWT	Back Pack Health Worker Team
CBO	Community-based organization
CBPHWT	Chin Back Pack Health Worker Team
CHRO	Chin Human Rights Organization
CNF	Chin National Front
CPE	Complex political emergency
CPI	Corruption Perceptions Index
CQ	Chloroquine
CRS	Catholic Relief Services
DDT	Dichloro-diphenyl-trichloroethane
DFID	Department for International Development (UK)
DKBA	Democratic Karen Buddhist Army
DOTS	Directly observed treatment short course
DPU	Dedicated People’s Union
EGAT	Electricity Generating Authority, Thailand
EU	European Union
FAO	UN Food and Agriculture Organization
FHAM	Fund for HIV/AIDS in Myanmar (Burma)
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
HELP	Health and Education for the Less-Privileged People
HRC	Human Rights Center, UC Berkeley
HU	Health Unlimited
HURFOM	Human Rights Foundation of Monland
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICG	International Crisis Group
ICRC	International Committee of the Red Cross
IDP	Internally displaced person

Acronyms

IDU	Injecting drug user
ILO	International Labour Organization
IMNA	Independent Mon News Agency
INGO	International nongovernmental organization
IPS	International Press Service
ITFDE	International Task Force for Disease Eradication
ITN	Insecticide-treated net
KDHW	Karen Department of Health and Welfare
KHRG	Karen Human Rights Group
KIO	Kachin Independence Organization
KNLA	Karen National Liberation Army
KNPLF	Karenni National People's Liberation Front
KNPP	Karenni National Progressive Party
KNU	Karen National Union
KWO	Karen Women's Organization
LNDO	Lahu National Development Organization
MDA	Mass drug administration
MDR	Multi-drug resistant
MEC	Myanmar Economic Cooperation
MMCWA	Myanmar Maternal and Child Welfare Association
MOU	Memorandum of Understanding
MSF	<i>Médecins Sans Frontières</i>
MSM	Men who have sex with men
MTC	Mae Tao Clinic
NACO	National AIDS Control Organization
NAP	National AIDS Programme
NGO	Nongovernmental organization
NLD	National League for Democracy
NSCN	National Socialist Council of Nagaland
NTP	National Tuberculosis Program
NUP	National Unity Party
OECD	Organisation for Economic Cooperation and Development
OSI	Open Society Institute
PCR	Polymerase chain reaction
PELF	Programme to Eliminate Lymphatic Filariasis
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand
PSI	Population Services International
PSLP	Palaung State Liberation Party
PWO	Palaung Women's Organization
RWU	Rakhaing Women's Union
SEARO	South-East Asia Regional Office (WHO)
SHAN	Shan Herald Agency for News
SHRF	Shan Human Rights Foundation
SP	Sulfadoxine-pyrimethamine
SPDC	State Peace and Development Council
SRDC	Shan Relief and Development Committee

SSA-S	Shan State Army–South
STI	Sexually transmitted infection
SWAN	Shan Women's Action Network
TB	Tuberculosis
TBBC	Thailand Burma Border Consortium
TCP	Targeted Condom Promotion
ULFA	United Liberation Front of Assam
UMEH	Union of Myanmar Economic Holdings
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFAO	United Nations Food and Agriculture Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
USAID	U.S. Agency for International Development
USDA	Union Solidarity and Development Association
USP-DQI	United States Pharmacopeia Drug Quality and Information Program
UWSA	United Wa State Army
VBDC	Vector Borne Disease Control
WCRP	Women and Child Rights Project
WFP	World Food Programme
WHO	World Health Organization
YMA	Young Mizo Association

1. Executive Summary

Decades of repressive military rule, civil war, corruption, bad governance, isolation, and widespread violations of human rights and international humanitarian law have rendered Burma's¹ health care system incapable of responding effectively to endemic and emerging infectious diseases.² Burma's major infectious diseases—malaria, HIV/AIDS, and tuberculosis (TB)—are severe health problems in many areas of the country. Malaria is the most common cause of morbidity and mortality due to infectious disease in Burma. Eighty-nine percent of the estimated population of 52 million lived in malarial risk areas in 1994, with about 80 percent of reported infections due to *Plasmodium falciparum*, the most dangerous form of the disease.³ Burma has one of the highest TB rates in the world, with nearly 97,000 new cases detected each year.⁴ Drug resistance to both TB and malaria is rising, as is the broad availability of counterfeit antimalarial drugs. In June 2007, a TB clinic operated by Médecins Sans Frontières–France in the Thai border town of Mae Sot reported it had confirmed two cases of extensively drug-resistant TB in Burmese migrants who had previously received treatment in Burma. Meanwhile, HIV/AIDS, once contained to high-risk groups in Burma, has spread to the general population, which is defined as a prevalence of 1 percent among reproductive-age adults.⁵

Meanwhile, the Burmese government spends less than 3 percent of national expenditures on health, while the military, with a standing army of over 400,000 troops, consumes 40 percent.⁶ By comparison, many of Burma's neighbors spend considerably more on health: Thailand (6.1%⁷), China (5.6 %⁸), India (6.1%⁹), Laos (3.2%¹⁰), Bangladesh (3.4%¹¹), and Cambodia (12%¹²).

¹ This report uses the name Burma rather than Myanmar. This is the form preferred by the leaders of Burma's pro-democracy movement, the legitimate winners of the 1990 elections. In Burma, "Bamah" and "Myanma" have both been used for centuries, being respectively the colloquial and the more formal names of the country in the Burmese language.

² The International Crisis Group reported in December 2006: "According to the UN resident coordinator, the situation [in Burma] does not yet qualify as a humanitarian crisis but 'there are geographic pockets of acute need in the country as well as aspects of suffering that constitute both a national and regional emergency,' and conditions continue to deteriorate. The country, he warns, is not only losing the fight to stop the progression of serious health epidemics within the general population but also the skills and capacities necessary to cope with these and other development challenges." International Crisis Group, *Myanmar: New Threats to Humanitarian Aid*, Crisis Group Asia Briefing No. 58, December 8, 2006 at 3.

³ See Frank Smithuis, *Treating and Preventing Malaria in Myanmar*, Amsterdam: Médecins Sans Frontières–Holland, 2006 at 9.

⁴ See Ministry of Health, *Health in Myanmar 2005* at 63.

⁵ See Jon Cohen, "The Next Frontier for HIV/AIDS: Myanmar," *Science*, 301:5640, September 19, 2003, 1650–55.

⁶ Budget data from the Burmese military authorities varies considerably. Many sources quote official health expenditures of 3 percent per annum. See, for example, World Food Programme, "Myanmar must do more to help its hungry millions," press release, August 5, 2005. However, foreign diplomats in Rangoon have reported that the official 2006/2007 budget for health is 2.4 percent. Moreover, it is unclear how much of the official health budget represents foreign aid dollars, which has been placed at 13 percent.

⁷ This is the figure for 2000. See Ministry of Public Health, Royal Thai Government at www.moph.go.th/ops/thealth.

⁸ This figure is for 2003. See *China Statistical Yearbook, 2003 and 2004*, National Bureau of Statistics (China Statistical Press).

⁹ This figure is for 2002. See *National Health Accounts*, World Health Organization, 2005.

In response to the Burmese government's chronic neglect to care for the health of its citizens, UN agencies and international aid organizations began arriving in Rangoon in the 1990s. Under the watchful eye of the military authorities, they launched programs aimed at lessening the burden of infectious diseases, and by 2004, 41 aid organizations were operating in Burma with a total budget of approximately \$30 million. That same year, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) signed a contract with the United Nations Development Programme (UNDP) to disperse \$98.4 million over a five-year period to combat infectious diseases in Burma.

But in August 2005 the Global Fund terminated the contract, explaining that new travel restrictions imposed by the Burmese government had severely limited the ability of the UNDP and its implementing partners to access project sites. Four months later, Médecins Sans Frontières–France (MSF) announced it was pulling out of Burma for similar reasons, and the International Committee of the Red Cross (ICRC) said it had suspended visits by its medical staff to prisons because the Burmese authorities had insisted that ICRC doctors be accompanied by members of the Union Solidarity and Development Association (USDA), a junta-backed social organization with direct ties to military leaders, including Senior General Than Shwe. In February 2006, the Burmese government issued guidelines to international organizations formalizing the kinds of travel restrictions that had led to the departure of the Global Fund and MSF–France.

To fill the breach left by the Global Fund's withdrawal, the European Union, along with Australia, Britain, the Netherlands, Norway, and Sweden, launched the "Three Diseases Fund," or 3D Fund, in October 2006. The fund, worth \$99.5 million over five years, aims to bypass the central government to provide aid to UN agencies, international and local nongovernmental organizations, and "civilian administrations" to fight infectious diseases in Burma. The 3D Fund will "target those most at risk of being infected by each of the three diseases, with a particular focus on those who have limited or no access to public health services due to geographical or security considerations, or for reasons of ethnicity, gender, stigmatization or financial status."¹³ The 3D Fund has stated that its resources will "be used effectively, efficiently, transparently, accountably and equitably ... with an emphasis on achievement of programme outputs."¹⁴

Against this background, our two centers—Human Rights Center, University of California, Berkeley and the Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health—launched a research project in July 2006 to understand the factors that have contributed to Burma's dire health situation and to the spread of infectious diseases in Burma and across its borders. We also wanted to see if it was possible to deliver international aid to combat infectious diseases in Burma in a manner that would be transparent and accountable, reach those most in need, and promote respect for human rights and international humanitarian law.

¹⁰ This figure is for 2003. See <http://www.who.int/countries/laos>.

¹¹ This figure is for 2003. See <http://www.who.int/countries/bangladesh>.

¹² This figure is for 2002. See *National Health Accounts*, World Health Organization, 2005.

¹³ United Nations Office for Project Services, *Three Diseases Fund: Assessing Funding, Handbook for Implementing Partners*, Rangoon, Myanmar, 2007 at 6.

¹⁴ Information about the Three Diseases Fund can be found at <http://www.3dfund.org>. The quote appears in a strategic paper entitled "Proposal: Three Diseases Fund, 16 May 2006" provided to the Human Rights Center (HRC), University of California, Berkeley by UNDP in August 2006. The strategic paper is on file at HRC.

We began our research by dispatching teams of researchers to Rangoon and the border regions of China, Thailand, Bangladesh, and India. During these missions, researchers gathered data about infectious diseases—primarily HIV/AIDS, tuberculosis, malaria, and lymphatic filariasis—from health clinics operated by local governments and nongovernmental organizations. The teams also interviewed health professionals, government officials, and representatives of nongovernmental and community-based organizations that operate preventative programs and provide therapeutic care to patients. After the initial trip, researchers made repeat visits to Burma and the border regions of Thailand and India to collect further information. In addition, one of our researchers interviewed staff members of the Global Fund in Geneva and representatives of the European Union in Bangkok charged with drafting the strategic plan for the 3D Fund. All interviews were conducted in accordance with procedures established by the Office for the Protection of Human Subjects of the University of California, Berkeley and Johns Hopkins University.¹⁵

This report is premised on four precepts related to health and human rights (see “Introduction”). First, successful public health infrastructures, programs, and outcomes are usually a result of good governance and a respect for human rights. Second, respect for human rights and international humanitarian law helps to ensure accountability, transparency, responsible use of health expenditures, and rapid and equitable delivery of relief in areas of armed conflict. Inversely, serious violations of human rights and international humanitarian law that affect the movement of large population groups can cause or exacerbate the spread of infectious diseases. This is particularly true among migrant or internally displaced populations who generally lack access to appropriate health services. Third, as the World Health Organization (WHO) affirmed in 2001, public health interventions for vulnerable groups are most effective if they also succeed in respecting, protecting, and fulfilling the rights of people marginalized by society.¹⁶ Finally, donors and nongovernmental organizations working in the health sector, especially in countries with highly repressive regimes, have a responsibility to respect and promote the human rights of those they serve.

We offer the following conclusions and recommendations:

Health Care System in Burma

- ***The Government of Burma must develop a national health care system that is participatory and incorporates human rights so as to ensure that health care is distributed effectively, equitably, and transparently.*** Promoting participation as a feature of health system reform is now commonplace. With the rise of Primary Health Care in the 1970s, community involvement was seen as an essential ingredient of a nation’s health improvement. More recently, the emphasis has shifted to stakeholder consultation in sector reform. With the rise of rights-based approaches, emphasis is increasingly being placed on the participation of service users not as “beneficiaries” or “consumers” but as citizens who have the right to have a say in shaping health care policies. Community

¹⁵ Given the sensitivity of the topic, we have erred on the side of caution and chosen not to provide the names of most of those we interviewed.

¹⁶ World Health Organization, *Transforming Health Systems: Gender and Rights in Reproductive Health—A Training Curriculum for Health Programme Managers*, WHO/RHR/01.29, Geneva, 2001.

participation in the promotion and implementation of prevention and treatment programs is essential in any campaign to combat infectious diseases.

Burma must develop a health care system that provides medical treatment and preventative care to all citizens, especially the most marginalized members of society including the very poor, ethnic and religious minorities, refugees and the displaced, persons living in conflict and cease-fire zones, and persons belonging to socially stigmatized groups including commercial sex workers, injecting drug users, and men who have sex with men.

- ***The Government of Burma should increase its expenditures in health and education.*** Decades of neglect by Burma's military government have turned the country into an incubator of infectious diseases. Those of gravest concern are HIV/AIDS, tuberculosis, malaria, acute respiratory infections, filariasis, and diarrheal diseases. The authorities have a responsibility to protect the people of Burma and residents of neighboring countries to turn back the spread of communicable diseases. Such an effort requires both public health measures and providing citizens with increased access to both formal and informal education. Schools are places not only for teaching traditional academic subjects, but also for disseminating information about measures that can be taken to halt the spread of infectious diseases. Military expenditures should be reallocated to support health and education. Burma is not at war with its neighbors, and its security is more profoundly threatened by the rise of drug-resistant malaria and tuberculosis, and emerging communicable diseases such as avian influenza and recrudescing polio myelitis, than from external military threats.

Donors and International Aid Organizations

- ***Donors and international aid organizations operating in Burma have a duty to uphold and promote internationally accepted standards of human rights and international humanitarian law.*** Donors and international aid organizations should put into practice the "Principles for Good International Engagement in Fragile States & Situations" drafted by the Organisation for Economic Co-operation and Development (OECD) in 2005. Principle 6 states: "Real or perceived discrimination is associated with fragility and conflict, and leads to service delivery failures. International interventions in fragile states¹⁷ should consistently promote gender equality, social inclusion and human rights. These are important elements that underpin the relationship between state and citizen, and form part of long-term strategies to prevent fragility. Measures to promote the voice and participation of women, youth, minorities and other excluded groups should be included in state-building and service delivery strategies from the onset."¹⁸
- ***The Government of Burma should immediately rescind the "Guidelines for UN Agencies, International Organizations and NGOs/INGOs on Cooperation Programme in***

¹⁷ States are fragile when state structures lack political will and/or capacity to provide basic functions needed for poverty reduction, development, and to safeguard the security and human rights of their populations.

¹⁸ The full set of principles can be accessed through the OECD web site at <http://www.oecd.org>

Myanmar” (See Appendix). These Guidelines, issued by the Ministry of National Planning and Economic Development in February 2006, directly contravene several formal agreements established between international organizations and the Burmese government since the early 1990s. They also contravene several international agreements on effective aid delivery, including the Paris Declaration on Aid Effectiveness, which was endorsed by the European Union, 27 regional and international institutions, including the World Bank and the Asian Development Bank, and over 90 countries in Paris in 2005. The Guidelines have restricted the work of international organizations, especially ICRC, operating in Burma. While aid to Burma should not be considered optional given the dire need, the “exigencies of need” should never override the ability of organizations to access project sites on a regular and unhindered basis to ensure that aid is being delivered in a manner that is transparent, accountable, efficient, and equitable. The Guidelines are antithetical to this fundamental principle.

- ***The Government of Burma should allow the International Committee of the Red Cross (ICRC) to resume visits to prisoners without the requirement that ICRC doctors be accompanied by members of the Union Solidarity and Development Association (USDA) or other organizations. As mandated by the Geneva Conventions, to which Burma has been a party since 1992, the ICRC conducts confidential, one-on-one visits with prisoners and has done so in dozens of countries since the Franco-Prussian war of 1870. In addition, the Government of Burma should allow ICRC to reopen field offices that have been closed since late 2006 due to government restrictions.*** Since 1999, ICRC has played an essential role by visiting and providing health care to prisoners in Burma and developing water and sanitation projects in war-torn communities where weakened infrastructure, isolation, and the security situation make the population particularly vulnerable.¹⁹ ICRC staff have convened surgical training seminars for scores of Burmese health workers stationed in conflict areas, built water and sanitation facilities reaching more than 70,000 beneficiaries, provided over 7,000 landmine victims and other physically disabled people with prosthetic services, and supported the local manufacture of 19,600 prostheses. Between 1999 and late 2005, ICRC made 453 visits to dozens of prisons and labor camps throughout the country and provided training to Burmese doctors on prison health care. ICRC has used information gleaned from these visits to persuade health authorities to improve prison conditions. Yet, due to government restrictions, ICRC has been forced to suspend its prison visits and close most of its field offices.
- ***Donors and foreign aid organizations should monitor and evaluate how international aid to combat infectious diseases in Burma is affecting domestic expenditures on health and education.*** Large infusions of foreign aid directed at the health sector can potentially lessen the burden of infectious diseases in Burma, but it can also have unintended consequences. Foreign aid can create dependency and divert health professionals and their institutions from addressing other serious health problems. Foreign aid can provide national authorities with a ready excuse for decreasing even further their already paltry expenditures in health. Donors and foreign aid organizations

¹⁹ Although a private humanitarian organization, the ICRC is not a nongovernmental organization. It has a widely recognized role to play due to its permanent and universal mandate granted by the 192 States signatory to the Geneva Conventions. This role distinguishes the ICRC from other humanitarian organizations.

have a responsibility to monitor domestic expenditures in health and education and, if problems arise, raise their concerns with the appropriate authorities.

Drugs and Drug Trafficking

- ***Relevant UN agencies, national and local governments, and international and local NGOs should establish a regional Narcotics Working Group.*** Since 1999 the Burmese government and the UN Office on Drugs and Crime (UNODC) have been engaged in an aggressive campaign to eradicate poppy cultivation and heroin production in Burma. UNODC has attempted to develop crop-replacement initiatives for poppy farmers. However, these initiatives have often faltered, leaving farmers and their families with few alternatives to feed their families. Tens of thousands of people have been forcibly relocated to villages along the Thai border where they have no sustainable income and are exposed to infectious diseases, especially malaria. At the same time, the region is experiencing a significant increase in the production and use of methamphetamines. At least three cease-fire organizations in Burma continue to manufacture and sell methamphetamines inside the country and across the border. Methamphetamine use increases sexual risk-taking and greater exposure to communicable diseases, including HIV/AIDS. Markedly increased rates of sexually transmitted infections have been found in northern Thai women who use methamphetamines. Finally, large profits from the sale of methamphetamines are fueling the “Casino Economy” along Burma’s border with China. These casinos and other entertainment venues are magnets for prostitution and trafficking of Burmese women and girls.

Given this situation, the Narcotics Working Group should develop a sophisticated list of indicators to measure the use and trafficking of drugs in the region. Distinct from traditional indicators, these indicators would capture detailed information about types of drug, how much is being used, and by whom. Access to hard-to-reach populations and regions would require fieldwork and cross-border approaches that value trust-building and cultural appropriateness. The working group could also monitor the human and environmental impact of poppy eradication programs and their effects on farmers and their families.

Three Diseases Fund

- ***The Three Diseases Fund (3D Fund) should play an active role in promoting the growth and capacity of local nongovernmental and community-based health organizations to respond to infectious diseases in Burma and the border regions.*** Only a few local nongovernmental and community-based organizations operate in the health sector in Burma. Yet these organizations could potentially play a key role in the effort to lessen the burden of communicable diseases in the region. These groups are well situated to provide the community services required for the implementation of treatment and prevention programs. They can also work in areas that may be inaccessible to UN agencies and international organizations.

The 3D Fund, which is now the largest aid donor to combat infectious diseases in Burma, deserves good marks for establishing an oversight board that includes independent experts and for posting regular updates and reports of quarterly meetings of its board on its web site. Yet the 3D Fund faces several challenges that must be overcome to conduct its work effectively. First and foremost, it must contend with the military regime's restrictions on the travel of foreign aid organizations. ICRC's closure of several field offices operating in or near combat zones suggests that access to these areas will continue to be heavily restricted and prevent aid from reaching those most in need. Second, while the 3D Fund's commitment to bypass the central government and fund civilian administrations and local nongovernmental organizations at the state and township level is admirable, it may be difficult to implement. The term "civilian administrations" is a highly ambiguous concept in Burma, especially in rural areas where the military and police hold unquestioned authority and influence.²⁰ This situation has been further complicated by reports that the Burmese authorities are establishing government-run "coordination committees" at the district and township level to coordinate with the 3D Fund and other relief efforts. According to the February 2006 Guidelines, members of these new coordination committees would be drawn from junta-backed social organizations such as the USDA, founded by junta leader Senior General Than Shwe.²¹ The involvement of representatives of these organizations could easily politicize and complicate the dispersal of funds at the district and township level. To overcome these obstacles, donors to the 3D Fund must be prepared to withhold funds until proper conditions prevail.

Such challenges notwithstanding, the 3D Fund's pledge to ensure its programs are accountable, transparent, equitable, and reach those most in need is highly commendable and deserves the support of governments and international health institutions.

Violations of Human Rights and International Humanitarian Law

- ***The Government of Burma must stop engaging in violations of human rights and international humanitarian law and must hold accountable government and military officials who are responsible for these abuses.*** Burma's policies of forcibly relocating civilian populations and requiring them to engage in forced labor have caused widespread migration, food insecurity, disruption in livelihoods, and lack of access to regular medical care. In conflict zones, the Burmese military is committing violations of the laws of war including intentional and wanton destruction of civilian homes and food supplies; killing, sexually assaulting, and torturing civilians; destroying medical supplies intended for civilian populations; and arresting, detaining, and killing medical workers. These abuses have left civilians, particularly young children, vulnerable to death and illness from malnutrition, malaria, TB, night blindness (vitamin A deficiency), and diarrheal diseases.

²⁰ The National League for Democracy (NLD) raised this issue in a letter dated June 12, 2006, to the First Secretary, British Embassy, Rangoon. The letter is in the files at HRC.

²¹ Htet Aung, "Government to keep tight rein on aid in Burma," *The Irrawaddy*, March 13, 2007.

In the first six months of 2007, the Burmese authorities detained over a dozen HIV/AIDS activists, most of whom have since been released. Of particular concern is Phyu Phyu Thin, a National League for Democracy youth member and a leader in the group's HIV/AIDS section, who was arrested on May 21, 2007, by authorities from the Ministry of Home Affairs and the Police Special Branch. According to relatives, she has since disappeared. Since 2002, Phyu Phyu Thin and her group have provided hundreds of HIV/AIDS patients with counseling, medicines, education, and housing.²²

Internally Displaced Persons, Refugees, and Migrants

- ***The Governments of Burma, India, Thailand, and Bangladesh should ratify the Convention Relating to the Status of Refugees and the Protocol Relating to the Status of Refugees. These governments should also stop violating the human rights of migrants.*** Refugee status for migrants fleeing their home country due to fear of persecution prohibits routine deportation and increases the availability of services and assistance, including medical care, to limit the spread of infectious diseases among highly mobile populations. Moreover, state-sponsored discriminatory policies and practices, as well as state-condoned vigilantism by private groups, only serve to drive migrants further underground and prevent them from seeking medical care when they are ill or injured. Recent trans-border cooperation between India and Burma to capture ethnic insurgents has resulted in increased abuses against migrants including arrest, mistreatment, torture, and execution.
- ***The Government of Burma should take steps to halt the internal armed conflict and violations of international human rights and humanitarian law that are creating an unprecedented number of internally displaced persons and migrants.*** Internal armed conflict and abuses of rights, including forced displacement and forced labor, are creating major social upheavals leading to thousands of people fleeing their homes and living in internally displaced persons camps within Burma or in migrant camps on the border regions. These camps lack adequate food, sanitation, clean water, shelter, and medical care. Large mobile populations living under such poor conditions may be a conduit for the introduction of infectious diseases such as TB, malaria, HIV/AIDS, lymphatic filariasis, and avian influenza to new and unprepared communities.
- ***The Government of Burma should recognize citizenship for the Rohingya in Arakan State by repealing or amending the 1982 Citizenship Law. Until that time, the United Nations High Commissioner for Refugees (UNHCR) must provide adequate resources to the Rohingya who are languishing in refugee camps in Bangladesh.*** Under the 1982 Citizenship Law, the members of the Muslim minority in North Rakhine State, generally known as the Rohingyas, have been denied Burmese citizenship, which has seriously curtailed the full exercise of their human rights and led to various discriminatory practices, including restricted access to medical care, food, and adequate housing. These oppressive practices have caused waves of Rohingya migration out of Burma into Bangladesh where they currently live in refugee camps administered by UNHCR. These

²² "Relatives of missing HIV activist threaten to sue authorities," *The Irrawaddy*, June 21, 2007.

camps are sorely inadequate, leaving the Rohingya in fetid, overcrowded living conditions where health care is lacking and the TB infection rate is soaring.

Responses to Infectious Diseases in Burma's Border Regions

- ***UN agencies, national and local governments, and international and local NGOs must cooperate closely to develop health care programs along Burma's borders.*** Some of the highest rates of TB, malaria, and HIV/AIDS in Burma are found along its frontiers. Yet the Burmese government provides little or no public services, including health care, to people living in the border regions and limits the travel of international organizations to conflicted areas of the border. Some ethnic-based organizations provide health care in these areas, but their resources are extremely limited. These organizations need to receive greater support. In addition, health care programs must be initiated across the border and brought to the Burmese frontier. The Back Pack Health Worker Team operates out of western Thailand and sends supplied health care workers on foot into eastern Burma to gather medical data and provide medical treatment and preventative care. It represents one successful cross-border model that should be expanded and replicated on Burma's borders with China, India, and Bangladesh.
- ***The governments of Burma and its neighbors must stop obstructing the passage of medical supplies and health care workers across the borders and develop national policies that promote cross-border health care.*** The Burmese frontier appears to be permeable to almost everything—people, timber, gems, natural gas, and infectious diseases—except public health programming. In order for cross-border health programs to reach people living in Burmese conflict and cease-fire zones, the governments of Burma and its neighbors must stop obstructing the passage of medical supplies and health workers and develop national policies to support these efforts.

Regional Coordination and Response

- ***UN agencies, national and local governments, and international and local NGOs must cooperate closely to facilitate greater information-sharing and collaboration among agencies and organizations working to lessen the burden of infectious diseases in Burma and its border regions. These institutions should also work together to develop a regional response to the growing problem of counterfeit antimalarial drugs.*** In January 2007, our two centers, in collaboration with the Global Health Access Program, convened a regional conference on “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia” in Bangkok, Thailand. The conference brought together 190 participants, representing 95 institutions from nine countries—Australia, Bangladesh, Burma, China, India, Thailand, Singapore, United States, and Vietnam—to discuss the efforts of governments, UN agencies, nongovernmental organizations, and health clinics to combat infectious diseases in Burma and its border regions. Conference speakers highlighted some of the key challenges health professionals face as they confront the spread of communicable diseases in the region. These include limited disease surveillance and data collection; divergence of “official” statistics with data from

conflict zones; the paucity of data from narcotics surveillance, including drug availability and use and data on infectious disease prevalence and incidence among drug users; lack of prevention and treatment programs; and widespread violations of international humanitarian law and medical neutrality in some border regions that restrict the ability of health professionals to access vulnerable communities.

Conference participants, especially from the NGO sector, stressed the need to: (1) implement a mapping process, utilizing global-positioning technologies, to record the location, activities, and service-range of health-based organizations working to combat infectious diseases in Burma and the border regions; (2) convene a series of border-specific training workshops to standardize procedures for surveillance, data collection, analysis, and dissemination of information about infectious diseases in the region; (3) convene a second regional conference to report on the progress in implementing standardized procedures for data collection and analysis and to meet with colleagues and donors from the region; and (4) promote the development and capacity of community-based health organizations to provide health care for their own people.

2. Introduction

Decades of repressive military rule, civil war, corruption, bad governance, isolation, and widespread violations of human rights and international humanitarian law have rendered Burma's health care system incapable of responding effectively to endemic and emerging infectious diseases. Burma's major infectious diseases—malaria, HIV/AIDS, and tuberculosis (TB)—are severe health problems in many areas of the country. Malaria is the leading cause of morbidity and mortality due to infectious disease in Burma. Eighty-nine percent of the estimated population of 52 million lived in malarial risk areas in 1994, with about 80 percent of reported infections due to *Plasmodium falciparum*, the most dangerous form of the disease.¹ Burma has one of the highest TB rates in the world, with nearly 97,000 new cases detected each year.² Drug resistance to both TB and malaria is rising, and HIV/AIDS, once contained to high-risk groups, has spread to the general population, which is defined as a prevalence of 1 percent among reproductive-age adults.³

Meanwhile, the Burmese government spends less than 3 percent of national expenditures on health, while the military, with a standing army of over 400,000 troops, consumes 40 percent.⁴ By comparison, many of Burma's neighbors spend considerably more on health: Thailand (6.1%⁵), China (5.6 %⁶), India (6.1%⁷), Laos (3.2%⁸), Bangladesh (3.4%⁹), and Cambodia (12%¹⁰).

Against this background, our two centers—the Human Rights Center, University of California, Berkeley and the Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health—launched a research project in July 2005 to understand the factors that have contributed to Burma's dire health situation and to the spread of infectious diseases in Burma and across its borders. We also wanted to see if it was possible to deliver international aid to combat infectious diseases in Burma in a manner that would be transparent and accountable, reach those most in need, and promote respect for human rights and international humanitarian law.

¹ See Frank Smithuis, *Treating and Preventing Malaria in Myanmar*, Amsterdam: Médecins Sans Frontières–Holland, 2006 at 9.

² See Ministry of Health, *Health in Myanmar 2005* at 63.

³ See Jon Cohen, "The Next Frontier for HIV/AIDS: Myanmar," *Science*, 301:5640, September 19, 2003, 1650–55.

⁴ Budget data from the Burmese military authorities varies considerably. Many sources quote official health expenditures of 3 percent per annum. See, for example, World Food Programme, "Myanmar must do more to help its hungry millions," press release, August 5, 2005. However, foreign diplomats in Rangoon have reported that the official 2006/2007 budget for health is 2.4 percent. Moreover, it is unclear how much of the official health budget represents foreign aid dollars, which has been placed at 13 percent.

⁵ This is the figure for 2000. See Ministry of Public Health, Royal Thai Government at www.moph.go.th/ops/health.

⁶ This figure is for 2003. See *China Statistical Yearbook, 2003 and 2004*, National Bureau of Statistics (China Statistical Press).

⁷ This figure is for 2002. See *National Health Accounts*, World Health Organization, 2005.

⁸ This figure is for 2003. See <http://www.who.int/countries/laos>.

⁹ This figure is for 2003. See <http://www.who.int/countries/bangladesh>.

¹⁰ This figure is for 2002. See *National Health Accounts*, World Health Organization, 2005.

We began our research by dispatching teams of researchers to Rangoon and the border regions of China, Thailand, Bangladesh, and India. During these missions, researchers gathered data about infectious diseases—primarily HIV/AIDS, tuberculosis, malaria, and lymphatic filariasis—from health clinics operated by local governments and nongovernmental organizations. The teams also interviewed health professionals, government officials, and representatives of nongovernmental and community-based organizations that operate preventative programs and provide therapeutic care to patients. After the initial trip, researchers made repeat visits to Burma and the border regions of Thailand and India to collect further information. In addition, one of our researchers interviewed staff members of the Global Fund in Geneva and representatives of the European Union in Bangkok charged with drafting the strategic plan for the Three Diseases Fund (3D Fund). All interviews were conducted in accordance with procedures established by the Office for the Protection of Human Subjects of the University of California, Berkeley and Johns Hopkins University.¹¹

Following the research missions, we hosted a regional conference on “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia” in Bangkok on January 24–25, 2007. The conference brought together 190 participants, representing 95 institutions from nine countries to discuss the efforts of governments, UN agencies, nongovernmental organizations, and health clinics to lessen the burden of infectious diseases in Burma and its border regions.¹² Our researchers had previously interviewed many of the conference participants for this report.

Limitations

While the study was conducted as rigorously as possible, some limitations need to be acknowledged. First, while we had good access to clinics and health-related organizations in the border areas of China, Thailand, India, and Bangladesh, we were unable to visit health facilities or conduct interviews in Burma outside of Rangoon due to government restrictions on travel and our own fear of placing respondents at risk of government reprisals. Burmese citizens who speak with foreigners are required to report such encounters to the authorities or face possible arrest and imprisonment. Despite these limitations, we managed to interview Burmese physicians and other health professionals, journalists, and human rights activists, as well as foreign aid workers and embassy officials in Rangoon. One of the Burmese health professionals we interviewed was a medical scientist working with the Ministry of Health. Second, data on infectious diseases collected by the Burmese authorities is generally unreliable due to methodological weaknesses, gaps in data, and numerical discrepancies. As a result, our interpretation of that data may reflect these shortcomings. Finally, in some cases, the responses we received in our interviews may have reflected some level of “social desirability.” Social desirability occurs when a respondent answers in a manner he or she thinks will please the interviewer.

¹¹ Given the sensitivity of the topic, we have erred on the side of caution and chosen not to provide the names of most of those we interviewed.

¹² It should be noted that the conclusions and recommendations contained in this report are those of the authors and sponsoring institutions and not necessarily those of conference participants.

Governance, Human Rights, and Infectious Diseases

This report is based on four precepts. First, *successful public health infrastructures, programs, and outcomes are usually a result of good governance and a respect for human rights*. A number of authors¹³ argue that “government behavior (sometimes captured by the term ‘governance’) ... plays a significant role in health outcomes—a role independent of ... host genetics, insect vectors, or individual behaviors.”¹⁴ Governance can be measured by indicators such as accountability, stability, rule of law, respect for human rights, and the existence of an independent civil society.

This precept is supported by recent studies that examine the relationship between the extent of freedom allowed by governments and its effect on a nation’s health.¹⁵ In a 2004 study published in the *British Medical Journal*, Alvaro Franco and his colleagues plotted life expectancy and maternal and infant mortality in 170 countries against the “freedom index”—a measure of political rights and civil liberties produced by Freedom House, a nongovernmental organization that publishes a yearly rating for most countries, classifying them as free, partially free, or not free.¹⁶ Franco and his colleagues found a significant relationship between high freedom ratings and good health indicators, even controlling for wealth and the size of the public sector. In their conclusion they speculate that democracies produce better health outcomes because they “allow for more space for social capital [such as social networks and pressure groups], opportunities for empowerment, better access to information, and better recognition by government of people’s needs.”¹⁷

In a similar study, again using life expectancy and infant and maternal mortality as health indicators, Alvarez-Dardet and Franco-Giraldo analyzed data collected in the 1990s from 23 post-communist countries.¹⁸ They found a significant correlation between the level of democratization and health. A third study by Daniel Reidpath and Pascale Allotey examined 176 countries using World Bank data and found that “[h]ealthy populations tend to have better governance, better physical infrastructure, and greater wealth.”¹⁹

Commenting on the mixed results of quantitative efforts to link governance factors to more narrow measures of infectious disease prevalence, Jonathan Cohen and Joseph Amon note that:

infectious disease risk is not spread evenly across populations, and comparisons between countries of the prevalence of a specific disease miss the overburdening

¹³ Jonathan Cohen and Joseph J. Amon, “Governance, Human Rights and Infectious Diseases: Theoretical, Empirical and Practical Perspectives,” in Ken Mayer and Hank Pizer (eds.), *Social Ecology of Infectious Diseases* (forthcoming). See also Amartya Sen, *Development as Freedom*, New York: Oxford University Press, 1999; J. Dreze and Amartya Sen, *India: Development and Participation*, New York: Oxford University Press, 2002; and Paul Farmer, *Infections and Inequities: The Modern Plagues*, Berkeley: University of California Press, 1999.

¹⁴ Jonathan Cohen and Joseph J. Amon, *supra* note 13.

¹⁵ Alvaro Franco, Carlos Alvarez-Dardet, Maria Teresa Ruiz, “Effect of Democracy on Health: Ecological Study,” *British Medical Journal* 329, 2004 at 1421–23.

¹⁶ Information about Freedom House can be obtained at <http://www.freedomhouse.org>.

¹⁷ Alvaro Franco et al., *supra* note 15.

¹⁸ Carlos Alvarez-Dardet and Alvaro Franco-Giraldo, “Democratisation and health after the fall of the Wall,” *Journal of Epidemiology and Community Health* 60, 2006 at 669–71.

¹⁹ Daniel D. Reidpath and Pascale Allotey, “Structure (governance) and Health: an Unsolicited Response,” *BMC International Health and Human Rights* 6:12, 2006 at 6.

of some communities or subgroups within a country. In addition, governance influences different infectious disease risks in different ways and present distinct challenges to governments—compelling different types of government policies and approaches. For example, the risks posed by mosquito-borne diseases such as malaria or dengue fever present different possibilities for spread and control than, for example, Hepatitis B or C, transmitted through sex or blood contact.²⁰

That said, it is clear that the way a government speaks about and responds to a particular infectious disease—and those communities and subgroups most affected by it—will influence its success in lessening the burden of the disease.²¹ Indeed, it is important for governments to address the spread of infectious diseases by working closely and “respectfully with at-risk populations, rather than adopting top-down approaches (such as criminalizing disease transmission, instituting mandatory testing, and quarantining people living with infectious diseases) that risk driving these populations even further to the margins of society where they cannot be reached with prevention services.”²²

Second, *a respect for human rights and international humanitarian law helps to ensure accountability, transparency, responsible use of health expenditures, and rapid and equitable delivery of relief in areas of armed conflict. Inversely, serious violations of human rights and international humanitarian law that affect the movement of large population groups can cause or exacerbate the spread of infectious diseases.*²³ This is particularly true among migrant or internally displaced populations who generally lack access to appropriate health services.

Paula Brentlinger, in her article on the inter-relationship between health, human rights, and malaria control,²⁴ notes that violations of international humanitarian law can cause or affect malaria-related morbidity and mortality during armed conflict. Violations of the laws of war,²⁵ including attacks on health facilities and medical personnel, the use of forced labor, forced displacement, the failure to protect civilians and resources necessary for their survival, and the failure to provide adequate relief can contribute to

²⁰ Jonathan Cohen and Joseph J. Amon, *supra* note 13.

²¹ See Jonathan Mann, “Human Rights and AIDS: The Future of the Pandemic,” in J. Mann, S. Gruskin, M. A. Grodin, G. J. Annas (eds.), *Health and Human Rights: A Reader*, New York: Routledge.

²² Jonathan Cohen and Joseph J. Amon, *supra* note 13.

²³ *Id.* Cohen and Amon note that “infectious pathogens can be stubbornly indifferent or even contrary to theories of health and human rights. HIV transmission can be limited in civil war settings, for example, even when human rights abuses are widespread and governments collapse. In Angola, for example, a protracted civil war which reduced cross-border travel and trade is thought to have left the country somewhat protected from the early introduction and spread of diseases compared to its neighbors. However, the war also impeded the ability of the government to conduct surveillance and education around the disease, and destroyed the health services needed to respond to AIDS. The war also curtailed the formation of a vibrant civil society, such as the development of NGOs and AIDS service organizations, which have been highly effective in both prevention and care elsewhere.”

²⁴ Paula E. Brentlinger, “Health, Human Rights, and Malarial Control: Historical Background and Current Challenges,” *Health and Human Rights* 9:2, 2006 at 11–38.

²⁵ See Protocol Additional to the Geneva Conventions of August 12, 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I). Article 12 provides for the protection of medical units. Articles 15 and 16 provide for the protection of medical and religious personnel and the general protection of medical duties. Articles 51, 54, and 70 provide for the protection of the civilian population, the protection of objects indispensable to the civilian population, and relief actions. See Geoffrey Best, *War and Law Since 1945*, Oxford: Clarendon Press, 1994.

forced migration of non-immune persons (or deployment of non-immune troops) to malaria-endemic areas (or, conversely, displacement or deployment of infected persons to a region where malaria is not endemic but hospitable *Anopheles* vectors exist); breakdown or destruction of health services; provision of poor-quality housing to displaced persons (for example, in refugee camps); and alteration of local vegetation in ways that favor the breeding of vectors.

Discrimination against specific population groups, acute malnutrition related to reductions in food production or interference with food distribution, and diversion of human and material resources away from the health sector to military activities may also contribute to worsening malaria-related morbidity and mortality.

Moreover, human rights abuses can fuel the spread of HIV/AIDS. Such violations include discrimination against those living with HIV or believed to be at risk of infection; sexual violence and coercion faced by women and girls; abuses against commercial sex workers, injecting drug users, and men who have sex with men; and violations of the right to information on HIV transmission. In some war-torn countries, rape has been used systematically as a weapon of war, potentially exposing tens of thousands of women and girls to HIV. In addition, persons living with HIV/AIDS may be subjected to stigmatization and discrimination in the workplace and denied government services.²⁶

Third, as the World Health Organization affirmed in 2001, *public health interventions for vulnerable groups are most effective if they also succeed in respecting, protecting, and fulfilling the rights of people marginalized by society.*²⁷ Indeed, it is now considered a standard of best practice to include vulnerable and marginalized populations in the design, implementation, and evaluation of health programs that directly affect their well-being. At the same time, health professionals employed in both the public and private sectors must be mindful that their actions do not further harm vulnerable populations. “If services providing HIV-related prevention and care to commercial sex workers or injecting drug users do not protect the dignity and confidentiality of their clients,” writes Susannah Mayhew and her colleagues at the London School of Hygiene and Medicine, “they risk driving these already hard-to-reach groups underground. In addition, services that do not pay attention to rights may result in future violations of the rights of clients. For example, unintentionally contributing to their identification may result in police harassment and incarcerations. Once in prison, vulnerability to HIV infection is increased if, as is usually the case, there are no condoms and no clean syringes.”²⁸

Finally, *donors and nongovernmental organizations working in the health sector, especially in countries with highly repressive regimes, have a responsibility to respect and promote the human rights of those they serve.* While in the classic understanding of human rights, the state is considered to be the primary duty-bearer of human rights and provider of public health services, a shift has occurred in recent years whereby governments in some developing countries have

²⁶ Numerous reports on human rights abuses and HIV/AIDS have been published since the virus emerged in the 1980s. See, for example, reports by Human Rights Watch at <http://www.hrw.org> and Physicians for Human Rights at <http://www.healthactionaids.org>.

²⁷ World Health Organization, *Transforming Health Systems: Gender and Rights in Reproductive Health—A Training Curriculum for Health Programme Managers*, WHO/RHR/01.29, Geneva, 2001.

²⁸ Susannah Mayhew, Megan Douthwaite, and Michael Hammer, “Balancing Protection and Pragmatism: A Framework for NGO Accountability in Rights-Based Approaches,” *Health and Human Rights* 9:2, 2006 at 183.

begun handing over their function of delivering health services to non-state actors, including nongovernmental organizations (NGOs).²⁹ In the early 2000s, in South Africa, for example, the provision of antiretroviral drugs to AIDS patients through NGOs and private-sector employers was critical in the face of a government that routinely blocked their introduction to the public sector. However, the lack of accountability of these sectors meant that certain life-or-death questions, such as eligibility criteria for antiretroviral treatment, were rarely examined.³⁰

In some countries, national expenditures on health have been so paltry international and local NGOs have had to step in to fill the breach, often with little or no oversight. This is the case in Burma where national health expenditures for 2006/2007 will be \$19.2 million,³¹ while foreign aid for health programs will be nearly double that amount.³² The Three Diseases Fund, or 3D Fund, a major European-funded health initiative that has taken over from the Global Fund for AIDS, Malaria and Tuberculosis, will provide most of these funds. The 3D Fund has declared that it will circumvent central government and provide funds directly to UN agencies, international and local NGOs, and civilian administrations at the district level. This situation poses a challenge for recipients of 3D Fund aid, especially nongovernmental organizations, as many—if not most—of these groups will be working with marginalized populations, including injecting drug users, commercial sex workers, ethnic minorities, and, should access be obtained, war-affected populations.

This shift from state to non-state institutions raises several questions. Will these organizations be able to uphold the human rights of their clients—especially if this means challenging repressive policies and practices of the state? If the situation becomes too untenable, should these groups suspend services? And, most importantly, who will come to the defense of nongovernmental organizations and their in-country staff should they run afoul of the authorities?

²⁹ *Id.*

³⁰ See, for example, a letter from Human Rights Watch to President Thabo M. Mbeki, dated November 21, 2001, at http://hrw.org/english/docs/2001/11/21/safric3377_txt.htm.

³¹ This figure is the equivalent of 24,183 million kyat and is based on the exchange rate effective April 2007. All dollar figures in this report refer to U.S. currency.

³² To date, the Burmese government has not made its 2006/2007 budget publicly available. However, we were able to obtain budget figures from foreign diplomats in Rangoon.

3. Background

Burma is a Buddhist nation of about 52 million people, two-thirds of whom belong to the ethnic group known as the Burmans. The other third of the population comprises over one hundred ethnic groups including the Shan, Karen, Rakhine, Mon, and Kachin. The majority of Burmese are farmers. Hundreds of thousands of Burmese live as internally displaced persons (IDPs) or as legal refugees in other countries, most of them in Thailand and Bangladesh. Two million are thought to live as undocumented workers in Thailand.

Burma today is a land of stark contrasts. Although abundant in natural resources, including land, water, forests, natural gas, coal, petroleum, gems, and other mineral resources, Burma is a UN Least Developed Nation, and among the poorest in the world. It is the world's second-largest producer of illegal opium (behind Afghanistan), and by far the region's largest supplier of methamphetamine-type stimulants (ATS).

The two key political issues in Burma today are “the restoration of democracy and the resolution of the political rights of ethnic nationalities.” Yet both aspirations seem forever ephemeral. While the military junta claims it is committed to building a future democracy, it insists that change must come gradually and on its own terms. And while the military junta asserts that it must prevent what it calls “the disintegration of the union” by concentrating political power at the center, “it achieves this objective through a brutal counter-insurgency campaign and the forced relocation of ethnic groups.”¹

In the pre-colonial days, Burman kings routinely conquered other ethnic groups, frequently extending their rule over neighboring kingdoms and principalities. Under British colonial rule, ethnic differences and tensions were exacerbated when certain minority groups were favored politically and economically. Tensions increased during World War II, when most Burmans favored Japan and the Axis Powers while some ethnic groups such as the Karen remained staunchly loyal to the British. Abuses by the predominantly Burman national army against ethnic minorities following World War II further stoked fears of ethnic Burman domination, fanning desires for increased local autonomy. By the time of the military coup in 1962, most of the ethnic groups that had suffered at the hands of the Burmese army were in open rebellion.

Militarization

The years leading up to the coup of 1962 marked the beginning of the militarization of Burma. Not unlike military regimes in South America in the 1970s and '80s, the Burmese armed forces, or *Tatmadaw*, believed they had the professional and organizational capacity to unite and manage the country. The *Tatmadaw* established its own profit-making corporation to supply its battalions with goods and materials. The corporation originally ran shops selling bulk goods, but it soon expanded into the import-export business and became a major player in the domestic economy. Boosted by its military and economic successes, the *Tatmadaw* increasingly identified

¹ Christina Fink, *Living Silence: Burma under Military Rule*, London: Zed Books, 2001 at 13.

Background

itself as playing an essential role in the country's internal affairs. Today, the *Tatmadaw* is a self-perpetuating elite that operates its own health care system, its own educational system, its own housing, and even its own private banks.

General Ne Win, who led the 1962 coup, sought to remake Burmese politics and society by promulgating a series of institutional reforms under the slogan of the “Burmese Way to Socialism.” He established a Revolutionary Council, which replaced approximately 2,000 civilian members of the country's administration with military personnel. From then on, all opportunities for social mobility were dependent on joining the military. New military-guided councils at the township and village levels were established to manage the redistribution of land and wealth largely to the favor of local military commanders. In March 1964, the Revolutionary Council demonetized 50-kyat and 100-kyat notes with the intention of removing wealth from foreign hands. Hundreds of thousands of ethnic Indian and Chinese business owners had no choice but to leave the country.

Businesses that did not collapse were given to military officers who had little education or relevant experience and found it difficult to handle their new jobs. “In cases where skilled civilians remained on staff,” writes anthropologist Christina Fink, “the new bosses often felt threatened by them. With no other opportunities available, many experienced professionals and bright young people emigrated, starting the brain drain which has continued ever since. The Revolutionary Council appeared to be unconcerned by the departure of so many of its most talented people, but the effect on the industry was devastating.”²

The “Burmese Way to Socialism” led to economic ruin from which Burma's economy has never fully recovered. In the 1950s, Burma had outpaced Malaysia and Thailand in industrial production but from 1964 onwards it declined steadily. Agricultural production foundered in a country once known as the “rice basket of Asia.” While the regime gave agricultural plots to many landless farmers, they were expected to sell all their rice to the government at below-market prices. Farmers resisted the new system by hoarding rice and selling it surreptitiously on the black market. Rice exports fell dramatically and, since rice exports were one of Burma's primary sources of foreign exchange, the government was unable to pay for necessary imports. This, in turn, helped create a thriving black market with goods coming from Thailand and other neighboring countries.³

By 1987 Burma's economy was in shambles, and the United Nations designated Burma a “Least Developed Country,” grouping it together with the poorest African nations for debt relief. Quietly at first, university students and intellectuals began organizing massive protests against the military government. When the marches began in earnest in the spring of 1988, the government closed the universities and imposed a ban on public gatherings.

A nationwide uprising led by student activists briefly drove the military from power in early August 1988, but it was short-lived. On the afternoon of September 18, 1988, troops appeared in the streets, attacking strike centers and killing at will. Thousands of people were killed, and many thousands more fled the cities and headed to the borderlands. Within two days, the military had re-established control.

² Fink, *supra* note 1 at 32–33.

³ David Steinberg, *Burma: A Socialist Nation of Southeast Asia*, Boulder, Colorado: Westview Press, 1982 at 79.

Under international and domestic pressure to democratize, the junta held elections, widely regarded as free and fair, on May 27, 1990. Despite a program of intimidation, the opposition, the National League for Democracy (NLD), led by the charismatic Aung San Suu Kyi, swept to victory in nationwide elections, winning 392 of 485 contested seats (over 80%). Ethnic parties took another 65 seats, while the military's party, the National Unity Party (NUP), secured only 10 seats out of the 413 candidates it fielded. But the military refused to accept the results and intermittently placed Aung San Suu Kyi under house arrest, where she has remained for most of the last 17 years. Today she is the sole Nobel Peace Laureate still in custody.⁴

The Union Solidarity and Development Association

In the aftermath of their electoral defeat, the military regime further entrenched their rule by quickly expanding their ranks, filling administrative offices with loyal servicemen and creating the Union Solidarity and Development Association (USDA). Established on September 15, 1993, the USDA, though purportedly a benign social organization, maintained direct ties with high-ranking military officers, including the current junta leader, Senior General Than Shwe, who became the association's first chairman.

Today the USDA boasts a membership of 22.8 million people, nearly half the population of Burma, and its presence can be felt in almost every aspect of civil society.⁵ The USDA uses aggressive and often coercive means to recruit new members. Incentives are offered to join with the explicit understanding that failing to do so could result in harassment and decreased opportunities for education and professional advancement. In some districts, people's names have been added to membership rolls without their ever being consulted. In some high schools, teachers have been ordered to give the names of their students to the USDA for automatic membership. Joining the USDA is presented to students as compulsory and, as a result, many of them are members, as are many—if not most—government employees.⁶

The USDA, in an effort to attract young people into its ranks, offers courses in computers and English to its members. Student membership also brings certain benefits, including access to sport leagues and other extra-curricular activities. The USDA encourages student members to monitor the activities of their classmates and to report any suspicious behavior. Some student members have reported receiving passing marks regardless of merit.⁷

Beginning in 1996, the military regime sought to turn the USDA into a counterforce against student activists in the NLD. This was reflected in a speech given by General Than Shwe to a USDA management course at the time of student demonstrations on December 11, 1996. In the speech, he warned the trainees to be vigilant of destructive forces both "inside and outside the country ... Parents, teachers and students must all keep vigil and prevent those with negative

⁴ Human Rights Watch, *Essential Background: Overview of Human Rights Issues in Burma*, 2005, at 31–32, <http://www.hrw.org/english/docs/2006/01/18/burma12268.htm>.

⁵ "Entire National People to Do Their Bit in Unison to Achieve National Goal USDA Members are to Actively Take Part in the Drive for Success of Seven Point Road Map," *New Light of Myanmar*, November 8, 2005.

⁶ See Network for Democracy and Development, *The White Shirts: How the USDA Will Become the New Face of Burma's Dictatorship*, May 2006; Christina Fink, *supra* note 1 at 95–96.

⁷ Network for Democracy and Development, *supra* note 6 at 22–23.

views, destructive elements and those subservient to colonialists from intruding into the education world and using students in their bids to gain political power.”⁸

USDA members have been linked to attacks on opposition leaders and human rights activists. In November 1996, USDA members attacked Aung Sang Suu Kyi’s motorcade and, in May 2003, attempted to assassinate the NLD leader. Aung San Suu Kyi escaped with minor injuries, but dozens of her supporters were killed. More recently, in April 2007, USDA members assaulted two members of the Human Rights Defenders and Promoters organization as they were leaving a village in Hinthada Township in Irrawaddy division. The two activists, Maung Maung Lay and Myint Niang, were hospitalized with head injuries.⁹

Counter-Insurgency and the “Four Cuts” Policy

Since 1989, the military junta has used a combination of military campaigns and deal-brokering with insurgent leaders to quash rebellions and solidify its control of the country. So far, 17 armed ethnic groups have agreed to cease-fires with the junta. Several groups, however, continue active resistance, particularly along the eastern frontier bordering Thailand. These include the Shan State Army-South (SSA-S); the Karenni National Progressive Party (KNPP); and the Karen National Liberation Army (KNLA), the armed wing of the Karen National Union (KNU).

The *Tatmadaw* employs a counter-insurgency strategy known as the Four Cuts policy to undermine local support for these groups, cutting off their access to food, money, intelligence, and recruits. “The human and social costs are incalculable,” writes Fink. “Villagers living in distant hamlets are forcibly relocated to strategic villages along roads, usually with a battalion of *Tatmadaw* soldiers based nearby. They are given no compensation and often no new land to farm. In the most extreme cases, they are put into fenced relocation sites that are more like concentration camps. Food is insufficient, water often unclean, and medicine completely lacking.”¹⁰

International human rights organizations estimate that the Four Cuts policy has resulted in the destruction of over 3,000 villages and the displacement of hundreds of thousands of people in eastern Burma since 1966.¹¹ Rarely disciplined for their actions, military troops often kill, torture, and rape civilians found outside of the relocation camps or permitted zones. Thousands of displaced villagers hide in the jungles, usually in small, fragmented communities where they are exposed to malaria and other diseases. The *Tatmadaw* prohibits foreigners from accessing these communities. Families seeking medical care often have to travel long distances, braving land mines, bandits, and military patrols, to reach township clinics and hospitals.¹²

⁸ “All Must Keep Vigil and Prevent Negatively-oriented Destructive and Subservient Traitors from Intruding into Educational Realm and Using Students in Bids to Gain Political Power,” *New Light of Myanmar*, December 11, 1996.

⁹ Yeni, “Burma’s Junta Vows to Crack Down on Human Rights Activists,” *The Irrawaddy*, April 23, 2007.

¹⁰ Fink, *supra* note 1 at 125.

¹¹ See Global IDP Project, *Burma: Displacement Continues Unabated in One of the World’s Worst IDP Situations*, June 27, 2005, at 3.

¹² See G. Risser, Oum Kher, and Sein Htun, *Running the Gauntlet: The Impact of Internal Displacement in Southern Shan State*, Bangkok: Institute of Asia Studies, Chulalonghorm University, 2004.

Armed Conflict and Health

In 2006, the Back Pack Health Worker Team, based on the eastern frontier of Burma, concluded that the poor health status of IDP communities in the eastern conflict zones was “intricately and inexorably linked to the human rights context in which health outcomes are observed.” The organization reached that conclusion after conducting a series of cluster-sample surveys designed to capture household data on demographics, morbidity, public health needs, mortality, and violations of human rights and international humanitarian law in these IDP communities.¹³

The survey focused on five factors in the preceding 12 months that could have potentially influenced health outcomes: forced labor of household members, injury or abuse by soldiers, theft or destruction of food/livestock by military forces, landmine injuries, and forced relocation due to security issues. The survey found that over half of the participating households had experienced at least one of the aforementioned abuses in the preceding year, a third had suffered from forced labor, and a quarter had experienced food seizure or destruction. Moreover, these abuses were linked to adverse health outcomes:

- Families who had been forced to flee were 2.4 times more likely to have a child under age 5 die than those who had not been forcibly displaced.
- Households who had been forced to flee were 3.1 times as likely to have malnourished children than those living in more stable conditions.
- Families that had suffered food destruction and theft, both violations of international humanitarian law, in the preceding 12 months were almost 50 percent more likely to suffer a death in the household. Children of these households were 4.4 times as likely to suffer from malnutrition compared to households whose food supply had not been compromised.
- Families that had been subjected to forced labor in the past year were at significantly higher risk of diarrheal disease and night blindness, an indicator of vitamin A deficiency and malnutrition.¹⁴

Forced Labor

Forced labor is a pervasive problem in Burma. In recent years, the military has compelled tens of thousands of civilians to work on infrastructure projects, including roads, bridges, and airports, and in support of the military. Those unable or unwilling to comply with military demands for forced labor are fined or must send replacements, including their children, to work in their stead.¹⁵ In at least two cases, the *Tatmadaw* is accused of using forced labor to construct gas

¹³ Back Pack Health Worker Team, *Chronic Emergency: Health and Human Rights in Eastern Burma*, September 2006, at 9–23. At the time of survey, these households included 9,853 persons, with an average household size of 5.4 persons.

¹⁴ *Id.* at 10.

¹⁵ Interview with Kevin Heppner, Karen Human Rights Organization, July 2006. Also, see Christina Fink, *supra* note 1 at 123.

Background

pipelines, a lucrative source of revenue for the regime: the Yadana gas pipeline, built by Total and Unocal, and the Yetagun pipeline, in which Premier Oil had a significant interest.

In 1999, the International Labor Organization (ILO) concluded that the practice of forced labor in Burma constituted “a contemporary form of slavery.” The ILO later banned the military regime from attending any of its meetings or receiving funding until it stopped using forced labor.¹⁶ The military junta reacted angrily to the expulsion, saying that in Burma villagers were happy to work for the military or to speed up development projects.¹⁷ In late 2006, exasperated by the lack of tangible progress in stopping this practice, the ILO was considering referring Burma to the International Court of Justice for its continued extensive use of forced labor. ILO representatives also briefed the Chief Prosecutor of the International Criminal Court on the use of forced labor in Burma and made relevant documents available to him.¹⁸ In February 2007, the ILO announced that it had reached an understanding with the Burmese government that allows “victims of forced labor to have full freedom to submit complaints to the ILO liaison office” in Rangoon with a guarantee that “no retaliatory action will be taken.”¹⁹

Political Prisoners and Child Soldiers

Human rights organizations estimate that there are more than 1,150 political prisoners in Burma.²⁰ No independent body is currently monitoring detention conditions in Burma, and Amnesty International reports that prison deaths, including those of political prisoners, increased in 2006.²¹

The Burmese military has long been accused of forcibly recruiting children into its armed forces and, in 2004, the London-based Coalition to Stop the Use of Child Soldiers reported that the junta had conscripted children as young as 11 into the army. The Coalition estimated that up to 20 percent of the *Tatmadaw* and armed ethnic insurgents were under 18—the current legal age of conscription—which would have put the total number of child soldiers in Burma at nearly 90,000, the highest of any country in the world.²²

Censorship and Freedom of Association

The military junta sharply restricts freedom of the press, owning or tightly controlling all daily newspapers and broadcast media in Burma. According to Reporters Without Borders, Burma ranked 164th out of 169 nations on the topic of press freedom for 2006. During the year, the Burmese authorities detained 11 journalists, seven of whom were given jail terms. The Press Scrutiny Board of the Ministry of Information examines publications and prohibits “any

¹⁶ International Labor Organization, *Resolution on Burma*, 1999.

¹⁷ “Myanmar Lashes West for ILO Expulsion,” Associated Press, June 17, 1999.

¹⁸ Glenn Kessler, “U.S. wants U.N. resolution on Burma,” *Washington Post*, November 18, 2006.

¹⁹ Khun Sam, “ILO-Burma Reach ‘Understanding’ on Forced Labor Issues,” *The Irrawaddy*, February 27, 2007.

²⁰ Human Rights Watch, *supra* note 4.

²¹ Amnesty International, “Ko Thet Win Aung, Prisoner of Conscience, Dies in Prison,” News Service No: 268 (ASA 16/015/2006), October 16, 2006.

²² Clive Parker, “UN Repeats Call for Action on Child Soldiers,” *The Irrawaddy*, November 29, 2006.

incorrect ideas and opinions which do not accord with the times.” Media are ostensibly allowed to offer criticism of government projects as long as it is deemed “constructive” and are allowed to report on natural disasters and poverty as long as it does not affect the national interest.

Among the topics that have been forbidden are human rights in Burma, the detention under house arrest of opposition leader Aung San Suu Kyi, and the activities of the *Tatmadaw*, especially its current offensives in Eastern Burma that have forcibly displaced over 27,000 people since December 2005. Certain Internet email servers and search engines, including Google and Yahoo, are also banned.²³ Regulations issued to Internet café owners prohibit customers from downloading websites and visiting politically affiliated sites. Every two weeks Internet cafes are required to submit the personal details of their customers, records of their Internet use, and random photo shots of computer screens.²⁴

In May 2006, the junta banned 24 business and professional associations including one catering to Chinese entrepreneurs and another offering free funeral services to the poor. In Burma, local and international nongovernmental organizations must register with the home ministry and relevant government ministries to operate officially in the country. Groups are often banned because they are perceived as being too political, too independent or because they do a better job than the government at providing services. Among the organizations the government refused to register were the Free Funeral Service Society, the Myanmar Chinese Chamber of Commerce, the Engineer Association, and the Construction Association.²⁵

Education

Since the early 1960s, successive military regimes have sought to contain student activism rather than improve the quality of public education and, over the years, universities have been shut down for extended periods of time whenever political unrest occurred. Between 1962 and 1999, the military closed down universities 13 times for periods ranging from a month to more than three years.²⁶ Between 1988 and 2000, the universities were closed more than they were open. Classes were canceled from June 1988 to May 1991, from December 1991 to May 1992, and from December 1996 to July 2000. Medical institutes reopened in February 1999. To make up for the closures, one-year courses were shortened to four months in order to maintain graduation rates.

Today, primary school enrollment rates are high and more schools are being constructed in Burma. Even so, UNICEF reports that “less than half of all children ... complete primary school. Many school expenses must be borne by students’ families, presenting an insurmountable financial obstacle for many impoverished households. Classroom facilities are often poor and under-equipped, and attrition rates among teachers are high due to low pay, poor working conditions and long separations from their families.”²⁷

²³ See David Wallechinsky, *Tyrants*, New York: Harper Collins Publishers, Inc., 2006 at 72.

²⁴ Shah Paung, “Restrictions Hit Internet Café Owners,” *The Irrawaddy*, February 19, 2007.

²⁵ Associated Press, “Myanmar cracks down on business groups including one offering free funerals,” May 16, 2007.

²⁶ Fink, *supra* note 1 at 182.

²⁷ UNICEF, *UNICEF in Myanmar: Protecting Lives, Nurturing Dreams*, September 2004 at 7.

Other factors have contributed to the demise of the education system. Students are required to spend time taking political ideology courses. They are not allowed to choose their own course of study but are assigned a particular track based on their secondary school matriculation exam scores. The military also decides how many students are permitted to enroll in each subject. The military must approve of university curricula and limits the scope of what may be taught, particularly in the humanities and social sciences. Many of the best educators and professionals have gone abroad, where they can earn a decent income and teach more freely. Educational exchange programs have also been limited. In March 2006 the Ministry of Education issued an order requiring postgraduate Burmese students studying overseas to obtain permission for any Burma-related research.²⁸ In response, a statement released by the International Association of University Presidents said that such an order would restrict the education of Burmese students and would hinder their abilities.

The poor state of Burma's universities has prompted many young people to enroll in non-degree education programs offered by the American Center and the British Council in Rangoon. The state-run *New Light of Myanmar* has often targeted the American Center for "inciting unrest" through its English-language courses, debate classes, films, and library, which contains books and other publications banned by the government.²⁹

The Courts and Political Reform

The judiciary is not independent. Justices are appointed or approved by the junta and adjudicate cases according to the junta's decrees. Administrative detention laws allow people to be held without being charged or tried, and deny them access to legal counsel for up to five years if the junta feels they have threatened the state's security or sovereignty.

In 2004, the Burmese military regime launched a seven-step "roadmap" it said would move the country toward constitutional and political reform. The following year the first step was launched with the re-convening of a national convention to deliberate on a new constitution. However, most of the delegates were hand-picked by the military and the process was boycotted by the NLD and major pro-democracy ethnic groups. The meetings were held outside Rangoon, ringed by army bases, and the junta prohibited free debate on the drafting of the constitution, warning delegates that discussing the process off-site or criticizing the process would be considered an offense carrying a prison term of up to 20 years. As a result, many have dismissed the process as another tool to legitimize and perpetuate military rule.³⁰

NLD leader Aung San Suu Kyi has stated multiple times that she harbors no rancor towards the military and that she would like to reach an agreement with the *Tatmadaw* that would allow the generals to withdraw from power without fear of retribution.³¹ However, the military junta has continued to spurn such offers, responding instead with increasing repression and further

²⁸ Nem Davies, "Education Ministry Clamps Down on Postgrad Burma Research," *Mizzima News*, June 5, 2006.

²⁹ Htet Aung, "Junta Urged to Honor the Right to Education," *The Irrawaddy*, March 19, 2007.

³⁰ See Altsean, *Interim Report Card: July 2004–February 2005*, www.altsean.org.

³¹ *Threat to Peace: A Call for the UN Security Council to Act in Burma, A Report Commission by Václav Havel, former President of the Czech Republic and Bishop Desmond M. Tutu, Archbishop Emeritus of Cape Town*, September 20, 2005, at 19.

harassment of NLD members and leaders, including Aung San Suu Kyi and Vice Chairman U Tin Oo, who remain under indefinite house arrest without charge. In late 2006, Burmese authorities re-arrested five leading democracy activists and sentenced Win Ko, a leading NLD member, to three years in prison after he staged a petition drive to free political prisoners.

The Burmese government remains unresponsive to outside pressure, and recent signs indicate that it is becoming even more reclusive. On November 6, 2005, at 6:37 am, an hour apparently chosen for astrological reasons, the junta began an abrupt relocation of the government, including its civil servants, to the remote jungle town of Pyinmana (Naypyidaw), some 250 miles north of the former capital, Rangoon. The junta claims it is financing the building of the new city by selling old ministries that it deserted in the former capital. The *Agence France-Presse* (AFP) reports that the International Monetary Fund estimates that “about 1–2 percent of GDP has been spent in the last few years by the government on the move” to Pyinmana. “The chances of it becoming a black hole are very good,” a western diplomat in Rangoon told the AFP in April 2007. “It is a continuous investment for 15 to 30 years before it becomes viable. That’s money that will not be channeled into health and education.”³²

The move to Pyinmana prompted protests from foreign governments and diplomatic missions and UN agencies in Rangoon. In interviews conducted in August 2006, several representatives of international humanitarian organizations in Burma roundly criticized the government’s relocation and some characterized it as evidence of the junta’s deepening isolation and paranoia. The informants said the move had greatly hindered their access to government officials and caused significant delays in acquiring approvals to launch new projects and travel outside of Rangoon.

The Economy

Today the military dominates nearly all aspects of Burma’s economy. It controls two of the country’s major companies, the Union of Myanmar Economic Holdings (UMEH), whose principal stockholders are military officers, and the Myanmar Economic Cooperation (MEC).³³ An annual report leaked by UMEH in 1995–96 stated that the two main objectives of UMEH are “to support military personnel and their families” and “to try and become the main logistics and support organization for the military.”³⁴ MEC’s purpose is to shift defense funds from the public to the private sector, and MEC is authorized to conduct business in almost any of field of commerce. Meanwhile, the Myanmar Investment Commission, which includes many members of the military cabinet and is controlled by the SPDC, approves all foreign investments in Burma. This arrangement enables the junta to direct resources toward the military companies that dominate the economy, such as UMEH.

The Association of South East Asian Nations (ASEAN) admitted Burma into its ranks in July 1997. There are several theories on the reasons for Burma’s admittance. One suggests that

³² Charlotte McDonald-Gibson, “As Myanmar’s new capital emerges, analysts question its true costs,” *Agence France-Presse*, April 6, 2007. The International Monetary Fund estimates Burma’s GDP for 2005/06 at \$12.2 billion, putting the cost of the new capital between \$122 million and \$244 million.

³³ *Id.* at 24–25.

³⁴ See The Burma Campaign UK, *The EU and Burma: The Case for Targeted Sanctions*, March 2004, www.burmacampaign.org.uk/reports/tageted_sanctions.htm.

Background

Burma's entry into ASEAN made its coveted natural resources, including timber, natural gas, and minerals, more accessible to member nations. Another posits that Burma's inclusion, along with Cambodia and Laos, was part of ASEAN's attempt to gain global power through membership enlargement.³⁵

Traditionally, ASEAN has maintained a strict principle of noninterference with the domestic policies of its members. While the United States and Europe have implemented economic sanctions against Burma's successive military regimes, ASEAN has pursued a policy of "constructive engagement" towards Burma. However, in 2003, ASEAN, in response to an attempted assassination of Aung San Su Kyi by USDA members and paramilitary forces aligned with the military junta, began making gestures towards expelling Burma and calling for the release of political prisoners, including Aung San Suu Kyi.³⁶ In July 2006, the foreign ministers of Malaysia and Indonesia, both ASEAN-member countries, issued harsh rebukes against the Burmese military regime's foot-dragging on promised political reforms.³⁷ In a direct reference to Burma, the Malaysian foreign minister, Syed Hamid Albar, said, "Any action the [Burmese] military takes, like closing down the NLD or not releasing Aung San Suu Kyi are all impediments and obstacles to their credibility in terms of the progress towards democracy."³⁸

The attempted assassination of Aung San Suu Kyi in 2003 prompted the United States to stiffen sanctions already imposed against Burma in 1997. The new measures included bans on imports of Burmese products and the provision of financial services by U.S. citizens. It also placed visa restrictions on officials from the military junta. "The import ban has had a substantial impact on the military junta," according to Jared Genser of the National Endowment for Democracy. "Over a ten-year period, U.S. imports from Burma had grown at an average annual rate of 28 percent a year from \$38 million in 1992 to \$470 million in 2001. As a result of the import ban, all of those imports were immediately cut off."³⁹

If there is any country capable of influencing the Burmese junta's behavior, it is China. Since the early 1990s, China has served as the principal lifeline for the Burmese regime. China's objectives in Burma are twofold. First, China seeks natural resources, such as oil, timber, and gas, to maintain its economic growth. Second, China "wants to secure its security capabilities by expanding its access to the Bay of Bengal and the Andaman Sea thus allowing for greater protection of its 'southwest silk road' trade routes and the development of a modern maritime reconnaissance system."⁴⁰ China is also the principal arms exporter to Burma. Without China's \$1.6 billion in military assistance and naval modernization, Burma would not have been able to create the second largest military, behind Vietnam, in Southeast Asia.⁴¹

³⁵ The admission of these three countries into ASEAN brought the association's population up to nearly 500 million and its land mass to 4.5 million square kilometers.

³⁶ See *CIA: The World Factbook: Burma*, <http://www.cia.gov/cia/publications/factbook/geos/bm.html>.

³⁷ Zin Linn, "Will ASEAN Change its Myanmar Tune?" *Asian Tribune*, July 29, 2006.

³⁸ See Syed Hamid Albar's speech before the ASEAN Inter-Parliamentary Myanmar Caucus, July 21, 2006.

³⁹ Jared Genser, "China's Role in the World: The China-Burma Relationship," Testimony before the U.S.-China Economic and Security Review Commission, August 3, 2006, at 4.

⁴⁰ *Id.* at 2.

⁴¹ See Wayne Bert, "Burma, China and the U.S.A.," *Pacific Affairs*, Vol. 77, No. 2, at 269.

China continues to be one of Burma's major trading partners. In 2005, Burmese trade with China reached \$1.21 billion, equivalent to 20 percent of Burma's foreign trade volume and matching Thai expenditures for roughly the same amount of access to Burma's natural gas. Both countries have announced a target of \$1.5 billion in bilateral trade in the future. Burma has also opened six trade points along the border with China to facilitate further transactions.

In April 2006, China's National Development Reform Commission approved plans to build a pipeline that would carry China's Middle East oil from a deep-water port off Sittwe across Burma to Yunnan, China's southern province. This would provide China with an alternative to the Strait of Malacca, on which it now depends for delivering its oil from the Middle East. To date, China has built 190 miles of Burmese highways, and was planning a 67-mile railroad, the final link in a pan-Asian network.⁴² Today, trucks loaded with Burmese gems, jade, teak, and food, as well as heroin and methamphetamines, pour across the Chinese border. In the opposite direction come trucks carrying Chinese goods such as fuel, housewares, clothes, electrical hardware, and auto parts. Burma is utterly dependent on its powerful neighbor for even the most basic products. "When China spits," a local saying goes, "Burma swims."

The Burmese authorities claim that the economy has been growing more than 10 percent annually in recent years, but, as the International Crisis Group pointed out in 2007, "independent surveys and observations show steadily deteriorating living standards for the large majority of the population, driven by high inflation, weakening health and education systems, and a generally depressed economic environment caused by decades of government mismanagement."⁴³

The Drug Trade

The 1990s were known as the boom days of the drug trade in Burma. By 1993, Burma was cultivating an estimated 165,800 hectares of opium, representing a potential yield of 1,791 tons.⁴⁴ In a 1996 report, the U.S. Embassy in Rangoon placed the value of opiate drug profits at \$922 million.⁴⁵

The drug trade plays a pivotal role in the Burmese economy, both in the public and private sectors and at the national and local level. Some speculate that the ruling regime used profits from the drug trade to finance weapons purchases and expand dramatically the military ranks

⁴² See Tim Johnson, "While Others Push to Free Myanmar, China Takes a More Profitable Path," *The Philadelphia Inquirer*, March 8, 2006 at A02.

⁴³ International Crisis Groups, *Myanmar: New Threats to Humanitarian Aid*, Crisis Group Asia Briefing No. 58, December 8, 2006, at 2.

⁴⁴ A.W. McCoy, "Lord of Drug Lords: One Life as Lesson for U.S. Drug Policy," *Crime, Law & Social Change*, 30:4, 1999 at 301-331. Pho Soke Maung, *Why Did U Khun Sa's MTA Exchange Arms for Peace*, Rangoon: Meik Kaung Press, May 1999.

⁴⁵ U.S. Embassy, *Foreign Economic Trends Report, Burma*, Rangoon, July 1996.

Background

from 180,000 to over 400,000.⁴⁶ Others believe that the Burmese building industry, expanded tourist infrastructure, and shipping and air transport were funded, in part, by narcotics profits.⁴⁷

In poppy-cultivation areas, regional and local military commanders rely on “kickbacks,” procured by protecting labs engaged in heroin processing and through taxes levied on farmers who grow poppies, to supplement their meager wages. It is not uncommon for local military units to coerce farmers to grow poppies, pay a tax on the poppy fields, and then sell the harvest to either the military or merchants of their choosing.⁴⁸ This system has become even more entrenched as the junta has found it increasingly difficult to pay its expanding rank and file soldiers adequately.⁴⁹ In the border regions, military units have been instructed to “live off the land”—either grow their own food or take it from local communities.⁵⁰

At the local level, poppy cultivation and participation in the drug trade help local Burmese provide food for their families, compensate for the lack of public services, and maintain an uneasy relationship with the local military. In 2002, an estimated 440,000 families in Shan State alone relied upon opium cultivation as a primary source of income.⁵¹ By 2006 that number had declined to 126,500 families, representing an estimated 632,500 people.⁵²

In 1999, under international pressure, the junta promulgated its 15-year plan for narcotics eradication, an ambitious plan to render 52 townships drug free by 2014 with investment in roads, bridges, agricultural projects, and law enforcement.⁵³ The SPDC began to extract “drug-free” pledges from militia and ethnic leaders in cease-fire zones where most of the prime poppy-cultivation land lies. In 2001, the UN estimated the gross annual income generated by the drug trade in Burma at \$540 million and, by 2006, that estimate had dropped to \$58 million.⁵⁴

Between 1998 and 2006, the UNODC claims there was an 83 percent decrease in opium cultivation, from 130,000 hectares to 21,000 hectares. The majority of the decline comes from the Northern Shan State, including the Kokang region, with a reported decline in cultivation from 19,600 hectares in 2003 to 6,000 hectares in the 2004 season, and the Wa Region, which the UNODC claims had no opium cultivation in 2006. Nevertheless, in its 2006 survey, the UNODC claimed that opium production increased from 312 metric tons in 2005 to 315 metric tons in

⁴⁶ See A. Selth, *Burma's Armed Forces: Power Without Glory*, Norwalk: Eastbridge, 2002.

⁴⁷ A. Davis and B. Hawke, “Burma. The Country that Won't Kick the Habit,” *Jane's Intelligence Review*, 10:3, March 1998 at 26–31; U.S. Department of State, Bureau for International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report 1998*, Washington, D.C., March, 1999.

⁴⁸ S. Hirsch, “Army Encourages Opium, Farmers Say,” *National Journal*, March 20, 2004, at 880.

⁴⁹ “Burmese Troops ‘Live off the Land,’” *Far Eastern Economic Review*, May 18, 2000, at 10; Karen Human Rights Group, *Abuse Under Orders, The SPDC and DKBA Armies Through the Eyes of their Soldiers*, #2001-01, March 27, 2001.

⁵⁰ Zong Arn, “Officer: We are Forced to Provide for Ourselves,” *Shan Herald Agency for News*, November 17, 2003.

⁵¹ In 2003, that number dropped to 350,000 and in 2004, it dropped again to 260,000 families. UNODC, *Myanmar Opium Survey 2003*, Vienna, June 2003; UNODC, *Myanmar Opium Survey 2004*, Vienna, October 2004.

⁵² See UNODC, *Opium Poppy Cultivation in the Golden Triangle. Lao PDR, Myanmar, Thailand*, Vienna, October 2006.

⁵³ Central Committee for Drug Abuse Control, *Efforts of Myanmar in Elimination of Narcotic Drugs. Annual Report 2001*, Rangoon, 2001.

⁵⁴ S. Hirsch, “Interview with UNODC Myanmar Representative Jean-Luc Lemahieu,” *Asian Tribune*, December 19, 2003.

2006, reflecting an increase in yield from opium poppies from 9.5 kg per hectare to 14.7 kg per hectare in 2006.⁵⁵

Some experts, however, claim that the eradication programs have not been that effective and have resulted in abuses of local farmers and their families. (See box: Opium Eradication and Human Rights.) They believe that the reduction in opium cultivation is the result of many factors, including multiple poor rainy seasons, drought, and the rise in manufacture of amphetamine-type stimulants or ATS. (ATS does not bear the stigma of “drug addiction” that opium or heroin consumption carry, and is seen as a “work drug” and more sociable, leading to increased use among rural communities in Burma, Thailand, and Laos.) Others claim that the reduction of poppy cultivation is not sustainable and will result in raising the price of opium, providing a market incentive for farmers to return to opium cultivation.

Despite these reductions, Burma remains Southeast Asia’s largest source of drugs. Addiction to Burmese heroin has expanded rapidly on both sides of the China border, particularly in Yunnan Province, and in the Indian border state of Manipur, which has one of the highest rates of HIV infection in India. These epidemics are fueled by injection drug use. Thailand has also felt significant impact from Burmese drugs: in 1999, the Thai Development Research Institute noted that the Burmese drug trade played a significant role in the growing addiction of Thais to heroin and amphetamines. Thai officials estimated that 600 million amphetamine pills produced in Burma entered Thailand in 2000 alone.⁵⁶

Some Chinese officials have expressed concern about drug trafficking and the spread of HIV/AIDS on the China-Burma border. During a visit of Burmese Prime Minister Soe Win in February 2006, Chinese Premier Wen Jiabao said that the spread of narcotics along China’s border with Burma had “severely damaged the local society” and that the drug trade “must be controlled through severe measures.”⁵⁷ Five months later, Chen Cunyi, the deputy secretary-general of China’s National Narcotics Control Commission, said that the northern region of Burma is the main source of drugs coming into China and presents the biggest nuisance to his nation.⁵⁸

⁵⁵ UNODC, *supra* note 52.

⁵⁶ “Burmese Troops ‘Live off the Land,’” *supra* note 46.

⁵⁷ “Premier Wen Jiabao Holds Talks with Prime Minister of Myanmar Soe Win,” Chinese Foreign Ministry Press Release, February 14, 2006.

⁵⁸ See BBC Monitoring International Reports, “China Faces ‘Pincer Attack’ of Narcotics from Burma, Afghanistan,” *Financial Times*, July 4, 2006.

Opium Eradication and Human Rights

Since 1999 the Burmese government and UNODC have been engaged in an aggressive campaign to eradicate poppy cultivation and heroin production in eastern Burma. While successfully reducing heroin production, the campaign has resulted in widespread violations of human rights, including forced relocation, food insecurity, and destruction of property without compensation, affecting thousands of families who once relied on poppy growing for their livelihood.

Although UNODC has attempted to develop crop replacement initiatives including fruit, lychee, tea and rubber plantations and basic manufacturing such as liquor and tobacco factories, mining and limited construction, these initiatives have often faltered, leaving poor farmers with few alternatives to feed their families. Former UNODC country head Jean-Luc Lemahieu believes that approximately two million farmers were affected by the eradication in 2005 alone.

The World Food Program (WFP) has stepped in to provide emergency assistance where failing crop replacement projects in Shan State have left farmers and their families without food. In late 2003, the WFP staged an emergency feeding program for 50,000 farmers in the Kokang area of Shan State and, in March 2004, began a one-year project to feed 180,000 more farmers.

In the Kokang area of Shan State, thousands of villagers have left their homes in search of food and employment after the Burmese military and Kokang authorities destroyed their opium fields. Clinics were closed and schools experienced a sharp decline in attendance as people were forced to travel in search of food and employment.

Between 1999–2001, the United Wa State Army, an ethnic cease-fire group, forcibly relocated up to 120,000 people from the Northern Wa State, a popular poppy cultivation region, to locations in the Southern Wa Area and to villages along the Thai border. Thousands of people died during the relocation as conditions in the new settlements led to massive outbreaks of malaria and anthrax. Furthermore, many of the settlement sites were already occupied, and existing Shan, Akha and Lahu villages, with an estimated 48,100 people, were also displaced.

*David Scott Mathieson
Human Rights Watch*

Sources: L. Jagan, "End of the Road for Burma's Drug Barons," *Bangkok Post* (Perspective), October 17, 2004 at 1 and Lahu National Development Organisation, *Unsettling Moves: The Wa Forced Resettlement Program in Eastern Shan State (1999–2001)*, Chiang Mai, April 2002.

The United Nations

The United Nations has largely failed in its efforts to persuade the Burmese regime to improve its human rights performance. So far, the military regime has ignored 28 consecutive non-binding UN resolutions, as well as appeals from four special envoys from the now defunct UN Commission for Human Rights, and two special envoys from former Secretary-General Kofi Annan.⁵⁹ In January 2007, China and Russia blocked the Security Council from demanding an end to political repression and human rights abuses in Burma by rejecting a resolution proposed by the United States. The vote was 9-3 in favor of the resolution, with South Africa joining China and Russia in the opposition. Indonesia, Qatar, and the Republic of Congo abstained. While they were in the minority, China and Russia were able to halt the resolution because they have veto power as permanent members of the council.⁶⁰

The Future

Burma's military regime continues to refuse to share power, decentralize decision-making, introduce measures to reform the economy, and respect basic human rights and international humanitarian law. This situation is further compounded by the deep-seated intransigence of the more conservative elements of the junta who hold absolute power over their ministries. The military regime's recent actions—the flawed National Convention with no seat at the table for the main lawful political parties and the lack of progress on the so-called roadmap to democracy; the continued detention of Aung San Suu Kyi (extended by the junta for another year on May 25, 2007, despite international calls for her release from the UN Secretary-General Ban Ki-moon, ASEAN, the European Union, and 59 former presidents and prime ministers); 61 widespread violations of international humanitarian law in eastern Burma; the continued detention of over 1,000 political prisoners; restrictions on the travel and activities of international organizations; and finally, the regime's growing inscrutability and unpredictability, as demonstrated by the manner of the shifting of the seat of government from Rangoon to Pyinmana in November 2005—hardly bode well for the future.

Indeed, without fundamental changes, the welfare of the majority of Burmese people will likely continue to decline. Of the many threats the Burmese people face, the possibility of sickness and death due to malaria, TB, and HIV/AIDS looms as one of the greatest.

⁵⁹ See Joseph Elderidge, "What International Support for Argentina Can Teach Us about Burma," *Asian Tribune*, November 29, 2006.

⁶⁰ See "Burma: Security Council Resolution Fails," *Associated Press*, January 15, 2007.

⁶¹ See *Agence France-Presse*, "Myanmar's Suu Kyi detained against international law," May 31, 2007.

4. The Politics of Foreign Aid

*There are no humanitarian solutions to humanitarian problems.*¹

Sadako Ogata, Former UN High Commissioner for Refugees

*By necessity we practice “the art of adaptability.” The Burmese authorities will grant travel permits for a few months at a time, then suddenly for some reason it all comes to a halt. So we wait, essentially under ‘city arrest’ in Yangon [Rangoon]. We submit travel requests and ask ministry officials to expedite our paperwork. Then one day, suddenly, without explanation, conditions improve and things begin moving again.*²

Foreign aid worker, Rangoon

In a major shift in the mid-1990s, Burma’s military junta began allowing international aid organizations to set up programs, particularly in the fields of health, education, and economic development, in Burma. But it was an uncomfortable relationship.³ The military authorities remained suspicious of Westerners, often referred to them in speeches as “neo-colonialists” impinging on Burma’s sovereignty, and tried to funnel assistance through government-affiliated groups, such as the Union Solidarity and Development Association (USDA). Writes Christina Fink:

The regime often sought to channel assistance towards [local] organizations working to support its own political objectives. For instance, a UNDP [United Nations Development Programme] household survey which was given to the government’s statistical office was then farmed out to members of the Union Solidarity and Development Association to administer. In 1996, two international organizations financed a health-related publication put out by the Myanmar Maternal and Child Welfare Association (MMCWA). Besides health news, the funded issues also ended up including MMCWA speeches criticizing ‘internal destructionists,’ in other words, the National League for Democracy. Such actions made it difficult for international [aid organizations] that wanted to continue to help ordinary citizens but could not stop the authorities from interfering or politicizing their assistance.⁴

Foreign aid workers, meanwhile, had to be circumspect to avoid angering the generals who could easily terminate their programs or deny them access to project sites. In a few cases, Fink writes, military commanders forced aid workers “to hand over vehicles ... in return for being able to

¹ Quoted in David Rieff, *A Bed for the Night: Humanitarianism in Crisis*, New York: Simon and Schuster, 2002 at 22.

² Interview with a foreign aid worker in Rangoon in August 2006.

³ In 1999, the International Committee of the Red Cross returned to Burma after a four-year absence because of the regime’s refusal to allow ICRC visits to political prisoners.

⁴ Christina Fink, *Living Silence: Burma under Military Rule*, London: Zed Books, 2001 at 247–48.

continue their programmes.”⁵ Despite these problems, some foreign aid organizations, by identifying and working with progressive and dedicated people within the government ministries, managed to launch a number of beneficial activities.

Not everyone supported the presence of foreign aid organizations in Burma. Some of the most vocal critics were Burmese pro-democracy representatives living abroad who argued that international aid only lent legitimacy to an illegitimate regime. Foreign assistance, they argued, allowed the military junta to divert monies slated for health care and education into the coffers of the armed forces. In response, international organizations argued that withholding intervention would be immoral given Burma’s dire health situation. Having an international presence in the country, they said, “was important in and of itself, because of the witnessing role [they] could play and the dialogues they could initiate with people in and out of government.”⁶

The debate over whether or not to provide Burma’s repressive regime with humanitarian aid was by no means unique to Burma. By the 1990s, the world was experiencing outbreaks of intrastate violence that forced governments and international aid groups to grapple with the value and pitfalls of providing aid in less-than-ideal circumstances. Among the concerns were whether or not emergency aid only serves to support existing military and political structures, whether it creates dependence on the part of recipient states, and whether it fails to address root causes of the violence. To understand how this debate has unfolded in Burma, it is worth examining the concept of “humanitarianism” and some of the ways it has evolved in theory and practice in recent years.

Humanitarian Aid and Human Rights

“Humanitarianism,” writes David Rieff, “is by definition an emblem of failure, not success. The disaster has already happened: the famine has started; the cholera is raging; or the refugees are already on the move.” When a natural or man-made disaster occurs, UN agencies and international and national nongovernmental organizations rush to the scene in an effort to save lives by providing “five essential” types of aid: protection/rescue, health, food, water, and shelter.⁷

Over the last century the organization that has most epitomized the values of humanitarianism has been the International Committee of the Red Cross (ICRC). The ICRC adheres to the principles and modalities of *humanity* (saving human lives and alleviating suffering wherever it is found); *impartiality* (implementing actions solely on the basis of need, without discrimination between or within affected populations); *neutrality* (neither favoring any side in an armed conflict or other dispute, nor engaging in controversies of a political, ethnic, religious, or ideological nature); *independence* (acting solely in the interests of victims); *proximity* (retaining close proximity to people in need of protection and assistance); *confidentiality* (keeping findings and recommendations confidential, sharing them only with the authorities concerned); and *transparency* (keeping the modalities of its work always the same, thus rendering it highly

⁵ Id. at 247.

⁶ Id. at 248.

⁷ Philip White and Lionel Cliffe, “Matching Response to Context in Complex Political Emergencies: ‘Relief’, ‘Development’, ‘Peace-building’ or Something In-between?” *Disasters* 24:4, 2000, 314–42 at 322.

predictable).⁸ These seven principles are predicated on ICRC's belief that humanitarian activities must not be influenced by political considerations.

While ICRC steadfastly abides by these principles, it has been criticized for failing to expose mass atrocities because of its strict adherence to the principle of neutrality. After the Second World War, ICRC was denounced for having knowledge of the Nazi concentration camps but being unwilling to make this information public for fear of forfeiting its access to prisoners of war and civilians.⁹ During the civil war in Biafra in the late 1960s,¹⁰ the British aid organization Oxfam broke ranks with ICRC because the latter was unwilling to speak out against war crimes being committed by the Nigerian military.¹¹ Later, Bernard Kouchner, a French doctor serving with the ICRC in Biafra, resigned from the organization because, in his words, ICRC workers had become "accomplices in the systemic massacre of a population."¹²

Kouchner went on in 1971 to establish Médecins Sans Frontières (MSF), a humanitarian aid organization that embraced the "right of criticism" or "denunciation" of governments or rebel groups that violated human rights.¹³ Twenty-eight years later, upon receiving the Nobel Peace Prize, then-MSF president James Orbinski questioned the principle of neutrality: "[S]ilence has long been confused with neutrality and has been presented as a necessary condition for humanitarian action. From its beginning, MSF was created in opposition to this assumption. We are not sure that words can always save lives, but we know that silence can certainly kill."¹⁴

By the 1990s, a growing number of relief organizations and donor governments had begun to embrace MSF's "rights-based approach" to humanitarian assistance.¹⁵ "When considered through the justice/human rights lens," Catholic Relief Services (CRS) said in 1999, "the mere provision of foodstuffs or medical supplies is an insufficient response to a humanitarian crisis."¹⁶ Relief assistance, CRS argued, should address the root causes of armed conflict and societal dislocation, not merely tend to its symptoms. In a radical departure from the founding principles of humanitarianism, some organizations maintained that aid should be withheld if governments failed to comply with their obligations under international human rights and humanitarian law.

⁸ See <http://www.icrc.org>. See also David Chandler, "The Road to Military Humanitarianism: How the Human Rights NGOs Shaped a New Humanitarian Agenda," *Human Rights Quarterly* 23, 2001, 678–700 at 679.

⁹ See Jean-Claude Favez, *The Red Cross and the Holocaust*, Cambridge: Cambridge University Press, 1999.

¹⁰ The crisis in Biafra involved the war of independence being fought by Igbo secessionists of the Biafra state in southeastern Nigeria against the federal government. The secessionist struggle received no diplomatic support from the West, the Soviet bloc, or other African states, which were concerned over the destabilizing effects of questioning state borders. Within a few months, the dominance of the government forces and lack of outside aid doomed the struggle to failure. The government's violent response to quell the uprising led to international coverage of widespread suffering and starvation among civilians. Chandler, *supra* note 8 at 684.

¹¹ *Id.* at 684.

¹² *Id.*

¹³ *Id.* at 685.

¹⁴ *Id.*

¹⁵ Much of the impetus came from the controversy over the delivery of aid to over a million Rwandan refugees (many of whom were responsible for mass killings in Rwanda) in the camps of Zaire. White and Cliffe, *supra* note 7 at 319.

¹⁶ Fiona Fox, "New Humanitarianism: Does it Provide a Moral Banner for the 21st Century?" *Disasters* 25:4, 2000, 275–89 at 278.

Rights-based humanitarianism also had its critics. Opponents contended that such an approach placed the political behavior of governments over the basic needs of victims and therefore contradicted the very principles of humanity and universality. Critics argued that a human rights approach to humanitarian aid would divide vulnerable populations into “deserving” and “undeserving” victims. They pointed to the suffering of the Afghans (under the Taliban government) and Serbs (under Milosevic)—both groups that had been singled out as “undeserving” victims because their governments failed to comply with human rights or political mandates.¹⁷

Further compounding the human rights debate was the growing trend by donor governments to combine humanitarian assistance with development aid. Traditionally, the two forms of assistance had been viewed as distinct and often unrelated responses to different sets of human needs and conditions.¹⁸ Unlike the urgent lifesaving objectives of humanitarianism, development aid implied a process of moving a developing country “forward in the direction of peace, justice, social equity, and an absence of, or at least a declining trend in ignorance, disease, and poverty.”¹⁹ To be effective, development aid was usually conditioned on the existence of an internationally accepted state that was willing to adopt anti-corruption measures and comply with its human rights obligations.²⁰ Viewed as a continuum, humanitarian relief was the “first responder” to man-made and natural disasters, providing assistance, largely through nongovernmental organizations, to save lives and alleviate suffering. As the emergency stabilized, humanitarian assistance would give way to rehabilitation work and eventually to long-term development projects.

However, the “humanitarian aid–development continuum” failed to address the emergence of intrastate wars in the 1990s and the resultant increase in refugees and internally displaced persons.²¹ These so-called “complex political emergencies,” or CPEs,²² were characterized by (a) ongoing and protracted violence and widespread violations of international human rights and humanitarian law; (b) the presence of a parallel economy that included the export of drugs, timber, precious stones, and other natural resources; (c) the manipulation of social and cultural identities; and (d) the aim of belligerents to control and, in extreme cases, persecute or destroy specific civilian populations.²³ Burma’s eastern regions, mired in conflict for decades, easily met this definition, as did zones of conflict in Afghanistan, Democratic Republic of Congo, Liberia, Somalia, Sri Lanka, and Sudan throughout the 1990s.

¹⁷ Much of this was spurred on by the growing influence that donor governments were having on the activities of relief organizations. For example, by the mid-1980s, the United Kingdom was channeling 70 percent of its aid to Sudan through nongovernmental organizations. (Fox, *supra* note 16 at 282.) In a similar move, the British government announced in 1998 that any relief organization sending British citizens to Afghanistan would be automatically disqualified from Department for International Development (DFID) funding. While the government couched this restriction in terms of security, some believe it was motivated more by Britain’s efforts to isolate the Taliban regime. See also Chandler, *supra* note 8 at 686 and Devon Curtis, “Politics and Humanitarian Aid: Debates, Dilemmas and Dissension,” Overseas Development Institute Humanitarian Policy Group Report 10, April 2001 at 9.

¹⁸ White and Cliffe, *supra* note 7 at 315.

¹⁹ *Id.* at 322.

²⁰ *Id.* at 324.

²¹ Nicolas Leader, “Proliferating Principles; Or How to Sup with the Devil without Getting Eaten,” *Disasters* 22:4, 1998, 288–308 at 291.

²² See M. Duffield, *Global Governance and the New Wars: The Merging of Development and Security*, London: Zed Books, 2001.

²³ *Supra* note 21 at 291.

Complex political emergencies challenged the theoretical division separating humanitarian aid from long-term development programs and called for interventions of a different nature. CPEs are protracted crises, often lasting for years and even decades, where the “emergency” is seldom “over.” Fighting between belligerents tends to ebb and flow and migrate geographically depending on the conditions on the ground. The lack of a finite endpoint to the violence, a traditional precondition for humanitarian aid to evolve into development aid, makes it difficult to progress beyond saving lives or, when fighting abates, to implement short-term livelihood rehabilitation programs.²⁴ These stopgap measures may include support to improve livelihoods through the provision of seed, tools, fertilizers, livestock, veterinary supplies, and fishing gear.²⁵

The Challenges and Obstacles of Humanitarian Aid

Foreign aid workers arriving in Burma in the 1990s faced formidable challenges and obstacles. Indeed all of Burma was in need of either long-term infrastructure development or emergency aid. Development programs were needed in the government-controlled “white zones,” which constituted most of the country, to combat poverty and the spread of infectious diseases, while emergency aid and short-term rehabilitation programs were urgently needed to support displaced communities in the conflicted “black zones” along the Thai-Burma border, and in the “brown zones,” or cease-fire areas, in which an uneasy truce existed between government troops and ethnic rebel forces. Responding to these needs bedeviled foreign aid organizations, which had to learn to adapt to the whims of the Burmese authorities.

By the early 2000s, Burma’s military rulers had begun to show a new willingness to work with the international community, and pro-democracy groups modified their call for isolating the regime. At the same time, international organizations, including the International Labor Organization (ILO), the United Nations High Commissioner for Refugees (UNHCR), and ICRC, launched new initiatives on forced labor, prison visits, and aid programs for conflict-affected populations. From 2001 to 2004, the number of international nongovernmental organizations working in Burma grew from 30 organizations with a total budget of \$15 million to 41 organizations with double that amount. Meanwhile, foreign aid for Burma doubled from around \$75 million in 2000 to \$150 million in 2005. In the health sector, international funding to combat HIV/AIDS, which the government had denied existed only a few years earlier, rose from less than \$1 million in 2000 to \$21.5 million in 2005.²⁶

Many observers credited General Khin Nyunt, then serving as both military intelligence chief, prime minister, and chair of the junta’s health committee, for facilitating the ability of aid organizations to deliver services in central Burma and some border areas in the early 2000s. Aid organizations welcomed the increased humanitarian space, which allowed them to move about

²⁴ It appears that short-term livelihood rehabilitation is sometimes broadly defined as “relief” and sometimes not. In the same article, livelihood rehabilitation that included agricultural assistance was said to be broadly defined as relief by UN Food and Agriculture Organization (FAO) but that livelihood rehabilitation in the form of food aid to pastoralists to build up their depleted herds was not considered relief. White and Cliffe, *supra* note 7 at 322.

²⁵ *Id.* at 322.

²⁶ Interviews with foreign aid workers in Rangoon in August 2006. See also International Crisis Group, *Myanmar: New Threats to Humanitarian Aid*, Asia Briefing No. 58, Yangon/Brussels, December 8, 2006, at 4–5.

the country more freely. When problems arose, they were often able to use contacts in military intelligence to resolve them.²⁷

However, the halcyon days of relief assistance in Burma were short-lived. On October 11, 2004, the military junta deposed Khin Nyunt, and the situation for aid organizations began to deteriorate rapidly. Within weeks, contacts between foreign relief workers and regime officials dropped off precipitously, and aid workers stationed in sensitive parts of the country found it increasingly difficult to access project sites.²⁸ In July 2005, new rules on travel were issued, and the authorities began encouraging international agencies to work more closely with government-affiliated organizations, such as the regime's main civilian-front organization, the Union Solidarity and Development Association (USDA). As the noose tightened, some donor agencies and humanitarian groups found ways of circumnavigating these new requirements, while others began to downsize their programs.

The Global Fund

In August 2005, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) became the first foreign aid agency to withdraw funding from Burma. A year earlier, the Global Fund had signed a contract with the United Nations Development Programme (UNDP) to disperse \$98.4 million over a five-year period to WHO, UNAIDS, and UNICEF and seven international humanitarian organizations²⁹ to combat HIV/AIDS, tuberculosis, and malaria in Burma. UNDP and its "implementing partners or sub-recipients" would be assisted by four national nongovernmental organizations: Myanmar Council of Churches, Myanmar Anti-Narcotics Association, Myanmar Medical Association, and Myanmar Nurses Association.³⁰ Among other things, the UNDP would fund programs to provide DOTS therapy for people suffering from tuberculosis and provide HIV testing and antiretroviral drugs (ARV) through a network of community-based health clinics.³¹

Before issuing grants, the Global Fund had instituted an "Additional Safeguards Policy" to be applied to funding in Burma and four other countries (Cuba, Iran, North Korea, and Sudan) where conditions suggested that funds could be placed in jeopardy without the use of additional measures. These conditions included:

²⁷ Id. at 5.

²⁸ U.S. Government Accountability Office, Report to the Committee on Foreign Affairs, House of Representatives, *International Organizations: Assistance Programs Constrained in Burma*, April 2007, GAO-07-457 at 17. Beginning in the late 1990s, General Khin Nyunt initiated a number of moves to test the environment for change. These moves included the resumption of activity in Burma of the ICRC in 1999, the acceptance of a new Special Envoy of the UN Secretary-General in 2000, the acceptance of a new UN Special Rapporteur for Human Rights in 2001, the commencement of a dialogue on forced labor with the International Labor Organization in 2000, and the acceptance of a Japanese-proposed program on structural adjustment of the economy in 2000.

²⁹ These consisted of Population Services International, Burnet Institute (Center for Harm Reduction), CARE Myanmar, CESVI Cooperation and Development, World Vision Myanmar, Marie Stopes International, and Médecins du Monde.

³⁰ The Global Fund to Fight AIDS, Tuberculosis and Malaria, *supra* note 27 at 1–5.

³¹ By the time of the pull out, the Global Fund had disbursed \$6.1 million of \$54.3 million for HIV/AIDS, \$3.0 million of \$27.0 million for malaria, and \$2.7 million of \$17.1 million for tuberculosis. See The Global Fund to Fight AIDS, Tuberculosis and Malaria, *supra* note 27 at 1. See also Andrew Marshall, "AIDS: Burma's Shadowy Mass Export," *The Irrawaddy*, July 2006, at 24.

1. significant concerns about governance
2. lack of process of identifying a broad range of implementing partners
3. major concerns about corruption
4. widespread lack of public accountability
5. recent or ongoing conflict in the grant environment
6. poorly developed civil society/lack of civil society participation
7. lack of a proven track record in managing donor funds in the health sector³²

The Global Fund instituted several specific safeguards to protect its assets in Burma. First, it sought and received the approval of the National League for Democracy. Second, it placed all entities receiving Global Fund grants under the continuous scrutiny of KPMG, an auditing firm with offices in Rangoon. Third, it received written assurances from the Burmese government that “the staff from UNDP, KPMG, and the Global Fund would have unhindered access to program sites.”³³ Fourth, it required that the UNDP and other grant recipients ensure that the Burmese government “did not benefit from, or take credit for, actions conducted with Global Fund funding.” Finally, it established a “zero cash policy,” which meant that no national entities were to receive any funds from the grants. UNDP would undertake all procurement of assets and payment of incidental expenses for food and transport of individuals (e.g., health, technical, and community workers). The UN agency would also implement all contracts and maintain ownership of all assets. In effect, this meant UNDP would serve as a shadow ministry of health in the fight against HIV/AIDS, tuberculosis, and malaria in Burma.

In announcing its withdrawal, the Global Fund said the regime’s new travel restrictions had limited the ability of its implementing partners and staff to access implementation areas. According to the Global Fund,

the government also imposed additional procedures for review of procurement of medical and other supplies (a vital aspect of Global Fund project implementation). As a result, the Global Fund concluded that these measures would effectively prevent the implementation of performance-based and time-bound programs in the country, breach the government’s commitment to provide unencumbered access, and frustrate the ability of the Principal Recipient to carry out its obligations. The travel restrictions appear to be the most recent manifestation of a gradual change in the government’s attitude towards international and national humanitarian efforts in Myanmar over the past few weeks.³⁴

The Global Fund’s withdrawal from Burma immediately became a bone of contention both inside and outside of the agency.³⁵ Many foreign aid workers in Rangoon rejected the Global Fund’s explanation for its withdrawal and characterized it as papering over the truth. The Global Fund’s withdrawal, they said, had less to do with the actual conditions on the ground and more

³² The Global Fund to Fight AIDS, Tuberculosis and Malaria, *supra* note 27 at 3–4.

³³ *Id.* at 4.

³⁴ The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Fact Sheet: Termination of Grants to Myanmar*, August 18, 2005, at 1–2.

³⁵ This impression is based on interviews with staff members at the Global Fund’s headquarters in Geneva in October 2006 and with foreign aid workers in Rangoon in August 2006.

with pressures from three U.S. Senators,³⁶ Burmese human rights advocates in Washington, D.C., and the Open Society Institute (OSI),³⁷ a New York–based foundation that funded the research for and publication of this report.³⁸ Other foreign aid workers were unsure about the politics surrounding the withdrawal of the Global Fund but believed the agency had acted too hastily. They argued that before leaving Burma the Global Fund should have given the Burmese authorities an ultimatum: either lift the travel restrictions or lose the funding.

The International Crisis Group (ICG), in a briefing paper on Burma published in December 2006, gave voice to the views of many foreign aid workers about the withdrawal of the Global Fund. While critical of the Burmese government’s “aggressively nationalistic line” and “new restrictions on international agencies, including aid organizations,”³⁹ ICG argued that “political figures and activists in the United States,”⁴⁰ through their pressure on the Global Fund and UNDP headquarters in New York, (1) undermined the UNDP’s ability to disperse funds efficiently to its partnering organizations in Burma, (2) contributed to further straining of relations between foreign aid groups and the Burmese regime, and (3) hastened the withdrawal of the Global Fund from Burma.

In making these charges, ICG pointed to letters sent by three U.S. Senators to the executive director of the Global Fund in September 2004 criticizing the organization and the UNDP for

³⁶ The senators alleged to have been involved in the Global Fund pullout were Senator Sam Brownback, Chairman, U.S. Senate Subcommittee on East Asia and Pacific Affairs; Senator Judd Gregg, Chairman, U.S. Senate Committee on Health, Education, Labor, and Pensions; and Senator Mitch McConnell, Chairman, U.S. Senate Subcommittee on Foreign Operations.

³⁷ Interviews with foreign aid workers in Rangoon in August 2006. See also International Crisis Group (ICG), *supra* note 25 at 12. The ICG briefing stated that “U.S.-based advocacy groups led by the Open Society Institute put strong pressure on the Global Fund to institute additional safeguards on its Myanmar programs.” The ICG briefing went on to cite a memorandum sent by OSI president Aryeh Neier to Brad Herbert of the Global Fund on September 24, 2004, in which OSI insisted that “none of [the Global Fund’s] programs should be conducted by or with financial assistance to the ruling military junta or government-organized NGOS (GONGOS).” The ICG report concluded that as a result of this memo “the Global Fund introduced tighter restrictions on use of its funds [in Burma], to the point that compromised program effectiveness, and seemed in breach of its own regulations.” In a response to the ICG briefing, Neier wrote that his memo to the Global Fund stated that OSI was in favor of the Global Fund grants moving forward, but with one condition: no funding for the military or GONGOS. The memo to the Global Fund also stated that “[t]his condition should not impede progress in the short term. There are legitimate NGOs that are in a position to undertake this work. Population Services International, for example, is already a sub-recipient of the Global Fund grant. Other NGOS can be engaged, among them Catholic Relief Services, Care International, Save the Children (U.S.), MSF Holland, World Vision and World Concern.” Aryeh Neier’s memorandum, “Critique of ICG Briefing on Burma,” January 17, 2007, was written in response to the ICG briefing, *supra* note 25, and is in the files of the Human Rights Center, University of California, Berkeley.

³⁸ OSI also provided funds to the Human Rights Center, University of California, Berkeley and the Center for Public Health and Human Rights, Bloomberg School of Public Health, Johns Hopkins University to convene a regional conference on “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” which was held in Bangkok on January 24–25, 2007. The conference brought together 190 participants, representing 95 institutions from nine countries—Australia, Bangladesh, Burma/Myanmar, China, India, Thailand, Singapore, United States, and Vietnam—to discuss the efforts of governments, UN agencies, nongovernmental organizations, and health clinics to lessen the burden of infectious diseases in Burma/Myanmar and the border regions. UC Berkeley and JHU have solicited further funding from OSI to provide training to nongovernmental organizations working to lessen the burden of infectious diseases in Burma and the border regions.

³⁹ International Crisis Group, *supra* note 25.

⁴⁰ International Crisis Group, *Crisis Group Response to OSI Critique of Asia Briefing No. 58, Myanmar: New Threats to Humanitarian Aid*, signed by ICG president Gareth Evans, January 20, 2007.

“failing to recognize that the SPDC [military regime] is solely responsible for creating the myriad humanitarian crises faced by Burma today,” and requesting that the Global Fund “withhold the disbursement of additional funds to Burma.”⁴¹ According to ICG, when the Global Fund refused to adhere to these conditions,

the Congress went after UNDP. In early 2005, Senator Mitch McConnell introduced an amendment to the 2006–2007 Foreign Appropriations Bill, which threatened to withdraw about \$50 million—roughly half—of U.S. core funding for the agency if it failed to certify that all its programs in Myanmar, including those it administered for others such as the Global Fund, provided “no financial, political, or military benefit, including the provisions of goods, services, or per diems, to the SPDC or any agency or entity of, or affiliated with, the SPDC.” Although the bill did not specifically mention the Global Fund, it was a thinly veiled attempt to force the UNDP to withdraw as the principal recipient of its money, a step which likely would have led to termination of the programs.⁴²

ICG was critical of both the Burmese military junta for its imposition of restrictions on the work of relief workers and foreign politicians and others who might wish to stop foreign aid altogether or place onerous conditions on it because of Burma’s terrible human rights record. “Iraq, Afghanistan, and Somalia all illustrate the many risks of allowing states to fail,” ICG argued. “Humanitarian aid is not a solution to [Burma’s] fundamental political and human rights problems: it is an emergency response in a situation with no good options.”⁴³

Two Global Fund executives who were at the agency at the time of the Burma pullout—Sir Richard G. A. Feachem, former Executive Director, and Brad Herbert, former Chief of Operations—reject any implication that the U.S. Congress or others influenced the agency’s decision to withdraw from Burma. Feachem says he made the decision on the advice of his then-Chief of Operations and other relevant senior staff. According to Herbert, neither Senator McConnell nor anyone associated with him had any part in the decision to cancel the grant.⁴⁴

Another high-level official in the Global Fund’s headquarters in Geneva acknowledged in an interview in November 2006 that “members of the U.S. Senate had at one point caused ‘a lot of noise’ over the Global Fund’s grant to Burma,” but ultimately the agency made its decision to withdraw based solely on the agency’s “hands off, performance-based approach” to grantmaking. This process, he said, “was simply not suited to a closed society like Burma.”⁴⁵ He said the Global Fund was designed to hold its principal recipients, such as the UNDP, to high standards of transparency and accountability. He referred to a Global Fund report that states: “Grant funding is not ‘owned’ by the people and organizations managing and implementing programs, and it can be lost if it is not efficiently managed and used to reach people in need of services.”⁴⁶

⁴¹ International Crisis Group, *supra* note 25 at 12.

⁴² *Id.*

⁴³ International Crisis Group, *supra* note 37.

⁴⁴ Aryeh Neier, *supra* note 35.

⁴⁵ Interview with Global Fund staff member in October 2006 in Geneva.

⁴⁶ The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Investing in Impact: Mid-Year Results Report, 2006*, Geneva, Switzerland at 12.

“Our withdrawal from Burma was clear cut,” the Global Fund official said, “the UNDP and its implementing partners were unable to uphold their oversight role because of conditions set by the government. And when we looked closer, we found that our funds were having only a marginal benefit to those most in need. Taken together, those two factors prompted us to terminate the program.” But another Global Fund staff member who closely observed the agency’s withdrawal from Burma saw it differently. He said that the “political agenda” set by the U.S. senators and Burmese advocacy groups in the United States played a major role in “strangling the Fund’s program in Myanmar.”⁴⁷

Whatever the reason (or reasons) for the Global Fund’s withdrawal from Burma, the incident underscored the difficulties donors face when they try to provide aid, especially “performance-based aid,” to nongovernmental institutions in a highly repressive military state. It also demonstrated why humanitarian assistance, as much as we might wish it to be, cannot be isolated from political realities on the ground. Indeed, humanitarianism and humanitarian aid reside not above the political world but in its very midst.

Médecins Sans Frontières (MSF-France)

In December 2005, four months after the Global Fund departed from Burma, MSF-France became the first international relief organization to pull out of the country. Citing government restrictions on staff travel to project areas as the primary cause for the withdrawal, the group’s in-country representative, Herve Isambert, said it had been very difficult “to provide equal access to health care. So by virtue of the poor performances of last year, we have decided to pull out.”⁴⁸ Once outside of the country, Isambert suggested that the military junta wanted “to get rid of all humanitarian workers in . . . politically sensitive regions. The restrictions imposed on us reduced us to the role of specialist contractors subjected to the political will of the military junta. In reality, the Myanmar authorities do not want anyone to witness the acts of violence they are committing against their own people.”⁴⁹

Government Restrictions on International Organizations

In February 2006, the Burmese Ministry of National Planning and Economic Development formalized the kind of travel restrictions that had led to the departure of the Global Fund and MSF-France the year before. The *Guidelines for UN Agencies, International Organizations and NGOS/INGOS on Cooperation Programme in Myanmar* (hereafter referred to as the “Guidelines”) set out in detail the steps foreign aid organizations had to follow to develop Memoranda of Understanding (MOU), open and register field offices, vet new staff members, acquire approval for internal travel, manage equipment purchases, and coordinate with state and division authorities. A senior official of the ministry told representatives from the U.S. Government Accountability Office (GAO) in 2006 that, among other things, the guidelines

⁴⁷ Interview with Global Fund staff member in October 2006 in Geneva.

⁴⁸ Shah Paung, “Another international aid group pulls out,” *The Irrawaddy*, December 20, 2005.

⁴⁹ See “Medical charity pulls French staff from Myanmar,” *Agence France-Presse*, March 31, 2006.

would help address the tendency of some international humanitarian entities to become involved in what the official referred to as “political matters.”⁵⁰

The English version of the Guidelines is highly restrictive (see Appendix). But the Burmese language version, which has not been distributed formally to the international community, is even more restrictive. A senior UN official familiar with the full range of UN programs in Burma told GAO representatives that three of the new government restrictions “were not acceptable to the United Nations.” These restrictions would require international organizations to

- agree that their programs will “enhance and safeguard the national interest,” “prevent infringement of the sovereignty of the State,” and “be on the right track ... to contributing to the socio-economic development of the Nation”
- coordinate their work with local and state coordinating committees that include representatives of the Union Solidarity and Development Association and similar government-backed groups
- select their Burmese national staff from government-prepared lists of individuals

Representatives of UN agencies and foreign aid organizations interviewed in Rangoon in August 2006 offered varying views about why the Burmese government had issued the new guidelines. Some speculated that the sheer number of MOUs between international organizations and multiple government ministries had become too cumbersome and needed to be centralized in a coherent manner. Others felt the government was reacting to the increase in the number of international organizations working in the country, many of which were not properly registered. But all agreed that the Guidelines, if vigorously enforced, could severely curtail the organizations’ ability to provide aid equitably and efficiently. They also said they would not agree to allow the regime to select their Burmese staff members. One foreign aid worker reported that some district government officials feared renewing contracts with her organization because they were unclear about the status of the Guidelines.⁵¹

International Committee of the Red Cross

Since its return to Burma in 1999, ICRC has played an essential role by visiting and providing health care to prisoners and developing water and sanitation projects in war-torn communities where weakened infrastructure, isolation, and the security situation make the population particularly vulnerable.⁵² ICRC staff have convened surgical training seminars for scores of Burmese health workers stationed in conflict areas, built water and sanitation facilities reaching more than 70,000 beneficiaries, provided over 7,000 landmine victims and other physically disabled people with prosthetic services, and supported the local manufacture of 19,600 prostheses.

⁵⁰ U.S. Government Accountability Office, *supra* note 27 at 18.

⁵¹ Interview with a foreign aid worker in Rangoon in August 2006.

⁵² Although a private humanitarian organization, the ICRC is not a nongovernmental organization. It has a widely recognized role to play due to its permanent and universal mandate granted by the 192 States signatory to the Geneva Conventions, to which Burma has been a party since 1992. This role distinguishes the ICRC from other humanitarian organizations.

Between 1999 and late 2005, ICRC made 453 visits to dozens of prisons and labor camps throughout the country and provided training to Burmese doctors on prison health care. ICRC has used information gleaned from these visits to push authorities to improve prison conditions. A Burmese doctor and former political prisoner recalled his first encounter with an ICRC doctor in Shwebo prison, which is located in Sagaing division and holds a number of political prisoners. “I don’t remember the exact date, but it must have been sometime during the rainy season in 2000,” the former prisoner said. “Before then, we never saw the ICRC. But I can tell you there was great relief in our cellblock when the ICRC arrived. Many prisoners were suffering from severe dysentery, and I had developed TB. The ICRC doctor arranged for me to have a chest X-ray, and I was finally given medications. As I recall, the doctor returned two or three more times and conditions in our block gradually improved.” After spending six years in Shwebo and a year in Rangoon prison, the Burmese doctor was released in 2004. He stayed a year in Rangoon and was later forced to flee to Thailand.⁵³

Beginning in 2004, ICRC field staff began sending reports to the organization’s headquarters in Rangoon complaining that local Burmese army commanders were placing restrictions on their access to towns and villages. Within a year, the Burmese authorities were also placing new restrictions on the organization’s access to prisons. “Basically, the situation is not good,” ICRC spokesperson Fiona Terry told the press in February 2006. “The government has not authorized us to visit [prisoners] since the end of last year.”⁵⁴

One of the government’s most contentious conditions, Terry said, was insisting that ICRC staff take representatives of the government-affiliated Union Solidarity and Development Association (USDA) on their visits to political prisoners. Such a condition violates ICRC’s strict practice of visiting and interviewing prisoners unaccompanied by representatives of governments or other entities. “We were happy if some Myanmar groups got involved in the welfare of detainees,” Terry said. “But, obviously, we are not able to visit with them. We have to have an independent view of what’s going on and to talk with detainees without any witness.”⁵⁵

ICRC’s relations with the Burmese government deteriorated even further during 2006 and, on November 27, the ICRC issued a press release stating that the Burmese government had ordered the organization to close its five field offices in Mandalay, Mawlamyine, Hpa-an, Taunggyi, and Kyaing Tong, effectively making it impossible for the organization to carry out assistance and protection work in border areas. The Burmese authorities also announced that ICRC visits to detainees would not be allowed to resume. Pierre Krähenbühl, the organization’s director of operations, said at the time “the ICRC is seriously worried that those most in need . . . will bear the brunt of this standoff.” Krähenbühl said the organization was significantly reducing its programs in Burma and transferring aid workers to ICRC missions in other countries.⁵⁶ By late 2006, the regime’s actions had reduced the scope of ICRC’s assistance and protection effort in Burma by 90 percent.⁵⁷

⁵³ Interview with former Burmese political prisoner in July 2006 in Mae Sot, Thailand.

⁵⁴ See C. Yeni Parker, “Rangoon aid agencies await their fate,” *The Irrawaddy*, February 8, 2006.

⁵⁵ E. Copley, “Red Cross says Myanmar stops prison visits,” *Reuters Foundation*, February 27, 2006.

⁵⁶ International Committee of the Red Cross, “Myanmar: ICRC pressed to close field offices,” press release, November 27, 2006.

⁵⁷ U.S. Government Accountability Office, *supra* note 27 at 22.

Criticism of the ICRC closure was swift and widespread. British MP and Foreign Office Minister, Ian McCartney, condemned in “the strongest terms” the Burmese junta’s decision. “This action . . . illustrates yet again its complete disregard for international human rights standards, and its unwillingness to engage constructively with the international community.”⁵⁸ *The Economist* wrote: “The junta’s rejection of the ICRC is bad news for hopes that it can be engaged in any serious dialogue about reform. If it cannot tolerate the scrupulously apolitical ICRC, it seems improbable that it will accept any form of international intervention, advice or mediation.”⁵⁹ Closer to home, the Singapore Ministry of Foreign Affairs said the move “does not augur well for the Myanmar government and its relations with the international community.”⁶⁰

By March 2007, relations between the ICRC and the Burmese regime had reached a breaking point. “The ICRC’s humanitarian work in Myanmar (Burma) has now reached near-paralysis,” said Krähenbühl, the director of operations. Speaking in Geneva, Krähenbühl said that ICRC staff were still unable to resume visits to detainees anywhere in Burma or conduct independent field operations in sensitive border areas. “Living and security conditions for civilians in sensitive border areas remain a real concern for ICRC,” he said. “There are also strong indications of a deterioration in conditions of detention and treatment at several places of detention.”⁶¹

Krähenbühl went on to say that the military regime’s restrictions were “jeopardizing the ICRC’s ability to discharge its internationally recognized mandate since they are incompatible with its independent and neutral approach to assessing the need for humanitarian action and to assisting vulnerable people.” As a result, ICRC closed two of its offices, one in Mawalmyine (Moulmein, Mon State) and the other in Kyaing Tong (Kengtung, Eastern Shan State), and left open the option of closing its remaining field offices in the future.⁶²

ICRC’s travails pose serious implications for the future of relief work in Burma. As an ICRC doctor in Rangoon said in an interview in August 2006, “The ICRC has been the organization most affected by the regime’s restrictions. Why? Because we work in the most sensitive areas of the country.”⁶³

Other International Relief Organizations

Since 2004, Burma’s military regime has impeded the work of the World Food Program (WFP) and UNHCR by restricting their ability to (1) move food and international personnel freely within Burma and (2) gather data needed to understand the scope and nature of Burma’s problems.

WFP has reported that it was unable to deliver 20 to 30 percent of its planned food shipments during 2005 because of government restrictions on travel. Meanwhile, UNHCR has said the

⁵⁸ Sai Silp, “Burma’s closure of ICRC offices draws more condemnation,” *The Irrawaddy*, November 29, 2006.

⁵⁹ “Red Cross does not mark the spot,” *The Economist*, November 30, 2006.

⁶⁰ Shah Paung, “Critics slam junta for ICRC ban,” *The Irrawaddy*, November 28, 2006.

⁶¹ International Committee of the Red Cross, “Myanmar: No progress in talks, ICRC closes offices,” press release 07/30, March 15, 2007.

⁶² Id.

⁶³ Interview with an ICRC doctor in Rangoon in August 2006.

regime's policies have affected the organization's efforts to assist displaced persons in the Thai-Burma border region. The U.S. GAO reported in April 2007:

While UNHCR has been allowed to implement certain "quick impact" projects (such as building of schools and bridges) in some 300 villages, UNHCR considers these projects to be only a first step toward fulfilling its protection objectives. Because regime officials closely monitor these projects, UNHCR staff cannot easily meet with villagers to improve UNHCR's understanding of the problems facing internally displaced persons. . . . UNHCR does not want to jeopardize its already limited access to the region or to put the local population at risk by holding public meetings on protection issues.⁶⁴

In addition, the regime has often rejected proposals that use the terms "research" or "data collection." Indeed, the Guidelines for international organizations contain the regime's first formal restriction on research. WFP has reported that while it has not encountered any problems carrying out surveys and assessments in the regions where it operates, it has encountered difficulty in conducting national surveys on food needs. At the same time, UNDP has said it completed two major research projects without encountering significant difficulties with the government.⁶⁵

The Three Diseases Fund

On October 12, 2006, six weeks before the Burmese authorities ordered ICRC to close its field offices, the UN Offices for Project Services (UNOP) and the Ministry of Health signed an MOU to launch the "Three Diseases Fund" (3D Fund) to combat HIV/AIDS, malaria, and tuberculosis in Burma. The fund, worth \$99.5 million over five years, will be financed by the European Union, Australia, Britain, the Netherlands, Norway, and Sweden. Over the next three years, the 3D Fund is expected to provide funding to some 40 international and local relief organizations in Burma.

According to the 3D Fund's strategic plan, the aid will bypass central government and go directly to "UN Agencies (as Implementing and Technical Support Agents), international nongovernmental organizations, and local civilian administrators" at the district level "to resource a programme of activities to reduce transmission and enhance provision of treatment and care for HIV/AIDS, TB, and Malaria for *the most in need populations* [emphasis added]." The strategic plan also states that "the Fund will only support activities of the Ministry of Health and other line Ministries *through decentralized cooperation with local civil administrations.*"

The 3D Fund strategic plan notes that "access to affordable quality health services is a key issue [in Burma] and *many of the most vulnerable communities, especially those in border and conflict areas, have to rely on substandard health care*" [emphasis added]. Alluding to but not naming the Global Fund, the strategic plan acknowledges that there were "structural weaknesses" in previous funding mechanisms. It also vows to ensure that its "resources will be used effectively,

⁶⁴ U.S. Government Accountability Office, *supra* note 27 at 20–23.

⁶⁵ *Id.* at 25–26.

efficiently, transparently, accountably and equitably in support of key components of national disease programmes and beyond, with an emphasis on achievement of programme outputs.”⁶⁶

The 3D Fund will be managed by three entities: The Donor Consortium, the Fund Board, and the Fund Manager. The Donor Consortium will act on behalf of the donors by reaching consensus regarding the development and operational aspects of the fund. It will also appoint a Fund Board to act as a managing committee on behalf of the donors, and this committee will have oversight of the Fund Manager. In effect, the Fund Board will serve as the watchdog for the donors by monitoring risk assessment and reviewing fund performance through field assessments and reporting from fund recipients. The Fund Board will appoint and oversee a Fund Manager. The Fund Board will comprise three donor representatives and three independent experts, and the CEO of the Fund Manager will act as its nonvoting secretary. The Fund Manager, which is the UN Office for Project Services (UNOPS), is responsible for “holding, disbursing, and monitoring the financial, technical and ethical performance of the Three Diseases Fund.”

The strategic plan states that the decision to select UNOPS as a Fund Manager “was based on UNOPS’s comparative advantage as an ‘independent’ UN organization with the mandate to provide financial and project management services for other organizations. The agency does not receive core funding from UN Member States and is therefore free from the constraints affecting UNDP that contributed to the withdrawal of the [Global Fund] from Myanmar.”

The 3D Fund strategic plan states that it will demand *accountability, transparency, and equity of access* from its “implementing partners, particularly the UN, international NGOs and local level officials from the Ministry of Health and other civilian authorities.” The strategic plan notes that the key features of a supportive operating environment for humanitarian assistance will include:

- **Timely and reliable access for project implementation and monitoring** ... through (i) prompt clearance of experts and other persons performing services on behalf of the Fund, or one of its implementing partners; (ii) prompt issuance, without cost, of necessary visas, licenses or permits; (iii) access to sites of work and all necessary rights of way; and (iv) free movement, within or to or from the country.⁶⁷

⁶⁶ The 3D Fund proposal and strategic plan is on file at the Human Rights Center, University of California, Berkeley. The 3D Fund’s strategic plan notes that “the Fund for HIV/AIDS in Myanmar (FHAM) showed during its three years of operation that external funds could be effectively channeled to support implementation by a variety of partners including the National AIDS Programme.” However, the 3D Fund also points to two weaknesses in the FHAM: “The first of these was in relation to the scope and impact of interventions, which [was] not extensive enough and did not target well *the most at-risk populations* [emphasis added]. The second identified weakness was in relation to the potential conflict of interest within the FHAM funding mechanism. ... [I]t was perceived that there was potential for less than rigorous assessment of proposals and independent monitoring. The absence of direct donor involvement in fund direction and decision making limited its scope and compromised its integrity in terms of partnerships within Myanmar and in terms of transparency with fund recipients involved in decision making on allocations.”

⁶⁷ The 3D Fund strategic plan further states: “This might best be achieved were the Government of Myanmar to consider: (a) facilitating travel for implementing partner and 3D Fund staff to established project sites where there is no current security concern (for example, in areas of the country open to tourists) on the basis of three days advance notice; (b) facilitating travel on the basis of two weeks advance notice for other areas of the country; [and] (c) facilitating visas for experts and other persons performing services on behalf of the 3D Fund, or one of its implementing partners, on the basis of four weeks advance notice.”

- **Fund Management—technical and administrative modalities** ... Management of all 3D Fund resources will follow transparent, independent, open competitive processes. Specifically, staff of all implementing partners should be recruited on the basis of suitability and qualifications for the job alone ... 3D Fund implementing partners will need to be able to rely on prompt issuance, without cost, of licenses and permits need for tax free importation of commodities and equipment which are essential for project implementation.
- **Respect for international humanitarian principles of humanity, neutrality and impartiality.** The Fund's success will depend on all stakeholders acting in accordance with recognized international humanitarian principles [see box]. ... It will be particularly important to ensure that assistance provided through the 3D Fund benefits people who are most in need, irrespective of their ethnic origin, social status, gender, nationality, political opinions, race or religion.

Friedrich Hamburger, head of the European Commission's diplomatic delegation to Burma, said in October 2006 that the donors to the 3D Fund had "been assured by the relevant [Burmese] authorities that conditions will be in place to allow for vital resources both to reach those who need them most and to be delivered effectively."⁶⁸

⁶⁸ See Inter Press Service, "Engaging Burma with Funds for HIV, TB, Malaria," October 19, 2006.

Guiding Principles for the Provision of Humanitarian Assistance

1. Human suffering should be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and elderly. The dignity and rights of all must be respected and protected.
2. Humanitarian assistance is to be provided without engaging in hostilities or taking sides in controversies of a political, religious or ideological nature. There will be no weapons or armed personnel on the premises or transport facilities of humanitarian organizations.
3. Humanitarian assistance is to be provided without discriminating on grounds of ethnic origin, social status, gender, nationality, political opinions, race or religion. Relief of suffering must be guided solely by needs and priority must be given to the most urgent cases of distress.
4. Humanitarian assistance aims to help reduce poverty, meet basic needs and enable communities to become more self-sufficient.
5. Humanitarian activities are guided by international humanitarian law and human rights and by the mandates given by international instruments to the various humanitarian organizations.
6. Humanitarian actors respect the culture, structures and customs of the communities where humanitarian programmes are carried out. Where possible and to the extent feasible, ways shall be found to involve the intended beneficiaries of humanitarian assistance and/or local personnel in the design, management and implementation of assistance programmes.
7. Humanitarian agencies hold themselves accountable to those they seek to assist and will be accountable for their actions to the government, and for their use of resources, to those who provide them. Humanitarian actors retain responsibility to manage human, financial and material resources for their activities. Management of these resources follows transparent, independent, open, competitive processes. Specifically, staff are recruited on the basis of suitability and qualifications for the job.
8. Equipment, supplies and facilities of humanitarian actors are not to be used for purposes other than those stated in programme objectives. Vehicles of humanitarian agencies are not to be used to transport persons or goods that have no direct connection with assistance programmes.
9. Humanitarian assistance is only of value if delivered in a timely fashion. Effective humanitarian operations require unhindered, sustained access for humanitarian personnel participating in relief activities to deliver, monitor, and assess humanitarian aid, enabling them to reach targeted members of the population in need of assistance.

Note: Charles Petrie, UN Resident Coordinator and UNDP Resident Representative, presented these principles in a letter to the Minister of National Planning and Economic Development (with copies to the Minister of Foreign Affairs and Minister of Home Affairs), dated March 7, 2006. The same principles were later included in an annex to the strategic plan of the 3D Fund.

Conclusion

The 3D Fund faces many challenges in Burma. First and foremost, it must contend with the military regime's restrictions on the travel of foreign aid organizations. The ICRC's closure of several field offices operating in or near combat zones suggests that access to these areas will continue to be heavily restricted and prevent aid from reaching those in need. It is unclear how the 3D Fund representatives will be able to travel freely throughout the country without a formal retraction of the military junta's Guidelines of February 2006.

Second, while the 3D Fund's commitment to bypass the central government and fund civilian administrations and local nongovernmental organizations at the state and district level is admirable, it may be difficult to implement. The term "civilian administrations" is a highly ambiguous concept in Burma, especially in rural areas where the military and police hold unquestioned authority and influence.⁶⁹ Since the 1962 *coup d'état* of General Ne Win, there has been no functioning "civilian authority" in Burma that has not been controlled by the military in some form or another.

This situation has been further complicated by reports that the Burmese authorities are establishing government-run "coordination committees" at the state and township level to coordinate with the 3D Fund and other relief efforts.⁷⁰ According to the February 2006 Guidelines, members of these new coordination committees would be drawn from junta-backed social organizations such as the Union Solidarity and Development Association, the Myanmar National Working Committee for Women Affairs, and, on the township level, from the Auxiliary Fire Brigades and the Veterans Association. The involvement of representatives of these organizations could easily politicize and complicate the dispersal of 3D Funds at the state and township level—a situation the agency wishes to avoid.⁷¹ Moreover, if the United Nations, which is one of the 3D Fund's implementing partners, is unwilling to work with coordination committees composed of members of the USDA and other junta-backed organizations, it stands to reason that the Fund will need to follow suit.

Third, many—if not most—Burmese pro-democracy organizations support the efforts of the 3D Fund and foreign aid organizations to lessen the burden of HIV/AIDS, malaria, tuberculosis, and other infectious diseases in Burma. But they insist that aid delivery should be transparent and accountable, reach those most in need, and not directly benefit the Burmese military—all conditions the 3D Fund has pledged to uphold. These organizations argue that donor governments and foreign aid agencies must acknowledge that the primary cause of the current crisis in Burma is the lack of an accountable government, and that foreign aid must complement but not replace or undermine political pressure for democratic change. In July 2006, the Burma Campaign UK and 19 other Burmese organizations in Europe and the United States called on foreign aid organizations to recognize that both aid and pressure for democratic change in Burma were

⁶⁹ The National League for Democracy (NLD) raised this issue in a letter dated June 12, 2006, to the First Secretary, British Embassy, Rangoon. The letter is in the files of the Human Rights Center, University of California, Berkeley.

⁷⁰ Htet Aung, "Government to keep tight rein on aid in Burma," *The Irrawaddy*, March 13, 2007.

⁷¹ Interview with a member of the board of the 3D Fund on January 25, 2007, in Bangkok.

essential and must be pursued simultaneously. Although not always appropriate for the same actors to pursue both strategies ([though] for the UN and Donor Governments this is imperative), it is vital that all agencies recognise the political roots of the humanitarian crisis. We ask agencies to be vigilant in avoiding indirect and inadvertent contribution to the root of the problem and to be respectful of the perspectives of those working towards political solutions. Mutual respect for and support of both strategies is of paramount importance. We encourage all agencies to creatively explore opportunities for supporting the promotion of democracy both directly and across their projects. A democratic society in Burma is vital to ensuring truly effective humanitarian assistance that directly benefits all Burmese people.⁷²

In this regard, one of the 3D Fund's greatest challenges may be fulfilling its mandate to help local health-related nongovernmental and community-based organizations develop their capacity to provide effective and equitable services. Capacity-building of organizations dedicated to health care delivery involves many fundamental activities (e.g., board development, evaluation, financial management, leadership development, peer learning, program design, strategic planning, team building) but at its core must be the development of an organizational culture that upholds medical ethics and human rights. This entails (1) applying a human rights framework to the design, implementation, and monitoring and evaluation of programmatic activities; (2) actively promoting the participation of affected communities in program development and implementation; (3) carrying out policies and programs in a nondiscriminatory manner; (4) maintaining transparency on how priorities are set and decisions made; (5) upholding accountability for the results.⁷³

Finally, it remains to be seen if the 3D Fund can find or develop local health-provider organizations in Burma that will have the capacity to respond meaningfully to the spread of infectious diseases and that are not part of the military government or its affiliated organizations, such as the USDA. Moreover, since the 3D Fund will not provide funds to ethnic health departments, such as the Karen Health Department, or to organizations based in neighboring countries that work cross-border, it is unclear if the Fund will be able to reach the underserved in the highly militarized border regions of the country. Service provision from within Burma is minimal or absent in the border regions, and it is along the borders, as the 3D fund has acknowledged, that the public health problems are greatest and the resources least.

Such challenges notwithstanding, the 3D Fund's pledge to ensure its programs are accountable, transparent, equitable, and reach those most in need is highly commendable and deserves the support of governments and international health institutions.

⁷² See The Burma Campaign UK, "Pro-Aid, Pro-Sanctions, Pro-Engagement: Position Paper on Humanitarian Aid to Burma," London, July 2006 at 4.

⁷³ See Sofia Gruskin, "Rights-Based Approaches to Health: Something for Everyone," *Health and Human Rights*, vol. 9, no. 2, 2006 at 8.

5. Burma

Decades of repressive military rule, civil war, corruption, bad governance, isolation, and widespread violations of human rights and international humanitarian law have rendered Burma's health care system incapable of responding effectively to endemic and emerging infectious diseases. Malaria, HIV/AIDS, and tuberculosis (TB), are major health problems in most areas of the country. Malaria is the most common cause of death due to infectious disease. Burma has one of the highest TB rates in the world, with nearly 97,000 new cases detected each year.¹ HIV/AIDS, once contained to high-risk groups, has spread to the general population, which is defined as a prevalence of 1 percent among reproductive-age adults. However the spread of the HIV infection across the country is heterogeneous, varying widely by geographical location and by population sub-group.²

Today Burma's health sector ranks as 190th of 191 nations, outperforming only war-torn Sierra Leone.³ One in three children in Burma is chronically malnourished, and 15 percent of the population is food-insecure. The country's under-five child mortality rate is 106 per 1,000 live births, compared to 21 per 1,000 live births in Thailand.⁴ Only 57 percent of births in Burma are supervised by a skilled medical practitioner, compared to 99.3 percent in Thailand and 85 percent in Vietnam. Despite Burma's extensive energy reserves in natural gas and abundant other natural resources including gems, timber, and fisheries, a quarter of Burmese live on less than \$1 a day.⁵

Burma's national expenditures in health and education, once the envy of Asia, are 3 percent and 10 percent, respectively, which means each year the government spends less than \$1 per person on health and education. Meanwhile the military, with a standing army of over 450,000 troops, consumes 40 percent of the budget.⁶ And Burma has been at peace with her neighbor states for several decades. In the meantime, most public hospitals and health clinics in Burma operate at rudimentary levels, lack skilled staff, and are in need of equipment and medical supplies.⁷

Burma has a shortage of physicians and other health professionals. In 2004, an estimated 17,000 physicians, 16,000 nurses, and 15,000 midwives were working in the country.⁸ Over 6,300 physicians were practicing in the public sector, but many of them supplement their low salaries by also working in the private sector. Most health professionals in the public sector, like other

¹ See Ministry of Health, *Health in Myanmar 2005* at 63.

² See Jon Cohen, "The Next Frontier for HIV/AIDS: Myanmar," *Science*, 301:5640, September 19, 2003, 1650–55.

³ World Health Organization, *World Report 2000: Health Systems Improving Performance*.

⁴ In a community health assessment survey conducted among 2,694 Palaung villagers in northern Shan State in November 2004, the under-five mortality rate was found to be 28.5 percent and the malnutrition rate was 31.2 percent. See The Paluang Women's Organization, *Poisoned Flowers: The Impacts of Spiraling Drug Addicton on Palaung Women in Burma*, 2006 at 19.

⁵ Clive Parker, "Burma 'Falling Further Behind' on Development Goals," *The Irrawaddy*, October 17, 2006.

⁶ World Food Programme, "Myanmar must do more to help its hungry millions," press release, August 5, 2005.

⁷ Center for Public Health, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, *Responding to AIDS, TB, Malaria, and Emerging Infectious Diseases in Burma: Dilemmas of Policy and Practice*, March 2006 at 14.

⁸ Ministry of Health, *supra* note 1 at 60.

government employees, have no or limited access to the Internet, which the military monitors and tightly controls. The ratio of doctors to nurses/midwives is troubling, especially as nurses and midwives are critical to frontline health services at the township level.

Despite these pressing health problems, Burma's military government has at times thwarted its own health ministry's efforts to launch vaccination campaigns to stop the spread of infectious diseases. The most recent case took place in October 2006 when the military junta prevented UNICEF from launching a national measles campaign aimed at vaccinating 13 million Burmese children, at a cost of \$11 million. According to a UN official speaking on condition of anonymity, the Burmese authorities cancelled the vaccination program because they feared the "potential political fallout" from deaths caused by adverse reactions to the vaccine.

The World Health Organization (WHO) acknowledges that a tiny percentage of children can potentially go into shock as a result of the vaccination, especially if adrenaline is not administered quickly, but believes "the benefits of protection afforded by a vaccine always far exceed the small risk of a true reaction." Measles is one of the main causes of death for the 11 percent of Burmese children who currently die before their fifth birthday.⁹ A full course of immunization in Burma costs hundreds of U.S. dollars. Without free vaccines supplied by organizations such as UNICEF, most parents in Burma could not afford to immunize their children. In early 2007, the military junta finally allowed the health ministry and WHO to launch the measles campaign.

Burma's health care system has been undermined by the systemic weaknesses of a foundering national economy. These economic factors include little to no access to foreign markets; weak state finances; a rudimentary banking system; chronic high inflation, officially calculated at 26 percent for 2006–07¹⁰ but unofficially said to be between 50 and 60 percent; and widespread un- and under-employment.¹¹ A strategy paper for 2007–13 prepared for the European Commission paints a gloomy picture of Burma's economy:

Corruption, ignorance of economic correlations and international isolation have led to economic stagnation. . . . There is a significant illegal economy that is based on smuggling of drugs, gemstones, and timber. This illicit trade sustains armed groups, among them both ethnic cease-fire and non-cessate-fire groups, as well as the Burma/Myanmar military, making it difficult to address this problem which both fuels conflict and spurs unsustainable resource exploitation. Moreover, profits derived from such illegal trade are not "trickling down" and do not contribute to poverty eradication or livelihood opportunities.

Corruption is systematic at the political and economic level. The military regime intentionally pursues a policy of corporate cronyism and allots privileges such as car import and telephone licenses to favored companies and family members. The unpredictable regulatory environment breeds rent-seeking behavior across all levels of

⁹ The Burmese military government reportedly suspended immunization programs in November 2005 and again between April and June 2006—the latter for diphtheria, whooping cough, and tetanus. See Clive Parker and Ko Latt, "SPDC Fears Undermine Immunization in Burma," *The Irrawaddy*, October 11, 2006.

¹⁰ Marwaan Macan-Markar, "Food prices spark open dissidence," *Inter Press News Service*, February 28, 2007.

¹¹ See Robert Taylor and Morten Pedersen, *Supporting Burma/Myanmar's National Reconciliation Process: Challenges and Opportunities, An Independent Report for the European Commission*, January 2005 at 3–4.

the economy. At a smaller scale, corruption is part of a coping strategy of public sector employees given their inadequate salaries.

Burma/Myanmar has one of the world's lowest levels of public sector expenditure (approximately 4 percent of GDP). In spite of these low levels, expenditures exceed revenues, thereby resulting in a fiscal deficit. The pressure on government to reduce spending even further prevents public investment in basic human and social infrastructure in spite of the desperate needs. Inflation is currently running at around 30 percent.¹²

In its 1999 annual report, the World Bank, while agreeing that sanctions imposed on Burma by the U.S. Congress two years earlier had played a role in limiting investment, also blamed the regime for not carrying out necessary reforms and asserted that the regime's economic policies had disproportionately affected Burma's poor.¹³ A recent BBC survey of 6,048 Burmese citizens, aged 15 to 59, found "the most important issues facing respondents focused on making a living." Eight-five percent of respondents said their strongest personal aspiration was getting a well-paying job. Other primary concerns were poor economic development (91%), poverty (75%), and unemployment (72%).¹⁴

But the real source of Burma's underfinanced health care system—and the failure to remedy it—is not poverty and a weak economy. It is the result of policies and priorities adopted by the succession of military regimes that have ruled Burma since the early 1960s. The latest top rule-making executive body, the State Peace and Development Council (SPDC), comprises a group of a dozen high-ranking military officers headed by General Than Shwe. Active-duty or retired military officers occupy 33 of 38 ministerial-level positions in the government including those of the prime minister and the mayors of Burma's two major cities Rangoon and Mandalay. The SPDC directly controls the Ministry of Health with Secretary-One of the ruling council, Lt. Gen. Thein Sein, directly chairing the National Health Committee.

In 2006, Transparency International ranked Burma as one of the four most corrupt countries in the world based on its annual Corruption Perceptions Index (CPI). The CPI found a strong correlation between "rampant corruption" and poverty in Burma and in other countries ranking in the lower half of the index.¹⁵

¹² *The European Commission-Burma/Myanmar Country Strategy Paper (2007–2013)* at 7.

¹³ Thomas Campton, "Burma's Debt is Pushing Economy to the Brink – The World Bank Warns," *International Herald Tribune*, November 15, 1999.

¹⁴ BBC World Service Trust, *Voices of Burma: National Survey for Media & Development, A Report of Findings*, London, February 2006 at 7. The BBC conducted the survey in June and July 2005.

¹⁵ See Transparency International, "2006 Corruption Perceptions Index reinforces link between poverty and corruption," Berlin, November 6, 2006. The 2006 Corruption Perceptions Index (CPI) is a composite index that draws on multiple expert-opinion surveys that pool perceptions of public sector corruption in 163 countries around the world. It scores countries on a scale from zero to ten, with zero indicating high levels of perceived corruption and ten indicating low levels of perceived corruption. Seventy-one countries—nearly half—scored below three, indicating that corruption was perceived as rampant. Haiti had the lowest score at 1.8; Burma, Guinea, and Iraq shared the penultimate slot, each with a score of 1.9.

The military junta is known for its secrecy, censorship, and sharp limitations on criticism of the government.¹⁶ As a result, many health professionals have fled Burma over the past 20 years.¹⁷ Scientists and health professionals remaining in Burma face tight controls over what they can say or publish about the government and its health care system. Like all Burmese citizens, scientists and health professionals can face years of imprisonment for openly criticizing their government and its policies. These restrictive conditions run counter to fundamental principles of scientific freedom and responsibility.¹⁸

Official health data in Burma is, at best, fragmentary and often unreliable. Burma has not held a reliable national census since the results of colonial-era surveys were destroyed in 1942.¹⁹ “Unlike other war-affected countries, it has been years since we have been able to send UN specialists into conflict zones to make comprehensive health assessments,” a Rangoon-based UN official said in August 2006.²⁰ In March 2006, in a move welcomed by foreign aid agencies in Burma, the National AIDS Programme, with support from WHO, dispatched an external assessment team, the first in 15 years, to review Burma’s health response to HIV/AIDS countrywide. Over ten days the assessment team collected AIDS data in eight states and divisions. However, the team was unable to access conflict zones or mining areas where HIV prevalence rates are high.

The Back Pack Health Worker Team, a humanitarian group based in Mae Sot, Thailand, is one of the few organizations that collects health data and provides basic health care to internally displaced communities in combat zones in eastern Burma. But they do so at considerable risk. Since 1998, when the team was formed, landmines or Burmese soldiers have killed seven backpack medics and one traditional birth attendant. Data gathering, the group notes, is “particularly risky, and even carrying a pen and paper can arouse the suspicion of SPDC soldiers.”²¹

Burma’s neglected health care system is incapable of responding to the country’s most serious infectious diseases and must be supplemented with foreign assistance. Even with substantial amounts of foreign aid, Burma’s capacity to curb these diseases is hindered by its military leaders. So far, the military junta has failed to recognize that the protection and promotion of human rights, international humanitarian law, and basic scientific freedoms form the bedrock for the development of effective and comprehensive prevention and treatment therapies. This situation is further exacerbated by the military junta’s restrictions on UN agencies and foreign aid organizations, whose mission is to prevent and treat these diseases, to move freely about the country.

¹⁶ Burma is not party to a raft of international human rights agreements, including the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social, and Cultural Rights; or the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment.

¹⁷ Jon Cohen, *supra* note 2 at 1651.

¹⁸ Richard P. Claude, in his book *Science in the Service of Human Rights*, characterizes these principles as (1) a reverence for truth that leads its practitioners to robust query and dissent; (2) avoidance of surmise based on ideological presuppositions in favor of reliance on empirically verifiable facts and measurable data; (3) a process of verification that requires open dissemination, communication, and the need for replication; and (4) a universality of discourse and goals whose common language and pursuits go beyond national borders. See Richard P. Claude, *Science in the Service of Human Rights*, Philadelphia: University of Pennsylvania Press, 2002 at 16.

¹⁹ See David Fullbrook, “Myanmar’s HIV/AIDS security threat,” *Asia Times*, December 2, 2006.

²⁰ Unless noted otherwise, all interviews inside Burma were conducted in July and August 2006. Interviews were conducted anonymously.

²¹ Back Pack Health Worker Team, *Chronic Emergency: Health and Human Rights in Eastern Burma*, May 2006 at 22.

Tuberculosis, HIV/AIDS, and malaria have reached epidemic proportions in Burma and pose a serious threat to the region. Two other diseases—avian influenza and filariasis—also have the potential to do great harm if not properly checked.

HIV/AIDS

The Burmese Ministry of Health reported in November 2006 that HIV infections in Burma had dropped from 1.5 percent in 2000 to 1.3 percent in 2005.²² Meanwhile, the UN's HIV/AIDS survey for 2006 states that the 1.3 infection rate applies only to adults (those over 24 years old), compared to a rate of 1.4 percent in 2003. However, for young Burmese aged 15 to 24 years old, which comprises the country's future doctors, bureaucrats, entrepreneurs, and parents, the UN estimates an HIV prevalence rate of 2.2 percent, which it describes as "a cause for serious concern."

Forty-three percent of injecting drug users and 32 percent of sex workers were found to be HIV positive in 2005, "proportions that have changed little since 2000," the UN report says. The UN does point to some notable successes in tackling the disease in Burma. HIV infection levels among pregnant women have reportedly declined from 2.2 percent in 2000 to 1.3 percent in 2005. Similarly, among men seeking treatment for other sexually transmitted diseases 8 percent were HIV positive in a 2001 study, compared to 4 percent in 2005.

Other AIDS researchers argue that Burma's surveillance methods are unreliable and thus the infection rates may be higher. Researchers at Johns Hopkins Bloomberg School of Public Health placed the HIV prevalence rate in mid-2000 at 3.4 percent—some 687,000 people—based on a national household survey in Burma and data from the national HIV sentinel surveillance of the National AIDS Programme of the Burmese Ministry of Health.²³ Officials with the Chinese Ministry of Health said in November 2006 that Burma's infections are probably four or five times what their data indicate. Similarly, Taiwanese health officials believe Burma's infection rates are three times as high as the military junta admits.²⁴ Moreover, despite the seriousness of the epidemic, the Ministry of Health expenditure on HIV is low. No official figures exist, but the UNAIDS Country Office estimates that in 2005 the Ministry of Health spent \$137,000 on HIV, equivalent to less than half of \$0.01 per person. This compares with \$1.43 per capita in Thailand and \$0.07 per capita in Cambodia, the other two high-prevalence countries in Southeast Asia.²⁵

Active surveillance of HIV/AIDS in Burma began in 1985, and the first HIV infection was diagnosed in 1988. The Ministry of Health established a National AIDS Committee in 1989, and a short-term plan for the prevention of HIV transmission was launched that same year. The first

²² See Clive Parker, "Burma says it's winning HIV/AIDS fight," *The Irrawaddy*, November 30, 2006. See also United Nations Expanded Theme Group on HIV/AIDS, UNAIDS, *Joint Programme for HIV/AIDS: Myanmar 2003–2005*, revised April 2004, and *AIDS, TB, Malaria & Avian Influenza – The UN Country Team's Experience*, Rangoon, June 26, 2006, at 1.

²³ C. Beyrer, M. H. Razak, A. Labrique, R. Brookmeyer, "Assessing the magnitude of the HIV/AIDS epidemic in Burma," *J Acquire Immune Defic Synd* 32:3, March 2003, 311–17; see also Center for Public Health and Human Rights, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, *supra* note 7 at 19–20.

²⁴ See David Fullbrook, *supra* note 19.

²⁵ See UNAIDS at http://www.unaids.org/en/Regions_Countries/Countries/myanmar.asp.

AIDS case was diagnosed in 1991. Biannual HIV sentinel surveillance began in 1992, along with the monthly reporting of HIV infection detected in blood donors and patients clinically diagnosed in health facilities. HIV sentinel surveillance has expanded to include 33 sites across all states and divisions.

HIV/AIDS laboratory activities are based at the National Health Laboratory in Rangoon and the Mandalay Public Health Laboratory. These facilities are responsible for distributing HIV test kits to medical facilities; training laboratory personnel; and providing laboratory services, including confirmation of HIV infection, HIV testing for samples collected from all sentinel sites, testing for CD4 enumeration (CD4 cells are the main immune warriors that HIV selectively targets and destroys), testing for opportunistic diseases, and quality assurance. Donors supply all the HIV test kits. The government provides buildings, personnel, and facilities for routine laboratory procedures.

As of August 2006, Burma had five flow cytometers in the public sector: two in laboratories run by the government and three in clinics operated by Médecins Sans Frontières. A few private clinics reportedly have flow cytometers as well. A flow cytometer is a machine that automatically counts CD4 cells and is critical for developing treatment therapies. None of the four Thai border-district hospitals that provide antiretroviral therapy (ART) have access to CD4 counting machines unless patients pay for private testing in Thailand.

By April 2006, HIV viral load measurement was still not available in the public sector. The National Health Laboratory has a machine that can perform the polymerase chain reaction (PCR) assay, a molecular copier of DNA that has become as ubiquitous in modern biology labs as microscopes, but it is used for research purposes only. A PCR machine measures the amount of HIV in an affected person's sera, a key test for evaluating health status and responses to treatment. UNICEF has recently acquired a new PCR machine for HIV viral load to help support the national program to prevent mother-to-child transmission of HIV.

In June 2006, the UN country team in Burma reported that “while the operating environment in Myanmar for international actors is very challenging, over recent years an increasing number of Myanmar people have received HIV-related services in most regions of the country.” Among the improvements the UN country team cited:

- condom use has more than tripled since 1999
- the number of community-based programmes reaching out to injecting drug users has grown from none in 2002 to more than 15 in 2005, and methadone maintenance therapy has been launched in detoxifying centres (part of the formal sector)
- more than 2 million children are learning about HIV in age-appropriate curriculum
- during 2005, more than 10,000 HIV-affected households received medical or social-economic care and support, more than two and a half times the number of households assisted in 2004
- the number of pregnant women being offered counseling and testing as part of a prevention of mother-to-child transmission package has gone from close to none in 2001 to 140,000 in 2005

Such progress notwithstanding, the UN country team noted that these services “are still insufficient to yield a sustainable impact on the epidemic.”²⁶

AIDS is a reportable disease in Burma. Hospitals and clinics are required to report AIDS cases to the central office of the National AIDS Programme. Yet the number of actual reported cases is low. Of the 39,230 new AIDS cases estimated for 2004,²⁷ 1,747 cases (4.5%), were reported to the public health system. AIDS case reporting is name-based and includes demographic data, race, address, and assumed mode of infection in relation to behavioral characteristics. Burmese health workers and foreign aid workers interviewed in August 2006 said the *name-based* manner of reporting raised serious concern for the protection of confidentiality. None of the informants knew if the reporting system had resulted in the public disclosure of the names of people with AIDS, but they were concerned that it could easily happen should this information fall into the wrong hands. Changing the name-based system to an anonymous code-based system with a single identifier would reduce the risk of breaches of confidentiality. Such a change would require investment in information-management infrastructure and human resources.

While there have been no reliable studies on the nature and extent of stigma and discrimination in Burma, anecdotal evidence suggests that it does exist and can lead to the loss of job and income and to difficulties in gaining employment. Burmese health professionals interviewed in August 2006 and January 2007 in Rangoon reported that people living with HIV harbored strong fears of disclosing their sero status to people in their communities and at their places of employment. The 2005 BBC survey confirmed this perception: 65 percent of respondents said they would not buy food from a food seller infected with HIV/AIDS. Forty-five percent said they would not visit the home of someone who had the HIV virus, while 42 percent said their community should not allow HIV-positive individuals to stay in their village or township.²⁸

Injecting drug users (IDU) comprise one of the largest groups of adults living with HIV infection in Burma. The IDU prevalence rate is estimated at 43.2 percent,²⁹ and in some areas, especially in mining camps and towns, it can reach as high as 60 to 90 percent.³⁰ “If you start injecting in Burma,” a Rangoon-based aid worker said, “you could easily be HIV positive in six to eight weeks.” By March 2009, the National AIDS Programme (NAP) hopes to reduce the number of HIV infections among IDUs by 6.74 percent.³¹

Men working in mining camps are particularly susceptible to intravenous drug addiction and HIV exposure. One foreign aid worker compared the camps to the American Wild West: “Imagine there is gambling and prostitution and thousands of young men with no or little education. The work is hellish, but the pay is enough to keep you supplied with heroin. Needles get exchanged. There is unprotected sex ... and before you know it you have hundreds of HIV carriers—both men and women—traveling back and forth from the camps to their home

²⁶ *AIDS, TB, Malaria & Avian Influenza – the UN Country Team’s Experience*, supra note 22 at 1–2.

²⁷ See *Report from the Technical Working Group on HIV/AIDS Projection and Demographic Impact Analysis in Myanmar*, Rangoon, September 28–30, 2005.

²⁸ BBC World Service Trust supra note 14 at 77.

²⁹ *Myanmar National Strategic Plan for HIV and AIDS: Operational Plan, April 2006–March 2009*, August 3, 2006, at 7.

³⁰ Interview with foreign aid worker in Rangoon, August 2006.

³¹ *Myanmar National Strategic Plan for HIV and AIDS*, supra note 29 at 5.

communities.”³² Foreign aid workers (and journalists) are generally barred from entering mining areas, while some Burmese health workers have access but not always on a regular basis.

Until recently, the military junta had a schizophrenic view of IDUs that ignored most of the tenets of harm reduction, a growing movement that treats addiction as a disease rather than a crime and strives to find practical ways to help addicts avoid dangers such as HIV. Since 2003, thanks to the persistence of Burmese physicians and foreign aid workers, IDU harm reduction strategies have been introduced in some regions of Burma, but their reach remains limited. By August 2006, there were 15 drop-in centers in 12 of the 29 townships where injecting drug use is a serious problem. All of these clinics offer education programs on safer injection and sex and operate needle- and syringe-exchange programs.

Despite these advances, only the clinic in Lashio township has achieved more than 50 percent coverage. UNAIDS reported in 2005 that more than one million needles and syringes were distributed through the drop-in centers with a return rate of 80 percent. Since March 2006, methadone maintenance therapy programs have been launched in the townships of Yangon, Lashio, Myitkyina, and Mogaung. Approximately 80 people had begun methadone treatment within a month of the program’s launch, but this number represents only a fraction of the targeted population.³³ Baseline data on injecting drug use in the targeted townships is greatly lacking and, until it is obtained, will limit the ability of the public sector and nongovernmental organizations to evaluate the coverage of their programs. Police in some townships have eased off on arresting or harassing people with syringes in their possession, but this trend is hardly uniform. Finally, access to antiretroviral therapy for injecting drug users appears to be very limited, even when they are stable on methadone.³⁴

Seventy percent of HIV transmissions in Burma are a result of sexual encounters, according to the National AIDS Programme. Commercial sex work, though illegal, persists in many townships in brothels or indirectly through massage parlors, karaoke bars, and guesthouses. Many prostitutes also work independently on the streets. AIDS outreach workers often find that these casual sex workers are difficult to recruit into condom-promotion programs because they are highly mobile and wish to keep their work hidden. The HIV prevalence rate among sex workers in 2005 was estimated at 32 percent.³⁵

Police often inhibit HIV-prevention efforts. Drop-in centers report that police officers, in an effort to meet their monthly quotas, tend to arrest more sex workers toward the end of the month. This, in turn, creates a “vicious circle”: sex workers, trying to avoid arrest, will move to the streets and, as a result, have less access to condoms and educational programs. At the same time, fewer sex workers visit the drop-in centers.

Of all the vulnerable groups, little is known about HIV infection among incarcerated and institutionalized populations and members of the armed forces largely because the military junta closely guards such information from the public. There are reportedly 41 prisons in Burma. In

³² Interview with foreign aid worker in Rangoon, August 2006.

³³ Interviews with foreign aid workers in Rangoon, August 2006.

³⁴ *Id.*

³⁵ *Id.*

2001, the total prison population was estimated at 62,300, of which 70 percent were drug offenders and 14 percent were women. No public information exists on other closed institutions. Moreover, the suspension of prison visits by the International Committee of the Red Cross has reportedly reduced the level and quality of medicines reaching prisoners.³⁶

Foreign aid workers interviewed in August 2006 said they knew very little about how the military health services responded to HIV within their ranks. What little they did know was largely anecdotal. An external review by the National AIDS Programme in 2006 states: “There is a strong commitment on the part of the military to expand and scale [up] their [HIV] prevention, treatment and care efforts with servicemen and their families.”³⁷ The review also notes: “The military medical services in each division and state provide a basic HIV education to recruits and servicemen as well as promotion and provision of condoms, although the supply was reported not sufficient to meet demand.”

This observation stands in stark contrast to press reports and observations provided by Burmese health workers and foreign aid workers. Orlando de Guzman, a journalist with U.S.-based Public Radio International’s “The World” program, interviewed a former Burmese army doctor in 2006 whose job was to discharge dozens of HIV-positive soldiers. They received “no antiretroviral drug, no care [or] support at all,” said the doctor, and their beds in a large military HIV ward were immediately occupied by new arrivals. A UNAIDS worker said that to the best of his knowledge the military did not operate a service-wide condom distribution program. Indeed, the external review by the National AIDS Programme offers no concrete examples of what the standard operating procedure is for soldiers of any rank who are diagnosed as HIV positive. Several informants interviewed for this report said in August 2006 that HIV-positive soldiers were often discharged from the military without follow-up medical care of any kind. Informants said that a great deal of prejudice still exists in the armed services toward soldiers diagnosed as HIV positive.

So far, the most successful HIV prevention initiatives in Burma have been two condom-distribution projects. These programs also include health education sessions and services for sexually transmitted infections (STI). The National AIDS Programme operates one of the programs, known as the 100% Targeted Condom Promotion campaign (TCP). The other is a social marketing program run by the nonprofit Population Services International (PSI), whose headquarters are in Washington, D.C. The National AIDS Programme reported in 2004 that the condom-use rate was around 62 percent in Rangoon, 90 percent in Mawlamyaing Township of Mon State, and 50 percent in Hpa-an Township of Kayin State. UNAIDS estimates that at least half of Burma’s 40,000 to 60,000 commercial sex workers have access to condoms and HIV education.³⁸

The TCP program was initiated in 2001 at four sites and has expanded to 154 sites across the country. The main implementers are AIDS/STI teams, local medical officers, and representatives

³⁶ See United States Government Accountability Office, Report to the Committee of Foreign Affairs, House of Representatives, *International Organizations: Assistance Programs Constrained in Burma*, April 2007, GAO-07-457 at 22.

³⁷ *National AIDS Programme Review (27 March–6 April 2006)*, April 6, 2006 at 45–46.

³⁸ Interview with UNAIDS staff member in Rangoon, August 2006.

of local agencies, including the police, NGOs, and entertainment-establishment owners. TCP distributes condoms during public festivals and directly to guesthouses, military units, taxi drivers, truck drivers, and factory workers.

Since 1996, PSI has worked in Burma staging safe-sex education sessions and selling condoms at a steep discount to grocery stores, street vendors, and other distributors, who then sell them for a few cents each. PSI believes that by constantly targeting teenagers and young adults with advertisements for a variety of new prophylactic products they can eventually change behaviors that lead to unsafe sex. Until recently, political and cultural factors made it difficult for PSI to educate members of high-risk groups such as IDUs and commercial sex workers. For example, a woman carrying a condom could be arrested as a prostitute. In recent years, the organization has been allowed to advertise condoms in magazines and on billboards. During the 2006 World Cup, PSI scored a resounding victory when it was permitted to run a series of amusing advertisements promoting condom use on Burmese television. Since 1996, PSI's annual condom sales have risen from 400,000 to 31.2 million in 2005. By 2006, PSI condoms were available at approximately 15,000 retail outlets nationwide.³⁹

Such progress notwithstanding, a BBC survey conducted in 2005 suggests that condom use in Burma is still low and that greater condom-use campaigns are needed, particularly in rural areas. Only 8 percent of respondents in the BBC survey had used condoms, while their use among urbanites was twice as high as rural residents. Of the men reporting condom usage, 36 percent were between 15 and 24 years old while 40 percent were between 25 and 34 years old.⁴⁰

AIDS treatment programs are still in their infancy in Burma. In March 2003, Artsen Zonder Grenzen (AZG or Médecins Sans Frontières–Holland) launched Burma's first specific antiretroviral combination treatment for people with AIDS in cooperation with the National AIDS Programme, Waibargyi hospital in Rangoon, and the General Hospital in Lashio. Within a year, the program had provided antiretroviral therapy to 1,523 patients (1,433 adults and 90 children) in Rangoon.⁴¹ Overall, 117 patients died. Of these, four were children. Most of the patients died within six months due to opportunistic infections and immune reconstitution syndrome. Patients at clinical stage 4 have a much higher death rate than stage-3 patients. Twenty-one percent of deaths were due to meningitis, with more than half identified as cryptococcal meningitis. Most patients improved dramatically within six months and could even return to work. Those previously prescribed incorrect treatment (mono or duo therapy) and patients selling their own antiretroviral therapy drugs due to poverty were rare but growing threats to the success of antiretroviral treatment. For prevention of mother-to-child transmission 203 HIV-positive mothers received antiretroviral drugs. In 82 percent of the cases, both the mother and the child received the appropriate drugs in time. AZG aimed to provide antiretroviral

³⁹ Interview with PSI/Myanmar staff member in Rangoon, August 2006.

⁴⁰ BBC World Service Trust, *supra* note 14 at 76.

⁴¹ First-line treatment for adults and children, with some modifications for infants, consists of Stavudine (d4T), Lamivudine (3TC), and Nevirapine (NVP) in a fixed-dose combination tablet. Efavirenz is used as an alternative treatment to Nevirapine when the patient has severe adverse effects from the latter. The standard second-line regime consists of Zidovudine (AZT), Didanosine (ddI), Lamivudine (3TC), and Lopinavir boosted by Ritonavir (LOP/r). (3TC is continued because it is proven to contribute to the suppression of HIV replication despite 3TC resistance.) Alternative regimes are indicated for pregnant women, those with previous treatment experience, and those with side effects from the standard regimes.

therapy to 4,000 AIDS patients in Rangoon and other townships by the end of 2006, and may have surpassed that amount by the time of writing.⁴²

AZG has faced a number of challenges during the nascent period of the antiretroviral therapy program. A patient's proximity to a clinic is a determinant of long-term follow-up and adherence. To ensure that patients regularly attend the clinic for drug collection and medical review, the program has extended its service to a total of 11 townships in Rangoon.

Antiretroviral therapy is a highly marketable commodity. HIV-positive patients without access to treatment are desperate to obtain it, while many of the patients who receive free treatment are tempted to sell it because of their own financial needs. So far, only a few cases of patients selling drugs have been reported, yet the concern remains as the program expands. Drug treatment adherence can also be a problem. Some patients stop therapy because they return to good health after an extended period on antiretroviral therapy or because of lifestyle changes due to working hours or the need to travel long distances to find work or because of addictions such as alcoholism. In response, AZG and its partners have created income-generating activities for patients and employed outreach workers, some of whom are AIDS patients, to undertake home visits to monitor compliance and the welfare of the patient's family.

Over the next three years (2007–09), the National AIDS Programme will give priority to (1) building capacity and enhancing resilience among populations at highest risk and vulnerability and to those severely affected by the HIV epidemic; (2) promoting community-based activities to reduce stigma and discrimination towards people living with HIV and whose behaviors are associated with infection; and (3) developing 'sound public health policies and practices,' and [a] monitoring and evaluation system ... [that] will provide a framework for the design of focused approaches suited to specific populations."⁴³

Burma has a growing AIDS awareness and advocacy movement that often runs afoul of the authorities. In August 2006, Burmese police in Thingangyun township arrested 11 members of the Friends of the Red Ribbon, an informal AIDS advocacy group, as they were about to hold a traditional merit-making service in a Buddhist temple for their friends who had died of the virus. "This is not a very helpful course of action on the part of the Myanmar government," J. V. R. Prasada Rao, head of the Asia-Pacific office of UNAIDS, told a journalist the day following the arrests. "It sends a very negative message." Police have dispersed similar ceremonies and arrested AIDS activists in Rangoon and other major cities. On April 4, 2007, the police arrested Maung Tin Ko, a 35-year-old HIV patient, as he staged a solo demonstration in Rangoon. Tin Ko, who is from Pokkoku Township in Magway Division, was protesting the fact that he could not receive antiretroviral therapy treatment in his hometown. Before his arrest, Tin Ko handed out a written pamphlet with the following declarations:

1. Please give medication to AIDS patients like me in our hometown.
2. There is an increase in AIDS patients like me in this country.

⁴² See Artsen Zonder Grenzen, *Antiretroviral Treatment Project Report*, Rangoon, April 2006.

⁴³ *Myanmar National HIV and AIDS*, supra note 29 at 3. In reference to stigma and discrimination, the report states: "In particular, initiatives will aim to reduce stigma and discrimination against sex workers, injecting drug users, and men who have sex with men, thereby ensuring that all these populations can play a central role in curbing the course of HIV and mitigating its impacts."

3. HIV/AIDS is a threat to Burma and the whole world.
4. HIV/AIDS is our national problem.
5. I donate my whole body here today for the benefit of all the people in this world so that researchers either from Burma or from the world can use my body for HIV/AIDS research.

Malaria

Malaria is the leading cause of morbidity and mortality in Burma. Seventy percent of the population lives in malaria-risk areas, with 30 percent living in high-risk areas.⁴⁴ High-risk groups include mobile populations in search of economic opportunities (e.g., forest-related workers, miners, workers in development projects, plantation workers) or ethnic groups that have been forcibly displaced by the military and have taken refuge in the forest; upland subsistence farmers; and ethnic groups living along Burma's borders.

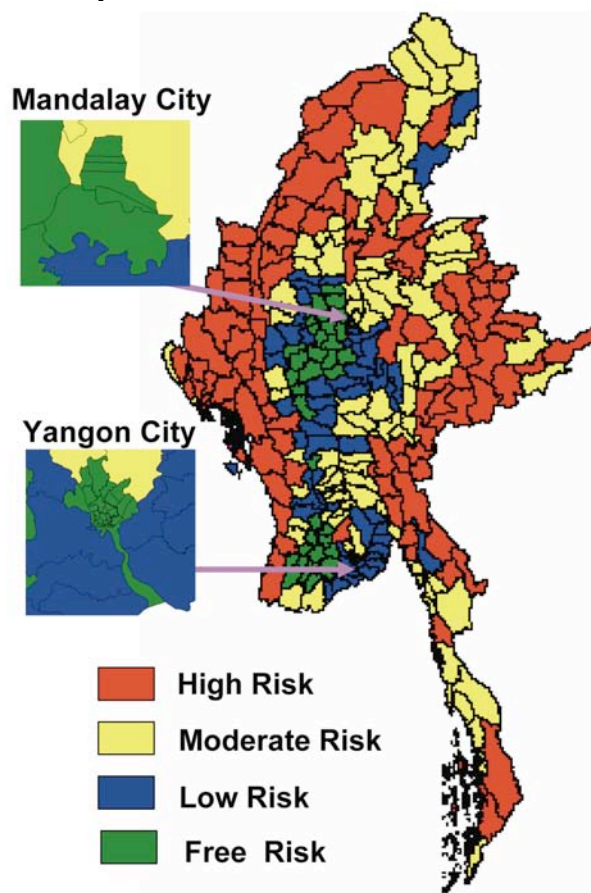
In 2004, the Vector Borne Disease Control (VBDC) of the Ministry of Health estimated a national incidence rate of 11.1 per 1,000 and mortality at 3.65 per 100,000 due to malaria. Among the internally displaced of eastern Burma, *Plasmodium falciparum*, the dominant malaria species in this area, now accounts for 45 percent of all adult and child deaths.⁴⁵ These figures place Burma at the top of the list of countries in the region for per capita malaria-related deaths, outstripping even India with its vastly larger population.⁴⁶ Malaria accounts for 10 percent of outpatients and 15 percent of inpatients admitted to government hospitals in Burma. About 74 percent of reported infections are due to *Plasmodium falciparum* and 20 percent are due to *Plasmodium vivax*. Over the period 1995–2004, an average of 632,000 malaria cases were reported (most—75 percent—were clinical cases of malaria without blood smear confirmation) and 3,000 deaths were estimated yearly. These figures are considerable underestimates, since only 25 to 40 percent of people infected with malaria report to public health facilities.⁴⁷ Others either self-medicate or seek care in the private sector and thus are not reported.

⁴⁴ *Union of Myanmar: Malaria Prevention and Control National Operational Plan, Fiscal Years 2006/2007 to 2008/2009*, Rangoon, August 3, 2006 at 3.

⁴⁵ A. Ham, L. C. Mullany, A. Richard, C. Maung, and C. Beyrer, "Mortality Rates in Conflict Zones, Karen, Karenni, and Mon States in Eastern Burma," *Trop Medicine and Int Health* 2005.

⁴⁶ C. Wongsrichanalai, A. L. Pickard, W. H. Wernsdorfer, S. R. Meshnick, "Epidemiology of Drug-resistant Malaria," *Lancet Infect Dis* 2:4, April 2002, 209–18.

⁴⁷ This information was gathered from various WHO and VBDC reports and data collected by Dr. Frank Smithuis of AZG. See also Frank Smithuis, *Treating and Preventing Malaria in Myanmar*, Médecins Sans Frontières–Holland, 2006. This study consists of a compilation of malaria studies conducted by Dr. Smithuis since the mid-1990s.

Map 1: Malaria Risk Areas in Burma

Source: WHO, Regional Office for Southeast Asia, January 2006. Available at http://www.searo.who.int/LinkFiles/Malaria_in_the_SEAR_Malaria_Risk_Areas_in_Myanmar.pdf.

Poor access to health care is also reflected in Burma's malaria deaths-relative-to-cases ratio of 3 percent, which is the highest in the region and outstrips the next highest, Bangladesh (0.8 percent), by a significant margin.⁴⁸ Studies have shown that border states, where access to health care services is poor or has been disrupted by armed conflict and forced displacement, have higher mortality rates for malaria. Chin and Karenni states have mortality rates four times the national rates, and Kachin state is almost five times higher than the national average.⁴⁹

In 2003 the Burmese government spent \$134,000 on malaria, with an additional \$800,000 from external funding. The following year, it reported having spent \$23 million, with \$622,000 from "other sources." However, this figure may be misleading as the total health expenditure for the same year totaled about 20 billion kyat, some \$18 million based on the unofficial exchange rate. This means the reported malaria budget alone was larger than the total national health care expenditure, suggesting that much of the reported budget was donor aid. Moreover, a rapid rise

⁴⁸ WHO, Regional Office of Southeast Asia, *Distribution of Reported Malaria Deaths in SEA Region*, 2003; February 25, 2006, http://www.whosea.org/LinkFiles/Malaria_distr_mal_cases03.pdf.

⁴⁹ C. Wongsrichanalai, K. Lin, L. W. Pang, M. A. Faiz, H. Noedl, T. Wimonwattawatee et al., "In vitro Susceptibility of Plasmodium falciparum Isolates from Myanmar to Antimalarial Drugs," *Am J Trop Med Hyg* 65:5, November 2001, 450–55.

in domestic funding to this degree compared to the previous year is highly unlikely given Burma's stagnate economy.⁵⁰

Not only is Burma highly endemic for malaria, it has also become an epicenter for drug-resistant *Plasmodium falciparum*, particularly along the frontiers of the country.⁵¹ Chloroquine (CQ) and sulfadoxine-pyrimethamine (SP), two former mainstays of malaria treatment, are often ineffective if used alone, and have been abandoned in favor of combination therapies.⁵² In Burma, CQ resistance was suspected for years on clinical grounds before it was confirmed in 1969 at the malaria institute of Burma.⁵³ In 1984, SP was introduced in Burma as a second line for CQ failures but it, too, developed resistance. Mefloquine monotherapy followed in 1996 as the third-line treatment for treatment failure with CQ and SP.

Despite the high failure rates for these drugs in Burma and elsewhere in south and Southeast Asia, WHO and UNICEF continued to provide CQ and SP for the treatment of *falciparum* malaria in Burma. According to Frank Smithuis of Médecins Sans Frontières–Holland, “the presence of multi-drug resistant strains of *Plasmodium falciparum* in the region, while the treatment regimen was not changed, has probably played an important role in the lack of control and probable increase of malaria infections.”⁵⁴

Multi-drug resistant *falciparum* malaria, defined as resistant to three or more drugs, is most problematic on the border with Thailand.⁵⁵ As a result, the Burmese malaria treatment guidelines recommend the use of combination therapy, particularly with artesunate and high-dose mefloquine, to reduce the spread of multi-drug resistance. Drug resistance to malaria generally arises due to incomplete or inappropriate use of antimalarials, program failure, and the sale and use of counterfeit or expired antimalarials, all of which are present in Burma. The Burmese government has almost no regulatory oversight of the importation and sale of antimalarial drugs, and the proportion of fake drugs is high.⁵⁶ While many antimalarial drugs sold in Burma contain no active ingredient, up to 70 percent contain substandard amounts, which is far worse from a public health standpoint: exposing malaria parasites to substandard levels of active ingredient promotes the selection of drug resistance and thus threatens the effectiveness of the entire

⁵⁰ See Center for Public Health and Human Rights, Department of Epidemiology, Johns Hopkins School of Public Health, *supra* note 7 at 27–34.

⁵¹ C. Wongsrichanalai, et al., *supra* note 48.

⁵² See F. Smithuis, M. Shahmanesh, M. K. Kyaw, O. Savran, S. Lwin, “Comparison of Chloroquine, Sulfadoxine/Pyrimethamine/Sulfadoxine, Mefloquine and Mefloquine-artesunate for the Treatment of *falciparum* Malaria in Kachin State, North Myanmar,” *Trop Med Int Health* 9:11, November 2004, 1184–90; and F. Smithuis, F. Monti, M. Grundl, A. Z. Oo, T. T. Kyaw, O. Phe O et al., “*Plasmodium falciparum*: Sensitivity in vivo to Chloroquine, Pyrimethamine/Sulfadoxine and Mefloquine in Western Myanmar,” *Trans R Soc Trop Med Hyg* 91:4, July–August 1997, 468–72.

⁵³ D. F. Clyde, N. Hlaing, and F. Tin, “Resistance to Chloroquine of *Plasmodium falciparum* from Burma,” *Trans R Soc Trop Med Hyg* 66, 1972, 369–70.

⁵⁴ Frank Smithuis, unpublished PhD dissertation, August 2006 at 8.

⁵⁵ C. Wongsrichanalai, et al., *supra* note 48.

⁵⁶ United States Pharmacopeia, *A Review of Drug Quality in Asia with a Focus on Anti-Infectives*, February 2004.

combination.⁵⁷ According to WHO, the Burmese ministry of health is very concerned about the emergence of fake antimalarial drugs but lacks the capacity to deal with the problem.⁵⁸

In July 2006, Wellcome Trust Oxford SE Asian Tropical Medicine Research Unit reported that at least 13 different types of counterfeit artesunate using the Guilin Pharmaceutical Co. Ltd. label have been found in Southeast Asia, including in Burma and along the western border of Thailand. The fake packets attempt to duplicate the blister-back stickers or holograms on the bonafide Guilin Pharmaceutical packet. Other features of the fake artesunate that differ from the genuine product include poor printing of bar codes on packets and blister packs, codes on blister packs printed with the font made of numerous small dots, poor stamping of code “AS” and score lines on tablets, raised edges of tablets, very hard tablets, blister pack abbreviations in capital letters (“MFG” and “EXP”) and unusually late expiration date in relation to date of manufacture (>3 years). Counterfeits tend to be cheaper than the genuine product.⁵⁹

Mosquito control using insecticide-treated nets (ITNs) has been proven to reduce episodes of clinical malaria, particularly in children.⁶⁰ However, the ecology of malaria in Burma poses multiple challenges to control. Transmission is seasonal, with cases in most areas clustering around the rainy season. This “unstable” transmission pattern, coupled with the high rate of *falciparum* malaria, increases the probability of severe infection and/or death. The effectiveness of prevention efforts, such as ITNs and residual house spraying, is diminished by the mosquito vectors (*A. dirus* and *A. minimus*) indigenous to forested areas that bite early in the evening and tend to rest outside the home.⁶¹

The National Operational Plan for Prevention and Control of Malaria in Myanmar has set out the following objectives for the next three years (2007–09):

- (1) treating with insecticides the estimated 8 million nets already owned by the families in malaria-risk areas and promoting their regular use;
- (2) control of malaria among high-risk groups such as the forest-related workers and ethnic groups;
- (3) ensuring early access to quality-assured malaria diagnosis and treatment especially in remote areas where malaria transmission is high;
- (4) improving malaria-related knowledge and practices of the population at risk and the health care providers;
- (5) improving malaria-control program management practices at all levels of the health system especially at township level;
- (6) further strengthening capacities of the [Vector Borne Disease Control] VBDC to efficiently and effectively provide support for malaria control at township level and below;
- (7) estimating the magnitude of [the] malaria problem, and (8) last but not least,

⁵⁷ A. M. Dondorp, P. N. Newton, M. Mayxay, W. Van Damme, F. M. Smithuis, S. Yeung, et al., “Fake Antimalarials in Southeast Asia are a Major Impediment to Malarial Control: Multinational Cross-sectional Survey on the Prevalence of Fake Antimalarials,” *Trop Med Int Health* 9:12, December 2004, 1241–46.

⁵⁸ Interview with WHO staff in August 2006, Rangoon.

⁵⁹ Updates on counterfeit antimalarials in Southeast Asia can be found at http://www.jr2.ox.uk/ndm/Tropical_Medicine/News.htm.

⁶⁰ C. Lengeler, “Insecticide-treated Bed Nets and Curtains for Preventing Malaria,” *Cochrane Database System Review* (2):CD000363, 2004.

⁶¹ T. T. Oo, V. Storch, N. Becker, “Anopheles Dirus and its Role in Malaria Transmission in Myanmar,” *J Vector Ecol* 28:2, December 2003, 175–83.

empowering communities at risk, including community-based organizations and NGOs, to actively participate in malaria prevention and control.⁶²

Tuberculosis

Burma ranks as one of 22 countries that account for 80 percent of the world's new TB cases, with 107,991 cases reported in 2005.⁶³ Of these, 12,337 were new sputum-smear-positive patients, of which one third were women. Those most affected are between 25 and 44 years of age, an age group that is socially and economically active and vital to the economy. Most TB patients are poor and have difficulties accessing health care and/or adhering to treatment because of a lack of health education or because of socioeconomic factors. Forty percent of Burma's population is believed to be infected with TB, and WHO estimates 7.1 percent of TB patients have HIV.⁶⁴ Sixty to 80 percent of people living with HIV also have TB, making this the most common AIDS-associated infection. Burma has the highest mortality rate (2.8 per 100,000) among TB patients co-infected with HIV in Southeast Asia.

TB drugs are widely available on the black market without control in Burma, and many are taken with inadequate supervision. The diagnostic test used for TB notification is sputum exam. In many cases, particularly with HIV co-infection, TB is missed using only this test, and a culture or attempt to grow the bacterium is necessary. A February 2006 WHO report noted that there was a "shortage of qualified staff, especially junior laboratory technicians," and that "a quarter of all sanctioned posts in the National TB Program are vacant."

Burma is experiencing rising rates of multi-drug resistant (MDR) tuberculosis. MDR tuberculosis is defined as resistance to two or more of the primary drugs used in the treatment of TB; it is difficult to treat, carries a high mortality, and is expensive to cure. Inpatient costs for treatment of MDR tuberculosis can average over \$25,000 per patient, with outpatient costs averaging over \$19,000.⁶⁵ In 2005, researchers in Rangoon found that 33.9 percent of TB isolates collected from TB patients in the city were resistant to any one of the four standard first-line drugs (isoniazid, rifampicin, ethambutol, or streptomycin). They also found that the rate of MDR tuberculosis had more than doubled to 4.2 percent in the past four years.⁶⁶ Moreover, the rate for patients who had received past treatment rose from 15.5 percent in 2002–03 to 18.4 percent in

⁶² *Union of Myanmar: Malaria Prevention and Control National Operational Plan, Fiscal Years 2006/2007 to 2008/2009*, supra note 43 at 4.

⁶³ WHO Regional Office for Southeast Asia, *TB in Southeast Asia: TB Epidemiology*, February 17, 2006, and *National Operational Plan TB, Myanmar (April 2006–March 2009)* at 6.

⁶⁴ *National Operational Plan TB, Myanmar (April 2006–March 2009)* at 6. A study conducted by Burmese researchers with the Ministry of Health in four pilot sites in Burma suggests that the prevalence of HIV and TB co-infection is the highest in Pray (17%) and the lowest in Hpa-an (3%) but 11 percent in Yango whereas in Nyaung the rate was 9 percent. The overall rate was 10 percent. The majority of co-infected patients were found in 30–34 year olds (21%). M. Thwel, A. M. Soel, W. Maung, T. Lwing, T. Aung, "Synergistic Outcome of National AIDS Program and National Tuberculosis Program: HIV/TB sentinel surveillance survey, 2005," abstract from the 2006 Toronto AIDS conference.

⁶⁵ S. S. Rajbhandary, S. M. Marks, N. N. Bock, "Costs of Patients Hospitalized for Multidrug-Resistant Tuberculosis," *Int J Tuberc Lung Dis* 2004 8:8, August 2004, 1012–16.

⁶⁶ S. Phyu, T. Ti, R. Jureen, T. Hmun, H. Myint, A. Htun, et al., "Drug-Resistant Mycobacterium Tuberculosis Among New Tuberculosis Patients, Yangon, Myanmar," *Emerg Infect Dis* 9:2, February 2003, 274–76.

2005.⁶⁷ To put this into perspective, the average MDR rate among new patients in Southeast Asia is 2 percent,⁶⁸ and the rate along the Thai-Burma border is an estimated 6.5 percent, compared to 1 percent for the rest of Thailand.⁶⁹ As the WHO and National Tuberculosis Program have themselves recognized: “A new drug resistance survey is urgently needed [in Burma].”⁷⁰

The WHO strategy for controlling TB is directly observed treatment short course, or DOTS, whereby a community or health care worker directly observes the patient swallowing his/her anti-tuberculosis treatment, usually a combination of drugs taken over at least six months. The regimen costs approximately \$11 per course.⁷¹ The optimal TB control strategy also entails case detection and monitoring systems, as well as an efficient laboratory infrastructure. According to the government, case detection rates “started to rise considerably since 1999 and continued to increase up to a level of 83 percent in 2004. An important caveat though is that the denominator of the case detection rate—the estimated smear-positive incidence rate—is based on disease prevalence survey carried in 1994.”⁷² The Ministry of Health and WHO claim to have 100 percent coverage across its 324 townships and a treatment success rate of 81 percent, just below the goal of 85 percent set by WHO for 2005.⁷³

However, a review of the data suggests that TB programs in Burma are performing more poorly than the government has previously acknowledged. A 2005 WHO report noted that “a national TB prevalence survey would provide a more accurate estimation of incidence and a baseline for assessing the impact of DOTS services on the TB epidemic,” indicating that basic information to gauge the extent of the epidemic has not yet been collected.⁷⁴ In August 2006, the National Tuberculosis Program (NTP) and WHO recognized that “the numbers of patients being registered by the NTP do not represent the total number of patients receiving anti-TB treatment since there continues to be incomplete reporting from large hospitals and general practitioner clinics; accurate data on numbers of patients seeking care at private health facilities, including traditional healers is not available.”⁷⁵ Indeed, the Department of Medical Research, Lower Myanmar reported in 2006 that “about 75 percent of TB suspects seek health care at the private clinics as first entry point for TB care while TB case management practices from the private practitioners are sub-optimal and not always following NTP Guidelines.”⁷⁶

This situation is further compounded by the military junta’s lack of adequate funding to combat TB nationwide. Instead, the government has consistently relied on international donors to make up for budgetary shortfalls. In 2004, for example, the government supported only 6 percent of the

⁶⁷ S. Phyu, T. Lwin, T. Ti, W. Maung, W. W. Mar, S. S. Shein, et al., “Drug-Resistant Tuberculosis in Yangon, Myanmar,” *Scand J Infect Dis* 37:11-12, 2005, 846–51.

⁶⁸ World Health Organization, Regional Office for Southeast Asia, *Tuberculosis Control in the Southeast Asia Region, Regional Report: 2005*, November 2005, SEA-TB-282, [http://w3.whosea.org/LinkFiles/Media_Centre_TB_annual_report_2005_\(SEA-TB-282\).pdf](http://w3.whosea.org/LinkFiles/Media_Centre_TB_annual_report_2005_(SEA-TB-282).pdf).

⁶⁹ *National Operational Plan TB, Myanmar (April 2006–March 2009)* at 6.

⁷⁰ *Id.* at 7.

⁷¹ J. Wise, “WHO Identifies 16 Countries Struggling to Control Tuberculosis,” *BMJ* 28:316, March 1998, 420.

⁷² *National Operational Plan TB, Myanmar*, supra note 68.

⁷³ See World Health Organization, *WHO Global TB Report 2005*, http://www.who.int/tb/publications/global_report/2005/annex1/en/index11.html.

⁷⁴ *Id.*

⁷⁵ *National Operational Plan TB, Myanmar*, supra note 68 at 7.

⁷⁶ *Id.*

National Tuberculosis Program, while international donors provided the balance.⁷⁷ Many foreign aid workers and Burmese health workers become uncomfortable when talking about the status of TB in Burma largely because the national surveillance data collected so far is outdated and unreliable and because the treatment program is underfunded and inadequate.

“If you can’t do TB treatment properly because of government restrictions, then you shouldn’t do it at all given the real danger of promoting multi-drug resistant TB,” said a TB specialist with Médecins Sans Frontières–France who had left Burma when the organization pulled out of the country in December 2005.⁷⁸ His words may seem somewhat extreme, but they underscore the frustration borne by many aid workers who believe TB could be brought under control in Burma if only the military junta would step aside and let them get on with the task at hand.

The *National Operational Plan TB, Myanmar (April 2006–March 2009)* sets out the following four objectives and outputs for the next several years:

1. To sustain and improve the quality of DOTS services to reach all TB patients. Output: Quality DOTS services provided to more than 90 percent of the total population including remote and underserved areas by the end of 2009.
2. To improve the treatment success rate among all detected TB patients including those with TB-HIV and multi-drug resistant forms of TB. Output: Treatment success rate among all TB patients at or above 80 percent (anticipating a lower treatment success rate among HIV/TB co-infected and MDR-TB patients).
3. To increase the number of new smear-positive TB cases to reach a case detection rate at or above 70 percent in all States/Divisions. Output: Case detection rate at or above 70 percent in all States/Divisions.
4. To measure both progress with programme implementation and the impact of interventions towards more accurately determining progress towards the millennium development goals. Output: Progress towards TB-related millennium development goals measured through TB prevalence survey, drug resistance survey, and TB/HIV surveillance.⁷⁹

Lymphatic Filariasis

Lymphatic filariasis is endemic in many parts of Burma. Approximately 120 million people worldwide are infected with the disease and it is an important cause of morbidity, with over 40 million people worldwide disfigured and disabled by its long-term outcome, elephantiasis. Most cases are caused by one species of parasite, *Wuchereria bancrofti*, transmitted by several

⁷⁷ See World Health Organization, *supra* note 72.

⁷⁸ Interview with Médecins Sans Frontières–France aid worker in Mae Sot, Thailand, July 2006.

⁷⁹ *National Operational Plan TB, Myanmar*, *supra* note 68 at 13–14.

mosquito species. The disease disproportionately affects the very poor, reducing productivity and incurring treatment costs in those least able to bear it.⁸⁰

The cornerstone of controlling this disease is mass drug administration (MDA), whereby single dose anti-parasitic drugs (diethylcarbamazine with ivermectin) are administered as widely as possible (80 to 90 percent) in communities at risk, for about four to six years.⁸¹ It is simple and inexpensive, usually costing less than one dollar per person per year; there are few public health measures that are as cost-effective, particularly for the poor. In recognition of these realities the World Health Organization issued Resolution 50.29 in 1997, calling on all member states to eliminate lymphatic filariasis, after the International Task Force for Disease Eradication named it one of six potentially eradicable diseases.⁸²

Using MDA strategy in endemic areas, Thailand has been able to eliminate transmission in almost the entire country; lymphatic filariasis is now mainly confined to the three provinces of Tak, Mae Hong Son, and Kanchanaburi, along the western border with Burma.⁸³ In contrast, Burma remains a highly endemic country for filariasis.⁸⁴ Every year two million cases of filariasis are reported to WHO in Burma, and even this figure is likely a gross underestimate, given the largely unknown situation in the country's border regions.⁸⁵ Many of these frontier areas lack programs for MDA. In the face of these gaps, the Burmese government has actually divested its filariasis control program. The National Programme to Eliminate Lymphatic Filariasis (PELF) annual report for 2004, submitted to WHO, states: "There is disease in budget source in 2004. WHO Biennium budget for PELF is only 6,000 US \$. Except for US \$9,000 from Liverpool LF Support Centre, there was no other extra budgetary support from SEAR office in this year."⁸⁶ By comparison, Thailand's annual budget for filariasis control stands closer

⁸⁰ See World Health Organization, *Lymphatic Filariasis: The Disease and Its Epidemiology*, January 24, 2006, available at <http://www.who.int>; D. Molyneux, "Lymphatic Filariasis (Elephantiasis) Elimination: A Public Health Success and Development Opportunity," *Filaria J* 2003 2:1, September 2003, 3; D. L. Heymann, *Control of Communicable Diseases*, Washington, D.C.: American Public Health Association Publication, 2004; Global Alliance to Eliminate Lymphatic Filariasis, January 26, 2006, available at <http://www.filaria.org>; and I. P. Suniash, R. Rajendran, T. R. Mani, A. Gajanana, R. Rueben, K. Satyanarayana, "Long-term Population Migration: An Important Aspect to be Considered During Mass Drug Administration for Lymphatic Filariasis," *Trop Med Int Health* 8:4, April 2003, 316–21.

⁸¹ See Global Alliance to Eliminate Lymphatic Filariasis. See also E. A. Ottesen, "The Global Programme to Eliminate Lymphatic Filariasis," *Trop Med Int Health* 5:9, September 2000, 591–94.

⁸² See Centers for Disease Control, *Recommendations of the International Task Force for Disease Eradication* 42, 1993, 1–38. See also World Health Organization, *Elimination of Lymphatic Filariasis as a Public Health Problem*, Fiftieth World Health Assembly, May 13, 1997, WHA50.29.

⁸³ See S. Tritteerapapab, I. Nuchprayoon, C. Porksakorn, Y. Poovorawan, A. L. Scott, "High Prevalence of *Wuchereria bancrofti* Infection Myanmar Migrants in Thailand," *Ann Trop Med Parasitol* 95:5, July 2001, 535–38; S. Tritteerapapab, K. Kanjanpas, S. Suwannadabba, S. Sangprakarn, Y. Poovorawan, A. L. Scott, "Transmission of the Nocturnal Periodic Strain of *Wuchereria bancrofti* by *Culex quinquefasciatus*: Establishing the Potential for Urban Filariasis in Thailand," *Epidemiol Infect* 25:1, August 2000, 207–12; Division of Communicable Disease Control, Ministry of Public Health, *Annual Report, Filariasis Unit, 2002*, Nonthaburi, Thailand.

⁸⁴ National Programme to Eliminate Lymphatic Filariasis, Ministry of Health, Myanmar, *Annual Report for the National Programme to Eliminate Lymphatic Filariasis*, December 2004, http://w3.whosea.org/LinkFiles/New_Lymphatic_Filariasis_Annual_Report_Myanmar_2004.pdf.

⁸⁵ Department of Communicable Diseases, World Health Organization, Regional Office for Southeast Asia, *Elimination of Lymphatic Filariasis in Myanmar*, January 2001, CDS Info, Vol. 2 (22), 16-31.

⁸⁶ National Programme to Eliminate Lymphatic Filariasis, *supra* note 83.

to 20 million bhat, or \$500,000; there are no uncertain areas of the country and, in 2002, only 185 new patients were reported to the Ministry of Public Health.⁸⁷

Among Burmese migrant populations in Thailand, cross-sectional surveys have demonstrated filariasis prevalence rates of up to 10 percent; another 40 percent had evidence of previous exposure to *Wuchereria bancrofti*.⁸⁸ Almost none had been treated at home in Burma.⁸⁹ As most immigrants are undocumented, the numbers of individuals at risk for filariasis and thus eligible for Thai MDA is unknown, and treatment delays are common. Given that mosquito types common in urban Thailand are capable of transmitting the strains of *W. bancrofti* found in migrants from Burma, the possibility of re-emergent filariasis in urban Thailand was raised in 1999–2000.⁹⁰ In 2004, this had come to pass, and migrants suffering from lymphatic filariasis were found in Chiang Mai, the largest city in northern Thailand, after fleeing from areas in Shan State.⁹¹

Avian Influenza

Avian influenza refers to a large group of different influenza viruses that primarily affect birds. Currently these viruses can infect other species, including pigs and humans, but it is rare. The vast majority of avian influenza viruses do not infect humans. However, due to changes in genomic structure of the avian influenza virus, some are capable of human transfer. The avian influenza A (H5N1) subtype first infected humans in Hong Kong in 1997, resulting in 18 cases, including six deaths. On that occasion, culling within three days of Hong Kong's poultry population, estimated at 1.5 million birds, is thought to have averted a possible pandemic.⁹² In December 2003, infections in people exposed to sick birds were identified. By March 1, 2007, 277 laboratory-confirmed human cases had occurred in Cambodia, Indonesia, Thailand, Vietnam, China, and Turkey, and 167 persons, more than 60 percent of cases, have died. Asia accounts for 84 percent of all reported cases of avian influenza and 87 percent of all reported deaths.⁹³

Burma's first outbreak of avian flu took place on a farm in the Kywesekan ward of Mandalay district, 430 miles north of Rangoon, on March 8, 2006, killing 112 birds.⁹⁴ Die-offs of poultry are also reported in other townships. That same day, national health authorities gathered

⁸⁷ See Division of Communicable Disease Control, Ministry of Public Health, *supra* note 82.

⁸⁸ See S. Triteerapapab, et al., *supra* note 82; S. Triteerapapab and J. Songtrus, "High Prevalence of Bancroftian filariasis in Myanmar-migrant Workers: a Study in Mae Sot District, Tak Province, Thailand," *J Med Assoc Thai* 82:7, July 1999, 735–39.

⁸⁹ *Id.* See also S. Koyadun and A. Bhumiratana, "Surveillance of Imported Bancroftian filariasis after Two-year Multiple-dose Diethylcarbamazine Treatment," *Southeast Asian J Trop Med Public Health* 36:4, July 2005, 822–31.

⁹⁰ *Id.* See also S. Triteerapapab, et al., "Transmission of the Nocturnal Periodic Strain of *Wuchereria bancrofti* by *Culex quinquefasciatus*: Establishing the Potential for Urban Filariasis in Thailand," *supra* note 82; S. Triteerapapab & J. Songtrus, *supra* note 87.

⁹¹ W. Huanok, "Thailand under Threat: How Burma's Dams Project Could Spread Disease," *The Irrawaddy*, June 13, 2005 at 15–16.

⁹² Three pandemics occurred in the 20th century: the first pandemic, "Spanish Flu," in 1918; the second, "Asian Flu," in 1957; and the third, "Hong Kong Flu," in 1968. The pandemics caused an estimated 20–40 million human deaths in 1918, two million in 1957, and one million in 1968.

⁹³ John R. MacArthur, "Emerging Infections: Avian Influenza," address, Conference on Responding to Infectious Diseases in the Border Regions of South and Southeast Asia, Bangkok, January 25, 2007.

⁹⁴ "Myanmar calls for international help after first bird flu outbreak," *Agence France-Presse*, March 14, 2006.

specimens from affected poultry for laboratory examination. The following day, a Mandalay laboratory confirmed through a PCR rapid test that the virus was the H5N1 influenza strain. (Five weeks earlier, the Ministry of Health had published the *National Strategic Plan for Prevention and Control of Avian Influenza and Human Influenza Pandemic Preparedness and Response*, a detailed step-by-step plan approved by the National Health Committee to respond to just such an outbreak.⁹⁵) By March 12, a laboratory in Bangkok had confirmed the Mandalay test results. The following day, the government was informed of these results, and it then directed the Ministry of Livestock and Fisheries to control the outbreak through culling of poultry farms in the Kyweseikan ward and other townships.⁹⁶ On March 13, the Burmese authorities informed WHO and the UN Food and Agriculture Organization (FAO) and submitted specimens for testing in Thailand and Australia. On March 15, Burmese authorities granted permission for FAO and USAID to send a team of experts to Burma. Meanwhile, the outbreak was reported to the public on Burmese-language television, and through a public awareness campaign launched via television, newspapers, and posters. In addition, affected areas were designated as “restricted zones” with movement of poultry and equipment banned. The virus left nine suspected cases of human transfer in its wake,⁹⁷ and altogether 342,000 chickens, 320,000 quail, 180,000 eggs, and 1.3 tons of feed were destroyed at 545 poultry farms. On April 26, the military junta lifted the ban on the movement of poultry throughout the country, and in September declared Burma a bird-flu-free country.⁹⁸

Nearly a year after the outbreak, John MacArthur, an Infectious Disease Advisor to USAID who participated on the international team of experts dispatched to Burma, said that despite some deficiencies, the Burmese authorities had been “open and transparent” in their response to the outbreak in March 2006. He said the national health authorities had engaged the international community early, submitted specimens to outside laboratories, allowed international teams to outbreak sites to assist, and informed the public upon confirmation of H5N1.⁹⁹ But he also suggested that the Burmese authorities needed to undertake several additional measures to improve their response to future H5N1 outbreaks. These measures included improving the sensitivity of a surveillance system to detect outbreaks, especially in remote areas; establishing a compensation policy for poultry farmers affected by outbreaks; improving the political commitment of local military commanders to allow reporting and response to outbreaks; changing high-risk behaviors on poultry farms; improving surveillance and response in border regions; and increasing the capacity of the national health infrastructure to respond to potential human-to-human transmission.¹⁰⁰

By all accounts, the Burmese health authorities intend to work closely with the international community to detect and respond to potential avian influenza outbreaks. The Ministry of Health, with assistance from WHO, has requested international funding (1) to purchase PCR rapid tests as well as culling supplies and equipment; (2) to establish rapid-response teams in each state and district, with a goal of reaching 130 teams (one per state/division and two per district); and (3) to

⁹⁵ Ministry of Health, *National Strategic Plan for Prevention and Control of Avian Influenza and Human Influenza Pandemic Preparedness and Response*, January 31, 2006.

⁹⁶ Interview with WHO staff in Rangoon, August 2006.

⁹⁷ Interview with WHO staff in Rangoon, August 2006.

⁹⁸ “No human cases detected with H5N1 in Myanmar,” *Xinhua General News Service*, March 6, 2007.

⁹⁹ John McArthur, *supra* note 92.

¹⁰⁰ *Id.*

strengthen a nationwide reporting system. In December 2006, UNICEF and the Livestock Breeding and Veterinary Department of Burma co-hosted a media training workshop attended by nearly 100 journalists from state and private media. UNICEF emphasized that communication was the first line of defense in the fight against avian influenza, and accurate information and informed reporting are vital in helping ordinary people understand the nature of the threat and the need for protective measures.¹

Burma was struck by another outbreak of avian influenza on March 21, 2007. This time the virus struck farms in five townships north of Rangoon, killing 1,863 poultry. Authorities monitored fowl within a one-kilometer radius of the farm where the virus was first detected and imposed a ban on the sale and transport of poultry within six kilometers of the outbreak. There were no reports of human-to-human transmissions.²

The UN Food and Agriculture Organization and other UN agencies have praised the Burmese Ministry of Health for its “quick and effective” response to outbreaks of avian flu since it first appeared in Burma in March 2006. Meanwhile, the United States, usually quick to criticize the military junta, has given the regime \$600,000 to help fight the disease. Such positive developments notwithstanding, a human outbreak of avian influenza could potentially be a disaster in a country where the health system is in tatters after decades of underfunding and neglect. As a UN official in Burma put it: “If you look at the infrastructure that exists, if human cases broke out, it would be more difficult than in many other countries in the region. It would be close to impossible to contain.”³

Conclusion

Recent studies of how health officials in 23 American cities responded to the Spanish flu pandemic of 1918 could be instructive for Burma and other countries facing a potential human outbreak of avian influenza. Using mathematical models, researchers Martin Bootsma and Neil Ferguson found that those American cities that instituted quarantine, school closings, bans on public gatherings, and other procedures early in the outbreak of the 1918 epidemic had peak death rates 30 percent to 50 percent lower than those that did not.⁴ According to Ferguson, the most successful interventions were in communities where the political and health authorities broadly agreed on what needed to be done and got significant cooperation from the public.⁵

Beyond their implications for responding to human outbreaks of avian influenza, these studies underscore why Burma, if it is ever going to deal effectively with the burden of infectious diseases, must create a health care system that actively encourages communities to become

¹“Media training workshop held in Myanmar to raise public awareness on bird flu,” *Xinhua General News Service*, December 8, 2006.

²“UN calls for stricter controls in Myanmar after new bird flu outbreak,” *Associated Press*, March 21, 2007.

³“Myanmar wins rare praise for bird flu action,” *Agence France-Presse*, April 19, 2007.

⁴M. C. J. Bootsma and N. M. Ferguson, “The Effect of Public Health Measures on the 1918 Influenza Pandemic in U.S. Cities,” *Proceedings of the National Academy of Sciences* 2007, <http://www.pnas.org/cgi/doi/10.1073/pnas.0611071104>.

⁵Nicolas Bakalar, “How (and How Not) to Battle Flu: A Tale of 23 Cities,” *New York Times*, April 17, 2007, at 8D.

engaged participants in—and not merely auxiliaries to—the development and implementation of health programs and interventions.

6. China-Burma Border Region

The China-Burma border region is of major commercial and political importance to China, and it is likely that China, given its dominant relationship with Burma, will decide what happens there for the foreseeable future. Extracted natural resources, principally timber¹ but also jade, gold, and natural gas, flow into China from Burma. The heroin trade also flows from Shan and Kachin States to the Burmese border towns of Ruili and on to Kunming, the capital of Yunnan Province. Because of the spread of injecting drug use, the China-Burma border region has one of the worst HIV problems in Asia. Some of China's earliest HIV infections were reported in Ruili in 1989, in injecting drug users. Since then HIV infection has spread along the drug smuggling routes and has been seen in every county in Yunnan Province, as well as north to Xinjiang and east to Guangdong.²

Although HIV is epidemic at the border, malaria may be an even greater problem. Drug-resistant *Plasmodium falciparum* malaria is prevalent on both sides of the border. Following decades of war, public health infrastructure in the border regions is minimal. Logging and mining operations in Kachin and Shan states have brought non-immune populations into the forest fringe, leading to many malaria outbreaks. Cholera outbreaks have also been reported on the border³ and Burma's only admitted H5N1 avian influenza outbreak took place near Mandalay, a day's drive from China. The chaos and lack of public health resources on the Burma side of the border are of serious concern to Chinese public health officials.

Finally, the border is permeable. There are many crossings in Kachin and Shan States for both legal and illegal trade. The heroin, gambling, prostitution, and illegal logging industries are all cross-border. Labor crosses the border in both directions. The Dai and Jingpo ethnic groups in Yunnan are related to the Shan and Kachin in Burma, and local residents move back and forth for marriage, work, socialization, and trade. An estimated 10 million people a year cross the border in each direction. Like most borders, the Yunnan-Burma border presents few obstacles to the movement of infectious diseases.

Background

The border between Burma and China runs roughly north-south for about two thousand kilometers from Tibet to Laos. On the China side of the border is Yunnan Province and on the Burma side are Kachin State to the north and Shan State (divided into Northern, Southern and Eastern Shan State) to the south.

The road from the Burmese city of Mandalay passes between Kachin State and Northern Shan State to enter China at the border town of Ruili. This is the ancient South Silk Road to India, and

¹ See Global Witness, *A Choice for China: Ending the Destruction of Burma's Northern Frontier Forests*, October 2005. Available at <http://www.globalpolicy.org/security/natres/timber/2005/10burma.pdf>. Note: in May 2006 the trade was officially ended.

² Chris Beyrer et al., "Responding to AIDS, Tuberculosis, Malaria, and Emerging Infectious Diseases in Burma: Dilemmas of Policy and Practice," *PloS Med* 3:10, 2006, e393.

³ Interview with official of Yunnan Provincial CDC, August 2006.

also the “Burma Road” of World War II, built with Anglo-American resources to supply the Kuomintang army against Japan. It is the artery of Chinese economic and geopolitical expansion into Burma, and on to the Indian Ocean. China is Burma’s principal trading partner and arms supplier and largest foreign investor,⁴ much of the business in Burma is Chinese-owned, and Mandalay is described as largely a Chinese city. Reportedly the road is now being extended to run all the way to Cox’s Bazaar in Bangladesh. It will provide Chinese access to the Bay of Bengal, and, according to some sources, will supply Chinese military installations on the Burmese coast.⁵

The status of the ethnic groups on the China-Burma border has major implications for infectious disease control. On the Burma side, the Kachin and Shan states are inhabited by many ethnic groups, most prominently the Kachin, Palaung, Shan, and Wa. Although population estimates vary widely, there are perhaps 500,000 Wa, 800,000 Palaung, 1.2 million Kachin, and some 6 million Shan people living in these states.

Former resistance groups inhabit a significant portion of Kachin and Shan states.⁶ On the China border most of these groups signed cease-fire agreements or surrendered to the Burmese military in the early 1990s. The largest and most organized of the cease-fire groups is the Kachin Independence Organization (the KIO, the political wing of the Kachin Independence Army), one of the few groups that still controls significant territory. Other ethnic organizations include the Shan State Peace Council, an alliance of the Shan cease-fire armies, and the Palaung State Liberation Party (PSLP), which signed a cease-fire in 1991. No major conflict has occurred on Burma’s northern border in the last ten years. The main efforts of these groups since the cease-fires have been economic productivity, political advocacy, and improved health and education. (An exception is the United Wa State Army, which has primarily been involved in drug production.)

Although the KIO initially controlled 15,000 of 34,000 square miles in Kachin state, containing a quarter of the population,⁷ its influence has eroded since the cease-fire in 1993, in part due to the loss of control of jade mining and other natural resources. It must now compete with Chinese businessmen to buy concessions for previously KIO-owned areas.⁸ Groups in the northern Shan State have also lost authority, culminating in the arrest of their leaders while attending the government-sponsored National Convention in 2005. The PSLP, finally forced to surrender last year, was obliged to stop all organized activity.

The Burmese government’s strategy, which typically provides no domestic support and obstructs international support, extends to the health activities of international humanitarian organizations

⁴ Burmese trade with China was \$1.21 billion in 2005, 20 percent of its foreign trade volume. See J. Genser, “China’s Role in the World: The China-Burma Relationship.” Testimony to the U.S.-China Economic and Security Review Commission, August 3, 2006.

⁵ D. Arnott, “Perspectives on Multilateral and Bilateral Responses,” *China-Burma Relations: Challenges to Democratization in Burma*, 69, 2003 at 69.

⁶ Human Rights Watch, *My Gun Was as Tall as Me: Child Soldiers in Burma*, <http://hrw.org/reports/2002/burma/Burma0902-05.htm>.

⁷ Global Witness, *supra* note 1.

⁸ Images Asia and Pan Kachin Development Society, *At What Price: Gold Mining in Kachin State, Burma*, available at <http://www.ibiblio.org/obl/docs/gold%20pdf1.pdf>.

operating from Rangoon. No significant international health-related activities have been reported in KIO or former PSLP areas of influence. Much has been made recently of the Burma measles vaccination campaign, which has reportedly been carried out every year since 1987.⁹ However, the only vaccination in KIO areas was conducted by an international humanitarian organization operating from China.¹⁰

Violations of human rights carried out by the Burmese government continue to plague local ethnic populations along the border. Although the violations are of a different nature than those in conflict zones in eastern Burma,¹¹ they have important consequences for infectious disease and health. Infant and child mortality rates collected by a Palaung health organization suggest that mortality rates are comparable to conflicted Karen areas of eastern Burma.¹² Forced displacement continues to be a problem. Militarization, mining and logging activities, and large-scale agricultural projects have led to widespread forced labor, food insecurity, and lack of access to basic health and education services.¹³

Community-based and nongovernmental organizations have gained a foothold in the post-cease-fire era in the China-Burma border region, but have suffered from continued persecution. The Burmese authorities closed a Shan clinic in Hsipaw township in 2005 near the time of the arrest of northern Shan leaders at the National Convention, and a Shan health worker was arrested and jailed for six months.¹⁴ Similarly, army troops closed down a Palaung clinic in Namkham township in 2005, forcing the health workers to resort to mobile operations. Continued support for health and education projects trickles in from international donors, but access is extremely difficult.

Since the ethnic organizations on the China border are not engaged in active conflict and no longer pose any real threat, the goal of these policies is not clear. Ethnic leaders claim that the regime's activities are designed to keep their areas underdeveloped, and to undermine their standing within their communities.¹⁵ Regardless of the motivation, because these border populations have high rates of infectious disease and play a vital role in further spread, public health strategy in the region remains a critical issue.

⁹ "Myanmar to vaccinate more than 13 million children against measles," Daily People's Online, October 2, 2006, http://english.people.com.cn/200610/02/eng20061002_308238.html.

¹⁰ Interview with KIO Health Department official, August 2006.

¹¹ Back Pack Health Worker Team, *Chronic Emergency: Health and Human Rights in Eastern Burma*, 2006.

¹² Palaung Youth Network Group, unpublished data.

¹³ See e.g. Human Rights Watch, "Burma: Events of 2006," <http://hrw.org/englishwr2k7/docs/2007/01/11/burma14865.htm>.

¹⁴ Interview with Shan health worker, Mae Sot, Thailand, January 2006.

¹⁵ Human Rights Watch, *Lessons from Cease-fires in Kachin and Mon States*, <http://hrw.org/reports/2005/burma0605/7.htm>.

Drugs

Kachin State and Shan State contain the principal opium-poppy growing areas in Burma, which was until recently the largest heroin exporter in the world.¹⁶ Most of the heroin passes across the Chinese border into Yunnan Province and then to Kunming and along trade routes either north to Xinjiang Province and central Asia, or east to Hong Kong and the United States.

The northeastern part of Shan State contains the Kokang region (Special Region 1), an essentially autonomous warlord principality that was a major opium-growing region until 2003. South of Kokang, along the border with China's Lincang Prefecture, is the Wa State (Special Region 2), controlled by the United Wa State Army (UWSA) and historically the principal opium-growing area in Burma. The border between the Wa State and China was not delineated until the 1960s. Under a cease-fire agreement between the UWSA and the Rangoon regime, the Wa Authority controls the region and the UWSA has kept its weapons.

The Wa area is also the primary location of UN Office on Drugs and Crime (UNODC) which attempts to control opium production in Burma—a large piece of social engineering involving complex negotiations between the UN, the Burmese government, and local power holders, and undoubtedly China as well. Both Kokang and the Wa fought against the Burmese government with the China-affiliated Burmese Communist Party (BCP) until 1989, and both are ethnically and historically close to China.

Other ethnic political organizations, such as the KIO and PSLP, have had hardline anti-drug policies. The KIO declared Kachin State an “opium-free zone” in the early 1990s. U.S. government satellites subsequently documented the reduction in poppy production.¹⁷ Following the cease-fire, however, the KIO was unable to maintain its anti-drug policy because of the increasing influence of the Burmese government,¹⁸ resulting in increased production in northern and western Kachin State. The Palaung Women's Organization (PWO) reports a similar increase in drug production and use after the PSLP was forced to surrender in 2005.¹⁹ The Burmese army reportedly permits production as long as taxes are paid at various stages in the production cycle.²⁰

Opium growing in Kokang was reportedly stopped in 2003. Opium growing in the Wa area was supposed to have been stopped by 2005, and has in fact been highly reduced according to the UNODC.²¹ Elsewhere in Shan State, fighting continues between the Burmese military and Shan ethnic organizations. Opium poppy growing is said by some sources to have been moved south from the Wa area, and there is large-scale production of amphetamine-type stimulants (ATS) in

¹⁶ UNODC Joint Kokang-Wa Humanitarian Needs Assessment Team, *Replacing Opium in Kokang and Wa Special Regions, 2005*, http://www.unodc.org/pdf/myanmar/replacing_opium_kogang_wa_regions.pdf. UNODC, *Myanmar Opium Survey 2005*, http://www.unodc.org/pdf/Myanmar_opium-survey-2005.pdf.

¹⁷ World Resources Institute, *Opium Cultivation in Kachin State*, 1998, http://pubs.wri.org/pubs_content_print.cfm?ContentID=1915.

¹⁸ Far East Economic Review, February 20, 1997, <http://www.ibiblio.org/obl/reg.burma/archives/199702/msg00260.html>.

¹⁹ “Poisoned Flowers,” Palaung Women's Organization, http://www.ibiblio.org/obl/docs3/PoisonedFlowers_final1.pdf.

²⁰ World Resources Institute, *supra* note 17.

²¹ UNODC, *supra* note 16.

Eastern Shan State.²² Burma is one of the world's largest producers of ATS, with most of the chemical precursors imported from China.

Although tensions have been reduced in recent years by peace agreements between the Burmese government and many of the conflict groups, and although the UNODC has apparently achieved major reductions in poppy growth, Shan state is turbulent, much of the border area is extremely remote, and health services are few. The reported reductions in opium cultivation are disputed by some ethnic organizations and there has been a small recent increase in Kachin State.²³ Furthermore, reductions in opium cultivation have produced an economic crisis in parts of Kokang and the Wa area, leading to the need for World Food Program support.²⁴ Poverty, poppy production, and the heroin trade are facts of life on the China border, and increasingly so is HIV.

Infectious Diseases

HIV/AIDS

There is very little quantitative information on HIV in the China-Burma border region. Nationally, Burma has perhaps the worst HIV problem in Southeast Asia, with an estimated adult prevalence of between 1 percent and 2 percent in the country as a whole. Recent seropositivity rates nationwide are reported as 1.8 percent in pregnant women, 43 percent in injecting drug users (IDU) and 32 percent in sex workers.²⁵ Rates in IDUs are even higher in the opium-growing regions of eastern Burma, reported at 47 percent in Myitkyina, capital of Kachin State, and 60 percent in Lashio, in Northern Shan State. UNODC considers the area between Myitkyina and Lashio to be a corridor of particularly high vulnerability for HIV.²⁶ Township-level rates are not, in general, available; however, the Ministry of Health includes Lashio and Myitkyina on its list of 29 priority townships for drug-user interventions, along with Mogaung in central Kachin State; Hopin and Bhamaw in south Kachin State; Muse (across the border from Ruili), Mogoke, and Kutkai in Northern Shan State; and Kyaingtone in Eastern Shan State.²⁷ These townships are all on or close to the Chinese border.

Seroprevalence data usually comes from the urban centers under government control, rather than from the more inaccessible areas controlled (to varying extents) by the cease-fire organizations. In this context, two fragments of data from the border are suggestive. First, the Kachin Independence Organization, the cease-fire organization in the Kachin Independent Area, recently

²² Shan Herald Agency for News, *Hand in Glove: The Burma Army and the Drug Trade in Shan State*, <http://www.shanland.org/resources/bookspub/drugs/Hand%20in%20Glove.pdf>.

²³ Palaung Women's Association, supra note 2. Kachin Women's Association Thailand, "Driven Away: Trafficking of Women on the China-Burma Border," http://www.ibiblio.org/obl/docs3/Driven_Away-ocr.pdf.

²⁴ International Crisis Group, "Burma: Aid to the Border Areas," Asia Report No. 82, Yangon/Brussels, 2004.

²⁵ Myanmar Ministry of Health, *First Coordinating Meeting on Three Diseases*, August 2006.

²⁶ UNODC, *Myanmar: Strategic Programme Framework 2004–2007*, http://www.unodc.org/pdf/myanmar/myanmar_strategic_programme_framework.pdf.

²⁷ Myanmar Ministry of Health, supra note 25.

found a seroprevalence rate of 9 percent among military recruits²⁸—about four times the nationwide rate in Burma for military personnel. In addition, 57 percent of IDUs tested positive for HIV. Second, the Palaung Women’s Organization reports very high levels of opiate addiction in villages in the Palaung area of Northern Shan State (in the UNODC “vulnerable corridor”), with catastrophic effects on families. Conditions reported in 11 villages are similar to those described below in villages on the Chinese side of the border, but with less awareness of HIV. To our knowledge, no seroprevalence studies have been conducted.

Outside funders have recognized the acuteness of the border HIV problem, its origin in the opium-growing areas, and the inability or unwillingness of the Burmese government to fund an intervention program without assistance. The Burma Joint Programme for HIV/AIDS was established in 2003, under the aegis of UNAIDS and with funding primarily from Europe, to “change behavior to reduce the transmission of HIV and to improve the health of people living with HIV/AIDS.” The Fund for HIV/AIDS in Burma (FHAM) was established to fund the Joint Programme. As of October 2005, FHAM had raised a total of \$49 million (directly and indirectly) to support the Programme during 2003–05.²⁹ The Programme has adopted a harm-reduction approach, following initial work by the Asia Regional HIV/AIDS Project (ARHP). Meanwhile, the main approach to prevention in sex workers appears to be a “100% condom” campaign on the Thai or Cambodian model, more directly associated with the national government than the interventions aimed at drug users and less under NGO control. There are treatment programs for sexually transmitted diseases in the urban centers, but programs addressed to sex workers are few.

Concurrently with the development of the Joint Programme, UNODC adopted as its second Strategic Objective “by 2008, to have reduced significantly the spread of HIV/AIDS through injecting drug use in targeted intervention areas.”³⁰ There is thus a coordinated approach to prevent HIV transmission among drug users in Burma, involving major international organizations and aimed specifically at some of the high-risk areas in the northeast.

This approach was incorporated into the HIV section of the Global Fund’s Round 5 proposal,³¹ and subsequently into the program of the Three Diseases Fund.³² It is largely harm-reduction based, centering on drop-in centers and needle-exchange programs in high-risk townships. In addition, a pilot methadone maintenance program has been developed in four townships (Yangon, Lashio, Myitkyina, and Mogaung) with some hundred or so IDUs currently on treatment in late 2006. Antiretroviral treatment has just begun in Burma, and treatment of drug

²⁸ Wang Bangyuan, “Build a Primary Health System along the China-Burma Border,” presentation given at the conference “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 2007.

²⁹ Joint Programme for HIV/AIDS in Myanmar, *2003–2005 Mid-term Review: Findings and recommendations of the review team*, http://data.unaids.org/Publications/IRC-pub06/Final%20MTR%20report_2005_en.pdf?preview=true.

³⁰ UNODC, *supra* note 26. The “targeted intervention areas” are initially in the Myitkyina-Lashio corridor described above. The UNODC “third strategic objective” is to reduce trafficking in human beings from Burma. This is primarily for sex work in China and Thailand.

³¹ Joint Programme of HIV/AIDS in Myanmar, *Progress Report 2003–2004*, and Fund for HIV/AIDS in Myanmar (FHAM), *Annual Progress Report 2004–2005*, http://data.unaids.org/pub/Report/2005/Myanmar_progress_report_03_04_en.pdf.

³² Myanmar Ministry of Health, *supra* note 25.

users is extremely rare. (It is worth noting that the current antiretroviral treatment sites include a cross-border treatment project on the Thai border.)

There is clearly a focused approach to preventing HIV in drug users in Burma that targets at least some of the border areas. Somewhat ironically, given the authoritarian nature of the government, this approach is harm-reduction based. But is it successful and does it get to the border areas?

In a severe but generally supportive mid-term review,³³ four independent reviewers noted that coverage of the Programme is extremely low for all interventions. (“Most reach no more than a few hundred people.” “Many of the proposed strategies ... are not yet being done, and indeed some of them cannot be taken forward in Burma at this time.” “With a few notable exceptions, those who are most vulnerable and at highest risk of contracting HIV are not being reached.”) On the other hand, the review noted that real progress had been made over a relatively short period, and that the Programme “successfully mobilized donor resources and a multi-sectoral response to HIV/AIDS in a very challenging situation, where a response is critically needed.”

The primary question is whether the response can expand from the urban centers into the border areas, where control is less likely to be in the hands of the central government. In this context, interviews with staff of three clinics in border areas were discouraging. We interviewed staff from a hospital in the Kachin Independent Area, from a clinic in a border gambling town in Kachin State but outside the Kachin Independent Area, and from a clinic in the high-risk corridor in Northern Shan State. Concern about HIV was high in all three groups. All reported pervasive intravenous drug use, a lack of the most basic information about HIV in the population, clinical AIDS, and very limited HIV seroprevalence information. In no case were any resources being received from central government, and HIV testing was not generally available. Although Population Services International (PSI), a major international humanitarian organization working from Rangoon, reports that it increased the total market for condoms in Burma to 40 million by 2005 through promotion campaigns, the groups we spoke to reported none of this activity in their areas.

Clearly more than the lack of resources is playing a role here. At least one international humanitarian organization has accessed KIO areas to provide some HIV services. However, it must work with some secrecy as this activity places its Memorandum of Understanding with the Burmese government at risk.³⁴ A European physician working for this organization reported that in Kachin state, two-weeks advance warning was required before staff could visit their own clinics, and that despite giving notice staff were subject to military checkpoints at 2–5 kilometer intervals *en route*. This physician also reported phone taps and military intelligence personnel working in the organization’s office.

HIV Infection in Yunnan Province

With the identification of 146 HIV-seropositive injecting drug users in Ruili in 1989, the Yunnan-Burma border was officially identified as the site of China’s principal HIV problem.

³³ Joint Programme for HIV/AIDS in Myanmar, *supra* note 29.

³⁴ Interview with NGO worker, August 2006.

HIV infection was already widespread in the border villages at that time.³⁵ Since then, the course of HIV infection in Yunnan has been relatively well studied. With health leadership from the provincial level, and with substantial international funding from the UK via the UK-China Collaboration (now folded into the Global Fund) and from AUSAID via the Asia Harm Reduction Project, Yunnan Province has become something of a laboratory for the development of IDU interventions. However, intervention has been cautious. For example, there have been needle-exchange sites in Yunnan for some years, but the program is still apparently regarded as a pilot program.

HIV seroprevalence data is considered a state secret in China, and during our visit to Yunnan in 2006 neither local nor provincial health officials would release prevalence data for border counties without central government authorization. However, four prefectures in Yunnan are now regarded as having “generalized HIV epidemics” with HIV seroprevalence rates among pregnant women greater than 1 percent. These are Dehong Prefecture, where the road crosses the China-Burma border at Ruili; Dali Prefecture, west along the road towards Kunming; Lincang Prefecture south of Dehong and running along the border with Kokang and the Wa area; and Wenshang Prefecture, further south on the Vietnamese border.³⁶ County-level seroprevalence rates in pregnant women may be 2 percent or higher in some parts of these prefectures.

Cross-border gambling in the many casinos along the China-Burma border is accompanied by widespread prostitution. (There are casinos at many—if not most—of the border crossings. Although the casinos are Chinese-owned and the patrons are Chinese, gambling is not legal in China so the casinos are positioned across the border in gambling enclaves.) In Ruili, the main border town, there were an estimated 700 Chinese sex workers in the main downtown sex area in summer 2006, plus a smaller number of lower-priced Burmese sex workers.³⁷

The situation of the Burmese sex workers is difficult because they are illegal and there is trafficking across the border.³⁸ There was apparently no large-scale organized intervention with sex workers in progress in Ruili in summer 2006, nor any available data on current HIV seroprevalence in the sex workers. It was explained that since “prostitution is illegal” it was difficult for the local health authority to intervene. Since Ruili is the largest and probably the best-organized of the border towns, HIV in sex workers clearly remains a major problem on the border. There appear to be essentially no sex-worker interventions on the Burmese side, except perhaps in Muse, opposite Ruili.

HIV seroprevalence rates in injecting drug users of 60–80 percent were recorded at Ruili in the 1990s. One recent survey reports the seroprevalence rate among IDUs in Yunnan as a whole is 20 percent, while the rate in commercial sex workers is 3.7 percent, and the rate in patients with sexually transmitted infections is 2.5 percent.³⁹ These are substantial rates for a province with 43 million inhabitants.

³⁵ Interview with Jing Paw, ethnographer, Ethnology Institute of Yunnan Academy of Social Sciences, August 2006.

³⁶ Interview with ARHP staff member, August 2006.

³⁷ Interview with NGO volunteer, August 2006.

³⁸ Interview with Burmese Women’s Union spokesperson, August 2006. Kachin Women’s Association Thailand, *supra* note 23. Available at http://www.ibiblio.org/obl/docs3/Driven_Away-ocr.pdf.

³⁹ C. Bartlett, personal communication.

The HIV problem has diffused across Yunnan, with those infected recently being largely younger, further from the border, and less likely to be ethnic minorities than in the 1990s. Rates on the border are still undoubtedly very high. Those infected in the 1980s and 1990s are now likely to have progressed to clinical AIDS. Two studies of border villages suggest rather startling levels of infection at the village level. In one village of 365 persons, 18 had died of AIDS by 2005 and a further 12 were known to be living with HIV infection, with a cumulative infection rate of at least 8 percent.⁴⁰ In a second village of 200 people, there had been 20 deaths and at least 30 were known to be HIV positive, with a cumulative infection rate of 15 percent.⁴¹ These figures suggest levels of HIV infection in the villages close to the border that are comparable to those in East Africa. This is almost certainly the case in villages on the Burma side of the border, particularly in the Palaung and Wa areas.

In 2003 the Chinese government adopted an aggressive national approach to AIDS. The policy for injecting drug users is now based on intensified policing, with the intent of putting a high proportion of injectors nationwide in “detoxification camps” and “re-education camps.” (There are currently an officially estimated 60,000 to 80,000 injectors in Yunnan, although NGO personnel believe this estimate is low.) In addition, the central government has adopted methadone maintenance as the primary method of reducing HIV-infection risk in drug users. Chinese national policy is to establish a methadone maintenance program in every county with more than 500 drug users. The strategy is to place half of the drug users in detox and re-education camps at any one time and 80–90 percent of the remainder in methadone maintenance. There are currently 29 methadone clinics in Yunnan, linked to the camps. In addition, antiretroviral treatment for HIV, just beginning in Yunnan, is linked to the maintenance programs.⁴²

With the intense government focus on law enforcement, local officials were distancing themselves from needle-exchange programs in the summer of 2006. In interviews with officials and NGO workers it was clear that the aggressive policing of drug users was making it somewhat difficult for needle exchanges to function properly.⁴³ However, there are currently 30–40 needle-exchange programs in Yunnan Province, supported by ARHP and the China–UK Project. In July 2006, a high-level official in the Yunnan Institute of Drug Abuse told us that “this does make our intervention work quite difficult. ... The whole society, including many government officials, does not really accept the idea of needle exchange among drug users. ... In contrast, methadone maintenance programs are more acceptable to the people.” This official does not believe that the current police policy will work in the long run: “We won’t see a lot of benefits coming out of the costly input of resources on expanded forced detox and re-education camps. At present the policies are still clashing.”

It remains to be seen what effect the current aggressive law-enforcement approach will have on injecting drug use and HIV infection in the China-Burma border region. No sequential seroprevalence data is available to examine trends and the Chinese government is likely to hold any such data closely. Furthermore, local officials suggest that improvements in surveillance

⁴⁰ Xu Zhixiang, “Healing from Social Suffering: Women’s Experiences in a Drug Abuse Afflicted, Jingpo Community, Yunnan, China,” M.A. thesis, Mahidol University, 2006, <http://www.sh.mahidol.ac.th/hssip/theses/2004/5.pdf>.

⁴¹ Interview with Jing Paw, ethnographer, *supra* note 35.

⁴² Interview with Dr. Li Jinhua, Yunnan Institute of Drug Abuse, August 2006.

⁴³ Interviews with field workers, Daytop needle exchange program, Yunnan, August 2006.

following the 2003 change in policy will make it difficult to see trends in seroprevalence rates. Although central and local governments are aggressively engaged in the issue, it is not clear that HIV infection is under control.

Malaria

Malaria in Burma

Burma suffers from a high burden of malaria with a very high proportion of *Plasmodium falciparum* cases. Both Kachin and Shan states are at high risk overall with 2004 official morbidity rates in the range 20–29 per 1,000 and 10–19 per 1,000 respectively and mortality rates of 8–10 per 100,000.⁴⁴ These treatment-based statistics severely underestimate the malaria burden on the border because no data is collected in many areas and because most treatment is in the private sector. Local data is sparse; however, among 20 KIO clinics, nearly 38 percent of all patients seen in a recent count (4,394 of 11,443) were diagnosed with malaria (usually diagnosed clinically). This is consistent with other studies from rural Burma documenting infection rates of 12–75 percent per year.⁴⁵ In a pilot KIO malaria program, 22 percent of asymptomatic villagers tested positive for *falciparum* malaria (by microscopy), consistent with other surveys documenting prevalence rates of 10–40 percent.⁴⁶ A foreign doctor who visited the KIO area in summer 2006 reported “a person with fever in every house.”

Township-level malaria data are sparse and there is no data at all for some areas in Kachin and Shan states.⁴⁷ Of 100 high-risk townships listed in the Myanmar National Malaria Plan, many are in the high-risk corridor for HIV between Myitkyina and Lashio. Thus, in the China border area, very high HIV infection rates coexist with very high malaria rates and a high prevalence of drug-resistant malaria—a situation with severe consequences for maternal health and perhaps HIV transmission. So far, this issue does not seem to have been raised in the Burma national plan.

⁴⁴ World Health Organization SEARO, “Malaria situation in SEARO countries: Myanmar,” http://www.searo.who.int/EN/Section10/Section21/Section340_4024.htm. WHO SEARO believes these numbers are underestimates.

⁴⁵ Soe-Soe, Khin-Saw-Aye, Htay-Aung, Nay-Win, Tin-Aung, Than-Swe, et al., “Premunition against *Plasmodium falciparum* in a Malaria Hyperendemic Village in Myanmar,” *Trans R Soc Trop Med Hyg* 95:1, January–February 2001, 81–84; K. Lin, S. Aung, S. Lwin, H. Min, N. N. Aye, R. Webber, “Promotion of Insecticide-Treated Mosquito Nets in Myanmar,” *Southeast Asian J Trop Med Public Health* 31:3, September 2000, 444–47; T. T. Win, K. Lin, S. Mizuno, M. Zhou, Q. Liu, M. U. Ferreira, et al., “Wide Distribution of *Plasmodium Ovale* in Myanmar,” *Trop Med Int Health* 7:3, March 2002, 231–39; S. Soe, M. Theisen, C. Roussilhon, K. S. Aye, P. Druilhe, “Association between Protection against Clinical Malaria and Antibodies in Merozoite Surface Antigens in an Area of Hyperendemicity in Myanmar: Complementarity between Responses to Merozoite Surface Protein 3 and the 220-Kilodalton Gultamate-Rich Protein,” *Infect Immun* 72:1, January 2004, 247–52; M. Lwin, H. Lin, N. Linn, M. P. Kyaw, M. Ohn, N. S. Maung, et al., “The Use of Personal Protective Measures in Control of Malaria in a Defined Community,” *Southeast Asian J Trop Med Public Health* 28:2, June 1997, 254–58.

⁴⁶ T. T. Oo, V. Storch, N. Becker, “*Anopheles dirus* and its role in Malaria Transmission in Myanmar,” *J Vector Ecol* 28:2, December 2003 at 175–83; W. Tun-Lin, M. M. Thu, S. M. Than, M. M. Mya, “Hyperendemic Malaria in a Forested, Hilly Myanmar Village,” *J Am Mosq Control Assoc* 11:4, December 1995, 401–07; Backpack Health Worker Team, *Chronic Emergency: Health and Human Rights in Eastern Burma*, 2006.

⁴⁷ World Health Organization SEARO, “Township-wise Distribution of Malaria Mortality in Burma, 2001,” http://www.searo.who.int/LinkFiles/Malaria_in_the_SEAR_mmr_town-mal01.pdf.

Although the extent of drug-resistant *P. falciparum* on the Yunnan border has not been as well documented as on the Thai border, drug resistance levels are universally believed to be very high. Surveillance data from Myitkyina reported by the Mekong Roll Back Malaria Partnership shows Adequate Clinical Responses to chloroquine (76%), SP (67%), and mefloquine (80%) in 2001–02. These rates are lower than at any other surveillance sites in Burma except on the Thai border.⁴⁸ More recent or more detailed surveillance data for drug resistance does not appear to be available. (The Roll Back Malaria–Mekong Partnership reports a surveillance site in Bhamaw, but no data was reported.) In a recent study in northern Kachin State, Smithuis et al. reported that chloroquine and mefloquine were completely ineffective for treatment of *falciparum* malaria.⁴⁹ Based in part on this study the Burmese national treatment protocol for *falciparum* malaria was changed to a three-day regimen with artesunate-mefloquine combination therapy in 2003.

The border regions are particularly susceptible to counterfeit malaria drugs, including fake artesunate.⁵⁰ Private sector–supplied pharmaceuticals with low concentrations of drugs such as artesunate are more dangerous, from the resistance point of view, than drugs with no active ingredient at all.⁵¹

The vulnerability of the border regions is extreme because in addition to remoteness, conflict, low living standards, decay of the public health system, and control by military forces who are essentially living off the land, there is major movement of non-immune populations. Logging in Shan State after the cease-fire there and current logging operations in Kachin State have moved non-immune populations into the forest fringe.⁵² Forced movement of non-immune Wa people south, as part of the poppy-control activities in Shan State, generated malaria outbreaks, which are officially admitted to have killed thousands of people.⁵³ Jade, gold mining, and uncontrolled logging in Kachin State have produced what has been described as a “wild west” atmosphere on the border. In this situation, with little or no health-systems support from the Burmese government, with major population movements within and into the country, and with self-medication the rule for malaria, the border is likely to remain a global hotspot for drug resistance.

The vulnerability of the border regions has been noted by all malaria organizations working in Burma. The National Operational Plan on Prevention and Control of Malaria (now included as part of the “Three Diseases” program) identifies as high-risk groups “mobile populations in search of economic opportunities (e.g., forest-related workers, miners, workers in development projects, plantation workers), upland subsistence farmers, settlers in the forest or forest fringes, and the national races (ethnic groups) living in remote endemic areas, particularly along the borders.”⁵⁴ The Asian Development Bank has identified the “conditions of ethnic minorities

⁴⁸ D. Socheat et al., “Mekong Malaria II. Update of malaria, multi-drug resistance and economic development in the Mekong region of Southeast Asia.” *Asian J Trop Med Publ Health* 34 Suppl 4:1–102, 2003.

⁴⁹ F. Smithuis et al., “Comparison of chloroquine, sulfadoxine/pyrimethamine, mefloquine and mefloquine-artesunate for the treatment of *falciparum* malaria in Kachin State, North Myanmar,” *Trop Med Int Health* 9: 11, November 2004, 1184–90.

⁵⁰ A. M. Dondor et al., “Fake antimalarials in Southeast Asia area a major impediment to malaria control: multinational cross-sectional study on the prevalence of fake antimalarials,” *Trop Med Intl Health* 9, 2004, 1241.

⁵¹ Beyrer et al., *supra* note 4.

⁵² See Global Witness, *supra* note 1, for an extensive description of logging in Kachin State.

⁵³ UNODC Joint Kokang-Wa Humanitarian Needs Assessment Team, *supra* note 16.

⁵⁴ Myanmar Ministry of Health, *supra* note 25.

living in isolated locations” as the primary malaria challenge and proposed targeted support to help address them.⁵⁵ The WHO Roll Back Malaria–Mekong Collaboration notes expressly that drug-resistant malaria is a border problem and that “cross-border control of malaria should be a priority for control of drug resistance.”⁵⁶

Given this consensus on the importance of the ethnic areas along the border it is somewhat alarming to discover that the Burmese national malaria plan does not penetrate very far into the border region. As of late 2006, the Burmese government was not providing malarial-control assistance to the Kachin Health Department of the KIO nor the Palaung and Shan health organizations. Health workers from these ethnic groups report severe shortages of medical supplies to diagnose or treat malaria. Villagers will often purchase as few as two or three tablets from local shops for malaria, and even health workers in clinics describe resorting to monotherapy or shorter-than-recommended courses of antimalarials, which contributes to drug resistance.

Insecticide treated nets (ITN), another mainstay of malaria control, were almost non-existent in the areas where these organizations operate. During the implementation phase of an ITN program in Kachin and Palaung areas, many villagers had never heard of an ITN or of “supatab” (the Burmese name for KO-Tab), a tablet marketed by Population Services International (PSI) to treat bednets. PSI, well-known internationally for effective social marketing strategies, sold 226,000 KO-tabs in 2005,⁵⁷ but apparently did not reach the border areas. The Kachin and Palaung groups had to travel to the urban areas of Myitkyina and Lashio respectively to purchase KO-tabs for their programs.

The Burmese National Malaria Control Programme was reviewed by outside reviewers in 2005, but the reviewers do not appear to have visited the border areas. A map of areas visited by the review team shows no visits in Kachin state, or in Northern or Eastern Shan states, or in fact anywhere close to the Yunnan border.⁵⁸ Given the disparity between the identification of high-risk areas and the actual provision of service, funders of the Three Diseases Fund may need to consider setting up a separate review process for the border areas. An experienced doctor working with international humanitarian organizations observed that the Three Diseases Fund would not work “unless the money is monitored right down to the person taking the medication.”⁵⁹

Malaria in Yunnan Province

Because of its border with Burma, Yunnan Province is China’s national malaria hotspot. Malaria is a re-emergent disease in China with estimated cases rising to about half a million nationwide in 2003. This rise follows major successes in reducing malaria incidence in the 1980s and is a result of the economic reforms of 1990. According to China’s surprisingly frank Global Fund Round 5 application, “the development of the private economy in the countryside has had a negative impact on the primary care network. This has been particularly pronounced in the

⁵⁵ Asian Development Bank, *Technical Assistance to the Greater Mekong Subregion for Strengthening Malaria Control for Ethnic Minorities*, TAT: OTH39040, May 2005.

⁵⁶ WHO SEARO, *Strategic Plan to Roll Back Malaria in the Southeast Asia Region*, SEA-MAL-237, 2004.

⁵⁷ See http://www.psi.org/where_we_work/Burma.html#malaria.

⁵⁸ WHO SEARO, *External Review of the National Malaria Control Programme in Burma 18–28 October 2005*, http://w3.whosea.org/EN/Section10/Section21/Section1979_10763.htm.

⁵⁹ “Hopes in Myanmar for new fund to fight deadly diseases,” *Agence France-Presse*, October 11, 2006.

poorest areas where the once strong Public Health System has been greatly weakened and in some cases destroyed.”⁶⁰ According to the application, in 2001 only one-third of township hospitals in malaria-endemic areas could perform blood examinations due to lack of facilities and/or a trained microscopist. The writers estimated that no more than 10 percent of patients were currently receiving prompt and accurate diagnoses at the village level. The bednet program was also said to have disintegrated with only 5 percent ownership of bednets in project areas. “The most endemic areas,” the application noted, “are the least accessible areas.”

These most endemic and least accessible areas are the counties along the border with Burma. Forty percent of all China’s malaria cases are in Yunnan province⁶¹ as are 60–80 percent of its *falciparum* cases. In 2001, 26 of 35 counties in China with *falciparum* malaria were along the Burma border. The Global Fund application was focused on these border counties and specifically aimed at problems of access and drug resistance in the border area. (It was expanded in Round 5 to include the counties immediately east of the border counties.) The primary Chinese concern appears to be that migration from within China to the economic boom areas on the Burma border and then back home could spread *Plasmodium falciparum* back north and east to areas of China where it has been eradicated. As noted above, there are some 10 million border crossings a year in each direction.

However, even though the Chinese malaria control program seems to have disintegrated in the 1990s, malaria incidence rates in the border counties are something like one tenth of the (undoubtedly underreported) rates on the Burma side.⁶² Malaria deaths in Yunnan Province as a whole were on the order of 30 per year in 2002 compared with perhaps thousands on the Burma side, and laboratory confirmation rates in 2002 were reported as greater than 90 percent versus 10 percent or less on the Burma side.

Even though counterfeit drugs are a problem (fake artesunate was reported in Ruili in 2004⁶³), and even though resistance to artemisinins has been seen since the middle 1990s,⁶⁴ malaria is essentially under control, or close to it, in Yunnan Province. This is probably true, or will soon be true, even in the border counties. “Compared to other Mekong countries,” a recent review of malaria surveillance in the Roll Back Malaria–Mekong Partnership noted, “malaria is not a major problem in Yunnan.”

The reviving Chinese malaria control program stops dead at the border. The difference between Chinese and Burmese malaria control efforts in the region is graphically visible in the malaria

⁶⁰ Global Fund for AIDS, Malaria, and Tuberculosis. China Round 5 Application, <http://www.theglobalfund.org/programs/grantdetails.aspx?compid=987&grantid=481&lang=en&CountryId=CHN>. The application notes that “critical weaknesses which developed in the reporting system following the economic reforms of 1990 mean that it is not possible to present hard data related to malaria incidence over the last 15 years.”

⁶¹ World Health Organization, Roll Back Malaria, *China country profile 2002*, <http://rbm.who.int/wmr2005/profiles/china.pdf>.

⁶² World Health Organization, Roll Back Malaria, *Mekong Malaria II: Update of malaria, multi-drug resistance, and economic development in the Mekong region of Southeast Asia*, http://w3.who-thai.org/LinkFiles/Roll_Back_Malaria_MekongMalaria_II_new.pdf.

⁶³ United States Pharmacopeia, Drug Quality and Information Program, “Fake Antimalarials Found in Yunnan Province China,” 2004, <http://www.usp.org/pdf/EN/dqi/fakeAntimalarialsMekongRegion.pdf>.

⁶⁴ National Institute of Parasitic Diseases, China CDC, “Current malaria situation, 2002, PR China,” <http://www.actmalaria.org/downloads/pdf/info/2003/China.pdf>.

data reported by the Roll Back Malaria–Mekong collaboration. In maps of incidence, mortality, and laboratory confirmation rates for the Yunnan border counties and the Burmese townships immediately opposite, the differences in rates are so large that the whole border is in fact outlined by the malaria rates. Given that the border is permeable to every variety of legal and illegal trade, it is unfortunate that malaria treatment and prevention are not able to cross it. It seems that the Burma-Yunnan border is permeable to everything except public health.

Cross-Border Initiatives

Formal cross-border initiatives in the region include the Roll Back Malaria–Mekong partnership, the Mekong Basin Disease Surveillance Project, the Asian Development Bank regional technical assistance program, and the Asian Collaborative Training Network for Malaria, all of which give high priority to drug-resistant malaria on the Burma-Yunnan border. There is a powerful consensus that drug-resistant *P. falciparum* is an issue of primary international concern. In addition, the Roll Back Malaria–Mekong partnership and other organizations have emphasized the importance of access to the ethnic groups living in the border regions. There is thus an international framework for a cross-border approach to infectious diseases that would supplement an expansion of the Burmese national malaria program into the underserved areas from the other direction (and perhaps the HIV and TB programs as well). However, although the Burmese government has signed on to the cross-border collaborations, its participation appears to be limited. Thus, no Burmese data appears in the recent reports of the Mekong Basin Disease Surveillance Project⁶⁵ and no Burmese sentinel site was reviewed by the USP–DQI review of border surveillance sites for drug quality on behalf of WHO in 2002.⁶⁶ Nor is there any evidence of up-to-date surveillance for malaria drug resistance.

Health Unlimited, a nongovernmental organization based in China with historic ties to the KIO and the Wa, has achieved considerable success in its efforts to bring health care to rural communities along the China-Burma border. By the end of 2007, the organization will have built some 60 health centers on the Burma side of the border, most of which are concentrated in Kachin State. It has also trained nearly 800 Burmese medical practitioners and health workers, thus improving the accessibility of primary health care to approximately 200,000 people.

The border ethnic groups told us they welcomed international support. The KIO, despite its former hardline stance on drugs, has begun negotiations to open harm-reduction programs with assistance from the China side. The KIO also receives some assistance with bednets and drugs from two small nongovernmental organizations operating across the border from China, and purchases most antimalarial supplies from China. Local Chinese government health officials recently joined KIO in a visit to Kachin areas to conduct malaria screening and insecticide treatment of bednets.

⁶⁵ Mekong Basin Disease Surveillance Project, http://www.mbdsoffice.org/Surveillance_report.html.

⁶⁶ United States Pharmacopeia, Drug Quality and Information Program, “Malaria Sentinel Surveillance Site Assessment, Mekong Region April 16–May 17 2002,” <http://72.14.253.104/search?q=cache:lgXRVxxtcjgJ:www.uspdqi.org/projects/mekongsentinelsiteassessmentreport.pdf+Malaria+Sentinel+Surveillance+Site+Assessment+%22abdelkrim+Smine%22&hl=en&ct=clnk&cd=1&gl>.

Chinese health officials also welcome cross-border support projects, though they told us such activities should be “low profile.” Yunnanese government entities including the Yunnan Center for Disease Control have recently begun to make cross-border overtures to KIO on HIV prevention, providing technical resources for an IDU survey and possibly harm reduction.

A local health worker in Ruili told us that most international border collaborations involve administrators traveling to Mandalay or Rangoon. She said that local and provincial-level contacts are probably more useful than the high-level collaborations sponsored by UN organizations, which must operate government-to-government. Given that the Burma border has been the source of two major cross-border public health problems in recent decades—HIV and drug-resistant malaria—and that it could easily be the source of new ones such as spread of lymphatic filariasis or avian influenza, it is hard to believe that the Chinese government would not support increased cross-border public health.

Conclusion

Different public health programs have different needs. Thus, the Joint Programme for HIV/AIDS, which is harm-reduction based, should be supported but needs to be expanded in the border areas; this is unlikely to happen without external pressure and monitoring. The malaria program in the border areas is almost nonexistent, and a natural approach to upgrading it would be a combination of international collaboration mechanisms with China, and expanding access to Burmese central resources. Finally, the Burmese government must recognize the right to public health of people in cease-fire areas or those ethnically affiliated with cease-fire groups.

7. Thai-Burma Border Region

Health indicators along Burma's eastern border with Thailand, which stretches over 2,400 km and is overwhelmingly populated by ethnic non-Burmans, are some of the worst in Asia. Infant, child, and maternal mortality rates in internally displaced (IDP) communities of eastern Burma are more akin to rates seen in other humanitarian disaster zones such as Sierra Leone, Angola, and the Democratic Republic of the Congo. Most deaths are due to infectious diseases that are both preventable and curable. Also, narcotics have been and continue to be an export across this border to Thailand and markets beyond, fueling addiction and infections.

The abusive policies of the Burmese government, including forced relocation, forced labor, and the seizure and destruction of food, coupled with pervasive poverty, have caused the displacement of hundreds of thousands of people in eastern Burma over the past twelve years, causing one of the largest human migrations Asia has seen in modern times. Today, an estimated 350,000 Burmese live in government-controlled relocation centers in eastern Burma and another 540,000 are internally displaced, often living in small communities in the jungle without access to adequate health care.

Hundreds of thousands of Burmese have also fled across the border to Thailand seeking safety and work. Today, perhaps two million Burmese eke out a living in Thailand as migrant workers, while approximately 140,000 others are considered official refugees by the Thai government. Burmese migrants, who often work in dangerous conditions, are particularly vulnerable to tuberculosis and HIV infection. At least one migrant group, the Shan, face a generalized HIV epidemic. Malaria is endemic on both sides of the Thai-Burma border and is particularly rampant in IDP communities in Burma. This border area also suffers from some of the highest rates of drug-resistant malaria in the world. These conditions pose a threat to public health in Thailand and place a heavy financial burden on Thai health care institutions, eroding their capacity to provide adequate services for all.

The Burmese military regime is largely responsible for these health problems, yet it has done little to correct them. Not only has the Burmese junta failed to invest in public infrastructure, but military campaigns in eastern Burma continue to disrupt the work of community-based organizations (CBOs) and nongovernmental organizations (NGOs) and limit the ability of international humanitarian organizations to access vulnerable populations. Burmese soldiers have harassed and killed ethnic health workers and destroyed village-level health clinics. Meanwhile, underfunded health groups struggle to provide care to Burmese migrants, a reality that Thai health officials have increasingly recognized. The international community urgently needs to become more engaged in health and human rights issues on the Thai-Burma border region. More financial and collaborative support is necessary to establish and sustain cross-border health projects, and greater pressure must be placed on the Burmese government to end its violations of international humanitarian law in eastern Burma.

Background

Until the 1980s, most of the Thai-Burma border was controlled by ethnic insurgent armies, including Mon, Karen, Karenni, and Shan groups, as well as those of various drug barons and Kuomintang remnants. Thailand cultivated cordial relations with many of these groups during the Cold War in an effort to isolate the Burmese regime and provide a buffer against the Communist Party of Burma (BCP).¹ By the end of the Cold War, relations between the Thai and Burmese governments improved.² However, the Thai-Burma border remained volatile and border clashes continued. Thailand frequently accused the Burmese and their allies of encroaching onto Thai soil and smuggling drugs, particularly amphetamine-type stimulants (ATS), into Thailand.³ In return, Rangoon frequently charged Thailand with supporting ethnic insurgent groups.⁴ Thailand's relationship with Burma reached a nadir under Prime Minister Chuan Leekpai, who publicly condemned the Burmese junta's human rights record and never paid a state visit to Burma.⁵ Chuan's military commanders, including General Surayud Chulanont, took a hardline stance on the junta's alliance with groups indicted for drug trafficking.⁶

In 2001, the newly elected Prime Minister Thaksin Shinawatra initiated a "forward engagement" policy cultivating amicable relations with the Burmese generals, which allowed for mutually advantageous economic deals.⁷ Today, Thailand is the third-largest foreign investor in Burma and is the largest buyer of Burmese natural gas.⁸ Growth of trade in other sectors has also skyrocketed. In the first eleven months of 2005, the value of Thai-Burmese trade reached a record 90.4 billion baht (\$2.4 billion), an increase of over 17 percent from the preceding year, making 2005–06 the most profitable year for Burma since 1989.⁹ In December 2005, a Memorandum of Understanding between Thailand's Electricity Generating Authority (EGAT) and Burma's military junta was signed, paving the way for the construction of a series of dams along the Salween River. The first planned is Hatgyi Dam, in Karen State, scheduled to begin in 2007. The project, shrouded in secrecy, is in an area where the Burmese military has been violently evicting villagers and destroying their homes.¹⁰ At a cost of \$1 billion, Hatgyi is the

¹ Chao Tzang Yawngnwe, *The Shan of Burma: Memoirs of a Shan Exile*, Singapore: Institute for Southeast Asian Studies, 1987 at 264–68; Martin Jelsma, Tom Kramer, and Pietje Vervest (eds.), *Trouble in the Triangle: Opium and Conflict in Burma*, Chiang Mai: Silkworm Books, 2006 at 33–59.

² Jelsma et al., supra note 1.

³ Jelsma et al., supra note 1 at 101–24.

⁴ Jelsma et al., supra note 1 at 45; Theerawat Khumthita, "Complaints of Infringement Heard, Denied by Both Sides," *Bangkok Post*, June 22, 2006.

⁵ "Thaksin Should be Careful Who He Listens to on Myanmar," *Business Day*, March 20, 2001.

⁶ "A Cycle of Friendship and Enmity," *The Irrawaddy*, November 2006, 3.

⁷ Will Baxter, "Dam the Salween, Damn Its People," *Asia Times Online*, September 15, 2006, http://www.atimes.com/atimes/Southeast_Asia/HI15Ae01.html; Jelsma et al., supra note 1, 107–13.

⁸ Altsean, *Burma Briefing: Issues and Concerns*, Volume 3, Bangkok: Altsean, 2006, <http://www.altsean.org/Burma%20Briefing%20Volume%203.pdf>; "Foreign Investment in Burma Hits \$7.6 Billion," *The Irrawaddy*, December 2005, <http://www.irrawaddy.org/aviewer.asp?a=5275&print=yes&c=e>; William Boot, "Burma's Bumper Energy Sale," *The Irrawaddy*, September 2006, 22–24; Iftekhar Ahmed, "Burma's Natural Gas Contributes to \$1.3 billion Trade Surplus," *Narinjara News*, September 14, 2006, http://www.bnionline.net/index.php?option=com_content&task=view&id=636&Itemid=6.

⁹ Daniel Ten Kate, "Business with Myanmar Thrives Amid Diplomatic Stress," *IHT ThaiDay*, December 24, 2005; Ahmed, supra note 8.

¹⁰ Ahmed, supra note 8.

single biggest economic deal involving Burma, Thailand, and China, whose state-controlled Sinohydro Corporation will be the main construction contractor.¹¹ Another planned dam, Tasang, in Shan State, is estimated to cost \$6 billion to build and will be, at 228 meters, the tallest dam in Asia. This area has also been heavily militarized, and since 1996 up to 300,000 Shan civilians have been forcibly displaced, many fleeing to Thailand.¹² Moreover, Thailand's business links with the Burmese generals benefited companies linked to Prime Minister Thaksin.¹³ In one highly irregular deal, Thailand's Export-Import Bank extended soft loans to Burma so it could purchase telecommunications goods and equipment from the Thaksin family's Shin Corporation.¹⁴

Thaksin, in an effort to maintain good relations with the Burmese junta, also cracked down on Burmese dissidents living in Thailand.¹⁵ He reined in the activities of ethnic resistance groups, pressuring some to negotiate with Rangoon, and banned Burmese pro-democracy groups from holding public demonstrations.¹⁶ He ordered the Thai police to crackdown on refugees, particularly ethnic Shans, arresting and deporting them.¹⁷ Thailand reassured the Burmese generals that they would not allow opposition groups in Thailand to mount any military or politically sensitive activities.¹⁸

On September 19, 2006, the Thai military deposed Thaksin in a bloodless coup and installed a military junta. The junta named the former Thai Army Chief General Surayud Chulanond as Prime Minister. While Army Chief, Surayud had incurred Rangoon's displeasure by taking a hard-line stance against Burma's narcotics trade, and was removed from his post by Premier Thaksin.¹⁹ Surayud has stated that all commitments made by his predecessor to Burma would be

¹¹ Id.

¹² Baxter, *supra* note 7; Shan Sapawa Environmental Organization (Sapawa), *Warning Signs: An Update on Plans to Dam the Salween in Burma's Shan State*, 2006 at 9–12; Shan Human Rights Foundation (SHRF), *Charting the Exodus from Shan State: Patterns of Shan Refugee Flow into Northern Chiang Mai Province of Thailand 1997–2002*, Chiang Mai, Thailand: SHRF, 2003 at 6–7,

<http://www.shanland.org/resources/bookspub/humanrights/Chartingtheexodus.pdf>. See also William Boot, "A Damming Indictment," *The Irrawaddy*, August 2006, <http://www.irrawaddy.org/aviewer.asp?a=6025&z=102>.

¹³ "A Cycle of Friendship and Enmity," *The Irrawaddy*, November 2006, 3.

¹⁴ Michael S. Schuman, "Going Nowhere," *Time*, January 26, 2006,

<http://www.time.com/time/asia/magazine/printout/0,13675,501060130-1151835,00.html>; Rungrawee C. Pinyorat and Phermsak Lilakul, "Burma Loan Approved, Junta Opts for Shin Sat," *The Nation*, August 24, 2004, <http://www.burmanet.org/news/2004/08/24/the-nation-burma-loan-approved-junta-opts-for-shinsat/>; "Loans to Burma Related to Thai PM's Business Interests," *Democratic Voice of Burma (DVB)*, September 2, 2004, <http://english.dvb.no/news.php?id=2994>.

¹⁵ Aung Zaw, "Thaksin and the Tyrants," *The Irrawaddy*, November 2003,

<http://www.irrawaddy.org/database/2003/vol11.9/c-thaksin.html>; Human Rights Watch, "Thailand: Burmese Democracy Activists Targeted by Thai Government," March 29, 2005, http://hrw.org/english/docs/2005/03/29/thaila10381_txt.htm.

¹⁶ Aung Zaw, *supra* note 15. See also Human Rights Watch, *Out of Sight, Out of Mind: Thai Policy Towards Burmese Refugees and Migrants*, New York: Human Rights Watch, 2004, <http://hrw.org/reports/2004/thailand0204/thailand0204.pdf>.

¹⁷ Shan Women's Action Network (SWAN), *Pushed Back into the Flames*, September 2005, http://www.whrnet.org/docs/pushed_back_into_the_flames.pdf.

¹⁸ Sai Silp, "Thai Army Chief Again Visits Burma," *The Irrawaddy*, September 11, 2006, <http://www.irrawaddy.org/aviewer.asp?a=6151&z=154>.

¹⁹ Jelsma, *supra* note 1 at 107–13; Aung Zaw, "Awkwardness with a Neighbour," *Bangkok Post*, November 13, 2006.

honored but refused to extend the lending period for soft loans.²⁰ The Surayud administration also is considering revitalizing links with armed ethnic groups to counter the increasing influx of narcotics from Burma.²¹

Ethnic Groups

Burma's border with Thailand comprises four ethnic states (Shan, Karenni, Karen, and Mon) and one division (Tenasserim). However, the region is also home to many other ethnic groups, including the Wa, Pa-O, Lahu, Padaung, Akha, Lahu, Lisu, and Palaung.²² Much of this frontier erupted in warfare after Ne Win's coup of 1962, which officially ended any possibility of secession or significant autonomy for ethnic minority peoples.²³ By the 1980s, all major ethnic groups in the border region were involved in armed rebellion.²⁴

The government responded with a combination of negotiations and brokered deals and an iron-fisted military policy (The Four Cuts Policy). Since 1989, 17 armed ethnic groups have signed cease-fires with the Burmese junta, splintering several large ethnic insurgencies along the frontiers. Today, only the Shan State Army–South (SSA-S), Karenni National Progressive Party (KNPP), and the Karen National Liberation Army (KNLA), the armed wing of the Karen National Union (KNU), are continuing armed resistance. Where these groups are active, the military junta has committed widespread abuses against ethnic civilians, including forced displacement, forced labor, and destruction of crops and food supplies. Within the past year, the army has destroyed hundreds of villages and displaced 27,000 civilians in the Karen State alone.²⁵ In government-controlled areas, arbitrary taxation, forced displacement, and forced labor are more common.²⁶ The latter is frequently employed in the construction of Burmese military bases and roads, solidifying the army's control of vast areas in eastern Burma.²⁷

Several ethnic organizations continue to provide limited social services for internally displaced and war-affected residents in eastern Burma. These include the Karen Department of Health and Welfare, the Karenni Health Department, the Shan Health Committee, the Mon National Health

²⁰ Achara Ashayagachat, "PM Non-committal on Loan Request," *The Nation*, November 24, 2006; "Thai Premier to Bring Change to Myanmar Relations," *Deutsche Presse-Agentur*, November 22, 2006, <http://www.burmanet.org/news/2006/11/22/deutsche-presse-agentur-thai-premier-to-bring-change-to-myanmar-relations/>.

²¹ "Mending Ties with Helpful Shan," *Bangkok Post*, February 22, 2007; "Shan Rebel Leader Warns Thailand to Prepare for Influx of Illegal Drugs," *Bangkok Post*, February 12, 2007, <http://www.burmanet.org/news/2007/02/12/bangkok-post-via-bbc-monitoring-shan-rebel-leader-warns-thailand-to-prepare-for-influx-of-illicit-drugs/>.

²² Yawnghwe, *supra* note 1 at 264–68.

²³ David I. Steinberg, *Burma: The State of Myanmar*, Washington, D.C.: Georgetown University Press, 2001 at 70–73.

²⁴ *Id.* at 185–87.

²⁵ "Interview: Mahn Sha, General Secretary, Karen National Union (KNU)," *Jane's Intelligence Review*, November 22, 2006, <http://www.burmanet.org/news/2006/11/22/janes-intelligence-review-interview-mahn-sha-general-secretary-karen-national-union-knu/>; Karen Human Rights Group (KHRG), *Papun Update: SPDC Attacks on Villages Continue*, October 6, 2006 at <http://www.khrg.org/khrg2006/khrg06f10.html>.

²⁶ Back Pack Health Worker Team, *Chronic Emergency: Health and Human Rights in Eastern Burma*, 2006; Karen Human Rights Group, *supra* note 25.

²⁷ Human Rights Watch, "They Came and Destroyed Our Village Again": *Plight of Internally Displaced Persons in Karen State*, 2005, <http://hrw.org/reports/2005/burma0605/index.htm>.

Committee, and a multitude of women's, youth, and other community groups. The most prominent organization is the Mae Tao Clinic, founded by Dr. Cynthia Maung in 1989 in Mae Sot, Thailand, which provides medical care to migrants from Burma. Dr. Maung, an ethnic Karen, and other local ethnic leaders also established the multiethnic Back Pack Health Worker Team (BPHWT), which provides primary health care services to internally displaced people in Karen, Karenni, Mon, and Shan areas.

The Thai government, despite some well-publicized ill-treatment of refugees and activists from Burma, has largely left such organizations alone. In Thailand, these groups are able to access financial and technical support from a wide range of nongovernmental organizations, religious groups, and international donors, enabling them to provide essential social services otherwise unavailable in eastern Burma.

The Thai government's official recognition of some Burmese migrants as refugees (with the notable exception of the Shan) has provided refuge to 140,000 displaced persons currently housed in nine official camps in Thailand.²⁸ Although the camps are fairly secure, that situation can quickly change. In 1997 and 1998, Burmese troops crossed into Thailand, attacking and burning refugee camps.²⁹ In 1994, the Thai government forcibly repatriated approximately 12,000 Mon refugees, drawing heavy criticism from international human rights organizations.³⁰ Despite these incidents, the refugee camps have provided food, protection, and essential services to tens of thousands of Burmese refugees for over 20 years.

Drugs

Rampant illicit drug use in Thailand has been a thorny issue in Thai-Burmese relations, one historically linked to political failures in Burma. Allies of the Burmese military government, most notably the United Wa State Army (UWSA), have been permitted to move from northern Shan State to areas adjacent to the Thai border and engage in narcotics production and trafficking.³¹ By the mid-2000s, 700–900 million ATS pills were being smuggled from Burma into Thailand annually, fueling soaring addiction rates in Thailand, particularly among youth.³² Thaksin exploited increasing Thai concern on this issue while on the campaign trail in 2001, promising a war on drugs, which was officially launched in 2003. The campaign sanctioned

²⁸ Achara Ashayagachat, "US Changes Stance on Refugees," *Bangkok Post*, August 30, 2006.

²⁹ See Human Rights Watch, *No Safety in Burma, No Sanctuary in Thailand*, 1997, <http://www.hrw.org/reports/1997/burma/>, and Karen Human Rights Group, <http://www.karenhumanrightsgroup.org/photoreports/99photos/set99a/huaykaloke.html>.

³⁰ Tony Broadmoor, "Precarious Peace in Monland," *The Irrawaddy*, February–March 2002, <http://www.irrawaddy.org/database/2002/vol10.2/cover4.html>.

³¹ Lahu National Development Organization (LNDO), *Unsettling Moves: The Wa Resettlement Program in Eastern Shan State, 1999–2000*, Chiang Mai: LNDO, 2002, <http://www.shanland.org/resources/bookpub/humanrights/wa/>; Altsean, *A Failing Grade: Burma's Drug Eradication Efforts*, Bangkok, 2004, <http://www.altsean.org/drug-report.html>; "New Ventures by Burma Gangs," *Bangkok Post*, December 27, 2005; SHAN, *Hand in Glove: The Burma Army and the Drug Trade in Shan State*, Chiang Mai: SHAN, 2006 at 7–10.

³² Altsean, *supra* note 31; Jon Ungphakorn, "Asian States Run out of Patience with Myanmar," *Taipei Times*, October 11, 2005, <http://www.taipetimes.com/News/editorials/archives/2005/10/11/2003275373>; Sai Silp, "New Drug Restrictions Focus on Migrants," *The Irrawaddy*, May 29, 2006, <http://www.irrawaddy.org/aviewer.asp?a=5764&z=154>.

extrajudicial execution of suspected drug dealers and distributors, claiming over 2,000 lives in three months.³³ Most of those killed were likely innocent, and police have closed many cases within one year without proper investigations.³⁴ Thai police have also been implicated in using the campaign to blackmail and destroy their enemies.³⁵ However, Thaksin steered clear of border activities that might antagonize the UWSA and their Burmese junta allies.³⁶ He scaled down the activities of Thai Task Force 399, a covert unit created from Thai and U.S. Special Forces to tackle drug trafficking along the border—long a sore point in Thailand’s relationship with Rangoon.³⁷ As a result, drug-producing allies of the junta were emboldened to continue their activities as Thai authorities became increasingly reluctant to deal with the source of the problem.³⁸ Today, there are no signs that cross-border smuggling of drugs from Burma has decreased; drug traffickers are simply using alternate routes.³⁹

Violations of Human Rights and International Humanitarian Law

The Burmese military government is responsible for widespread and systematic violations of human rights and international humanitarian law in the Thai-Burma border regions, particularly against ethnic minorities. These abuses include summary executions, forced displacement, forced labor, rape, confiscation of land and property, attacks against health clinics and medical personnel, and the destruction of rice fields and food storage facilities.⁴⁰ Forced displacement is particularly common and used as a counter-insurgency strategy. Up to 9 percent of IDP households in eastern Burma have been forcibly displaced within the preceding 12 months; in the more heavily contested areas of northern Karen State, the corresponding figure was over 60 percent.⁴¹ Since 1996, the Burmese army had destroyed or forced civilians to abandon over 3,000 villages in eastern Burma.⁴²

Other abuses commonly accompany forced displacement. A third of IDP households in eastern Burma had experienced arbitrary taxation or forced labor within the preceding 12 months.⁴³ Rape

³³ See Human Rights Watch, *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violation of Human Rights*, 2004, <http://hrw.org/reports/2004/thailand0704/>.

³⁴ Ampa Santimataneadol, “Most Drug War Victims ‘Innocent’: NHRC Investigations Clear Alleged Criminals,” *Bangkok Post*, September 19, 2006.

³⁵ *Id.*, Human Rights Watch, *supra* note 33.

³⁶ Tom Fawthrop, “Thai-Myanmar Ties: Drug Lords Cash In,” *Asia Times*, January 17, 2003, http://www.atimes.com/atimes/Southeast_Asia/EA17Ae02.html.

³⁷ *Id.*; Shawn Nance, “Goodbye to Task Force 399?” *The Irrawaddy*, August 8, 2002, <http://www.irrawaddy.org/aviewer.asp?a=2032&z=22>; Michael Black and Roland Fields, “The Real ‘Long War’ is in Myanmar,” *Asia Times*, June 9, 2006, <http://www.burmanet.org/news/2006/06/09/asia-times-the-real-long-war-is-in-myanmar-michael-black-and-roland-fields/>.

³⁸ Fawthrop, *supra* note 36.

³⁹ SHAN, *Show Business II: Rangoon’s “War on Drugs” in Shan State*, 2005; Santimataneadol, *supra* note 34; “Military Moves Against Drug Traffickers,” *Bangkok Post*, November 30, 2006.

⁴⁰ See Thailand Burma Border Consortium (TBBC), *Internal Displacement and Vulnerability in Eastern Burma*, 2004, <http://www.tbcc.org/resources/2004-IDP.pdf> and Altsean, *Interim Report Card: July 2004–February 2005*, 2005, <http://www.altsean.org/interim-RC-jul04-feb05.pdf>.

⁴¹ BPHWT, *supra* note 26.

⁴² TBBC, *Internal Displacement in Eastern Burma: 2006 Survey*, Bangkok: Wanida Press, 2006.

⁴³ TBBC, *supra* note 42.

of ethnic civilian women and girls in these areas has been particularly well documented.⁴⁴ Widespread abuses of civilians by army troops worsened significantly after 1996–97, when the central government, unable to support the costs of maintaining one of the largest standing armies in Asia, introduced a policy of self-sufficiency for the regional commands, forcing those operating along the frontiers of Burma to engage in the illicit economy (including the narcotics trade) and increase arbitrary taxation, confiscation of land and property, and forced labor.⁴⁵

The brunt of these policies has been directed at Karen and Shan States. Between 1996 and 1998, the Burmese army had forcibly relocated over 300,000 residents from over 1,400 villages in Shan State.⁴⁶ In other areas of Shan State, the Burmese authorities forced farmers to sell quotas of rice at depressed prices to the government, which, when combined with forced relocation, resulted in precipitous declines in agricultural production.⁴⁷

Although less frequently reported, armed militia groups operating along the eastern frontier have also been implicated in violations of human rights and international humanitarian law. These groups include the Karen National Union (KNU), the largest group still mounting armed resistance against the Burmese government, and the Karen Peace Force and the Democratic Karen Buddhist Army (DKBA), both allies of the Burmese government.⁴⁸

As a result of these policies, an estimated 350,000 Burmese reside in government-controlled relocation centers while at least another 540,000 live as internally displaced persons in eastern Burma.⁴⁹ In Shan State, perhaps 400,000 villagers have fled their homes and are living as internally displaced persons or as undocumented migrants in Thailand.⁵⁰

⁴⁴ See SHRF and SWAN, *License to Rape: The Burmese Military Regime's Use of Sexual Violence in the Ongoing War in Shan State*, 2002; Betsy Apple and Veronika Martin, *No Safe Place: Burma's Army and the Rape of Ethnic Women*, 2003, http://www.refugeesinternational.org/files/3023_file_no_safe_place.pdf; Karen Women's Organization (KWO), *Shattering Silences: Karen Women Speak Out About the Burmese Military Regime's Use of Rape as a Strategy of War in Karen State*, 2004; Women and Child Rights Project (WCRP) and Human Rights Foundation of Monland (HURFOM), *Catwalk to the Barracks: Conscription of Women for Sexual Slavery and other Practices of Sexual Violence by Troops of the Burmese Military Regime in Mon Areas*, 2005, <http://www.rehmonnya.org/catwalk-to-the-barracks.php>.

⁴⁵ SHAN, *supra* note 31; Global Witness, *A Conflict of Interests: The Uncertain Future of Burma's Forests*, 2003, http://www.globalwitness.org/media_library_detail.php/113/en/a_conflict_of_interest_english; "Urban Development at the Cost of Rural Areas," *Independent Mon News Agency (IMNA)*, June 29, 2006.

⁴⁶ SHRF, *Dispossessed: A Report on Forced Relocation and Extrajudicial Killings in Shan State, Burma*, 1998, <http://www.shanland.org/resources/bookspub/humanrights/dispossessed/>.

⁴⁷ See Shan Relief and Development Committee (SRDC), *Deserted Fields: The Destruction of Agriculture in Mong Nai Township, Shan State*, 2006.

⁴⁸ BPHWT, *supra* note 26; "KNU Forces Villagers to Join Guerrilla Unit," *Kaowao News*, September 23, 2006, <http://www.ibiblio.org/obl/docs3/KW116.htm>.

⁴⁹ Human Rights Watch, *supra* note 27; Gary Risser, Oum Kher, and Sein Htun, *Running the Gauntlet: The Impact of Internal Displacement in Southern Shan State*, Bangkok: Chulalongkorn University, 2003, <http://www.ibiblio.org/obl/docs3/Gauntlet-ocr.pdf>; Kavita Shukla, *Ending the Waiting Game: Strategies for Responding to Internally Displaced People in Burma*, Refugees International, 2006, http://www.refugeesinternational.org/files/8705_file_EndingtheWaitingGame.pdf.

⁵⁰ Charm Tong, "Neglected Health care: The Shan Experience," conference address, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia," Bangkok, January 24, 2007.

Migration

Thailand is not a signatory to the 1951 United Nations Convention Relating to the Status of Refugees or the 1967 Protocol Relating to the Status of Refugees. The Thai government prefers to consider these individuals “temporarily displaced” after “fleeing fighting.”⁵¹ This narrow definition often excludes ethnicities like the Shan, who have fled fighting and human rights abuses. Without official refugee status, these groups are denied access to refugee camps and certain forms of humanitarian assistance.⁵² Classified as “economic migrants,” they are forced to find work, often in exploitative conditions, including in the Thai sex industry where they are vulnerable to sexually transmitted infections, including HIV.⁵³ Thailand’s demand for cheap labor has led to the implementation of a guest-worker registration program, which allows migrants access to the Thai government’s universal health care plan.⁵⁴ However, most Burmese migrants have not registered for these services due to restrictions and complicated measures that accompany the registration process. Recently, as part of the work permit application process, the Thai government has required migrants to provide additional personal information that could potentially be sent to governments of origin for verification purposes. As a result, many Burmese migrants, particularly members of ethnic groups that have fled abuses at home, are wary of applying for work permits, particularly since it is against Burmese law to leave the country without permission.⁵⁵ Today, most of the two million Burmese migrants believed to be in Thailand remain undocumented and are considered “illegal” by the Thai authorities.⁵⁶ They live in constant fear of arrest and deportation back to Burma.⁵⁷

Health Indicators

The health situation in IDP communities in eastern Burma is dire. In a report recently released by the Back Pack Health Worker Team, IDP communities along the frontier with Thailand had infant, child, and maternal mortality rates far higher than Burma’s official rates.⁵⁸ Table 1 summarizes these health indicators.

⁵¹ Therese M. Caouette and Mary E. Pack, “Pushing Past Definitions: Migration from Burma to Thailand,” 2002, http://www.refugeesinternational.org/files/3074_file_burma.pdf.

⁵² *Id.* at 7–9; SHRF, *supra* note 12 at 5; SWAN, *Shan Refugees: Dispelling the Myths*, 2003 at 5; Supamart Kasem, “Burmese Migrants: War Refugee Camps Open their Doors,” *Bangkok Post*, April 7, 2006; Tong, *supra* note 50.

⁵³ Chris Beyrer, “Shan Women and Girls and the Sex Industry in Southeast Asia: Political Causes and Human Rights Implications,” *Social Science and Medicine* 53, 2001, 543–50; Caouette and Pack, *supra* note 51 at 1–2; Karen Leiter, Ingrid Tamm, Chris Beyrer, Moh Wit, Vincent Iacopino, *No Status: Migration, Trafficking & Exploitation of Women in Thailand 1997–2002*, 2004; Tong, *supra* note 50.

⁵⁴ Leiter, et al., *supra* note 53.

⁵⁵ Khun Sam, “Burmese Workers Fear Thai ID Papers,” *The Irrawaddy*, September 27, 2006, <http://www.irrawaddy.org/aviewer.asp?a=6194&z=154>; Kwanchewan Buadaeng, “Introduction to the Project and Accomplishments in the Past Period,” conference address, “Evaluation and Development of Public Health Media for Cross-Border Migrants: The Case of Shan Migrants in Chiang Mai Province,” Chiang Mai, May 30, 2006; Sai Silp, “More Migrant Identity Applications Submitted to Burma,” *The Irrawaddy*, November 7, 2006, <http://www.irrawaddy.org/aviewer.asp?a=6358&z=154/>.

⁵⁶ See Leiter et al., *supra* note 53; Caouette and Pack, *supra* note 51; Atsadaporn Kamthai, “Call to Curb Illegal Workers,” *The Nation*, June 19, 2006, http://www.nationmultimedia.com/2006/06/19/national/national_30006774.php.

⁵⁷ SWAN, *supra* note 17.

⁵⁸ BPHWT, *supra* note 26.

Table 1: A Comparison of Basic Health Indicators, 2004

	Infant Mortality Rate (IMR)	Under-5 (child) Mortality Rate (U5MR)	Maternal Mortality Rate (MMR)	Lifetime Risk of Maternal Death (1 in XX)
Thailand	18	21	44	900
Burma (official)	76	106	360	75
IDPs in eastern conflict zones of Burma	91	221	1,000–1,200	12
Rwanda			1,400	10
Sierra Leone	165	283	N/A	N/A
Angola	154	260	N/A	N/A
Congo, D. R.	129	205	990	13

IMR: rate of deaths in children aged less than one year, per 1,000 live births.

U5MR: rate of deaths in children aged less than five years, per 1,000 live births. Also called Child Mortality Rate.

MMR: ratio of deaths among women after 28 weeks gestation and before six weeks postpartum, per 100,000 live births.

(Sources: UNICEF, <http://www.unicef.org/infobycountry/index.html>, and BPHWT, 2006)

Most deaths recorded by the Back Packer teams were from infectious diseases, especially malaria, which accounted for almost half the identified deaths of the internally displaced in eastern Burma.⁵⁹ In IDP communities, the Back Packer team surveys demonstrated widespread violations of human rights and international humanitarian law, including the high prevalence of forced displacement, food seizure and/or destruction, and forced labor. These abuses were found to be directly linked to adverse health outcomes, as depicted in Table 2.

⁵⁹ Id.

Table 2: Prevalence of Selected Human Rights Abuses and Adverse Health Consequences in IDP Communities of Eastern Burma

Human Rights Violation in the Preceding 12 months	Overall Prevalence of Human Rights Violation in IDP Households, Eastern Burma	Linked Health Consequence	Odds Ratio
Forced Displacement	9.0%	Childhood (under 5) death	2.4
		Childhood malnutrition	3.1
		Decreased use of contraception	6.1
		Landmine Injury	4.5
Food Insecurity (food destroyed or looted)	25.7%	Overall death	1.5
		Moderate child malnutrition in household	4.4
		Severe child malnutrition in household	2.0
		Landmine injury	4.6
		Head of Household suffering from malaria at time of survey	1.7
Forced Labor	32.9%	Diarrhea in two weeks prior to survey	1.6
		Night blindness (vitamin A deficiency)	2.1

(Adapted from BPHWT, 2006)

Despite the overwhelming evidence of large-scale population migration within the borders of Burma and beyond, the Burmese government refuses to acknowledge that IDPs exist in Burma or that there are Burmese refugees living in Thailand and thus fails to provide for their needs.⁶⁰

Travel restrictions placed on local and international humanitarian organizations by the Burmese government greatly hinders their access to affected communities in eastern Burma.⁶¹ In some of the areas, the Burmese military blocks supplies of medications and other essentials from reaching civilians. Health workers trying to provide aid are often targeted: since the inception of the Back Pack Health Worker Team in 1998, seven medics and one traditional birth attendant have been killed by Burmese soldiers or landmines.⁶² The activities of the few international humanitarian aid organizations operating in these areas have also been sharply limited. Most notably,

⁶⁰ Shukla, supra note 49 at 1–2.

⁶¹ Id. at 2–6; BPHWT, supra note 26.

⁶² KHRG, *Flight, Hunger, and Survival: Repression and Displacement in the Villages of Papun and Nyaunglebin Districts*, <http://www.khrg.org/khrg2001/khrg0103a.html>; BPHWT, supra note 26; Human Rights Watch, supra note 27.

Médecins Sans Frontières–France (MSF–France) stopped its work in conflict areas in the Mon and Karen states in 2001, and the International Committee of the Red Cross has closed all of its field offices in eastern Burma because of travel restrictions (see “Burma” chapter).

Burma’s failure to provide adequate health and social services has driven many Burmese across the border to Thailand in search of these services.⁶³ Each year, the Mae Tao Clinic sees an increase in the number of patients seeking care. In 2005, the clinic logged 90,000 outpatient visits and 8,000 inpatient admissions. Of these, almost half were Burmese residents who had crossed the border.⁶⁴ For specialized services such as eye surgery, the ratio of Burma residents to Thailand residents is 5:1, with many patients coming from major urban areas in Burma.⁶⁵ Similarly, about half of the patients in MSF–France’s TB program in Mae Sot came across the border specifically for treatment. Of those crossing from Burma, only 12 percent were from the nearest Burmese town of Myawaddy; most traveled from elsewhere in Karen State or further away.⁶⁶

Increasing numbers of Burmese migrants are seeking care at Thai government hospitals, straining already tight Thai public health budgets. At Nakorping Hospital in Chiang Mai, 30 percent of pregnant women seeking care are migrants.⁶⁷ These are mostly ethnic Shans who have fled Burma, of whom only about half are legally registered and able to access the government’s universal health care plan.⁶⁸ In 2003, Mae Sot Hospital spent 20 million baht (approximately \$625,000) to treat Burmese migrants.⁶⁹ Mae Hong Son, a Thai province bordering Shan State and home to over 50,000 stateless people, spends over 40 million baht (approximately \$1,250,000) per year providing care to migrants.⁷⁰

Burma’s under-financed health care system is contributing to the emergence and re-emergence of diseases in Thailand, a reality not lost on the Thai authorities. Saengchai Sothiworakul, chairman of a panel evaluating the impact of migration from Burma to Thailand for the National Economic and Social Advisory Council, notes: “What we feared most are communicable diseases. Several diseases which disappeared from Thailand have since re-emerged along Tak’s [a western Thai province bordering Karen State] border, such as elephantiasis, tuberculosis, dengue fever and syphilis.”⁷¹

⁶³ Cynthia Maung, interview, Mae Sot, Thailand, July 9, 2006; Mae Tao Clinic (MTC), *Annual Report 2005*, 2006, <http://www.maetaoclinic.org/>.

⁶⁴ MTC, supra note 63; Cynthia Maung, “Mae Tao Clinic: A Local Solution for Health Services, Training, and Outreach,” conference address, “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 24, 2007.

⁶⁵ MTC, supra note 63; Maung, supra note 63; Shah Paung, “Thailand to Improve Health Conditions for Migrant Workers,” *The Irrawaddy*, July 7, 2006, <http://www.irrawaddy.org/aviewer.asp?a=5965&z=154>.

⁶⁶ Fabrice Roy, “Médecins Sans Frontières TB Programme,” conference address, “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 24, 2007.

⁶⁷ Kamthai, supra note 56.

⁶⁸ Buadaeng, supra note 55.

⁶⁹ Kasem, supra note 52.

⁷⁰ Apiradee Treerutkuarkul, “Stateless Left in Health care Limbo,” *Bangkok Post*, February 19, 2007; “NHSO to Cover Those Awaiting Citizenship,” *The Nation*, February 4, 2007.

⁷¹ Kasem, supra note 52.

Infectious Diseases

HIV/AIDS

Burma continues to be the major source of heroin and ATS for Thai markets, fueling drug addiction and HIV infection in many border regions.⁷² These problems persist despite claims by the Thaksin Shinawatra administration that his “War on Drugs” has been a success.⁷³ Although Thailand has achieved notable successes in HIV/AIDS control with the “100% Condom Campaign,” the incidence and prevalence rates of HIV in intravenous drug users (IDUs) remains high.⁷⁴ In addition to narcotics use and trafficking, other factors disproportionately present in rural Burma fuel the spread of HIV. As noted in a World Health Organization (WHO) report, “poverty, internal and external mobility, risk behavior, and a generalized lack of response capacity, coupled with an acknowledged high prevalence rate of HIV infection, means that this very serious epidemic may grown out of control.”⁷⁵

As in many other parts of the world, commercial sex workers and IDUs suffer from especially high rates of HIV infection on the Thai-Burma border. But there is also concern that the virus may be spreading into the general population. In sentinel surveillance conducted by the Burmese Ministry of Health, the prevalence of HIV in women presenting for antenatal care is often above 1 percent, suggesting a generalized epidemic. (See Figure 1.) However, this figure appears to vary from year to year, further indicating that official data may be inaccurate and that sentinel surveillance is too limited.⁷⁶

⁷² Chris Beyrer, Myat Htoo Razak, Alain Labrique, Ronald Brookmeyer, “Assessing the Magnitude of the HIV/AIDS Epidemic in Burma,” 32 *JAIDS* 2003, 311–17; Transnational Institute, *HIV/AIDS and Drug Use in Burma/Myanmar*, http://www.tni-archives.org/detail_page.phtml?page=policybriefings_brief17.

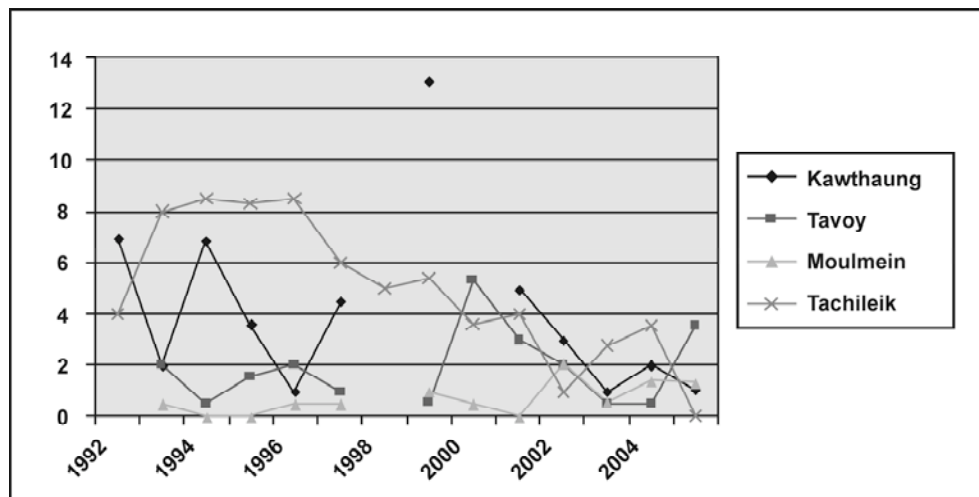
⁷³ “Drug Traffickers Still at Large,” *Bangkok Post*, February 13, 2007; Sai Silp, *supra* note 32; Subin Kheunkaew, “Drug Use on the Rise as Supplies Keep Flowing,” *Bangkok Post*, December 1, 2006.

⁷⁴ Suphak Vanichseni, Dwip Kitayaporn, Tim D. Mastro, Philip A Mock, Suwanee Raktham, Don C. Des Jarlais, Sathit Sujarita, La-Ong Srisuwanvilai, Nancy L. Young, Chantapong Wasi, Shambavi Subbarao, William L. Heyward, Jose Esparza, Kachit Choopanya, “Continued High HIV-1 Incidence in a Vaccine Trial Preparatory Cohort of Injection Drug Users in Bangkok, Thailand,” *AIDS* 15, 2001, 397–405; Viroj Verachai, Tipwan Phutiprawan, Pathom Sawanpanyalert, “HIV Infection Among Substance Abusers in Thanyarak Institute on Drug Abuse, Thailand, 1987–2002,” *J Med Assoc Thai* 88, 2005, 76–79.

⁷⁵ WHO, Summary of Country Profiles for HIV/AIDS Treatment Scale-Up, [http://www.who.int/3by5/support/june2005_mmr.pdf#search=%22\(hpa-an%20OR%20%22hpa%20an%22\)%20%20HIV%20prevalence%22](http://www.who.int/3by5/support/june2005_mmr.pdf#search=%22(hpa-an%20OR%20%22hpa%20an%22)%20%20HIV%20prevalence%22).

⁷⁶ Chris Beyrer, Luke Mullany, Adam Richards, Aaron Samuals, Voravit Suwanvanichkij, Tom Lee, Nicole Frank, *Responding to AIDS, TB, Malaria and Emerging Infectious Diseases in Burma: Dilemmas of Policy and Practice*, March 2006, www.jhsph.edu/burma; UNAIDS, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Myanmar*, August 2006, http://www.who.int/GlobalAtlas/predefinedReports/EFS2006/EFS_PDFs/EFS2006_MM.pdf.

Figure 1: HIV Prevalence in Pregnant Women in Sites near the Thai-Burma Border



(Adapted from UNAIDS.)

Note the considerable year-to-year variation and that for Kawthaung and Moulmein, there are missing figures, all of which suggest problems with data quality.

The lack of accurate surveillance data on HIV is especially concerning, given anecdotal data that suggests a high prevalence of HIV infection in the general population living in eastern Burma. Prevalence rates such as 9 percent in Shan men and 7.5 percent in pregnant women in Hpa-an, the capital of Karen State and a “pass through” site for many Burmese migrants workers heading to Thailand, have been cited.⁷⁷ Following worldwide trends, the epidemic in Burma is increasingly affecting women, particularly those whose husbands or boyfriends used drugs or bought sex, often during migration for work.⁷⁸ A Burmese physician who has worked in Mon State and Tenasserim Division recently noted that “HIV/AIDS was not a big problem [about a decade ago] but now it is horrible, in Tavoy, in Mon State. Many people cross the border to work in border towns like Ranong.”⁷⁹ Uncertainties about the accuracy of official HIV data add to the concern about Burma’s ability and willingness to monitor and control the epidemic along its borders. Recent reports suggest that the central office for AIDS control in northern Burma, responsible for the most-affected Shan and Kachin States, is woefully understaffed and underbudgeted.⁸⁰

Meanwhile, there is a growing concern about the prevalence of HIV on the Thai side of the border.⁸¹ In a clinic that serves mostly Burmese sex workers in Mae Sot, the prevalence of HIV is

⁷⁷ Andrew Marshall, “AIDS: Burma’s Shadowy Mass Export,” *The Irrawaddy*, July 2006; Marwaan Macan-Markar, “Burma: HIV Threat Overshadows Political Instability,” *Inter Press Service*, July 21, 2005, <http://ww2.aegis.org/news/ips/2005/IP050718.html>; WHO, supra note 75.

⁷⁸ Marshall, supra note 77; Yeni, “Burma Not Doing Enough to Control AIDS, Says UN Report,” *The Irrawaddy*, November 22, 2005, <http://www.irrawaddy.org/aviewer.asp?a=5205&print=yes&c=e>.

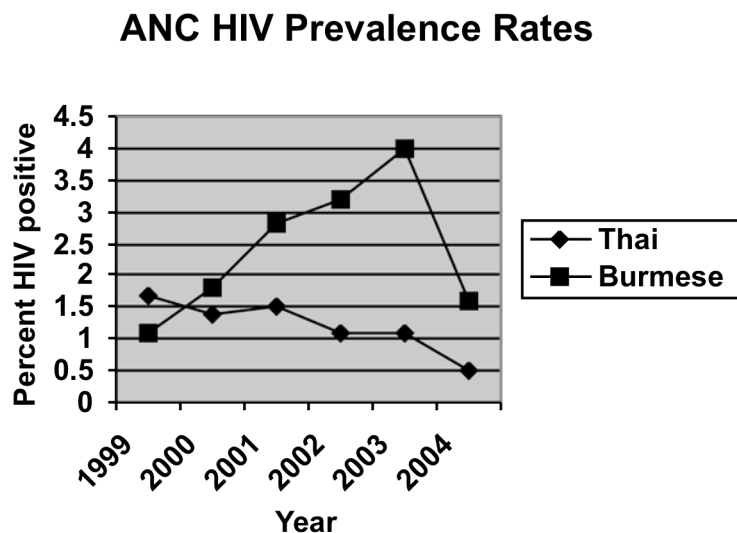
⁷⁹ Anonymous Burmese physician, interview, Mae Sot, Thailand, September 16, 2006.

⁸⁰ Beyrer et al., supra note 76.

⁸¹ Leiter et al., supra note 53.

around 10 percent.⁸² Sentinel surveillance surveys of migrant sex workers in another border town, Ranong, demonstrate a persistent one-quarter to one-third are infected with HIV.⁸³ There is increasing evidence from the Thai side to show that the epidemic is generalizing beyond high-risk groups. In Mae Sot, HIV infection rates in women presenting for antenatal care have been increasing. At the Mae Tao Clinic, the most recent prevalence rate is 2.2 percent, compared with 0.8 percent five years earlier.⁸⁴ The rate in Burmese women presenting for antenatal care at Mae Sot Hospital is 1.6 percent, triple that of their Thai counterparts.⁸⁵ (See Figure 2.) Two percent of migrant women presenting for antenatal care in Ranong in 2004 were infected with HIV.⁸⁶

Figure 2: Prevalence of HIV Infection in Target Burmese and Thai Populations, Tak Province, 1999–2004



(Source: Sawasdiwuthipong, supra note 82)

The situation is particularly dire for Shan migrants, many of whom are denied official status in Thailand and often work as undocumented migrants, including in the Thai sex industry.⁸⁷ For

⁸² W. Sawasdiwuthipong, K. Phisuthikul, P. Tatip, T. Ampong, Y. Tatip, P. Mahasakdipan, “Experiences Controlling Infectious Diseases in Burmese Migrants, Amphur Mae Sot, Tak Province, 2004,” *Journal of Health Science* 15, 2006, 243–50 [In Thai]; Leiter et al., supra note 53.

⁸³ WHO Thailand and Department of Disease Control, Ministry of Public Health, *Overview of Thai-Myanmar Border Health Situation 2005*, <http://w3.who-thai.org/EN/Section3/Section39.htm>.

⁸⁴ Mae Tao Clinic, supra note 63.

⁸⁵ Sawasdiwuthipong, et al., supra note 82.

⁸⁶ World Health Organization Thailand, supra note 83.

⁸⁷ Thomas E. Guadamuz, Piyada Kunawararak, Chris Beyrer, Jitrat Pumpaisanchai, David D. Celentano, “Sexual Risk Behaviors and Demographic Characteristics of Male Sex Workers in Chiang Mai, Thailand, 2003,” XV International AIDS Conference, Bangkok, July 11–16, 2004, Abstract Number WePeC6194; Joseph Hyder, Voravit Suwanvanichkij, Nick Tomson, Madeleine Taylor, Chris Beyrer, “HIV Vulnerability Among Shan Migrants in Thailand,” XVI International AIDS Conference, Toronto, August 13–18, 2006, Abstract Number TUPE0652; Beyrer, supra note 53; Tawngtai, “Fear, Ignorance Raises Risk of HIV in Migrant Workers,” SHAN, November 28, 2005, <http://www.shanland.org/articles/humanrights/2005/News-16-281105>; Nem Davies, “Burmese Male Sex

many, the combination of low levels of knowledge, lack of legal status, and fear heightens the risk for exploitation, including trafficking and debt-bondage.⁸⁸ In a 1997 survey of all the major ethnic minorities living in northern Thailand, the Shan had the highest prevalence of HIV, at 8.75 percent.⁸⁹ In a 2002 survey, Shan migrant construction workers in Chiang Mai had an overall HIV prevalence rate of 4.9 percent, double that of their northern Thai counterparts.⁹⁰

Without access to lifesaving antiretroviral treatment, an increasing number of Burmese migrants are falling ill and dying of AIDS in Thailand. At the Mae Tao Clinic, AIDS is now responsible for almost a quarter of deaths among this population.⁹¹ Similarly, in Chiang Mai Province, the second most commonly reported disease in migrants to local health authorities is AIDS.⁹² While data collection for HIV along the eastern frontiers of Burma remains weak, available data suggests a maturing and generalized epidemic. Furthermore, the high rates among Burmese migrants on the Thai side of the border suggest that Burma is a primary exporter of the virus into Thailand. Moreover, the ongoing failure to address the root causes of migration is a virtual guarantee that Thailand will continue to have problems with HIV into the foreseeable future.⁹³

Tuberculosis

Epidemiologic data on tuberculosis (TB) in eastern Burma is sparse, but what information is available raises cause for concern. TB is the most prevalent infectious disease found in Burmese migrants who undergo health screening for work-permit registration on the Thai side of the border.⁹⁴ In Tak Province alone, 885 out of 30,000 Burmese migrants who registered to work in the province in 2002 had active tuberculosis that required treatment. By 2006, the figure had climbed to 4,000.⁹⁵ The Mae Tao Clinic diagnosed 700 cases of TB in Burmese migrants in 2004, with residents of Burma outnumbering residents of Thailand 2:1.⁹⁶ This is consistent with data from MSF–France in Mae Sot, which shows that almost half of their patients came from Burma for TB treatment.⁹⁷

Workers in Thailand Face Stigma and AIDS Risks,” *Mizzima News*, January 27, 2006, <http://www.mizzima.com/mizzima/archives/news-in-2006/news-in-Jan/27-Jan-06-65.htm>.

⁸⁸ Beyrer, *supra* note 53; Leiter et al., *supra* note 53.

⁸⁹ Chris Beyrer, David D. Celentano, Somboon Suprasert, Werasit Sittitrai, Kenrad E. Nelson, B. Kongsub, Vivian Go, Praphan Phanupak, “Widely Varying HIV Prevalence and Risk Behaviours among the Ethnic Minority Peoples of Northern Thailand,” *AIDS Care* 9, 1997, 427–39.

⁹⁰ Kriengkrai Srithanaviboonchai, Kyung-Hee Choi, Fritz van Griensven, Esther S. Hudes, Surasing Visaruratana, Jeffrey S. Mandel, “HIV-1 in Ethnic Shan Migrant Workers in Northern Thailand,” *AIDS* 16, 2002, 929–31.

⁹¹ Mae Tao Clinic, *supra* note 63.

⁹² WHO Thailand, *supra* note 83.

⁹³ Leiter et al., *supra* note 53; see <http://www.theworld.org/?q=node/6502>.

⁹⁴ Shah Paung, “Thailand to Improve Health Conditions for Migrant Workers,” *The Irrawaddy*, July 7, 2006; Sumalee Amarinsangpen, “Strategic Plan to Control Tuberculosis to Meet Decade-end Development Goals, BE 2558,” Speech, Update on TB Situation in Thailand and Around the World and Launch of New Project in Northern Thailand, “TB Photovoice,” Chiang Mai, Thailand, November 28, 2006.

⁹⁵ “Tuberculosis Tops Disease List,” *Bangkok Post*, July 6, 2006.

⁹⁶ Marwaan Macan-Markar, “Millennium Goals: Burma Must Tackle TB and HIV,” *Inter Press Service*, September 5, 2005; Beyrer et al., *supra* note 76; Mae Tao Clinic, *Annual Report 2004*, Mae Sot: Mae Tao Clinic, 2005.

⁹⁷ Roy, *supra* note 66.

The situation is further compounded by the fact that TB rates are likely to increase as HIV becomes entrenched in migrant communities. In 2006, among cases reported to the Thai Ministry of Public Health, almost 20 percent of migrants with AIDS are infected with tuberculosis.⁹⁸ That same year, MSF–France in Mae Sot reported that 16 percent of TB patients at its clinic were co-infected with HIV.⁹⁹ In some northern Thai border provinces almost half the patients diagnosed with tuberculosis are now non-Thai, overwhelming the capacity of local health care providers to isolate and follow up with patients.¹⁰⁰ TB cure rates in these migrants are significantly lower than their Thai counterparts, and treatment default rates are higher.¹⁰¹ In Chiang Rai, a northern Thai province bordering Shan State, only 25.8 percent of non-Thai patients with TB were cured.¹⁰² Similarly, in Mae Sot, treatment-discontinuation rates in Burmese patients with tuberculosis are consistently higher than in Thais (Table 3).¹⁰³ These failures reflect not only the high burden of the disease in migrants but also the barriers to their abilities to access care in Thailand.¹⁰⁴

Table 3: Percentage of Missed Treatment (Discontinuous Treatment) in Patients with Sputum-Positive Tuberculosis, A. Mae Sot, 1999-2004

	Thai		Burmese	
	Number of sputum+ cases	%missed treatment	Number of sputum+ cases	% missed treatment
1999	33	21.2	16	68.8
2000	69	27.5	26	35.6
2001	61	23.0	18	5.6
2002	46	15.1	23	47.8
2003	51	2.0	67	19.7
2004	50	0.0	43	37.2

Source: Sawasdiwuthipong, supra note 82.

TB in Thailand continues to increase despite efforts at control.¹⁰⁵ This has raised alarms for public health authorities as it has implications for the general population, threatening to reverse Thailand’s gains in controlling the disease.

⁹⁸ Surasak Thanaisawanyangkoon, “An Epidemiologic Study on AIDS among Migrant Workers in Thailand,” XVI International AIDS Conference, Toronto, August 13–18, 2006, abstract CDC0123.

⁹⁹ Roy, supra note 66.

¹⁰⁰ P. Wandee, S. Supawitkul, N. Pinta, Y. Ngoentong, S. Khunkonkapan, P. Kaewkampa, S. Sumanapun, W. Levine, S. Sinsomboontong, T. Mednavyn, “Dual TB/HIV epidemic in northern Thailand and Myanmar Border: The vital need for bridging cross-country cooperation,” XV International AIDS Conference, Bangkok, July 11–16, 2004, abstract B10478; Nipaporn Ouppinjai, “TB Related Problems or Obstacles,” speech, “Update on TB Situation in Thailand and Around the World and Launch of New Project in Northern Thailand,” “TB Photovoice,” Chiang Mai, Thailand, November 28, 2006.

¹⁰¹ Jittimane Sukson, *Report on the Thai/Myanmar Border TB Situation, including Multi-Drug Resistant TB in the border area*, no date, http://w3.who-thai.org/LinkFiles/Border_Health_3_Report_on_the_T-M_Border_TB_Situation.zip.

¹⁰² Wandee et al., supra note 100.

¹⁰³ Sawasdiwuthipong et al., supra note 82.

¹⁰⁴ Sawasdiwuthipong, supra note 82; Wandee, supra note 100; Supamart Kasem, “Aliens Seen as Health-Care Burden,” *Bangkok Post*, August 20, 2004; WHO Thailand, supra note 83; Sukson, supra note 101.

¹⁰⁵ Arthit Khwankhom, “Alarm over rising cost from new TB cases,” *The Nation*, January 12, 2007.

Failures in TB control have more urgent implications given the possibility of multi-drug resistance that generally arises as a result of failure to complete a full course of treatment. However, data on multi-drug resistant (MDR) tuberculosis along the Thai-Burma border is sparse and often discordant. In Mae Sot, MSF–France reported that about 1.5% of their TB patients in 2006 had MDR TB.¹⁰⁶ Other figures for the border are much higher. In one evaluation, MDR TB accounted for 6.5 percent of TB isolates collected on the Thai side of the border with Burma, compared with the national average of 0.9 percent.¹⁰⁷ A survey by the National Tuberculosis Reference Laboratory of Thailand in 2002 found a 5.3 percent rate on the border, resembling MDR rates seen in other high-risk settings, such as prisons.¹⁰⁸ The cost of treating MDR TB is currently estimated at almost 100,000 baht (approximately \$3,000) per patient per month,¹⁰⁹ with significant economic implications for control.¹¹⁰

Malaria

The Thai-Burma border region is a highly endemic zone for malaria, particularly for multi-drug resistant malaria. A survey by the Back Pack Health Worker Team, published in 2006, found that malaria was the cause of almost half the deaths in internally displaced communities in eastern Burma. Of all age groups, young children were particularly vulnerable.¹¹¹ In 2004, the Back Pack medics diagnosed and treated over 15,500 cases of presumptive and confirmed malaria in a population of 176,200 internally displaced persons.¹¹² The team also found that, at any given time, 12.4 percent of the internally displaced were infected with *Plasmodium falciparum*, the most dangerous form of malaria, representing a massive reservoir of untreated individuals.¹¹³ These figures are consistent with prevalence rates for malaria of 10–40 percent in other rural areas of Burma.¹¹⁴

Similar data has been reported by the Karen Department of Health and Welfare (KDHW), which treated over 10,000 cases of malaria out of a population of over 80,000 internally displaced persons in eastern Burma.¹¹⁵ Where KDHW operates, 44 percent of all deaths are due to malaria.¹¹⁶ Other clinics and mobile health teams managed by local community-based organizations along Burma's

¹⁰⁶ Roy, supra note 66.

¹⁰⁷ Suksont, supra note 101.

¹⁰⁸ National Tuberculosis Reference Laboratory, Ministry of Public Health, Thailand, undated. Provided to author by Thai public health officer, September 17, 2006, Mae Sot, Thailand

¹⁰⁹ Khwankhom, supra note 105.

¹¹⁰ Pirom Kamolratanakul, Narin Hiransuthikul, Naruemol Singhadong, Yutichai Kasetjaroen, Somsak Akksilp, Somrat Lertmaharit, "Cost Analysis of Different Types of Tuberculosis Patient at Tuberculosis Centers in Thailand," *Southeast Asian J Trop Med Public Health* 33, 2002, 321–30; Beyrer et al., supra note 76.

¹¹¹ BPHWT, supra note 26.

¹¹² BPHWT, *Annual Report 2004*, 2005.

¹¹³ Id.; BPHWT, supra note 26.

¹¹⁴ Tin Tin Oo, Volker Storch, Norbert Becker, "Anopheles dirius and its role in Malaria Transmission in Myanmar," *J Vector Ecol* 28, 2003, 175–83; W. Tun-Lin, Myat Myat Thu, Sein Maung Than, Maung Maung Mya, "Hyperendemic Malaria in a Forested, Hilly Myanmar Village," *J Am Mosq Control Assoc* 11, 1995, 401–07.

¹¹⁵ BPHWT, supra note 112.

¹¹⁶ Eh Kalu Shwe Oo, "Indigenous Health Worker Reduction of Malaria in Karen State," conference address, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia," Bangkok, January 24, 2007.

eastern frontier, including Shan, Palaung, Mon, and Karenni groups, also report that malaria is the most significant health problem in their respective areas.¹¹⁷

The Back Pack Health Worker Team has concluded that the spread of malaria in eastern Burma is linked to the Burmese military's practice of forced displacement and destruction of villages and food stores. During a recent survey, the group found that households of internally displaced persons that suffered food destruction or confiscation by the military had higher odds of having malaria, as they were forced to forage in the jungles for longer periods of time without shelter or protective equipment, and thus were at a higher risk of contracting malaria.¹¹⁸

Burmese migrants have higher prevalence rates of malaria than other population groups living along the Thai-Burma border. Of approximately 25,000 cases of malaria reported to the Thai Ministry of Public Health in 2005, 92 percent (23,000) were found in Burmese migrants.¹¹⁹ Thirty percent of all reported cases of malaria in Thailand occur in Tak Province, adjacent to Burma's Karen State.¹²⁰ Here, malaria is the most commonly reported disease in migrants.¹²¹ In one estimate, the annual incidence of *Plasmodium falciparum* malaria was 87.8 per 1,000 in Thais and 285.9 per 1,000 for non-Thais.¹²² In 2005, the Mae Tao Clinic in Mae Sot treated 7,505 cases of malaria, almost double the number of patients the preceding year.¹²³

Burmese migrants in Thailand are not only more likely to be ill from malaria but also commonly have asymptomatic parasitemia. According to a study published in 2002, Burmese migrants in Tak Province had a 4.4 percent asymptomatic parasitemia prevalence rate compared to 0.2% in local Thais.¹²⁴ This large reservoir of both symptomatic and asymptomatic individuals who remain untreated has contributed to large outbreaks of malaria in Thailand. Control of these outbreaks has been complicated by high mobility in undocumented migrants, a problem compounded by difficulties in accessing care and prevention.¹²⁵ In 2005, a severe outbreak of malaria occurred in the southern Thai border province of Ranong. Thai health officials found that 345 ethnic Thais out of a population of approximately 29,000 had contracted malaria. By

¹¹⁷ Beyrer et al., supra note 76; "Over Five Percent of Pregnant Women on Border Afflicted by Malaria," *Kaowao News*, July 21, 2006, http://www.bnionline.net/index.php?option=com_content&task=view&id=271&Itemid=6.

¹¹⁸ BPHWT, supra note 26.

¹¹⁹ Sai Silp, "Thai Officials Worried About Counterfeit Malaria Drugs," *The Irrawaddy*, September 7, 2006, <http://www.irrawaddy.org/aviewer.asp?a=6141&z=154>.

¹²⁰ Chansuda Wongsrichanalai, Krongthong Thimasarn, Jeeraphat Sirichaisinthop, "Antimalarial Drug Combination Policy: A Caveat," *Lancet* 355, 2000, 2245-47; "Dengue on the Upsurge," *The Nation*, June 26, 2006.

¹²¹ WHO Thailand, supra note 83.

¹²² Verena Ilona Carrara, Supakit Sirilak, Janjira Thonglairuam, Chaiporn Rojanawatsirivet, Stephane Proux, Valery Gilbos, Al Brockman, Elizabeth A. Ashley, Rose McGready, Somjai Leemingsawat, Cornchai Looareesuwan, Pratap Singhasivanon, Nicholas White, and Francois Nosten, "Deployment of Early Diagnosis and Mefloquine-Artesunate Treatment of Falciparum Malaria in Thailand: The Tak Malaria Initiative," *PLoS Med* 3, 2000, e183. DOI: 10.1371/journal.pmed.0030183.

¹²³ Mae Tao Clinic, supra note 63.

¹²⁴ Viroj Wiwanitkit, "High Prevalence of Malaria in Myanmar Migrant Workers in a Rural District near the Thailand-Myanmar Border," *Scand J Infect Dis* 34, 2002, 236-37.

¹²⁵ Arthit Khwankhom, "Malaria Rife in Border Provinces," *The Nation*, June 7, 2005; "Aliens Targeted for Disease Prevention," *The Nation*, June 16, 2005; Saksit Meesubkwang, "Nearly 500 Malaria Deaths in Mae Hong Son," *Chiang Mai Mail*, July 16-22, 2005, <http://www.chiangmai-mail.com/143/news.shtml#hd1>; Shah Paung and Sai Silp, "Global Fund Opens New Malaria Posts Along Thai-Burmese Border," *The Irrawaddy*, March 30, 2006, <http://www.irrawaddy.org/aviewer.asp?a=5605&z=154>.

comparison, malaria was detected in 1,000 of approximately 6,000 migrants, the vast majority of whom were Burmese.¹²⁶

Multi-drug resistant malaria is an increasing problem along the Thai-Burma border for several reasons.¹²⁷ First, many Burmese who lack access to adequate health care often buy and take medications without supervision and control.¹²⁸ As a result, they may purchase ineffective drugs or fail to adhere to the treatment regime. Second, while the mainstay of treatment for *falciparum* malaria along the border is artesunate with mefloquine combination therapy,¹²⁹ counterfeiters have undermined this treatment therapy by producing and selling fake artesunate. Recent studies have found that counterfeit artesunate is common throughout Burma, with over a fifth of drugs sampled in one analysis being fake.¹³⁰ Counterfeit and expired drugs believed to originate from outside of Thailand have also been discovered in pharmacies in 10 Thai provinces bordering Burma.¹³¹ Finally, the Burmese government's use of forced labor places workers at a higher risk of exposure to mosquitoes that carry the disease. Once infected, these laborers may seek out cheap and inappropriate antimalarials, largely because they have no access to adequate health services.

A Burmese physician who formerly worked in Mon State and Tenasserim Division has described the problem as follows:

I think malaria has become worse [around the Yadana Pipeline project, in Tenasserim Division, where forced labor was employed]. The workers have to clear the forest and ... have increased exposure to mosquitoes that may be better at transmitting malaria. Many laborers have also contracted malaria working on railway construction projects [the Ye-Tavoy Railroad]. They had forced labor ... every household was asked to send one worker to help. ... If someone got sick with malaria, they had to pay for their own treatment. There were often places that sold medicines [at the forced labor sites]. The workers often bought ineffective medicines. Many bought chloroquine, which doesn't work anymore, and so many died of cerebral malaria. There is no control of medicines in many areas of Mon State. Pharmacy shops sell them but sometimes even betel nut stalls sell medicines.

¹²⁶ "Malaria Sweeps Through South," *The Nation*, June 9, 2005.

¹²⁷ Chansuda Wongsrichanalai, Amy L. Pickard, Walther H. Wernsdorfer, Steven R. Meshnick, "Epidemiology of Drug Resistant Malaria," *The Lancet Infect Dis* 2, 2002, 209–18; Carrara, et al., supra note 122; Robert Hutagalung, "Malaria on Thai-Myanmar (Burma) Border, the Burning Issues," conference address, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia," Bangkok, January 24, 2007.

¹²⁸ Chansuda Wongsrichanalai, Khin Lin, Lorrin W. Pang, M. A. Faiz, Harald Noedl, Theera Wimonwattrawatee, Anintita Laoboonchai, Fumihiko Kawamoto, "In Vitro Susceptibility of *Plasmodium Falciparum* Isolates from Myanmar to Antimalarial Drugs," *Am J Trop Med Hyg* 65, 2001, 450–55; Wongsrichanalai, et al., supra note 120.

¹²⁹ Wongsrichanalai, et al., supra note 127; Wongsrichanalai, et al., supra note 120; F. Nosten, M. van Vugt, R. Price, C. Luxemburger, K. L. Thway, A. Brockman, R. McGready, F. ter Kuile, S. Looareesuwan, N. J. White, "Effects of Artesunate-Mefloquine Combination on Incidence of *Plasmodium Falciparum* Malaria and Mefloquine Resistance in Western Thailand: A Prospective Study," *Lancet* 356, 2000, 297–302.

¹³⁰ A. M. Dondorp, P. N. Newton, M. Mayxay, W. Van Damme, F. M. Smithuis, S. Yeung, A. Petit, A. J. Lyman, A. Johnson, T. T. Hien, R. McGready, J. J. Farrar, S. Looareesuwan, N. P. Day, M. D. Green, N. J. White, "Fake Antimalarials in Southeast Asia are a Major Impediment to Malaria Control: Multinational Cross-Sectional Survey on the Prevalence of Fake Antimalarials," *Trop Med Int Health* 9, 2004, 1241–46.

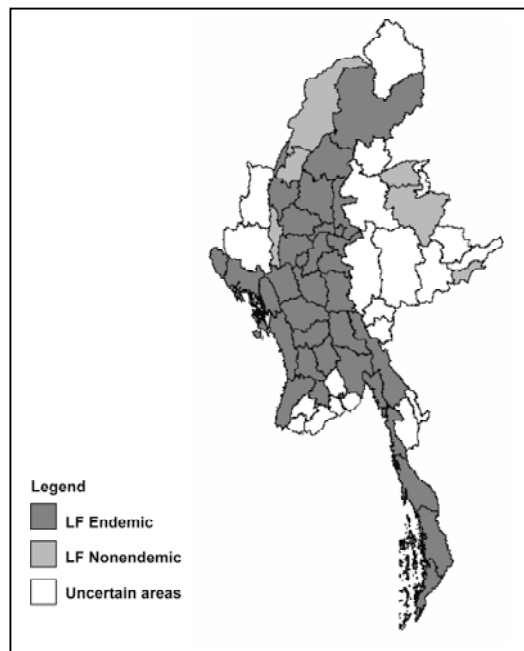
¹³¹ Silp, supra note 119.

Thai-Burma Border Region

There is a lot of indiscriminate use of [antimicrobial agents] and I worry about the spread of resistant strains.¹³²

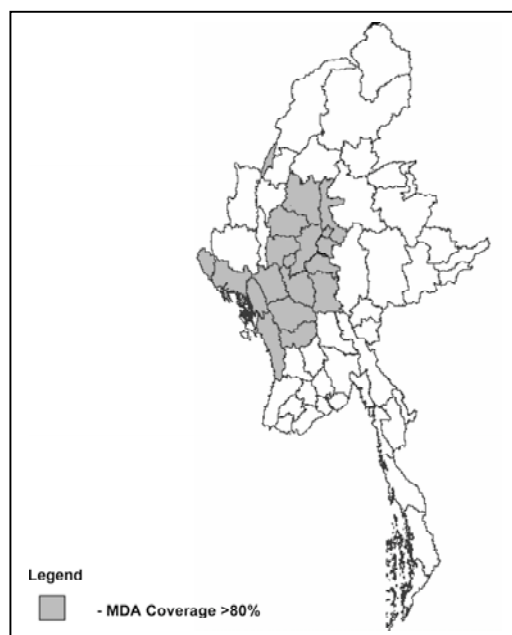
Filariasis

Lymphatic filariasis remains highly endemic in Burma.¹³³ The epidemiologic situation for lymphatic filariasis remains unknown in many areas of Burma, and adequate mass-drug-administration (MDA) treatment programs are nonexistent.¹³⁴



Map 1: Map of lymphatic filariasis in Burma

Map 2: Areas of the country where more than 80 percent of the population is covered by MDA programs.



Source: National Programme to Eliminate Lymphatic Filariasis, supra note 133.

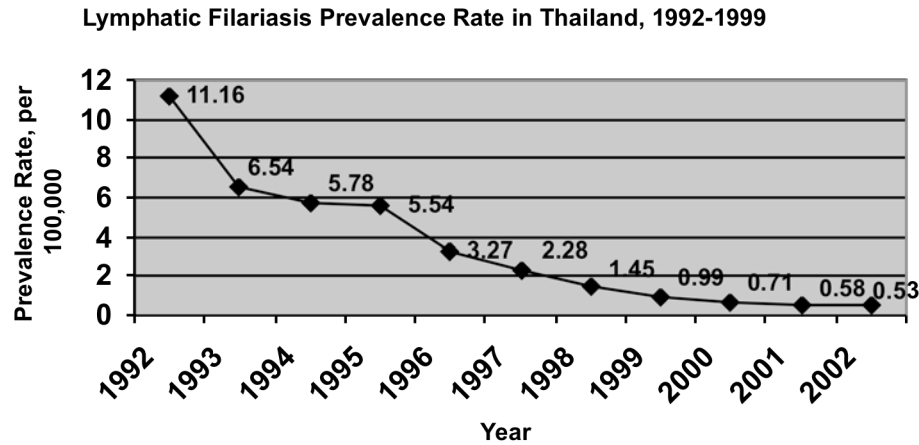
¹³² Anonymous Burmese Physician, supra note 79.

¹³³ National Programme to Eliminate Lymphatic Filariasis, Ministry of Health, Myanmar, *Annual Report for the National Programme to Eliminate Lymphatic Filariasis*, December, 2004, http://w3.whosea.org/LinkFiles/New_Lymphatic_Filariasis_Annual_Report_Myanmar_2004.pdf; Beyrer et al., supra note 76.

¹³⁴ National Programme to Eliminate Lymphatic Filariasis, supra note 133; Adik Wibowo, “Communicable Diseases in Myanmar,” conference address, “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 24, 2007.

In sharp contrast, Thailand, using MDA in areas known to be endemic, has been able to reduce significantly the prevalence of this disease.¹³⁵ Today, the disease is mainly present in the three western border provinces of Tak, Mae Hong Son, and Kanchanaburi, all adjacent to Burma.¹³⁶ Figure 3 shows the yearly prevalence of lymphatic filariasis in Thailand from 1992 to 2002.

Figure 3: Prevalence of Lymphatic Filariasis in Thailand



Adapted from: Division of Communicable Disease Control, Ministry of Public Health, Thailand, *supra* note 135.

Burmese migrants are more likely to be infected with filariasis than any other population group in Thailand. Ten percent of Burmese migrants are infected, many without symptoms, with another 40 percent exhibiting previous exposure to *Wuchereria bancrofti*, the etiologic agents.¹³⁷ Almost no one in these surveys was treated for this disease prior to coming to Thailand.¹³⁸ The mandatory Thai health evaluation for guest-worker registration includes a survey for lymphatic filariasis. However, as more undocumented migrants flee Burma, often venturing to Thai urban areas far from the border, concern has been raised in Thailand, where competent mosquito vectors exist, of the possibility of re-emergent urban filariasis.¹³⁹ In 2004, two Shan migrants

¹³⁵ Division of Communicable Diseases Control, Ministry of Public Health, Thailand, *Annual Report, Filariasis Unit*, Nonthaburi: Ministry of Public Health, 2002 [in Thai].

¹³⁶ *Id.*; Surang Tritteeraprabab, Issarang Nuchprayoon, Chantima Porksakorn, Yong Poovoravan, Alan L. Scott, “High Prevalence of *Wuchereria bancrofti* Infection Among Myanmar Migrants in Thailand,” *Ann Trop Med Parasitol* 95, 2001, 535–38; Surang Tritteeraprabab, Kobkarn Kanjanopas, S. Suwannadabba, Songpun Sangprakarn, Yong Poovorawan, Alan L. Scott, “Transmission of the Nocturnal Periodic Strain of *Wuchereria bancrofti* by *Culex quinquefasciatus*: Establishing the Potential for Urban Filariasis in Thailand,” *Epidemiol Infect* 125, 2000, 207–12.

¹³⁷ Tritteeraprabab et al., *supra* note 136; Surang Tritteeraprabab, Jiraporn Songtrus, “High Prevalence of Bancroftian filariasis in Myanmar Migrant Workers: A Study in Mae Sot District, Tak Province, Thailand,” *J Med Assoc Thai* 82, 1999, 735–39.

¹³⁸ Tritteeraprabab and Songtrus, *supra* note 137; Surachart Koyadun and Adisak Bhumiratana, “Surveillance of Imported Bancroftian Filariasis After Two-Year Multiple-Dose Diethylcarbamazine Treatment,” *Southeast Asian J Trop Med Public Health* 36, 2005, 822–31.

¹³⁹ Tritteeraprabab et al., “High Prevalence of *Wuchereria bancrofti* Infection Among Myanmar Migrants in Thailand,” *supra* note 136; Tritteeraprabab and Songtrus, *supra* note 137; Tritteeraprabab et al., “Transmission of the Nocturnal Periodic Strain of *Wuchereria bancrofti* by *Culex quinquefasciatus*: Establishing the Potential for Urban Filariasis in Thailand,” *supra* note 136; Withaya Huanok, “Thailand Under Threat: How Burma’s Dams Project Could Spread Disease,” *The Irrawaddy*, June 2005.

from Burma with symptomatic lymphatic filariasis were found in Chiang Mai City, the first time it has been found there in decades.¹⁴⁰

Other Infectious Diseases

Cholera continues to occur in Burma in both rural and urban settings, including Rangoon.¹⁴¹ Information regarding outbreaks is difficult to confirm and often hidden, making this an underreported disease.¹⁴² Even less information about cholera exists along the Thai-Burmese borders, although occasionally outbreaks have been reported in refugee communities displaced by civil conflict.¹⁴³ Similarly, several outbreaks of dengue fever have occurred in the northern Thai border provinces of Chiang Rai and Chiang Mai, adjacent to Laos and Burma's Shan State, with cross-border migration by hidden populations complicating attempts at control.¹⁴⁴

Other infectious diseases, including oropharyngeal anthrax, diphtheria, tetanus, and avian influenza, continue to be prevalent in Burmese migrants to Thailand. The first cases of oropharyngeal anthrax were described in northern Thailand following an outbreak resulting from consumption of affected cattle smuggled across the Thai-Burma border.¹⁴⁵ In Mae Sot district, some vaccine-preventable illnesses, including diphtheria and tetanus, are found almost solely in Burmese migrants.¹⁴⁶ Thai health authorities have publicly warned that Thailand is at the highest risk of a polio resurgence in a decade, partly because health officials have been unable to access undocumented migrants.¹⁴⁷

In recent years, Thailand and Burma have experienced outbreaks of avian influenza within their borders. In October 2006, after an outbreak of avian influenza struck poultry farms north the

¹⁴⁰ Withaya Huanok, "Thailand Under Threat: How Burma's Dams Project Could Spread Disease," *The Irrawaddy*, June 2005.

¹⁴¹ K. N. Oo, W. M. Than, T. Win, M. Thida, K. S. Aung, "Vibrio cholerae non-O1 as a Causal Pathogen in Cholera Patients in Yangon, Myanmar," *J Diarrhoeal Dis Res* 13, 1995, 176–79; "Cholera Outbreak at Paunde in Central Burma Kills One," *Democratic Voice of Burma*, September 22, 2006, <http://english.dvb.no/news.php?id=7917>; "Children Die from Cholera in Mandalay where Bird Flu Occurred," *Democratic Voice of Burma*, April 13, 2006, <http://english.dvb.no/news.php?id=6840>; Taramon, "Cholera Spreads Along the Border," *Kaowao News*, January 4, 2004, http://www.burmatoday.net/kaowao/2004/01/040126_cholera_kaowao60.htm.

¹⁴² "Children Die from Cholera in Mandalay where Bird Flu Occurred," supra note 141; Beyrer et al., supra note 76; "Cholera Outbreaks in Upper Burma Kill at Least Four," *Democratic Voice of Burma*, December 8, 2005; "Cholera Outbreak in Burma Tharawaddy Latest: 40 Dead Within One Day," *Democratic Voice of Burma*, September 30, 2005.

¹⁴³ Patrick McDowell, "Burma Refugee Cholera Probed," *Associated Press*, March 9, 1997, <http://www.burmalibrary.org/reg.burma/archives/199703/msg00154.html>; Banyol Kin, "Number of People with Cholera Increase in Htam Hin Refugee Camp," *Independent Mon News Agency (IMNA)*, April 6, 2006, http://www.monnews-imna.com/web2006/april/6_2.htm.

¹⁴⁴ "Thai Malaria Warning," *The Irrawaddy*, May 29, 2006, <http://www.irrawaddy.org/aviewer.asp?a=5700&z=148>; Sai Silp, "Border Migration Major Cause of Dengue Fever," *The Irrawaddy*, March 24, 2006, <http://www.irrawaddy.org/aviewer.asp?a=5589&z=154>.

¹⁴⁵ Thira Sirisanthana, Niramom Navacharoen, Prasit Tharavichitkul, Virat Sirisanthana, Arthur E. Brown, "Outbreak of Oral-Oropharyngeal Anthrax: An Unusual Manifestation of Human Infection with Bacillus anthracis," *Am J Trop Med Hyg* 33, 1984, 144–50; Thira Sirisanthana, "Re-Emerging Infection: Anthrax," conference address, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia," Bangkok, January 25, 2007.

¹⁴⁶ Sawasdiwuthipong, supra note 82.

¹⁴⁷ Arthit Khwankhom, "Southern Provinces a Hotbed for Polio," *The Nation*, December 8, 2006.

Burmese city of Mandalay, Thai health officials convened a meeting with health organizations based along the Thai-Burma border to prepare an influenza preparedness plan.¹⁴⁸ Thai health authorities acknowledged at the meeting that the large number of undocumented Burmese migrants, coupled with Burma's poor health infrastructure, posed a significant threat of spreading of avian influenza, especially in the border provinces.¹⁴⁹

Conclusion

The Thai government has become increasingly concerned about the disproportionate burden of infectious diseases in migrants and recognizes that the borders of Burma pose a "high risk" area for health.¹⁵⁰ Thai health officials in Mae Hong Son Province have noted: "Due to the high mobility of legal and illegal migrant workers along [our] border, data collection, provision of water supply and sanitation, disease control and following up for treatment cannot be effectively implemented. This leads to disease transmission and outbreaks among Thai and non-Thai populations."¹⁵¹

Thai health officials have begun forging partnerships with local health-based groups to increase access to care for migrants. One example is the Tak Malaria Initiative, which was formed to address problems of malaria in Tak province with the assistance of the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria.¹⁵² The Initiative's goal is to expand rapid diagnosis and combination treatment for *falciparum* malaria by establishing malaria posts and training local staff in the five districts that border Burma. Media advertising for these services was developed and publicized in Thai, Burmese, and Karen. Over the course of six years, the program has realized sustained decreases in *falciparum* malaria incidence, morbidity, and mortality. However, the most significant decreases in incidence were noted in Thais, likely as a result of their being less mobile, with less cross-border migration to zones where large malaria reservoirs persist.¹⁵³ Similar efforts are now being expanded to other provinces in Thailand, particularly along the border with Burma.¹⁵⁴

Another Global Fund-supported initiative is PHAMIT (Prevention of HIV/AIDS Among Migrant Workers in Thailand). A partnership of eight nongovernmental organizations and the Thai Ministry of Public Health, PHAMIT is disseminating HIV and reproductive health information along the Thai-Burma border. PHAMIT also partners with migrant-community health stations and local health providers to help increase access to health services.¹⁵⁵

¹⁴⁸ "Medics on Border Ready for Bird Flu," *The Nation*, January 26, 2006.

¹⁴⁹ The First Avian Influenza Border Coordination Meeting, October 27, 2006, in Mae Sot, Thailand, was particularly well attended by representatives from these border provinces. See also Supamart Kasem, "Bird Flu Centre to Track Virus in Burmese," *Bangkok Post*, January 29, 2006; "Chiang Mai Public Health Authorities Identify Migrant Workers as High Risk for Avian Influenza due to Lack of Knowledge," *Salween Post*, January 1-February 15, 2007, 22 [in Thai].

¹⁵⁰ Sai Silp, "Border Health Conference Begins in Ratchaburi," *The Irrawaddy*, April 27, 2006.

¹⁵¹ WHO Thailand and Department of Disease Control, Ministry of Public Health, *supra* note 83.

¹⁵² Carrara, *supra* note 122; Shah Paung and Sai Silp, *supra* note 125.

¹⁵³ Carrara, *supra* note 122.

¹⁵⁴ Shah Paung and Sai Silp, *supra* note 125; Sai Silp, *supra* note 119.

¹⁵⁵ See www.phamit.org.

In sharp contrast, the Burmese government denies the existence of displaced populations in conflict zones of eastern Burma and offers few programs to address their needs.¹⁵⁶ The failure of the Burmese government to recognize and address the needs of its citizens abroad was highlighted by its response to the tsunami of December 2004, which killed thousands of non-Thais in Thailand. Foreign governments and relief organizations quickly moved to help those affected; the glaring absence was Burma, which failed to send any aid to the thousands of Burmese who were killed or affected by the disaster.¹⁵⁷

In recent years, Thai and Burmese health officials have held meetings better to coordinate health delivery along the Thai-Burma border, but these events have produced few, if any, concrete results.¹⁵⁸ This lack of action is largely due to the Burmese junta's firm control over the activities of its health officials, especially when they engage with their overseas colleagues. Travel restrictions imposed on Burmese health officials have at times bordered on the absurd. For example, Burmese military authorities recently required local health officials traveling to a cross-border health meeting in Mae Sot to travel from Myawaddy to Rangoon, fly from Rangoon to Bangkok, then travel on road from Bangkok to Mae Sot, rather than simply cross the bridge over the Moei River which forms the natural boundary between Mae Sot and Myawaddy.¹⁵⁹

Major decisions made by central military authorities and the presence of the Burmese military along the border may dissuade local health officials from implementing coordinated activities with nongovernmental organizations working on the Thai side. A Burmese physician living in Mae Sot provides this example: "We wanted to do HIV awareness [with Burmese health authorities in the Burmese border town of Myawaddy]. We had one poster that had a picture of Mae La [a Karen refugee camp just across the border, in Thailand]. But they told us please don't use that one, they are afraid: the Burmese government doesn't like to acknowledge that they have refugees."¹⁶⁰

Only a few international humanitarian organizations maintain health programs near conflict zones in eastern Burma.¹⁶¹ MSF–Switzerland operates in Karenni State, near the capital of Loikaw, providing primary health care and malaria treatment.¹⁶² However, these activities are confined to areas controlled by the KNPLF, a cease-fire group allied to the Burmese government.

Because most eastern border zones are off-limits to international humanitarian organizations operating inside Burma, Thailand-based health groups have moved in to help fill this gap, despite the fact that the Thai government does not officially allow cross-border programs.¹⁶³ These

¹⁵⁶ Shukla, *supra* note 49 at 1–2.

¹⁵⁷ Rungrawee C. Pinyorat, "Burmese Migrants in Thailand Become Forgotten Tsunami Victims," *The Irrawaddy*, January 22, 2005, <http://www.irrawaddy.org/aviewer.asp?a=4307&z=150>.

¹⁵⁸ E. Aung, "Access to Antiretroviral Therapy by Burmese Migrants in Thailand," XVI International AIDS Conference, Toronto. Abstract CDE0384.

¹⁵⁹ Anonymous public health official, interview, Mae Sot, Thailand, September 14, 2006.

¹⁶⁰ Anonymous Burmese physician, *supra* note 79.

¹⁶¹ Shukla, *supra* note 49, at 13–14.

¹⁶² Communication with MSF–Switzerland physician, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia Conference," Bangkok, January 2007; see also <http://www.uk2.msf.org/aboutus/documents/InternationalActivityReport2005-2006.pdf>.

¹⁶³ Shukla, *supra* note 49, at 17–18; Tom J. Lee, Luke C. Mullany, Adam K. Richards, Cynthia Maung, "Burma: The Impact of Human Rights Violations on Health Among Internally Displaced Persons in Conflict Zones," in Chris

include ethnic-based health organizations, such as KDHW, the Mon National Health Committee, the Shan Health Committee, and the Karenni Mobile Health Worker Team.¹⁶⁴ These clinics implement a variety of programs including vitamin-A distribution, reproductive health, malaria treatment and control, and vaccination.¹⁶⁵ They have been able to demonstrate dramatic, sustained control of malaria in the areas they serve.¹⁶⁶

Such efforts notwithstanding, these organizations face significant logistical and financial barriers. They also face constant threats from the Burmese army.¹⁶⁷ Burmese soldiers have deliberately blocked supplies and aid being delivered to communities of internally displaced persons living in conflict zones.¹⁶⁸ In addition, Burmese troops have killed members of BPHWT and destroyed several of their clinics.¹⁶⁹

Other organizations operate on the Thai side of the border, serving increasing numbers of migrants coming across the border specifically for health services. MSF–France operates the largest TB treatment program in Mae Sot, and other organizations caring for non-Thai patients with suspected tuberculosis will refer patients there for evaluation and care. Similarly, the Mae Tao Clinic, founded in 1989, provides a range of curative and preventive health services for Burmese migrants and is a key institution providing training in health. In 2005, there were over 8,000 admissions and 99,000 outpatient consultations, many coming from deep within Burma, for basic medical services.¹⁷⁰

Such incidents have cast a “chilling effect” on community-based health organizations working in or near conflict zones in eastern Burma. A Burmese physician now living in Mae Sot put it this way: “The activities of these health groups need to be registered and approved. If they are doing something that is not, the authorities can take action. It has been like this for a long time but [the Burmese government] has become more strict lately. [One community-based organization in Myawaddy] is not allowed to have an office. They have to meet secretly.”¹⁷¹

Beyrer and Hank F. Pizer, eds., *Public Health and Human Rights: Evidence-Based Approaches*, Baltimore, MD, Johns Hopkins Press, 2006.

¹⁶⁴ Beyrer et al., *supra* note 76.

¹⁶⁵ Htee Moo and Adam Richards, “Malaria Control Among Internally Displaced Persons in Eastern Burma: A Public Health and Human Rights Approach,” conference address, “Lessons Learned from Rights-Based Approaches to Health,” Atlanta, GA, April 15, 2005.

¹⁶⁶ Eh Kalu Shwe Oo, *supra* note 116.

¹⁶⁷ *Id.*

¹⁶⁸ Karen Human Rights Group, *Flight, Hunger and Survival: Repression and Displacement in the Villages of Papun and Nyaunglebin Districts*, <http://www.khrg2001/khrg0103a.html>; Human Rights Watch, *supra* note 27.

¹⁶⁹ Beyrer et al., *supra* note 76; BPHWT, *supra* note 26.

¹⁷⁰ Mae Tao Clinic, *supra* note 63; Maung, *supra* note 63.

¹⁷¹ Anonymous Burmese physician, *supra* note 79.

8. Bangladesh-Burma Border Region

The inability or unwillingness of the governments of Bangladesh and Burma and the international community to resolve the long-standing crisis of Burmese refugees in southeastern Bangladesh threatens the health of populations on both sides of the border. Tens if not hundreds of thousands of Muslim Rohingyas from Burma's Arakan State are now living in the Cox's Bazar and Teknaf coastal strip of Bangladesh, most of them illegally, in squalid conditions that promote the spread of infectious diseases, malnutrition, and other ailments. There are also estimated to be thousands of Rakhaings, the other main ethnic group from Arakan, living in Bangladesh.

Though Muslims have lived in Arakan for centuries, the Burmese government and many Rakhaings maintain that they are illegal migrants from Bangladesh, with no rights to citizenship in Arakan or Burma. The Bangladeshi government does not recognize them as citizens of Bangladesh, since many have roots in Burma that extend back generations. The Rohingyas are essentially stateless and suffer from all the physical, political, and economic vulnerabilities that such status imparts. Although the international community expressed concern during large-scale refugee crises in the 1980s and 1990s and took some steps to defuse the situation, its attention waned once the acute problems and threats have eased into chronic—but festering—wounds.

The prevalence of HIV in Bangladesh remains significantly below that in Burma. This is undoubtedly in part because circumcision inhibits viral transmission, and HIV rates in Muslim countries are in general much lower than in non-Muslim neighbor states. But the high rate of other sexually transmitted infections indicates a significant level of unsafe behaviors. Given frequent cross-border movement in the southeastern region, as well as the limited awareness and understanding of HIV among many sectors of the population, especially among disenfranchised and undocumented migrants, the virus could spread efficiently if it gained a bit of traction.

Malaria is endemic in 13 of Bangladesh's 64 districts, including in the Chittagong Hill Tracts that border Burma and India's Mizoram State and, to a lesser degree, the Cox's Bazar and Teknaf area. Bangladesh also has one of the world's highest tuberculosis rates, and the crowded living conditions of the Rohingyas and Bengalis in the southeast corner place them at particular risk. The increasing prevalence of drug-resistant strains of both TB and malaria represent a serious threat to public health.

The recent reappearance of polio along the Bangladesh-Burma border highlights the complexity, and the cross-border nature of infectious disease patterns. In March 2007, a young boy with polio from the Burmese side of the border was brought to Bangladesh for treatment at two different hospitals. As more cases appeared on the Burmese side, both countries launched vaccination campaigns in their respective border areas. Burma's official media have cited "a neighboring country"—a clear reference to Bangladesh—as the source of the polio outbreak.

Introduction

Southeastern Bangladesh shares a relatively short land border—270 kilometers—with Burma. The Burmese state of Arakan, also known as either Rakhine or Rakhaing, occupies the southern part of the border, with Chin State along the border to the north. The Bengalis of the Chittagong area and the Rakhaing people in Arakan share an entangled history that dates back centuries and includes a lengthy period when both areas were integral parts of Britain’s empire.

The governments of Bangladesh and Burma cooperate with each other in trade, economic development, border control, and other matters of mutual interest; along with India, the two countries had been negotiating an agreement on a gas pipeline that would cross from Arakan to the northeast Indian states and then through Bangladesh to Kolkata.¹ However, Bangladeshi politics have proven to be extremely volatile in recent years, and successive Bangladeshi governments have differed on the pipeline project in terms of concessions demanded from the Indian government; no final deal was ever signed. Burma finally announced in March 2007 that it was awarding the pipeline project, and the flow of natural gas, to China.

The relationship between Bangladesh and Burma has also been strained by the refugee problems of recent decades, with successive waves of Rohingyas—as most members of the Muslim population in Arakan are called—fleeing their homes to settle in the southeastern tip of Bangladesh, particularly around Cox’s Bazar and Teknaf.² More than 20,000 official refugees, some of whom have been in Bangladesh for more than a decade, remain in two camps administered by the United Nations High Commissioner for Refugees. Human Rights Watch estimates that there are as many as 100,000 unregistered Rohingyas living in the area as well,³ although estimates of the number from other observers have ranged as high as 200,000.⁴

Bangladesh and Burma have not managed to solve the refugee problem, nor have they addressed the issues that caused the flow across the border, in particular the Burmese government’s extremely repressive policies toward the Rohingya population. That paralysis, along with the international community’s apparent indifference to the situation and its lack of success in brokering a satisfactory settlement, has exacerbated the threat to the public health of communities in the border regions. So have the fetid living conditions of many of the Rohingya refugees, as well as their overall lack of access to critical health care services.

Although national surveillance has indicated that HIV rates could be slowly increasing in Bangladesh, they remain well below the levels in neighboring countries. However, high levels of unsafe sexual and drug-taking behaviors combined with a constant flow of back-and-forth traffic across the border suggest that a generalized epidemic could break out.⁵ One reason that has not

¹ “Bangladesh again turns eye to three nations pipeline,” *Narinjara News*, March 5, 2007.

² For more historical background and a full discussion of the successive refugee crises of recent decades, see Human Rights Watch, *Burmese Refugees in Bangladesh: Still No Durable Solution*, May 2000.

³ Human Rights Watch press release, http://hrw.org/english/docs/2007/03/27/bangla15571_txt.htm, March 27, 2007.

⁴ Remarks delivered by Chris Lewa at the “Regional Conference on the Protection for Refugees from Burma,” Chiang Mai, November 6–7, 2003; “The situation of Burmese refugees in Bangladesh,” *Forum-Asia*, <http://www.ibiblio.org/obl/docs/CMP2003-11-07.htm>.

⁵ Information on current state of HIV infection in Bangladesh is from the government’s “National HIV Serological Surveillance, 2004–2005: Sixth Round Technical Report,” September 2005.

happened so far is most likely the fact that the Muslim Rohingyas from Burma and their Bangladeshi counterparts are circumcised, which studies have shown to inhibit HIV transmission.⁶ But circumcision does not provide absolute protection, and vigilance is warranted given high prevalence of other sexually transmitted infections in the border regions and other areas of the country.

In terms of other major infectious diseases, the situation is grimmer. Bangladesh has one of the world's most serious epidemics of tuberculosis (TB); the country ranks sixth on the World Health Organization's 2006 list of high-burden countries, with an estimated 300,000 new cases and 70,000 deaths a year.⁷ TB is a problem throughout the country, but the crowded conditions in which both legal and illegal Rohingya refugees live and the difficulties they face in accessing appropriate medical treatment place them at significant risk and present an ideal environment for the spread of TB infection. The chaotic conditions of life, which make it challenging to ensure that people routinely take their medications and complete their full course of treatment, can facilitate the development of drug-resistant strains of the bacterium.

Malaria is considered endemic in 13 of the country's 64 districts, in particular those northeastern districts that border India as well as the southeast region adjacent to Burma, with widespread drug resistance reported.⁸ Many of these areas are remote and have very little or no health care infrastructure, so monitoring disease patterns and providing treatment present enormous obstacles. *Plasmodium falciparum* accounts for more than two-thirds of the total malaria burden. There were an estimated 1,250 deaths among the 435,000 probable or clinically diagnosed cases in 2003; in addition, 574 people died out of 57,000 with laboratory-confirmed cases.

More recently, a resurgence of polio—with seven cases reported in Burma near the border as of late May 2007—has alarmed public health officials in both countries and caused tensions between them.⁹ Bangladesh had not experienced any polio cases since 2000, but the disease resurfaced in 2006 and the country launched a mass-vaccination campaign. In 2007, authorities discovered that a little boy with polio from Arakan's Maungdaw district had been taken across the border for treatment in hospitals in Chittagong and Cox's Bazar before being sent back to Burma. Subsequently, additional cases of polio were identified in Arakan near the border, and both countries began emergency vaccination campaigns to prevent the disease from spreading, with official Burmese media blaming Bangladesh for the outbreak.

The border is porous, exacerbating the potential for the spread of infectious diseases. The northern end of the border lies in the middle of the Chittagong Hill Tracts, specifically in the

⁶ Interview with Dr. Tasnim Azim, head of the HIV/AIDS Programme & Virology Laboratory, International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). Unless otherwise noted, all interviews were conducted in Bangladesh in July 2006.

⁷ World Health Organization (WHO) report on tuberculosis in Bangladesh, http://www.who.org/communicable_dis_tb.html.

⁸ WHO report on malaria in Bangladesh, http://www.who.org/communicable_dis_malaria.html.

⁹ Information about the polio outbreak is from the following news articles: "Polio Strikes Seven Children in Burma," *Radio Free Europe*, May 26, 2007; "Bangladesh: Polio vaccination drive launched," *Reuters*, May 21, 2007; "Health Minister receives WHO representatives," *New Light of Myanmar*, May 9, 2007; "Bangladesh district bordering Myanmar steps up efforts to check polio," *International Herald Tribune*, April 25, 2007; "Bangladesh begins new polio drive," *BBC News*, March 2, 2007

malaria-endemic district known as Bandarban. The border runs due south and then hits the Naaf River, which separates the two countries until it opens into the Bay of Bengal. In addition to the official daily traffic, there is significant illegal movement between the two countries, much of it related to the smuggling of drugs and other commodities. Even when border guards officially monitor the flow, they can be bribed with cash, drugs, or sex, according to several key informants. The border has also been heavily landmined in the past 15 years, which the Burmese regime has defended as necessary to prevent incursions by armed ethnic opposition groups operating out of Bangladesh.¹⁰ However, the mines have reportedly sometimes been laid on the Bangladeshi side of the border, and hundreds of Bangladeshi nationals have been killed over the years while working or traveling through the heavily forested and hilly terrain.¹¹

Arakan State and Southeastern Bangladesh: A Long and Complex History

The state of Arakan is a coastal strip of land wedged between the Bay of Bengal to the west and the Arakan Yoma mountains to the east. The Yoma range rises to more than 10,000 feet in places and has historically helped to isolate the region from the central Burmese government. The majority ethnic group from Arakan, known variously as the Arakan, Rakhine, or Rakhaing people,¹² make up about two-thirds of Arakan's estimated population of 2.7 million. They are ethnically close to the Burmans, and their language is a variant of Burmese, although this connection has not warmed relations between the two groups.

Most of the remaining residents of Arakan are the Muslim Rohingyas, although there are also small numbers of people from other ethnic groups. The Burmese Rohingyas are related to the Bengalis of Bangladesh and in particular to the Chittagonians, the main population group in the country's southeast region. Their language is extremely close to the Chittagonian variant of Bengali, with the two populations able to understand each other easily. The Rohingyas comprise a large majority in some swaths of northern Arakan adjacent to the Naaf River and Bangladesh's southeastern border, in particular the regional townships of Maungdaw and Buthidaung.

They have long sought—and been refused—official designation as one of the more than 100 indigenous ethnic groups recognized by the Burmese state. Successive Burmese governments have fanned anti-Muslim feelings when it has suited their interests, but those tensions increased after the events of September 11, 2001. The military regime was reported to have increased surveillance and repression of areas with large Muslim populations, like Arakan. At the same time, there were rumors that foreign Muslim extremists and Rohingya separatists were entering the country from Bangladesh and that some Rohingyas had joined the Taliban forces.¹³ For much of its history, Arakan has served as the crossroads between the Indian subcontinent and Southeast Asia, and it has experienced epochs of both independence and subjugation. Muslim

¹⁰ Human Rights Documentation Unit, National Coalition Government of the Union of Burma, "Burma Human Rights Yearbook, 2001–2002," <http://www.burmalibrary.org/show.php?cat=1315>, accessed April 1, 2007.

¹¹ "Burma Human Rights Yearbook 2001–2002," WHO, *supra* note 7.

¹² Rakhaing is preferred by some who have settled in Bangladesh as part of the opposition to the government of Burma, although armed rebels still call themselves the Arakan Liberation Party; some international NGOs, such as Médecins Sans Frontières–Holland, have adopted Rakhine. This report will use Arakan for the state name and Rakhaing for the people.

¹³ Maung Maung Oo, "Terror in America, Backlash in Burma," *The Irrawaddy*, October–November 2001.

traders started arriving during the eighth century, and Muslim administrators and advisors often played key roles in the political life of Arakan kingdoms. Strong financial and diplomatic ties between Arakan and Bengal ensured that the border between them frequently experienced significant population flows, with the direction and strength of the migration determined by prevailing political, economic, and social factors.

The rulers of Arakan repeatedly clashed with their neighbors to the east and south, the Burmans, who finally conquered the area in 1784. The invasion caused a flood of Muslim refugees to flee to the area of southeastern Bangladesh now known as Cox's Bazar. Forty years later, the British absorbed Arakan into India, and then Burma after that. Although Muslims had lived in Arakan for centuries, the number grew during the British period, with regular waves of laborers imported from Bengal to toil in the forests and fields of Burma. When the British left, the Muslims remained.

After Burma achieved its independence in 1948, the new government began to treat the Muslims, by this time widely referred to as the Rohingyas, as immigrants from Bengal rather than legitimate and long-time citizens of Burma. Their movements within Arakan were restricted to the Rohingya population centers and they were denied other citizenship rights, a situation that led to armed conflict in the early 1950s. After General Ne Win seized power in 1962, his government cracked down even more on Rohingya social and political groups. In the late 1970s, the regime sought to prepare for a national census and conducted an aggressive campaign to register the people it deemed citizens and designate others as foreigners. Hundreds of thousands of Rohingyas fled to Bangladesh, with many accusing the Burmese army of committing widespread abuses, including rape, torture, and murder, and evicting them from the country.¹⁴

A majority of the refugees were eventually repatriated. However, following the crackdown on the 1988 student democracy movement and the rejection of the 1990 national election results, the regime directed greater military pressure against areas not fully under its control, including Arakan. The army confiscated the land and food supply of many Rohingyas, forced them to relocate to areas under military control, and pressed them into labor. Some were tortured and executed. More than a quarter of a million fled to nearby Bangladesh during 1991 and 1992, with smaller waves of refugees streaming across the border when conditions worsened at other points in the 1990s.

Most of these new Rohingya refugees were repatriated between 1993 and 1997 under an agreement implemented by the United Nations High Commissioner for Refugees (UNHCR). But efforts to complete the task were hampered by Burma's continued reluctance to grant full citizenship rights to Rohingyas as well as the unwillingness of many of the remaining refugees to return to Burma under the existing regime, especially with reports of increased repression against Rohingyas, sparked by heightened concerns about Muslim groups after 9/11. Bangladesh remains home to about 22,000 registered refugees living in two UNHCR camps called Nayapara and Kutupalong, both located on the strip of land between Cox's Bazar and Teknaf, and some have complained about attempts by Bangladeshi authorities to force them to return to Burma unwillingly.¹⁵

¹⁴ For more details on the causes and consequences of the successive refugee crises, see Human Rights Watch, *supra* note 2; and Amnesty International, *The Rohingya Minority: Fundamental Rights Denied*, May 2004.

¹⁵ Amnesty International, *supra* note 14.

However, it is also estimated that between 100,000 and 200,000 Rohingyas are living in the area illegally. About 6,000 were living until recently in an unofficial encampment squeezed into the narrow band between the Naaf River and the road that runs between Cox's Bazar and Teknaf,¹⁶ where they had settled several years ago after being evicted from rented homes because of their undocumented status. However, according to Human Rights Watch, in March 2007 the Bangladeshi authorities destroyed a large part of the makeshift encampment in order to enlarge the nearby highway without making any provisions for housing elsewhere.¹⁷

In fact, many of the Rohingyas currently in Bangladesh are believed to be among those who were repatriated to Burma during the 1990s but returned to Bangladesh for extended periods to find work in construction or agriculture, engage in smuggling or prostitution, escape persecution, spend time with family members and friends, or seek medical care. Since it can be impossible to distinguish Rohingyas from Chittagonians visually, and even sometimes by accent, the exact figure remains unknown. Yet conditions both for the official and unofficial refugees have remained extremely poor, with regular reports of abuses inflicted by Bangladeshi security personnel, including sexual violence against women.¹⁸ International humanitarian personnel noted in interviews that authorities have thwarted the building of permanent structures in order to discourage migrants from staying indefinitely in Bangladesh. MSF officials said they obtained permission to build latrines for the makeshift camp, despite major problems with sewage being swept across the area by the tides from the Naaf River, only after making repeated appeals to the government.¹⁹ "The Rohingya have been caught between a hammer and anvil for over a decade in desperate circumstances, with Bangladesh making it difficult for them to seek refuge and Burma continuing to abuse the rights of the Muslim minority in Arakan State," said Brad Adams, Human Rights Watch's Asia director.²⁰

There are considerably fewer Rakhaings than Rohingyas in Bangladesh, with some estimating that the total number is about 25,000, although fewer than 200 of them are officially recognized as refugees by United Nations High Commissioner for Refugees.²¹ The Rakhaing Women's Union (RWU) and the Arakan Liberation Party (ALP), both of which advocate for Arakan independence from Burma, have for several years run clinics along the border to provide primary medical care to Rakhaings and others living in the hill tracts that characterize the northern part of the Bangladesh-Burma border region. The ALP site, called the Chakma clinic, is actually located not in Bangladesh but right across the country's northeastern border with Mizoram, India, in a corner where the three nations meet. The RWU clinic, which focuses on maternal and child health, is further south in the Chittagong Hill Tracts, near the village of Moduk.

Many Rakhaing, especially those affiliated with the groups seeking to establish an independent state, agree with the Burmese regime that the Rohingyas are not one of the country's legitimate indigenous groups and have no right to press claims on Arakan. These Rakhaing routinely and disdainfully refer to the Rohingyas as "the so-called Rohingyas,"²² and they insist, like the

¹⁶ Interview with Frido Herinckx, Bangladesh head of mission, MSF-Holland.

¹⁷ Human Rights Watch, *supra* note 3.

¹⁸ *Id.*

¹⁹ Interviews with personnel from international NGOs in Cox's Bazar and Teknaf.

²⁰ Human Rights Watch, *supra* note 3.

²¹ Interview with Mra Raza Linn, chairwoman and founder of Rakhaing Women's Union.

²² Interviews with Mra Raza Linn and the head of the health department of the Arakan Liberation Party.

Burmese government, that the Muslims are actually illegal Bengali immigrants who want to pursue their own economic and political interests in Arakan at the expense of the majority population. Mra Raza Linn of the RWU attributed Rohingya demands for recognition of their status within Burma to instigation by “Muslim extremists” seeking to stir up the feelings of their co-religionists.

Rakhaing and Rohingya political and revolutionary organizations have frequently operated out of Bangladesh and continue to do so. They have been plagued by internal debates and splits over tactics and goals but have also formed strategic alliances. Among the Rohingyas, the organizations have included the Arakan Rohingya National Organization, the Arakan Rohingya Islamic Front, and the Rohingya Solidarity Organization. In addition to the Arakan Liberation Party, the National Unity Party of Arakan has engaged in occasional armed fights with the Burmese military, while the Arakan League for Democracy is an ally of Burma’s National League for Democracy. The Arakan branch of the Communist Party of Burma has signed a cease-fire agreement with the regime.²³

The expatriate communities both have media that try to report on what is happening to their compatriots on the Burmese side. Kaladan Press is an online news agency that chronicles the situation of the Rohingyas, and Narinjara News does the same for the Rakhaings. Both editors are based in Bangladesh and appear to be in regular contact with anonymous correspondents inside Burma.²⁴

The Border Region

Concern about cross-border disease transmission focuses on the southeastern strip of Bangladesh, and especially the area stretching from Cox’s Bazar south to Teknaf. Cox’s Bazar is a popular tourist resort, with beach-lovers and others converging there from all parts of Bangladesh and even neighboring countries; it is also starting to attract some attention from Western travelers in search of little-known destinations, as noted—and promoted—in a recent article in *The New York Times*.²⁵ The district’s seasonal and permanent populations include tens if not hundreds of thousands of illegal refugees living in fetid conditions.²⁶

The tourist traffic attracts a large number of sex workers to the area, from both the Bangladeshi and refugee populations. There are also many injecting drug users, especially since some of the drug trafficking routes out of Burma pass through the area. And Cox’s Bazar and Teknaf are thriving centers for smuggling food, clothes, medicine, arms, and other goods back and forth across the border. Truckers and others involved in the transport of goods regularly converge on the area, with many believed to engage in unsafe sexual and drug-taking behaviors.

Locations along the Naaf River serve as the primary border-crossing points for the region, whether people are seeking to cross over legally or illegally. The Burmese and Bangladesh

²³ Amnesty International, *supra* note 14.

²⁴ Personal interviews with the editors of Kaladan Press and Narinjara News in July, 2006.

²⁵ Jeff Koyan, “Lured By the Beach Side of a Beleaguered Land,” *New York Times*, December 24, 2006.

²⁶ Information about the characteristics of the border region was drawn largely from interviews with key informants, including international and local NGO officials, peer educators, and local journalists.

authorities allow movement across the river, but obtaining official permission can be cumbersome, time-consuming, and expensive. There are frequent reports of harassment by both Burmese and Bangladeshi border guards and of demands for bribes and sexual services in exchange for safe passage. Key informants uniformly agree that there is also significant unofficial cross-border movement in both directions, for a great variety of reasons. Smuggling drugs and other contraband is a prime occupation, but some simply want to visit family members on the other side of the border while others come from Burma to Bangladesh specifically seeking health care.

Border security forces—the Bangladesh Rifles and the Nasaka, their Burmese counterparts—occasionally hold meetings in Cox’s Bazar for prisoner returns and discussion of bilateral border issues. Most recently, on March 29, 2007, *Kaladan Press* reported that 15 Bangladeshis who had been jailed in Arakan after being caught collecting firewood or fishing on the wrong side of the border were returned by Nasaka at a meeting in Maungdaw with the Bangladesh Rifles.²⁷ A year earlier, at a meeting in Maungdaw, expatriate news outlets reported that Bangladesh handed over 75 Burmese who had been arrested while trying to cross the border from Arakan illegally.²⁸

This complex of factors renders the border region an area of potential high risk for the transmission of infectious diseases, especially sexually transmitted infections, including HIV. A recent study conducted by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), a leading infectious diseases research center in Dhaka, highlights the potential for the spread of sexually transmitted infections (STIs) and HIV in the southeast corner of Bangladesh.²⁹ The study, a cross-sectional survey of a convenience sample of 433 boatmen from the Teknaf area, revealed high levels of unsafe sexual behavior combined with significant cross-border movement. The study identified three groups of boatmen: those who transport people holding legal travel documents; those engaged in unofficial crossings, often to transport smugglers, migrant workers and others; and deep-sea fishermen.

More than a third of all the boatmen reported spending time in Burma in the course of work, and 17 percent of those who did also reported intimate contact with sex workers while there. Depending upon the group, between 10 and 21 percent of the men reported having had male-to-male sex in the previous year, and 13 to 20 percent reported group sex, with the groups ranging in size from two to 14 people. Condom use, however, was extremely low. The boatmen also evidenced little understanding of how HIV is transmitted and were not aware of their own risk for infection. Many reported symptoms consistent with infection by a number of sexually transmitted pathogens, although no confirmatory diagnostic testing was performed. Although the presence or rate of HIV infection was not determined during this study, it is evident that unsafe sexual behaviors are prevalent, and there is little knowledge of how HIV spreads and how to protect oneself from infection.

Commercial sex work on the Bangladesh side is also a significant potential disseminator of HIV. Visitors flock to the area from all over the country for rest and relaxation. Many prostitutes are known to have links with, and serve the clientele of, specific hotels. Others operate

²⁷ “Fifteen Bangladeshis released after flag meeting,” *Kaladan Press*, March 29, 2007.

²⁸ “Bangladesh hands 75 Burmese to security forces,” *Mizzima Journal*, March 2006.

²⁹ Interview with Dr. Rukhsana Gaza, associate scientist at ICDDR,B and the primary researcher on the study.

independently of the hotels. According to peer group educators with the local NGO, Health and Education for the Less-Privileged People (HELP), who have in the past worked as prostitutes themselves, on a good night, a woman will have sex with up to 20 men. They said it was not unheard of for a woman to have 100 clients in a single 24-hour period, and condoms are not consistently used.³⁰

The situation in the border region is complicated by the presence of the tens or hundreds of thousands of undocumented Rohingya migrants from Burma, many of whom have settled near Cox's Bazar and Teknaf with family members and friends who preceded them. Some live with people they know in the two UNHCR refugee camps located in the region, although they themselves are unregistered. While refugee camp residents have access to at least a minimal level of medical care, which is provided onsite by the Government of Bangladesh, the illegal migrants do not. The crowded living conditions—both in the camps and outside—create ideal conditions for the spread of tuberculosis and other respiratory infections. While official refugees are technically not supposed to leave the camps, many find themselves forced to do so in order to seek food and firewood or earn money through commerce or sex work in order to supplement their rations, according to interviews with humanitarian officials. Regular movement into and out of the camps exposes both camp residents and those who live in the larger community to increased risk of infectious diseases and the spread of drug-resistant strains.

The 2005 annual report from UNHCR about the two camps provides some insight into conditions there. When the government of Bangladesh officially began administering the health program at the camps in August 2003, it reported that, “the quality of health services deteriorated” and noted that UNHCR had to cope with “an acute shortage of medicines” and other shortfalls in basic health care.”³¹ Moreover, the Bangladeshi government reported that, “The health clinic’s infrastructure is in poor condition with lack of water supply and non-functioning latrine. Since government controls all construction work, attempts by UNHCR to get these repaired were not allowed.”³² The most common diseases reported were respiratory problems, with 77 cases per 1,000 people per month, skin infections (53 cases per 1,000 per month), and diarrhea (28 cases per 1,000 per month).

On the Burma side of the border, the conditions that have long fueled the exodus of Rohingyas have not changed, according to international observers, expatriate press reports, and refugees themselves. While independent verification of such conditions is difficult because access to the region is severely restricted by the regime, consistent reporting of confiscated land, forced labor, restrictions on movement and other basic freedoms, severe discrimination based on religion and ethnicity, and limited or no access to health care is compelling. A 2003 report from Forum-Asia stated: “Their lack of mobility has devastating consequences, limiting their access to markets, employment opportunities, health facilities and higher education. . . . Forced labourers continue to be recruited for army camp construction and maintenance, sentry duty, portering, and especially for such tasks as shrimp farm maintenance, plantation work, brick baking, bamboo collection and woodcutting for commercial ventures belonging to the military.”³³

³⁰ Interviews with peer educators from HELP.

³¹ UNHCR, “Bangladesh Health and Nutrition Annual Report 2005.”

³² Id.

³³ Forum-Asia, *supra* note 4.

There are also frequent reports of displacement of Rohingyas and confiscation of their land to make way for the creation of “model villages” built for settlers moved in by the regime from other parts of Burma. Most recently, the government was said to have forced 300 carpenters from Buthidaung and Maungdaw to build 120 houses for Taungbro, a new village in the area.³⁴ In early April 2007, 500 new settlers were reported to have arrived via boat in Akyab, the capital of Arakan, en route to Taungbro, which is near the Bangladesh border.³⁵ These forced-settlement policies continue to cause severe tension and occasional violence between the recent arrivals from central Burma and local Rohingyas; such a clash recently occurred in a model village near Maungdaw, Shwe Yin Aye, with 50 people suffering injuries, including 32 who required hospitalization.³⁶

HIV/AIDS

Although HIV infection rates among nearby countries, including India, Thailand, and Burma, are high enough to cause significant concern, Bangladesh, to date, has not experienced a generalized HIV epidemic. Given the situation in neighboring countries, the infection rate is surprisingly low. According to UNAIDS, the rate among adults of reproductive age is less than 0.1 %, which would mean less than 140,000 HIV-infected people in a population of 140 million, although only a tiny fraction of those have been identified to date. Dr. Tasmin Azim, an HIV expert at the ICDDR,B, speculated that the Muslim practice of male circumcision was likely to be a contributing factor in keeping rates as low as they are. “Why HIV is so slow to spread, we really do not know,” said Dr. Azim. “Circumcision is an issue, because circumcision protects. So it can slow down the epidemic considerably, but it’s not absolute.”³⁷

The most recent national HIV surveillance data was collected from August 2004 to April 2005.³⁸ The participants were not randomly selected but were drawn from individuals attending clinics as well as from outreach and intervention programs. Among other demographic groups surveyed were truckers, dockworkers, rickshaw pullers, and others considered members of “bridge” populations—those who may serve as epidemiologic links between high-risk cohorts, such as sex workers, and the larger population. Male sex workers and men who have sex with men were also included.

Rates among most groups, even high-risk groups, remain well under 1 percent. However, injecting drug users (IDUs) in central Bangladesh, which includes Dhaka, the capital, were found to have an HIV-infection rate of 4.9 percent, with 52 of 1,061 testing positive. This was in contrast to rates of 1.4 percent in 2000 and 4 percent in 2002. Moreover, while no HIV at all was detected in IDUs outside Dhaka in previous surveillance rounds, this round identified two additional cases among IDUs—one in the southeast, near the Burma border, and one in the northwest.

No cases of HIV were found among female sex workers in the southeast corner bordering Burma, although nine cases in total were found among the 4,000 tested in all sections of the

³⁴ “300 Carpenters Forced to Construct New Model Village,” *Narinjara News*, March 26, 2007.

³⁵ “Over 500 New Settlers Arrive in Akyab Bound for Model Village from Burma Proper,” *Narinjara News*, April 3, 2007.

³⁶ “Security Beefed Up on Western Border After Murder and Clash,” *Narinjara News*, March 31, 2007.

³⁷ Interview with Dr. Azim.

³⁸ “National HIV Serological Surveillance, 2004–2005: Sixth Round Technical Report,” *supra* note 5.

country. The highest female sex-worker infection rate was found in the northwest frontier area bordering India, where two out of 120 casual female sex workers screened were found to be HIV-positive.

The low rates of HIV infection in these groups should not be taken as cause for celebration. High rates of other major sexually transmitted infections, which were included in the surveillance studies, not only indicate that significant levels of unprotected intercourse or other unsafe behaviors take place among these populations but constitute a worrisome trend in themselves. In the southeast border areas, syphilis rates were 9 percent among IDUs and 10 percent among female sex workers, among the highest in the country. Not only can untreated sexually transmitted infections (STIs) lead to long-term medical problems, they also facilitate the spread of HIV.

Little is publicly known or disclosed about HIV/AIDS rates across the border in Arakan. If the prevalence in Arakan reflects HIV rates in southeastern Bangladesh, then it is relatively low, which would not be surprising for the primarily Muslim Rohingya-majority areas that lie directly across the southern parts of the border.

Some information is provided by expatriate media, such as Kaladan Press and Narinjara News, which publish occasional accounts of people diagnosed with HIV/AIDS who suffer serious human rights abuses, as well as other news related to HIV. Although government hospitals exist in the large townships in Arakan, editors of these two news services reported that little or no treatment is available at these facilities and that the infected are sometimes forcibly removed from their families. They also reported that people who find out they are HIV-positive are terrified to reveal it to anyone, even to family members.³⁹

Dr. A. Q. M. Serajul Islam, a professor in the department of dermatology and sexually transmitted infections at Chittagong Medical College, who treats dozens of HIV-positive patients privately, offered a similar account. Of the 67 patients enrolled in his clinic as of July 2006, two were Rohingyas from Arakan, he reported. “They come here because where they are there is no care, just traditional healers,” said Dr. Islam. “And there they don’t disclose their HIV status, because the moment the government knows, they will be taken away to some center for treatment, away from their families.”⁴⁰

³⁹ Interviews with Tin Soe, assistant editor of Kaladan Press in Chittagong, and Khaing Mrat Kyaw, editor of Narinjara News in Dhaka.

⁴⁰ Interview with Dr. Islam in Chittagong.

Malaria

Malaria is endemic in some parts of Bangladesh, with 13 out of 64 districts considered to be high-risk zones; about 15 million people live in these districts.⁴¹ The endemic areas are concentrated along the borders with India and Burma. The region known as the Chittagong Hill Tracts, parts of which lie on the frontier with Arakan, account for about two-thirds of the country's laboratory-confirmed malaria cases. The prevalence of malaria drops in areas further south toward Cox's Bazar and Teknaf, where many of the Rohingyas have settled, although the disease is still considered endemic in that coastal strip.

There were 435,000 probable or clinically diagnosed malaria cases in Bangladesh in 2003, with an estimated 1,250 deaths; there were also 57,000 laboratory-confirmed cases and, among those, 574 deaths.⁴² *Plasmodium falciparum* is the most common malarial species, accounting for up to 71 percent of the total cases. Increased levels of drug resistance to the traditional first-line drugs, chloroquine and sulphadoxine-pyramethamine, have been reported from the Chittagong Hill Tracts region bordering Burma, although data on patterns and prevalence of such resistance remain limited. In 2004, the government adopted artemisinin combination therapy (ACT), specifically artemether-lumefantrine, as the approved first-line treatment for laboratory-confirmed cases.⁴³ Recognizing that the new treatment regimens are expensive and may not always be available in sufficient quantities, researchers are testing alternatives.⁴⁴

The difficult terrain in the Chittagong Hill Tracts region complicates the situation, impeding the provision of services and medicines to those who need it most. Many villages are poorly served by the transportation system and can be reached only after many hours or even days of trekking. WHO also reported that a shortage of trained staff and weak surveillance and supervision systems have generated problems in Bangladesh's malaria control program, much of which targets the regions near the Burma border.⁴⁵ Moreover, according to ICDDR,B, "due to the lack of financial resources and the resulting shortcomings in malaria research, surveillance, and control, the disease burden may be far greater than reported."⁴⁶

Cases of malaria have also been reported by UNHCR in the two refugee camps, although certainly the disease is not as widespread as farther north. In fact, the agency reported that in 2005 there were far more cases in Kutupalong than Nayapara camp—30.7 cases per 1,000 of *P. falciparum* compared to 7.4 cases per 1,000—specifically because residents of Kutupalong were more likely to leave the camp to travel to the highly endemic district of Bandarban and because the water supply system in the camp provided a breeding ground for mosquitoes.⁴⁷

⁴¹ WHO, *supra* note 8.

⁴² WHO, *World Malaria Report 2005*. Bangladesh country profile accessed at <http://rbm.who.int/wmr2005/profiles/bangladesh.pdf>.

⁴³ ICDDR,B, "New strategies for treating falciparum malaria in Bangladesh," *Health and Science Bulletin* 4:3, September 2006.

⁴⁴ Interview with Dr. Rashidul Haque, head of parasitology laboratory, ICDDR,B.

⁴⁵ WHO, *supra* note 8.

⁴⁶ ICDDR,B, *supra* note 43.

⁴⁷ UNHCR, *supra* note 31.

Across the border in Arakan, the most authoritative information on the malaria situation comes from MSF–Holland, which has been active in Burma since 1992. MSF has conducted a number of studies in Arakan that have documented high rates of resistance to first-line drugs and has been treating malaria there with ACT since 1996. Since launching its malaria project in Arakan State in 1994, MSF has treated about 850,000 people for the disease.⁴⁸ In 2004, the organization tested 265,000 residents of Arakan for malaria, and 115,000 received treatment; the same year, the national government recorded a total of 152,000 cases of laboratory-confirmed malaria for the entire country. Over a number of years, 82 percent of the malaria cases in Arakan were caused by *P. falciparum*, although the percentage appeared to be declining somewhat more recently.

The number of patients increased 20 times during the first decade of the MSF project, and the positivity levels of screening tests, which averaged 54 percent, have not declined significantly over the years. MSF expected that the numbers of patients and the rate of positive diagnoses would start to decline as evidence that the program was having an impact on the epidemic. But despite eventually opening 30 clinics, overall coverage was relatively low because of the large geographic distances, rugged terrain, poor transportation networks, and the undoubtedly high burden of disease. “The increase in patients can only be explained by the enormity of the problem and the popularity of the project,” wrote Dr. Frank Smithuis, MSF’s country director in Burma.

Tuberculosis

According to WHO, Bangladesh ranks sixth in the world of countries with the highest burden of disease from tuberculosis.⁴⁹ There are an estimated 300,000 new cases a year, an incidence of 220 per 100,000 people. About 70,000 people die from TB annually—in other words, one person every 7.5 minutes—despite the existence of effective treatment that is provided free of charge. Extreme population density, widespread poverty, and crowded living conditions, as well as poor nutrition, sanitation, and other factors affecting general health status allow the bacterium to spread with relative efficiency in many parts of the country.

Countries with a high TB prevalence also frequently experience major HIV problems, generating an epidemic of co-infection that exacts a tremendous toll on both individuals and society. With its current low rates of HIV, Bangladesh has so far been lucky enough to escape this situation. Recommended by WHO, Bangladesh adopted directly observed treatment, short-course, or DOTS, to combat TB in 1993.⁵⁰ The strategy includes diagnosis by direct microscopic examination of sputum smears, directly observed treatment, a commitment to providing an uninterrupted supply of necessary drugs, and standard recording and monitoring protocols for detection and treatment results. The case-detection rate of new smear-positive cases has risen under the strategy from less than 35 percent in 2001 to 61 percent in 2005, with a treatment success rate last year of 89 percent. The official WHO target for DOTS programs is to achieve a 70 percent detection rate and a treatment success rate of at least 85 percent. A recent study

⁴⁸ Frank Smithuis, *Treating and Preventing Malaria in Myanmar*, Chapter 10: “The development and results of a large-scale malaria project in Rakhine State, Myanmar” at 105–19. The information in this and the subsequent paragraph are from this chapter.

⁴⁹ WHO, *supra* note 7.

⁵⁰ J.A. Kumaresan et al., “Review of national tuberculosis programmes: the experience in Bangladesh,” *International Journal of Tuberculosis and Lung Disease* vol. 3, 1999, 1140–42.

analyzed 657 TB isolates from both rural and urban settings and found that 48.4 percent were resistant to at least one drug, with 5.5 percent resistant to more than one—a high and worrisome rate of multi-drug resistance.⁵¹

Partially due to the challenges of diagnosing tuberculosis onsite, obtaining accurate rates of disease among refugees from Burma is difficult. The UNHCR annual report for 2005 noted that 40 new TB patients were registered that year at the camps but the agency considered the incidence—one case per 1,000 per month—to be a serious undercount; case-detection capability “is much below the acceptable standard” due to a lack of staff sufficiently trained in TB detection and a shortage of technological resources.⁵² The UNHCR report also noted that the poor health and nutritional status of the refugees and the high incidence of respiratory infections suggest that the true TB rate in the camps is significantly higher. All humanitarian officials interviewed expressed concern about tuberculosis as a major and continuing health concern that is exacerbated by the Rohingya’s living conditions, both inside and outside the official refugee camps.⁵³ Even less information is available about tuberculosis in Arakan State, although anecdotal reports occasionally appear in the expatriate press.

Polio

Until last year, neither Bangladesh nor Burma had reported any cases of polio since 2000.⁵⁴ In 2006, however, Burma reported a case of a child near Mandalay, although that later turned out to be based on a reaction to a polio vaccine. In Bangladesh, a 9-year-old girl from the Chittagong division was diagnosed with polio, and a Mumbai laboratory identified the viral strain as closely related to a strain from the Indian State of Uttar Pradesh. The country launched a nationwide multi-stage vaccination campaign but still experienced 17 reported cases of polio.

In March 2007, a little boy with polio from Arakan’s Maungdaw district was taken across the border for screening and treatment at hospitals in Chittagong and Cox’s Bazar before being taken back to Burma. When Bangladeshi health authorities learned of the episode, they ordered an emergency vaccination campaign for 2 million children in the southeastern region in addition to the national effort launched in 2006. By late May 2007, seven cases of polio were reported to have been identified in Arakan near the border with Bangladesh, and Burma began its own emergency regional immunization campaign.

Polio’s reappearance, however, has apparently led to tensions between the two countries. On May 9, 2007, the *New Light of Myanmar*, a government newspaper, published an article about a meeting between Burma’s health minister, Dr. Kyaw Myint and international NGO officials to

⁵¹ K. Zaman et al., “Drug resistance of Mycobacterium tuberculosis in selected urban and rural areas in Bangladesh,” *Scandinavian Journal of Infectious Diseases*, 37, 2005, 21–26.

⁵² UNHCR, *supra* note 31.

⁵³ Interviews with humanitarian aid workers from international NGOs.

⁵⁴ Information about the polio outbreak is from the following news articles: “Polio Strikes Seven Children in Burma,” Radio Free Europe, May 26, 2007; “Bangladesh: Polio vaccination drive launched,” Reuters, May 21, 2007; “Health Minister receives WHO representatives,” *New Light of Myanmar*, May 9, 2007; “Bangladesh district bordering Myanmar steps up efforts to check polio,” *International Herald Tribune*, April 25, 2007; “Bangladesh begins new polio drive,” *BBC News*, March 2, 2007.

discuss the polio situation. The article stated that the disease, “was spread from certain neighboring countries which still have the virus,” a clear reference to Bangladesh. The incident highlights how lack of cross-border cooperation and communication can contribute to increased transmission of infectious agents, greater morbidity and mortality on both sides of the border, and to serious disruptions of bilateral relations.

Conclusion

Although the flow of refugees, both legal and illegal, has been a regular fact of life in southeastern Bangladesh for years, the current situation represents both a health and human rights disaster for the disenfranchised. No effort to lessen the burden of infectious disease in the region is likely to succeed without a determined commitment on the part of all concerned to resolve the refugee issue.

9. Indo-Burma Border Region

*What is the border? Just a line on a map. We share the same cultures, are affected by the same common illnesses, fight the same insurgencies, and find ourselves equally far from the seats of power and thus often forgotten. In India, we have government and international agencies, NGOs, and civil society organizations. Who is our counterpart in Myanmar?*¹

Dr. Biangtung Langkham, Director of Emmanuel Hospitals,
Project Orchid, Northeast India

Although geographically isolated and afflicted with political instability for decades, the Indo-Burma border region is rapidly growing in regional political and economic importance. India has looked to Burma to meet its growing need for natural resources and to suppress insurgencies, and because of this relationship has increasingly ignored human rights abuses along its borders.

The Indo-Burma border region is a site of ethnic conflict and widespread violations of international humanitarian law and human rights. This situation has exacerbated the spread of infectious disease and obstructed efforts to control it. The Burmese regime has increasingly militarized Sagaing Division and Chin State, contributing to displacement, forced labor for infrastructure projects such as roads and dams, and interference in local health-related activities. Although less militarized, northeast India's ethnic tensions have led to discrimination, deportation of migrants, and decreased access to health services.

Drug trafficking from Southeast Asia's Golden Triangle has been a driving force for an HIV epidemic in a region ill-equipped to handle the health burden and necessary prevention measures for injecting drug users (IDUs) and other high-risk groups. Home to two of the six most prevalent states for HIV infection in all of India, Nagaland and Manipur—with antenatal prevalence rates at 1.43 percent and 1.5 percent respectively in 2004—share a highly permeable border with Burma and a burgeoning HIV dilemma that has spread from IDUs to their partners and the general population.

Finally, there are few health prevention and treatment services in the border region. On the Indian side, despite admirable efforts by Indian government and nongovernmental organizations, access to primary health care and disease prevention services remains limited outside of the state capitals. On the Burma side, government and international nongovernmental health services are virtually non-existent. Rough terrain, poor communication networks, and travel restrictions imposed on the international aid community make health-care delivery deficient in border areas

¹ Biangtung Langkham, "Indo-Myanmar Border," conference address, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia," Bangkok, January 24, 2007.

where the need is generally most acute. Local community-based health organizations operating in western Burma have had limited success in accessing these populations.

Many individuals infected with TB, HIV, or malaria thus receive ineffective or no treatment because of their illegal status, rural residence, and limited access to medications; the true burden of disease is much higher than officially reported. The dearth of health information is one of the major problems plaguing the northeast Indo-Burma border. A collaborative approach involving UN agencies, national and local governments, and international and local NGOs is needed to improve disease surveillance, service delivery, and prevention programs throughout northeast India and western Burma.

Indo-Burma Relationship

In the last decade, India, the world's largest democracy, has become increasingly friendly with the Burmese military regime. Strategic partnerships in natural gas, railways, road construction, counter-insurgency efforts, and arms delivery have bolstered this relationship, which has experienced multiple swings since both countries obtained their independence after World War II. Throughout the 1950s, India and Burma maintained cooperative ties.

Relations between the two countries were largely severed after the signing of a Sino-Burmese treaty of friendship and non-aggression with China in 1960 and after the military coup led by General Ne Win two years later.² Indeed, China's relationship with Burma has long posed a particular concern for India. The strategic land route between China and the often-contested regions of northeast India passes through Burma. Burmese silence during a Chinese-Indian conflict in northeast India in 1962 confirmed India's suspicions that Burma was pro-China. Relationships were further strained when Ne Win's nationalist policies of the early 1960s left more than 12,000 Indians living in Burma impoverished and unable even to pay their way back to India.³

Ties between General Ne Win and India's late prime minister, Indira Gandhi, helped to improve relations again in the late 1960s, especially as Burma's relations with China experienced signs of strain. In March 1967, the two countries officially demarcated the 1,643 km border between northeast India and western Burma.⁴ In the years since, the two countries have often helped each other in their respective counter-insurgency efforts against the Naga, Mizo, and Manipuri populations, who live on both sides of the newly defined border. Both governments continue to experience difficulties in effectively policing this border, which many local residents consider a fluid boundary to be crossed at will. From 1977 to 1988, Burma's renewed association with China posed new challenges for Indo-Burma relations, as did India's provision of asylum to Burma's ousted Prime Minister U Nu from 1974–1980.⁵

² U. S. Singh, *Burma and India: 1948–1962*, New Delhi: Oxford & IBH Publishing Company, 1979.

³ B. Pakem, *India Burma Relations*, Shillong, Meghalaya, India: North Eastern Hill University, OMSONS Publications, 1992.

⁴ Boundary Agreement between the Government of India and the Government of the Union of Burma, Rangoon, March 10, 1967.

⁵ H. Kapur, *India's Foreign Policy, 1947–92 Shadows and Substance*, India: Sage Publications, 1994.

After the crackdown on the democracy movement in 1988, India criticized Burma's suppression of political opposition and its poor human rights record and even provided refugee status to Burmese citizens fleeing the regime's repression.⁶ Following the 1988 events, the Indian government committed support to the democratic movement and practiced "complete disengagement" with the Burmese regime.⁷ Refugee camps were opened in Mizoram and Manipur. Then External Affairs Commissioner (later Prime Minister) Narashima Rao issued strict instructions to welcome any legitimate refugee entering northeast India from Burma.⁸ India sponsored the 1992 United Nations resolution condemning the junta for violations of human rights.

Since the early 1990s, India's relationship with Burma has shifted from an apparent support of the democratic aspirations of its people to a more pragmatic approach. This change presents a concern to the pro-democracy forces as well as to the estimated 100,000 Burmese nationals living in India. This shift in strategy resulted from persistent insurgencies in northeast India, concern over China's influence in Burma, desire for greater access to its neighbor's vast natural resources, and the Indian government's pursuit of a global economy with its "Look-East Policy" requiring Burma's cooperation in the areas of natural resources, trade, and energy. The Indian government first began to seek favor with Burma in the early 1990s by complying with junta demands to cancel broadcasts of a Burmese language radio station that criticized the military regime.⁹

The change in approach was not monolithic. In the early years of renewed contacts, India continued to demand the release of political prisoners in Burma and offer asylum to democratic activists. The government lauded the Nobel Peace Prize awarded to Daw Aung San Suu Kyi in 1991 and even awarded her the prestigious Jawaharlal Nehru Award for International Understanding four years later. In 1992, President Venkataraman appealed for a restoration of democracy in Burma and expressed concern over the delay in forming a popular government.¹⁰

India's calls for democracy weakened over the years as the country, aware of China's growing role in Burma, began to pursue closer economic, political, and military ties. Incidents of antidemocratic activity in India in support of its renewed links with Burma have included the arrest of a Burmese language journalist in Manipur in 1999 (later released), the banning of pro-democracy meetings, and the refusal to grant Indian visas to pro-democracy Burmese citizens.¹¹ General Than Shwe paid a diplomatic visit to India in 2004. India has increased arms sales to Burma and, under much international scrutiny, Indian President Abdul Kalam visited Burma last year to discuss joint economic ventures and development.¹² It was the first visit by an Indian head of state since 1987.

In March 2007, the China-India competition for Burma's favor took a significant turn when the junta formally announced plans to award the long-contested Shwe (golden) gas field pipeline to

⁶ Id.

⁷ International Institute for Democracy and Electoral Assistance, "Challenges to Democratization in Burma: Perspectives on Multilateral and Bilateral Responses," 2001.

⁸ Id.

⁹ Id.

¹⁰ V. N. Khana, *Foreign Policy of India*, Noida, India: Vikas Publishing House Pvt. Ltd., 1997.

¹¹ International Institute for Democracy and Electoral Assistance, *supra* note 7.

¹² Subir Bhaumik, "India's Balancing Act," *The Irrawaddy*, April 2006.

China. India had hoped that the natural gas from two fields off the coast of Arakan State, first discovered in 2003, could have been a crucial supply source for its rapidly expanding energy needs. One field alone holds an estimated 4.8 trillion cubic tons of natural gas.¹³ The rights to develop the gas fields are split between Korean corporations, which own a 70 percent stake in the venture, and two Indian companies, Gas Authority of India Limited and Oil and Natural Gas Videsh Limited,¹⁴ which own the remaining 30 percent.

The decision to award the natural gas pipeline to China likely reflects China's ability to shield the junta from international censure through its permanent seat on the UN Security Council.¹⁵ The Indian pipeline route was originally scheduled to travel 897 kilometers through Bangladesh to Kolkata, but difficulties in negotiating an agreement with Bangladesh prompted an expensive (\$1.3 billion) 1,400-kilometer proposed re-routing from Sittwe, a port in Arakan State, up through Arakan and into Chin State, and finally through Mizoram, Assam, and Bihar and into Kolkata.¹⁶ Instead, the 900-kilometer China pipeline will require substantially more Burmese infrastructure to reach the China border.

Despite this setback, India's pursuit of other economic interests in Burma continue unabated. Burma is a member of both BIMSTEC (Bangladesh, India, Myanmar, Sri Lanka, and Thailand Economic Cooperation) and the Association of Southeast Asian Nations (ASEAN), making the country a crucial regional and bi-lateral trade partner for India.¹⁷ Through these partnerships, Burma is a major player in such regional projects such as the Trans-Asian Highway, new railway systems, and the development of the Sittwe port. Burma is the gateway to the Bay of Bengal in the west and Andaman Sea in the south. These points are of particular value to India as its northeast states have no open sea access. Since 1998, India has provided over \$100 million to the junta for development projects such as the Rangoon-Mandalay railway line and an additional \$27 million for a 160-kilometer Tamu-Kaletwa highway in Burma's Sagaing Division.¹⁸ The Indian government also doubled development aid to Burma for the 2007–08 fiscal year,¹⁹ and President Kalam, during his 2006 visit to Rangoon, declared that he hoped bilateral trade would reach \$2 billion within three years.²⁰ India is the second largest market for Burma, following Thailand, and absorbs 25 percent of the country's exports.²¹

India and Burma are also cooperating on counter-insurgency efforts in northeast India. India faces long-standing ethnic revolts in the states of Nagaland and Manipur and some parts of Mizoram from, respectively, the National Socialist Council of Nagaland (NSCN), the United Liberation Front of Assam (ULFA), and the Mizo National Front. Burma faces similar problems from the Naga Khaplang group, which operates from the Indian side of the Naga border, and the

¹³ "Myanmar's Pipeline Politics," *The Economist*, March 23, 2007.

¹⁴ "Indian President Begins Burma Visit," *The Irrawaddy*, March 8, 2007.

¹⁵ *The Economist*, supra note 13.

¹⁶ The Shwe Gas Movement, <http://www.shwe.org/shwe-stakeholders/governments/india>.

¹⁷ "Indo-Burma Bilateral Trade," *Mizzima News Group*, July 1999.

¹⁸ Soe Myint, "Government to Government: The distasteful Burma-India Embrace," *The Himal Southeast Asian*, February 2007.

¹⁹ Neichu Angami, conference address, "Responding to Infectious Diseases in the Border Regions of South and Southeast Asia," Bangkok, January 24, 2007.

²⁰ Subir Bhaumik, supra note 12.

²¹ Soe Myint, supra note 18.

Chin National Front (CNF), which is based in Chin State but has many active supporters living illegally in Mizoram.

In recent years, the two countries have agreed to strengthen intelligence exchange mechanisms along their border to quell cross-border movement and violence. In January 2006, the Burmese military and the Indian Army undertook a coordinated operation to root out NSCN rebels on the Nagaland border.²² The Burmese military holds border post meetings at the Moreh border in Manipur, and India agreed in early 2006 to create four additional border posts for army meetings. India is also constructing iron fencing along Mizoram's 404-kilometer border with Burma and along the porous 14-kilometer border at Moreh. Indian army chief General Sankar Roychoudhury, now a member of the upper house of the Indian parliament, bluntly stated India's position on the issue: "We want our relations with the Burmese military government to improve further. The Burmese army is attacking some of our northeastern rebels based in that country and we are happy about it."²³

In addition to coordinated military efforts, India continues to engage in arms sales to Burma. In early 2006, India sold Burma two BN-2 maritime surveillance aircraft bought from the United Kingdom in the 1980s.²⁴ The aircraft were delivered over British government objections that the sales violated the EU arms embargo. In late 2006, India sold tanks, artillery pieces, and counterinsurgency helicopters to Burma. The helicopter sales were of particular concern to the international community, since they could facilitate junta attacks on ground targets that are likely to cause great suffering among civilians.²⁵

Ethnic Groups and Human Rights Abuses

Four states in northeast India share borders with Burma (from north to south): Arunachal Pradesh, Nagaland, Manipur, and Mizoram. The northwestern Burma border includes the Sagaing Division, with its vast reaches including more than 4.5 million inhabitants, and Chin State, home to more than 500,000 of the estimated one million Chin in Burma, and a small portion of Kachin State (discussed in the "China" chapter). The predominant Burmese ethnic groups in these border areas are the Kukis, Nagas, and Zomis to the north, and the Chin, Mara, and Rakhaing (or Arakan, discussed in the "Bangladesh" chapter) to the south.

The border between India and Burma splits various ethnic groups into different countries, contributing to the formation of several armed ethnic organizations resisting either India, Burma, or both. Nagaland, for example, was split into Burmese Nagaland to the east and Indian Nagaland to the west after the British withdrew in 1947. This border, however, does little to stem population movement across it. An Indian Naga health advocate explained the relationship between eastern and western Nagas this way: "In Mon district there is a Naga village that straddles the border. The inhabitants cannot claim a country—the village leader's home straddles the border line."²⁶

²² See www.mizzima.com.

²³ Subir Bhaumik, *supra* note 12.

²⁴ See Human Rights Watch, "India: Military Aid to Burma Fuels Abuses," December 7, 2006.

²⁵ *Id.*

²⁶ Local respondent interview, July 2006.

Although not on the same scale as in eastern Burma, the Naga and other ethnic groups have suffered significant conflict-related displacement, perhaps numbering in the tens of thousands.²⁷ Despite some ongoing skirmishes, however, several armed groups have signed long-term cease-fires or are not engaged in active conflict. One of the main resistance organizations, CNF has not yet entered into a cease-fire agreement with the regime but has begun preliminary cease-fire talks.²⁸

Displacement in western Burma results less from open conflict between the military and ethnic groups than from other abuses associated with increased militarization by the Burmese regime. In the Sagaing Division, major causes of displacement have included land confiscation for infrastructure projects such as roads^{29, 30} and dams,³¹ forced labor,³² interference in agriculture causing food insecurity,³³ extortion,³⁴ and religious discrimination.³⁵ In a recent survey of 560 migrants and refugees from Burma in neighboring countries, the majority of respondents from the Sagaing Division reported experiencing one or more of these rights violations as a reason for their displacement.³⁶

With a reported eight Burmese military battalions present in Chin State (see Map 1), residents of these areas have experienced a similar range of human rights abuses, also including gender-based violence.³⁷ “Unsafe State: State-Sanctioned Sexual Violence Against Women in Burma,” issued by the Women’s League of Chinland, reports 38 cases of rape at the hands of the Burmese military over a five-year period occurring in proximity to army bases.

²⁷ S. Lanjouw et al., “Internal Displacement in Burma,” *Disasters*, 2000, 24:3, 228–39.

²⁸ “CNF Junta for Second Round of Talks Soon,” *Mizzima News*, March 20, 2007.

²⁹ “Eviction order served to residents of Tamu-Kalay Highway,” *Kuki International Forum*, March 14, 2004.

³⁰ “Thousand acres of land may be confiscated for road construction,” *Khonumthung News*, October 17, 2006.

³¹ “Over 380 houses compelled to relocate for Tamanthi Dam,” *Mizzima News*, March 5 2007,

<http://www.mizzima.com/MizzimaNews/News/2007/Mar/07-Mar-2007.html>.

³² “Intervention by the ILO to the SPDC dated 10 December 2004,” International Labour Organisation, December 10, 2004.

³³ “Burmese farmers forced to grow summer paddy,” *Democratic Voice of Burma*, January 2, 2006.

³⁴ “Brick Tax for Pagoda in Wuntho Township,” National League for Democracy via *Human Rights Yearbook, Burma, 2000*, para 5.11.

³⁵ “Religious discrimination against Nagas,” *Carrying the Cross* (extract), Christian Solidarity Worldwide, February 2007.

³⁶ A. Bosson, *A Forced Migration/Internal Displacement in Burma*, Internal Displacement Monitoring Center, 2007.

³⁷ Women’s League of Chinland, *Unsafe State: State-Sanctioned Sexual Violence Against Women in Burma*, March 2007.

Map 1: Militarization in Chin State

Source: “Unsafe State: State-Sanctioned Sexual Violence Against Women in Burma,”
Women’s League of Chinland, March 2007

The Chin Human Rights Organization’s (CHRO) most recent report, issued in January/February 2007, details threats to village-level food security by the government’s wide-ranging plan to force local farmers to grow the bio-diesel plant, jatropa, on one acre per household.³⁸ Villagers are reportedly forced to purchase seeds, cultivate the plant, and hand over the crop to the military government. Soldiers also demand food supplies from local farmers. A local villager reported to CHRO: “Whenever the Burmese troops come we have to give them whatever they want ... they threatened us that they’ll burn our house and farms if we don’t give, and we are afraid of that.”³⁹ Compulsory work assignments also threaten local productivity. According to CHRO, anti-Christian measures include the compulsory building of pagodas instead of churches, and forced labor at the time of religious services. Because of the military’s increasing demands for food and labor, many families who were previously self-sufficient can no longer survive.

In the same CHRO survey for the Sagaing Division, Chins reported these human rights abuses as a reason for displacement.⁴⁰ Chin have mostly fled to neighboring Bangladesh, the northeast Indian States of Mizoram and Manipur, as well as Delhi and Malaysia. Currently there are an

³⁸ Chin Human Rights Organization, January/February 2007 Report, www.chro.org.

³⁹ Id.

⁴⁰ Internal Displacement Monitoring Center, 2007, *supra* note 36.

estimated 60,000 Chin living in India, with more than 50,000 in Mizoram, and 12,000 Chin in Malaysia. Most of them are living in these areas illegally.⁴¹ The Indian government initially established refugee camps for the Chin, but these sites were closed in 1995 as Indo-Burma relations improved. Many of the Chin who arrive through northeast India reportedly flee to Delhi to avoid immediate deportation and seek more permanent status.⁴²

In Delhi, Chin refugees are able to access the offices of the UN High Commissioner for Refugees (UNHCR). There are currently roughly 1,000 registered Chin in Delhi. In Mizoram, however, the Chin are governed under the terms of the India Foreigners Act of 1946, which does not distinguish between illegal immigrants and refugees. India has not signed the 1951 Convention Relating to the Status of Refugees or the 1967 protocol, even though it sits on the executive committee of UNHCR.⁴³ The Indian government does not allow UNHCR into Mizoram, and with no domestic refugee law to protect Chin migrants, they are left vulnerable to discrimination and an array of other human rights abuses.

Movement from Burma into Mizoram and Manipur has been suppressed in recent years by an increased military presence in the border areas, with repeated clashes between the Burmese army and Chin resistance forces on one side and between the Assam Rifles, an Indian paramilitary force, and northeast Indian insurgents on the other. Coordinated attempts between the government forces to block the Indo-Burma border with increased troops from both sides have led to the arrest, torture, and execution of many Chin during their attempts to cross over into Mizoram.⁴⁴

While ethnically and culturally similar to their Christian Mizo neighbors, the Chin are often distinguishable from Indian citizens by accent and other subtle linguistic differences. Many Chin attempt to remain undetected by staying in low-paying jobs in the capital city of Aizawl or by engaging in subsistence farming in the mountainous and remote border regions. Forced repatriation has become a serious problem for Chin in recent years. In 2000, Mizoram repatriated hundreds of Chin to Burma, and 87 of them were reportedly arrested and sent to forced labor camps.⁴⁵

Chin without documentation are subject to deportation when they are arrested and unable to pay the standard bribe of 200–500 rupees (\$4.50 to \$11).⁴⁶ According to Chin key informants in Mizoram, the Young Mizo Association (YMA), a broad-based social organization that appears to be widely admired among Mizos for its aggressive defense of indigenous culture, plays a disturbing role in advocating and promoting discrimination and punitive actions against Chin refugees. The group's xenophobic attitude was evident in a September 2006 statement: "The YMA Order: Proposed Measures to be taken by the YMA Against Foreigners and Others Staying Illegally."⁴⁷ Initiatives undertaken by the YMA include the continued practice of door-to-door searches in rural villages for illegal migrants without proper housing documentation.⁴⁸

⁴¹ Chin Human Rights Organization, www.chro.org.

⁴² Women's League of Chinland, *supra* note 37.

⁴³ Refugees International, <http://www.refugeesinternational.org/content/country/detail/2946/>.

⁴⁴ CHRO, *supra* note 41.

⁴⁵ *Id.*

⁴⁶ "Shame of Forgotten Refugees," *The Irrawaddy*, April 2007.

⁴⁷ CHRO, *Rhododendron News*, Volume IX, No. V, September–October 2006, http://www.chro.org/index.php/rhododendron_-_2006/212.

⁴⁸ *The Irrawaddy*, *supra* note 46.

YMA members intermittently call for the eviction of Chin refugees, and they control many important social services. Drug distribution centers for malaria and HIV prevention and education services throughout rural Mizoram are at least partially administered by YMA members. The group's presence and power likely keep many Chin from seeking health services and lead to underreporting of Chin health problems in Mizoram. In March 2002, in Lunglei District, the YMA were reportedly responsible for the forcible eviction of 5,000 Chin families. The deportation was part of a YMA-launched campaign, in collaboration with the local authorities, to evict 10,000 Chin from their homes. Over half were forced to return to Burma.⁴⁹ In July 2003, a Chin man allegedly raped a Mizo woman. Since that time, the YMA has heightened pressure on the government to expel the Chin, with an additional 6,000 being sent back to Burma. Many of the returnees face serious risk of arrest and human rights abuses if detained by the authorities on the Burmese side. According to a Chin doctor living in Aizawl: "The YMA is a big problem. When a Chin does something bad, they make it seem like the whole Chin people are guilty."

In an effort to address their community's concerns, many Chin health, education, and other civil society organizations have been established in Mizoram. However, these organizations have difficulty registering officially in Mizoram State, thus limiting their ability to conduct basic activities such as transferring funds or ordering medical supplies from outside of the northeast.⁵⁰ One group conducting HIV education and prevention in primarily Chin communities in the border areas of Champai and Lunglei districts successfully registered in Mizoram with the assistance of sympathetic Mizos.⁵¹

Local Ethnic Health Organizations

Despite these barriers, an impressive local effort has been orchestrated to address health needs of Burmese ethnic groups along the border areas and deeper within the Chin State and Sagaing Division. The Burmese regime-sponsored health system includes one hospital in each of the nine townships in the state. Local interviews, however, indicate that only two of the nine hospitals are functioning. In response to local needs, the Chin Back Pack Health Worker Team (CBPHWT) coordinates a network of mobile health worker teams that provides primary health care for approximately 36,000 people living within Chin State.

Because of the widespread presence of military camps, the health workers must move from village to village quickly. "We have to make agreements with local villagers not to mention our names ... they will act as if they're doing it, not that we are." CBPHWT is also involved in local capacity-building; villages select the people who will be trained as future health workers. Other Burmese health organizations from Arakan, Chin, Kuki, Naga, and Zomi ethnic groups provide limited health and/or prevention services within Chin State and Sagaing Division. These health organizations have the potential to expand the scope of their services but lack access to adequate resources and training.

⁴⁹ Refugees International, *Between a Rock and Hard Place: Burmese Chin Refugees Living in India*, July, 2007.

⁵⁰ Interviews with members of several Chin organizations in Aizawl, India, July 2006 and January 2007.

⁵¹ Interview with staff member, Integrated Voluntary Public Health Education Network, Mizoram, India, January 2007.

Currently, access to the northeast border region by international organizations is limited by an Indian government policy requiring permits for foreigners to reach the border states of Nagaland, Manipur, and Mizoram. The permit process requires groups of four and limits visits to ten days. Indian officials state the restrictions are for the protection of travelers given the insurgencies, but some locals believe they represent an attempt by the national government to restrict the autonomy of the states. Limited foreign access in the region was lifted in 2004 in Churachandpur district of Manipur where Médecins Sans Frontières (MSF) obtained permission to conduct malaria-control activities. In 2005, MSF expanded their work to treat sexually transmitted infections (STIs), HIV/AIDS, and TB in the district.⁵²

The Indian military sometimes hinders the activities of Burmese health care providers working in northeast India. In January 2007, India's state militia, the Assam Rifles, arrested 24 Burmese ethnic health workers conducting a training workshop in the Saiha district of Mizoram. The militia accused the health workers of organizing Burmese armed insurgency activities from inside Mizoram.⁵³ Although the health workers were eventually released, they were prohibited from further health training.

Finally, health workers who cross the border into Burma report that they often face discrimination, extensive searches, and demands for bribes from both Indian and Burmese soldiers. A Namphalong-based health worker attempted to return to Burma following an HIV-care training camp in Manipur and faced five hours of interrogation into her suspected "anti-national" activities.⁵⁴ In addition, health workers cited risk of arrest throughout the Western Burma border region if they operated without UN Development Program (UNDP)- or other INGO-sponsored health-training certificates.⁵⁵

Drugs

Situated between the Golden Crescent and the Golden Triangle, the world's two largest regions of opium production, India is distinctly vulnerable to epidemics of injecting drug use and drug-driven HIV/AIDS. Although more heroin is produced in Afghanistan and Pakistan, the vast majority of this passes through India en route to its final destinations. Much of the narcotics passing from Burma through northeast India, however, are consumed locally.⁵⁶ Burma, the world's second-largest producer and exporter of illicit opium, introduced heroin to northeast India in the late 1970s. Since then, the northeast has undergone a significant shift from traditional cannabis and opium use.⁵⁷ The trend continues today—as of 2006, the UN Office on Drugs and Crime (UNODC) reports that the four states bordering Burma have higher rates of heroin seizures and injection drug use than the northeastern states not bordering Burma.⁵⁸

⁵² Doctors Without Borders, <http://www.doctorswithoutborders.org/news/india.ctm>.

⁵³ Interview with Dr. Aung Kyaw Oo, January 2007.

⁵⁴ "Burma Junta Forces Health Workers Underground," *Washington Times*, March 2, 2007.

⁵⁵ Interviews with health workers, January 2007.

⁵⁶ UNODC, *South Asia Regional Profile*, September 2005, 36, http://www.unodc.org/pdf/india/publications/south_Asia_Regional_Profile_Sept_2005/10_india.pdf.

⁵⁷ UNODC, *Drug Use in the Northeastern States of India*, 2006, 5, http://www.unodc.org/pdf/india/drug_use/executive_summary.pdf.

⁵⁸ *Id.*

Heroin entering the northeast from Burma is typically very pure (known as “Number 4”⁵⁹). Increased law enforcement, coupled with rising prices for heroin, however, has shifted consumption patterns to the cheaper heroin product, known as “Brown sugar” and finally to Spasmaproxyvon, a frequently injected oral narcotic analgesic (containing propoxyphene).⁶⁰

In northeast India, injection drug use is widely recognized as the driving force for the region’s growing HIV/AIDS problem. As in other parts of south and Southeast Asia, the HIV/AIDS epidemic northeast India has been associated with widespread needle sharing. In 2000, a Manipur study of 191 IDUs reported 93 percent having shared injecting equipment,⁶¹ and three-quarters were infected with HIV.

Some of the strongest evidence linking drug-trafficking routes with HIV comes from molecular epidemiological data, which suggest that unusual recombinant forms of HIV generated in the extremely high-exposure injection-drug-use settings in northern Burma are subsequently found along drug-trafficking routes such as northeastern India.⁶²

Further molecular evidence of spread comes from a 2006 study of IDUs in Darjeeling, a district of West Bengal, India, which found 11.8 percent HIV seroprevalence.⁶³ Most revealing, the IDU sequences from Darjeeling were found to be closer to the C strains from Manipur; this relationship strengthens the epidemic’s link to the Golden Triangle via the Manipur-Burma border, rather than to the C sequences from IDUs in Nepal, another neighboring country, as some have suggested.⁶⁴ The authors concluded that their results “indicate a rapid spread of HIV-1 by possible drug trafficking along international boundaries,” and may “help in the invasion of HIV-1 among IDUs of Darjeeling through the Manipur–Myanmar border of India.”

⁵⁹ NCB, 2002.

⁶⁰ UNODC, *Myanmar Country Report*.

⁶¹ A. D. Eicher, N. Crofts, S. Benjamin, P. Deutschmann, A. J. Rodger, “A Certain Fate: Spread of HIV among Young Injecting Drug Users in Manipur, North-East India,” Shalom, Macfarlane Burnet Centre for Medical Research, Fairfield, Victoria, Australia.

⁶² C. Beyrer, M. H. Razak, K. Lisam, J. Chen, W. Lui, X. F. Yu, “Overland Heroin Trafficking Routes and HIV-1 Spread in South and South-east Asia,” *AIDS* 14:1, January 7, 2000, 75–83.

⁶³ Ranajoy Mullick, Satarupa Sengupta, Kamalesh Sarkar, M. K. Saha, Sekhar Chakrabarti, “Phylogenetic Analysis of *env*, *gag*, and *tat* Genes of HIV Type 1 Detected among the Injecting Drug Users in West Bengal, India,” *AIDS Research and Human Retroviruses* 22:12, November 12, 2006, 1293–99.

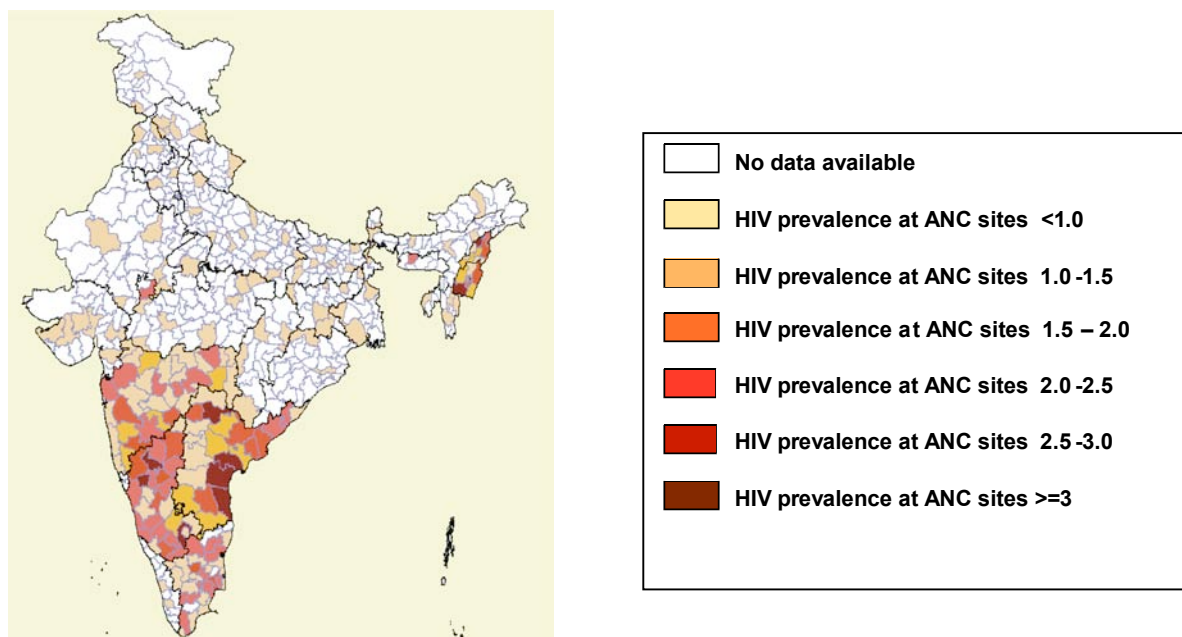
⁶⁴ Id.

Infectious Diseases

HIV/AIDS

The national HIV prevalence rate of 0.9 percent⁶⁵ masks the significant variation among regions of the country and various risk groups, particularly along the Indo-Burma border. Nagaland and Manipur have been identified as two of the six highest prevalence states (among 35 total) targeted for HIV prevention. Together with four southern states (Tamil Nadu, Andhra Pradesh, Karnataka, and Maharashtra), these states account for more than 80 percent of the country's reported HIV cases. Rates among women seeking antenatal care in these six states, as measured in 2004, exceeded 1 percent, with rates in some high-risk groups exceeding 5 percent.⁶⁶ (See Map 2.) While heterosexual transmission accounts for the majority of reported cases in the southern states, injection drug use has historically been the predominant mode of transmission in Manipur and Nagaland.⁶⁷

Map 2: India's HIV Prevalence by State



⁶⁵ National AIDS Control Organization, http://www.nacoonline.org/facts_overview.htm.

⁶⁶ Id.

⁶⁷ UNAIDS India, <http://www.UNAIDS.org.in>

Table 1: Sentinel Surveillance Data, National AIDS Control Organization (NACO), 2004
Sites with 75% coverage of desired sample size (STD:250 & ANC:400) are included for analysis.

Name of State	Number of Sites in 2004	% HIV Prevalence 2001 (320 sites)	% HIV Prevalence 2002 (384 sites)	% HIV Prevalence 2003 (455 sites)	% HIV Prevalence 2004 (670 sites)
Andhra Pradesh	STD: 8 ANC: 23	26.60 1.50	30.40 1.25	19.60 1.25	16.40 2.25
Karnataka	STD: 7 ANC: 27 IDU: 1	16.40 1.13 2.00	13.60 1.75 2.26	10.40 1.25 2.80	12.00 1.25 0.00
Maharashtra	STD: 9 ANC: 35	9.20 1.38	7.60 1.25	10.00 1.25	10.40 1.25
Manipur	STD: 2 ANC: 10 IDU: 3	10.50 1.75 56.26	9.60 1.12 39.06	13.00 1.25 24.40	22.00 1.5 7.20
Mizoram	STD: 2 ANC: 3 IDU: 1	2.20 0.33 2.00	2.60 1.50 1.60	3.80 1.38 4.00	1.00 1.25 6.80
Nagaland	STD: 1 ANC: 8 IDU: 3	7.40 1.25 5.50	2.42 1.25 10.28	0.90 1.25 13.86	1.70 1.43 4.49

Unlike traditional urban transmission patterns centered on mobile male labor populations and commercial sex work, the HIV epidemic in northeast India has its roots in border areas that serve as zones for drug trafficking and injection drug use. HIV infection rates among injection drug users in Manipur increased from 2 percent in 1989 to 64 percent in 2000.⁶⁸ Similarly in Nagaland, HIV prevalence among IDUs increased to nearly 14 percent in 2003, and in Mizoram to 6.8 percent in 2004.⁶⁹

Although the rates of infection among IDUs appear to be stabilizing, those among women seeking antenatal care (ANC) continue to rise, suggesting an increase in the proportion of new infections attributable to heterosexual transmission. In Manipur, a 2000 study showed that 45 percent of wives of HIV-positive IDUs became positive within 6 years of their spouses' documented infection. None of the wives in the study reported injection drug use and 98 percent were monogamous.⁷⁰ ANC rates in Nagaland and Manipur have exceeded 1 percent since 1999. Mizoram has been close behind, reporting ANC rates of 1.5 percent in 2002 and similarly high rates in 2003 and 2004.⁷¹

⁶⁸ National AIDS Control Organization, *supra* note 65.

⁶⁹ National AIDS Control Organization, *supra* note 65.

⁷⁰ S. Panda, S. A. Chatterjee, Bhattacharya, et al., "Transmission of HIV from Injection Drug Users to their Wives in India," *International Journal STD AIDS*, 11, 2000, 468–73.

⁷¹ *Id.*

ANC rates in these three states are strikingly high in several border districts known for drug trafficking. Manipur’s Churachandpur and Chandel districts reported ANC rates of more than 8 percent in 2005.⁷² According to Nagaland surveillance data, the ANC rate in the border district of Tuensang has been more than 3 percent for five consecutive years (Table 2), with Noklak, the district capital, also reporting an ANC rate of more than 8 percent—the highest in all of Nagaland.⁷³ South of Manipur in Mizoram, the border district of Champai also reported mean ANC rates of 3 percent from 2001–05.⁷⁴

Table 2: Nagaland’s Border District of Tuensang’s HIV Surveillance Data, 2001–05⁷⁵

<u>Year</u>	<u>IDU %</u>	<u>ANC %</u>
2001	5.5	3.05
2002	24.63	8.00
2003	24.8	4.20
2004	8.8	3.64
2005	10.8	4.73

The reduction in HIV infections among IDUs may be due in part to the expansive collaboration between donors, state AIDS-control organizations, and a multitude of local NGOs. In 2003, the Bill and Melinda Gates Foundation partnered with the National AIDS Control Organization (NACO) to implement a \$200 million initiative for prevention programs targeting men who have sex with men (MSM), commercial sex workers, and IDUs in the six states with the highest prevalence. In Nagaland and Manipur, more than 50 local NGOs have developed in the last five to ten years, focusing primarily on IDUs through peer-education networks and harm reduction.⁷⁶ These programs may have achieved limited success, with IDU rates in Nagaland and Manipur falling from their high points.

The challenge for these collaborative efforts as the epidemic evolves is to reach out to other disenfranchised and high-risk groups, such as rural communities, migrants, sex workers, and MSMs. The majority of the groups partnering with Avahan (Project Orchid in Northeast India) focus largely on IDUs, and concentrate services in urban centers. Only one needle-exchange project is situated in the highest-prevalence Tuanseng district, over 10 hours by car from Kohima, the capital of Nagaland.

Local state governments and NGO services are increasingly targeting sex workers, who had HIV rates exceeding 10 percent in Nagaland, Manipur, and Mizoram in 2006, among the highest in India.⁷⁷ The 2005 annual report of the Nagaland State AIDS Control Society states: “It is important to understand that HIV transmission in the State does not merely confine itself to IDUs and their sexual partners but it has percolated down to the general population through the sexual

⁷² National AIDS Control Organization, *supra* note 65.

⁷³ Nagaland State AIDS Control Society (NSACS), 2005 Annual Report.

⁷⁴ Mizoram State AIDS Control Society (MZSACS), 2005 Annual Report.

⁷⁵ NSACS, *supra* note 73.

⁷⁶ See http://www.nacoonline.org/directory_ngo.htm.

⁷⁷ National AIDS Control Organization, HIV/AIDS Epidemiological Surveillance & Estimation Report for 2005.

route. More efforts have to be taken to address vulnerable women like commercial sex workers.”⁷⁸

Few treatment services for people with HIV/AIDS exist on the Indo-Burma border. In April 2004, the National AIDS Control Organization established the only antiretroviral therapy (ART) center in Nagaland in the state capital at Kohima Hospital, which, as of July 2006, was treating 210 patients.⁷⁹ The situation is similar in Mizoram, with ART being delivered to only 25 patients in Aizawl, the capital.

Little data is available on the extent of the HIV/AIDS epidemic in western Burma. The National AIDS Program reports a total of 30 sentinel sites, with only one site near the Indo-Burma border in Haka, the capital of Chin State. Two sites in Sagaing Division are quite far from the border, in Monywa and Shwebo.⁸⁰ Given the highly permeable nature of the Indo-Burma border and the closely related border populations, it is possible that the HIV rates in northwestern Burma approximate the more extensively measured rates in northeast India, whose sentinel sites are also closer geographically. Given the strikingly high HIV rates along the border with northeast India, it is surprising to find that UNAIDS Myanmar reports that the western border of Burma has the lowest HIV rates in Burma.⁸¹

Regarding HIV services in western Burma, independent reviewers of the National AIDS Program report that coverage, “which is not actually measured by any indicators, appears to be extremely low for all interventions. Most reach no more than a few hundred people.”⁸² The 2006 national review cited one government IDU treatment facility on the western border,⁸³ and Population Services International (PSI) operates a single district office in Kalay township in western Burma for its HIV-prevention programs.⁸⁴ Given the militarization and restrictions on health workers noted earlier, it is unclear whether access to these critical services could be expanded.

A potentially important source of HIV services for inhabitants of western Burma is being provided by State AIDS Control Societies and local NGO partners in India. In the Manipuri border town of Moreh, for example, the Dedicated People’s Union (DPU), registered 131 IDUs from Tamu and Namphalong towns directly across the border in western Burma.⁸⁵ DPU estimates that 300 commercial sex workers and 400 IDUs reside in the two towns and that 100 to 130 cross over each day for drugs, particularly now that popular injectable pharmaceutical products are readily available in India. As of December 2006, 80 to 95 IDUs from Burma regularly received harm-reduction services from DPU in Moreh.⁸⁶

⁷⁸ National AIDS Control Organization, “Observed HIV Prevalence Levels State-wide: 1998–2004,” www.nacoonline.org/facts_statewise.htm.

⁷⁹ Interview, Kiphire Foundation, July 2006.

⁸⁰ Ministry of Health, Myanmar and Regional Office for Southeast Asia, World Health Organization, *Review of the Myanmar National AIDS Programme 2006*, September 2006 at 6.

⁸¹ Joint Programme for HIV/AIDS: Myanmar 2003–05 Midterm Review at 52.

⁸² Joint Programme for HIV/AIDS, *supra* note 81.

⁸³ *Id.* at 58.

⁸⁴ Sam O’Connor, “PSI/Myanmar Response to Infectious Disease in Myanmar,” conference address, “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 24, 2007.

⁸⁵ Dr. Langkham, “Indo-Myanmar Border,” conference address, “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 24, 2007.

⁸⁶ *Id.*

Tuberculosis

India's national tuberculosis program (the Revised National Tuberculosis Program) provides services on a massive scale,⁸⁷ treating 1.4 million patients in 2006, according to the WHO-recommended protocol for directly observed treatment, short course (DOTS) adopted in 1997.⁸⁸ Although information on the disease is limited in northeast India, all four of the Indian states bordering Burma have implemented TB programs since then according to national guidelines, treating nearly 12,000 cases in 2006. In Nagaland, the program currently offers 250 DOTS centers, 29 Designated Microscope Centers, and eight district TB centers that monitor the work of village DOTS providers and conduct interviews with patients and family members to identify new cases for possible testing and treatment.

Although impressive in its magnitude, the TB program has several weaknesses. People who receive positive TB smears are supposed to be referred to voluntary counseling and testing centers for HIV tests. However, there is no cross-monitoring of co-infection and few of these centers exist in rural areas. Since TB cultures cannot be performed anywhere in northeast India, cultures must be sent to Bangalore for further testing. Finally, the director of the TB program in Nagaland told us that poor access to testing and DOTS in rural areas was the biggest failing of the current program.⁸⁹

In Mizoram, some promising signs of cooperation between Chin and Mizo populations have arisen. Local Chin health organizations reported that suspected TB cases in border areas were routinely referred to—and accepted by—Saiha hospital in southern Mizoram, as well as the main public hospital in the capital.⁹⁰ Saiha hospital had even offered diagnostic training workshops to the Chin health workers.

Unfortunately, Chin migrants still pose a challenge for proper TB control. The Mizoram TB program director told us in July 2006 that most DOTS defaulters were Chin who moved frequently and were difficult to track.⁹¹ In addition, YMA members have volunteered to staff many rural DOTS outposts, a situation that could discourage Chin migrants from seeking treatment. According to 2006 data from Mizoram, only 58 percent of newly diagnosed smear-positive patients started DOTS within seven days of diagnosis, and only 66 percent had a follow-up sputum after completing treatment, the lowest reported by any state in India.⁹²

As with HIV, available TB data specific to western Burma is sparse. Regarding TB programs, although the Ministry of Health reports 100 percent coverage across its 324 townships,⁹³ none of the health workers we interviewed from Chin and Sagaing Division reported the existence of diagnosis and treatment services for tuberculosis in their areas. The National Review of Burma's TB program is slated for 2007.

⁸⁷ R. Steinbrook, "Tuberculosis and HIV in India," *NEJM*, vol. 356, March 2007, 1198–99.

⁸⁸ TB Control India, <http://www.tbcindia.org/key.asp>.

⁸⁹ Interview with Nagaland TB Director, July 2006.

⁹⁰ Interview with Chin Human Rights Organization, January 2007.

⁹¹ Interview with the Mizoram TB Director, July 2006.

⁹² TB Control India, *supra* note 88.

⁹³ See World Health Organization, *WHO Global TB Report 2005*, http://www.who.int/tb/publications/global_report/2005/annex1/en/index11.html.

Malaria

In 2003, India reported 1,006 malaria deaths and 1.87 million cases, including 860,000 *Plasmodium falciparum* cases. Malaria remains a major cause of morbidity and mortality in northeast India, an area that accounts for less than 4 percent of the country's population but nearly 10 percent of *falciparum* malaria cases and 20 percent of reported malaria deaths for India.⁹⁴ Mizoram, for example, has less than 0.1 percent of the country's population but is ranked third among the states in total malaria deaths and first in the actual rate of death.⁹⁵

A key issue in the growing epidemic of *falciparum* malaria in northeast India is increasing drug resistance to chloroquine (CQ) and sulphadoxine/pyrimethamine (SP), two first-line antimalarials used under the existing Indian National Drug Policy.⁹⁶ The national policy recommends SP as first-line therapy for *falciparum* cases in chloroquine-resistant areas. Unfortunately, drug resistance to CQ has spread throughout the northeast, and SP resistance is also rapidly increasing (Map 3).⁹⁷ Although combination therapy (artesunate plus SP) is theoretically recommended as second-line therapy, it is not easily available. The Mizoram Malaria Program director reported that the use of such an important medicine as artesunate-SP was restricted to physicians.⁹⁸

The spread of drug-resistant strains, first reported in 2003, along the Indo-Burma border is of particular concern because of the high degree of drug resistance to CQ, SP, and mefloquine reported earlier from western Burma.^{99, 100, 101} In 2005, researchers determined that treatment failure with CQ and SP was highest along the border and decreased further into the interior of India.¹⁰² As migration from western Burma to northeast India increases, so does the need for a national evaluation of regionally appropriate malaria treatment.

⁹⁴ V. Dev et al., "Transmission of Malaria and its Control in The Northeastern Region of India," *Journal of the Association of Physicians in India*, November 2003.

⁹⁵ See <http://www.nvbdc.gov.in/malaria3.html>.

⁹⁶ P. K. Mohapatra et al., "Evaluation of chloroquine (CQ) and Sulphadoxine/pyrimethamine (SP) in Uncomplicated Falciparum Malaria in Indo-Myanmar Border Areas," *Trop Med Intl Health*, 10:5, 478–83.

⁹⁷ P. K. Mohapatra, A. Prakash, D. R. Bhattacharyya, B. K. Goswami, J. Mahanta, "Concurrent Multi-drug Resistant Plasmodium Falciparum from Northeast India, a Case Report," *Journal of the Association of Physicians in India* 47, 1999, 823–24.

⁹⁸ Interview with the Mizoram Malaria Program director, July 2006.

⁹⁹ P. K. Mohapatra, N. S. Namchoom, A. Prakash, D. R. Bhattacharyya, B. K. Goswami, J. Mahanta, "Therapeutic Efficacy of Antimalarials in Plasmodium Falciparum Malaria in an Indo-Myanmar Border Area of Arunachal Pradesh," *Indian Journal of Medical Research* 118, 2003, 71–76.

¹⁰⁰ F. M. Smithuis, F. Monti, M. Grundi et al., "Plasmodium Falciparum: Sensitivity in Vivo to Chloroquine, Pyrimethamine/Sulfadoxine and Mefloquine in Western Myanmar," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 91, 1997, 468–72.

¹⁰¹ M. N. Ejov, T. Tun, S. Aung, K. Sein, "Response of Falciparum Malaria to Different Antimalarials in Myanmar," *Bulletin of the World Health Organization* 77, 1999, 244–49.

¹⁰² P. K. Mohapatra, et al., supra note 96.

Map 3: Drug Resistance to Antimalarials (CQ and SP)



Source: National Vector Borne Disease Control Program¹⁰³

India's National Vector Borne Disease Control Program combats malaria through indoor spraying with DDT and other pesticides, the distribution of insecticide-treated nets, and a system known as Early Case Detection and Prompt Treatment.¹⁰⁴ The case detection and treatment efforts in rural areas are largely provided through a network of drug distribution centers, which may be little more than a lay person trained to deliver chloroquine presumptively, without diagnostic testing. In a visit to a Nagaland village near the border of both Manipur and Burma, there appeared to be little awareness of such services in rural areas, and villagers and field NGOs interviewed had not heard of them.

Our research team queried the directors for malaria control in both Nagaland and Mizoram regarding the increase in malaria cases between 2004 and 2005,¹⁰⁵ despite control measures. Both believed the increases reflected real growth in malaria burden rather than reporting bias. Citing the opinions of others interviewed, they both attributed these increases, in part, to migration into India from Burma—one of numerous examples of the repeated theme of migrants as carriers of disease.

¹⁰³ See <http://www.nvbdc.gov.in/DRUG.html>.

¹⁰⁴ National Vector Borne Disease Control Program, *Malaria Control Strategies*, <http://www.nvbdc.gov.in/malaria11.html>.

¹⁰⁵ National Vector Borne Disease Control Program, *Malaria Situation in India*, <http://www.nvbdc.gov.in/Doc/Malaria%20Situation.pdf>.

Although state officials asserted that distribution centers do not discriminate against non-Indian citizens, fear of local organizations that manage the sites has created significant barriers to malaria treatment access, especially in Mizoram. YMA members, the most powerful organization in Mizoram,¹⁰⁶ have been charged with running many drug-distribution centers. Interviews with Chin refugees confirmed that the role of the YMA in the distribution of drugs was perceived as a reason for avoiding treatment. Yet the head of the vector-borne disease program in Mizoram challenged that perception by noting it was “difficult to provide medical treatment to Burma migrants as influx population are mostly ignorant and do not approach health facilities.”¹⁰⁷

The western region of Burma is considered high-risk for malaria, especially among subsistence farmers, migrants, and forest-related workers. In 2004, Arakan and Chin states reported the highest official malaria morbidity rates for all of Burma: 62 per 1,000 and 40 per 1,000 respectively. In Chin state, malaria accounts for more than half of all health-care consultations.¹⁰⁸

Despite this increased risk, the Burmese government and international NGOs working within Burma do not appear to reach the northwestern border areas. The only INGO known to offer malaria-related services in western Burma is Population Services International, which distributes insecticide tabs for net treatment, artesunate-combination therapies, and rapid diagnostic tests. Although they maintain an office in Tamu, directly across the border from Manipur, none of the health workers we interviewed reported access to these products. Malaria services are mostly distributed through their Sun Quality Health Franchise, a network of private physicians, that appears to be primarily based in more central areas of Burma.¹⁰⁹

Conclusion

Much needs to be done to lessen the burden of infectious diseases in the Indo-Burma border region. First, the Indian and Burmese regimes should work together to reduce militarization of the border areas, which has led to violations of international humanitarian law and human rights, and likely worsening of infectious disease epidemics. Other abuses that have impeded the effective delivery of health interventions, such as the arrest of health workers, restriction in their freedom of movement, and discrimination in the delivery of health services, should be ended.

Second, drug trafficking into a vulnerable population ill-equipped to manage the effects has created one of the worst HIV epidemics in South and Southeast Asia. Effective interventions such as harm-reduction targeting IDUs need to be expanded, in addition to improving HIV prevention and treatment services for largely ignored rural populations, migrants, and other high-risk groups such as sex workers and MSMs.

Third, restrictions on international NGOs need to be removed, so their considerable resources and technical expertise can be brought to bear. Local community-based organizations, which are likely

¹⁰⁶ Mizoram government website, <http://mizoram.nic.in/more/yma.htm>.

¹⁰⁷ Dr. Lalkailiani, “Communicable Disease in Mizoram,” conference address, “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia,” Bangkok, January 24, 2007.

¹⁰⁸ European Commission Humanitarian Aid Office, 2004, http://ec.europa.eu/echo/pdf_files/decisions/2004/dec_myanmar_01000.pdf.

¹⁰⁹ Sam O’Connor, *supra* note 84.

to be composed of disenfranchised groups such as displaced persons, should be allowed to register and operate freely, and should be provided additional support by the government and donors.

Finally, national and local governments, international nongovernmental and local community-based organizations, and UN agencies should collaborate to develop a common cross-border strategy to improve disease surveillance, prevention, and treatment, and strategies for control of infectious diseases.

10. Conclusions and Recommendations

We offer the following conclusions and recommendations:

Health Care System in Burma

- ***The Government of Burma must develop a national health care system that is participatory and incorporates human rights to ensure that health care is distributed effectively, equitably, and transparently.*** Promoting participation as a feature of health system reform is now commonplace. With the rise of Primary Health Care in the 1970s, community involvement was seen as an essential ingredient of a nation's health improvement. More recently, the emphasis has shifted to stakeholder consultation in sector reform. With the rise of rights-based approaches, emphasis is increasingly being placed on the participation of service users not as "beneficiaries" or "consumers" but as citizens who have the right to have a say in shaping health care policies. Community participation in the promotion and implementation of prevention and treatment programs is essential in any campaign to combat infectious diseases.

Burma must develop a health care system that provides medical treatment and preventative care to all citizens, especially the most marginalized members of society including the very poor, ethnic and religious minorities, refugees and the displaced, persons living in conflict and cease-fire zones, and persons belonging to socially stigmatized groups including commercial sex workers, injecting drug users, and men who have sex with men.

- ***The Government of Burma should increase its expenditures on health and education.*** Decades of neglect by Burma's military government have turned the country into an incubator of infectious diseases. Those of gravest concern are HIV/AIDS, tuberculosis, malaria, acute respiratory infections, filariasis, and diarrheal diseases. The authorities have a responsibility to protect the people of Burma and residents of neighboring countries to turn back the spread of communicable diseases. Such an effort requires both public health measures and providing citizens with increased access to both formal and informal education. Schools are places not only for teaching traditional academic subjects, but also for disseminating information about measures that can be taken to halt the spread of infectious diseases. Military expenditures should be re-routed to support health and education. Burma is not at war with its neighbors, and its security is more profoundly threatened by the rise of drug-resistant malaria and tuberculosis, and emerging communicable diseases such as avian influenza and recrudescing polio myelitis, than from external military threats.

Donors and International Aid Organizations

- ***Donors and international aid organizations operating in Burma have a duty to uphold and promote internationally accepted standards of human rights and international humanitarian law.*** Donors and international aid organizations should put into practice the “Principles for Good International Engagement in Fragile States & Situations” drafted by the Organisation for Economic Co-operation and Development (OECD) in 2005. Principle 6 states: “Real or perceived discrimination is associated with fragility and conflict, and leads to service delivery failures. International interventions in fragile states¹ should consistently promote gender equality, social inclusion and human rights. These are important elements that underpin the relationship between state and citizen, and form part of long-term strategies to prevent fragility. Measures to promote the voice and participation of women, youth, minorities and other excluded groups should be included in state-building and service delivery strategies from the onset.”²
- ***The Government of Burma should immediately rescind the “Guidelines for UN Agencies, International Organizations and NGOs/INGOs on Cooperation Programme in Myanmar” (See Appendix).*** These Guidelines, issued by the Ministry of National Planning and Economic Development in February 2006, directly contravene several formal agreements established between international organizations and the Burmese government since the early 1990s. They also contravene several international agreements on effective aid delivery, including the Paris Declaration on Aid Effectiveness, which was endorsed by the European Union; 27 regional and international institutions, including the World Bank and the Asian Development Bank; and over 90 countries in Paris in 2005. The Guidelines have restricted the work of international organizations, especially the International Committee of the Red Cross (ICRC), operating in Burma. While aid to Burma should not be considered optional given the dire need, the “exigencies of need” should never override the ability of organizations to access project sites on a regular and unhindered basis to ensure that aid is being delivered in a manner that is transparent, accountable, efficient, and equitable. The Guidelines are antithetical to this fundamental principle.
- ***The Government of Burma should allow the International Committee of the Red Cross (ICRC) to resume visits to prisoners without the requirement that ICRC doctors be accompanied by members of the Union Solidarity and Development Association (USDA) or other organizations. As mandated by the Geneva Conventions, to which Burma has been a party since 1992, ICRC conducts confidential, one-on-one visits with prisoners and has done so in dozens of countries since the Franco-Prussian war of 1870. In addition, the Government of Burma should allow ICRC to reopen field offices that have been closed since late 2006 due to government restrictions.*** Since 1999, the ICRC has played an essential role by visiting and providing health care to prisoners in Burma and developing water and sanitation projects in war-torn communities where weakened infrastructure, isolation, and the security situation make the population

¹ States are fragile when state structures lack political will and/or capacity to provide basic functions needed for poverty reduction, development, and to safeguard the security and human rights of their populations.

² The full set of principles can be accessed through the OECD web site at <http://www.oecd.org>.

particularly vulnerable.³ ICRC staff have convened surgical training seminars for scores of Burmese health workers stationed in conflict areas, built water and sanitation facilities reaching more than 70,000 beneficiaries, provided over 7,000 landmine victims and other physically disabled people with prosthetic services, and supported the local manufacture of 19,600 prostheses. Between 1999 and late 2005, ICRC made 453 visits to dozens of prisons and labor camps throughout the country and provided training to Burmese doctors on prison health care. ICRC has used information gleaned from these visits to persuade health authorities to improve prison conditions. Yet, due to government restrictions, ICRC has been forced to suspend its prison visits and to close most of its field offices.

- ***Donors and foreign aid organizations should monitor and evaluate how international aid to combat infectious diseases in Burma is affecting domestic expenditures in health and education.*** Large infusions of foreign aid directed at the health sector can potentially lessen the burden of infectious diseases in Burma, but it can also have unintended consequences. Foreign aid can create dependency and divert health professionals and their institutions from addressing other serious health problems. Foreign aid can provide national authorities with a ready excuse for decreasing even further their already paltry expenditures in health. Donors and foreign aid organizations have a responsibility to monitor domestic expenditures in health and education and, if problems arise, raise their concerns with the appropriate authorities.

Drugs and Drug Trafficking

- ***Relevant UN agencies, national and local governments, and international and local NGOs should establish a regional Narcotics Working Group.*** Since 1999 the Burmese government and the UN Office on Drugs and Crime (UNODC) have been engaged in an aggressive campaign to eradicate poppy cultivation and heroin production in Burma. UNODC has attempted to develop crop-replacement initiatives for poppy farmers. However, these initiatives have often faltered, leaving farmers and their families with few alternatives to feed their families. Tens of thousands of people have been forcibly relocated to villages along the Thai border where they have no sustainable income and are exposed to infectious diseases, especially malaria. At the same time, the region is experiencing a significant increase in the production and use of methamphetamines. At least three cease-fire organizations in Burma continue to manufacture and sell methamphetamines inside the country and across the border. Methamphetamine use increases sexual risk-taking and greater exposure to communicable diseases, including HIV/AIDS. Markedly increased STD rates have been found in northern Thai women who use methamphetamines. Finally, large profits from the sale of methamphetamines are fueling the “Casino Economy” along Burma’s border with China. These casinos and other entertainment venues are magnets for prostitution and trafficking of Burmese women and girls.

³ Although a private humanitarian organization, the ICRC is not a nongovernmental organization. It has a widely recognized role to play due to its permanent and universal mandate granted by the 192 States signatory to the Geneva Conventions. This role distinguishes the ICRC from other humanitarian organizations.

Given this situation, the Narcotics Working Group should develop a sophisticated list of indicators to measure the use and trafficking of drugs in the region. Distinct from traditional indicators, these indicators would capture detailed information about types of drug, how much is being trafficked, and by whom. Access to hard-to-reach populations and regions would require fieldwork and cross-border approaches that value trust-building and cultural appropriateness. The working group could also monitor the human and environmental impact of poppy-eradication programs and their effects on farmers and their families.

Three Diseases Fund

- ***The Three Diseases Fund (3D Fund) should play an active role in promoting the growth and capacity of local nongovernmental and community-based health organizations to respond to infectious diseases in Burma and the border regions.*** Only a few local nongovernmental and community-based organizations operate in the health sector in Burma. Yet these organizations have the potential to play a key role in the effort to lessen the burden of communicable diseases in the region. These groups are well situated to provide the community services required for the implementation of treatment and prevention programs. They can also work in areas that may be inaccessible to UN agencies and international organizations.

The 3D Fund, which is now the largest aid donor to combat infectious diseases in Burma, deserves good marks for establishing an oversight board that includes independent experts and for posting regular updates and reports of quarterly meetings of its board on its web site. Yet the 3D Fund faces several challenges that must be overcome to conduct its work effectively. First and foremost, it must contend with the military regime's restrictions on the travel of foreign aid organizations. The ICRC's closure of several field offices operating in or near combat zones suggests that access to these areas will continue to be heavily restricted and prevent aid from reaching those most in need. Second, while the 3D Fund's commitment to bypass the central government and fund civilian administrations and local nongovernmental organizations at the state and township level is admirable, it may be difficult to implement. The term "civilian administrations" is a highly ambiguous concept in Burma, especially in rural areas where the military and police hold unquestioned authority and influence.⁴ This situation has been further complicated by reports that the Burmese authorities are establishing government-run "coordination committees" at the district and township level to coordinate with the 3D Fund and other relief efforts. According to the February 2006 Guidelines, members of these new coordination committees would be drawn from junta-backed social organizations such as the Union Solidarity and Development Association, founded by junta leader Senior General Than Shwe.⁵ The involvement of representatives of these organizations could easily politicize and complicate the dispersal of funds at the district

⁴ The National League for Democracy (NLD) raised this issue in a letter dated June 12, 2006, to the First Secretary, British Embassy, Rangoon. The letter is in the files of the Human Rights Center, University of California, Berkeley.

⁵ Htet Aung, "Government to keep tight rein on aid in Burma," *The Irrawaddy*, March 13, 2007.

and township level. To overcome these obstacles, donors to the 3D Fund must be prepared to withhold funds until proper conditions prevail.

Such challenges notwithstanding, the 3D Fund's pledge to ensure its programs are accountable, transparent, equitable, and reach those most in need is highly commendable and deserves the support of governments and international health institutions.

Violations of Human Rights and International Humanitarian Law

- ***The Government of Burma must stop engaging in violations of human rights and international humanitarian law and must hold accountable government and military officials who are responsible for these abuses.*** Burma's policies of forcibly relocating civilian populations and requiring them to engage in forced labor have caused widespread migration, food insecurity, disruption in livelihood, and lack of access to regular medical care. In conflict zones, the Burmese military is committing violations of the laws of war including intentional and wanton destruction of civilian homes and food supplies; killing, sexually assaulting, and torturing civilians; destroying medical supplies intended for civilian populations; and arresting, detaining, and killing medical workers. These abuses have left civilians, particularly young children, vulnerable to death and illness from malnutrition, malaria, TB, night blindness (vitamin A deficiency), and diarrheal diseases.

In the first six months of 2007, the Burmese authorities detained over a dozen HIV/AIDS activists, most of whom have since been released. Of particular concern is Phyu Phyu Thin, a National League for Democracy youth member and a leader in the group's HIV/AIDS section, who was arrested on May 21, 2007 by authorities from the Ministry of Home Affairs and the Police Special Branch. According to relatives, she has since disappeared. Since 2002, Phyu Phyu Thin and her group have provided hundreds of HIV/AIDS patients with counseling, medicines, education, and housing.⁶

Internally Displaced Persons, Refugees, and Migrants

- ***The Governments of Burma, India, Thailand, and Bangladesh should ratify the Convention Relating to the Status of Refugees and the Protocol Relating to the Status of Refugees. These governments should also stop violating the human rights of migrants.*** Refugee status for migrants fleeing their home country due to fear of persecution prohibits routine deportation and increases the availability of services and assistance, including medical care, to limit the spread of infectious diseases among highly mobile populations. Moreover, state-sponsored discriminatory policies and practices, as well as state-condoned vigilantism by private groups, only serve to drive migrants further underground and prevent them from seeking medical care when they are ill or injured. Recent trans-border cooperation between India and Burma to capture ethnic insurgents has resulted in increased abuses against migrants including arrest, mistreatment, torture, and execution.

⁶ "Relatives of missing HIV activist threaten to sue authorities," *The Irrawaddy*, June 21, 2007.

Conclusions and Recommendations

- ***The Government of Burma should take steps to halt the internal armed conflict and violations of international human rights and humanitarian law that are creating an unprecedented number of internally displaced persons and migrants.*** Internal armed conflict and abuses of rights, including forced displacement and forced labor, are creating major social upheavals leading to thousands of people fleeing their homes and living in internally displaced persons camps within Burma or in migrant camps in the border regions. These camps lack adequate food, sanitation, clean water, shelter, and medical care. Large mobile populations living under such poor conditions may be a conduit for the introduction of infectious diseases such as TB, malaria, HIV/AIDS, lymphatic filariasis, and avian influenza to new and unprepared communities.
- ***The Government of Burma should recognize citizenship for the Rohingya in Arakan State by repealing or amending the 1982 Citizenship Law. Until that time, the United Nations High Commissioner for Refugees (UNHCR) must provide adequate resources to the Rohingya who are languishing in refugee camps in Bangladesh.*** Under the 1982 Citizenship Law, the members of the Muslim minority in North Rakhine State, generally known as the Rohingyas, have been denied Burmese citizenship, which has seriously curtailed the full exercise of their human rights and led to various discriminatory practices, including restricted access to medical care, food, and adequate housing. These oppressive practices have caused waves of Rohingya migration out of Burma into Bangladesh where they currently live in refugee camps administered by UNHCR. These camps are sorely inadequate, leaving the Rohingya in fetid, overcrowded living conditions where health care is lacking and the TB infection rate is soaring.

Responses to Infectious Diseases in Burma's Border Regions

- ***UN agencies, national and local governments, and international and local NGOs must cooperate closely to develop health care programs along Burma's borders.*** Some of the highest rates of TB, malaria, and HIV/AIDS in Burma are found along its frontiers. Yet the Burmese government provides little or no public services, including health care, to people living in the border regions and limits the travel of international organizations to conflicted areas of the border. Some ethnic-based organizations provide health care in these areas, but their resources are extremely limited. These organizations need to receive greater support. In addition, health care programs must be initiated across the border and brought to the Burmese frontier. The Back Pack Health Worker Team operates out of western Thailand and sends supplied health care workers on foot into eastern Burma to gather medical data and provide medical treatment and preventative care. It represents one successful cross-border model that should be expanded and replicated on Burma's borders with China, India, and Bangladesh.
- ***The governments of Burma and its neighbors must stop obstructing the passage of medical supplies and health care workers across the borders and develop national policies that promote cross-border health care.*** The Burmese frontier appears to be permeable to almost everything—people, timber, gems, natural gas, and infectious diseases—except public health programming. In order for cross-border health programs to reach people living in Burmese conflict and cease-fire zones, the governments of

Burma and its neighbors must stop obstructing the passage of medical supplies and health workers and develop national policies to support these efforts.

Regional Coordination and Response

- ***UN agencies, national and local governments, and international and local NGOs must cooperate closely to facilitate greater information-sharing and collaboration among agencies and organizations working to lessen the burden of infectious diseases in Burma and its border regions. These institutions should also work together to develop a regional response to the growing problem of counterfeit antimalarial drugs.*** In January 2007, our two centers, in collaboration with the Global Health Access Program, convened a regional conference on “Responding to Infectious Diseases in the Border Regions of South and Southeast Asia” in Bangkok, Thailand. The conference brought together 190 participants, representing 95 institutions from nine countries—Australia, Bangladesh, Burma, China, India, Thailand, Singapore, United States, and Vietnam—to discuss the efforts of governments, UN agencies, nongovernmental organizations, and health clinics to combat infectious diseases in Burma and its border regions. Conference speakers highlighted some of the key challenges health professionals face as they confront the spread of communicable diseases in the region. These include limited disease surveillance and data collection; divergence of “official” statistics from data from conflict zones; the paucity of data from narcotics surveillance, including drug availability and use and data on infectious disease prevalence and incidence among drug users; lack of prevention and treatment programs; and widespread violations of international humanitarian law and medical neutrality in some border regions that restrict the ability of health professionals to access vulnerable communities.

Conference participants, especially from the NGO sector, stressed the need to: (1) implement a mapping process, utilizing global-positioning technologies, to record the location, activities, and service-range of health-based organizations working to combat infectious diseases in Burma and the border regions; (2) convene a series of border-specific training workshops to standardize procedures for surveillance, data collection, analysis, and dissemination of information about infectious diseases in the region; (3) convene a second regional conference similar to the 2007 Bangkok conference to report on the progress in implementing standardized procedures for data collection and analysis and meet with colleagues and donors from the region; and (4) promote the development and capacity of community-based health organizations to provide health care for their own peoples.

Authors and Acknowledgements

The Authors

Eric Stover is Faculty Director of the Human Rights Center and Adjunct Professor of Law and Public Health at the University of California, Berkeley.

Voravit Suwanvanichkij is Research Associate at the Center for Public Health and Human Rights of the Johns Hopkins Bloomberg School of Public Health.

Andrew Moss is Emeritus Professor of Epidemiology at the University of California, San Francisco and Senior Research Fellow at the Human Rights Center, University of California, Berkeley.

David Tuller is a health and science writer and a doctoral student in the School of Public Health, University of California, Berkeley.

Thomas J. Lee is Director of the Global Health Access Program and Adjunct Associate Professor of Emergency Medicine at the University of California, Los Angeles.

Emily Whichard is Program Officer of the Global Health Access Program and a medical student at the University of California, San Francisco.

Rachel Shigekane is Senior Program Officer at the Human Rights Center and Lecturer in Peace and Conflict Studies, University of California, Berkeley.

Chris Beyrer is Professor of Epidemiology and Director of the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health.

David Scott Mathieson is Burma Consultant for Human Rights Watch

Chapter credits

Executive Summary: Eric Stover, Rachel Shigekane

Introduction: Eric Stover

Background: Eric Stover, Voravit Suwanvanichkij, David Scott Mathieson, Rachel Shigekane

The Politics of Foreign Aid: Eric Stover, Rachel Shigekane, Andrew Moss

Burma: Eric Stover, Chris Beyrer

China-Burma Border Region: Andrew Moss, Thomas Lee

Thai-Burma Border Region: Voravit Suwanvanichkij

Bangladesh-Burma Border Region: David Tuller

Indo-Burma Border Region: Thomas Lee, Emily Whichard, David Tuller

Conclusions and Recommendations: Eric Stover, Rachel Shigekane

Authors and Acknowledgements

Eric Stover, Rachel Shigekane, and Camille Crittenden, Executive Director of the Human Rights Center, edited the report.

Acknowledgements

We wish to thank Nicole Franck of the Center for Public Health and Human Rights for her support and for serving as the principal organizer of a regional conference on “Responding to Infectious Diseases in South and Southeast Asia,” held in Bangkok in January 2007. We greatly benefited from the presentations and discussion that took place at the conference. However, the conclusions and recommendations of this report are those of the authors, and do not necessarily reflect the views of the conference participants.

We extend our gratitude to several individuals—Liza Jimenez, Anna Sussman, Charles Zhixiang Xu, Brang Aung, Joe Amon, and Mainul Islam Khan—who helped facilitate our research. We also thank Nic Dunlop for permission to use his photographs and John R. Palmer for copyediting. Finally, we wish to acknowledge the generous support of the Open Society Institute and The Sandler Family Supporting Foundation.

Appendix:

Guidelines for UN Agencies, International Organizations and NGO/INGOs on Cooperation Programme in Myanmar

Issued by the Ministry of National Planning and Economic Development, February 2006.
(See <http://www.burmalibrary.org>.)

- The UNODC Representative called on the Minister for Foreign Affairs after completion of his assignment in December 2005. During the meeting, he reported that there are 22 INGOs who have been engaging in Southern Shan State, Wa area. He observed that there have been no collaboration and coordination among these INGOs. He also mentioned that these INGOs are not aware of the presence of the other INGOs working in that area and the effective services have not been rendered to the people in that area.
- In this regard, he recommended the Minister that there should be collaboration and coordination among these INGOs and their programmes should be coordinated and guided by the central responsible body.
- In the light of these circumstances, the programmes and projects that are being conducted with the assistance of UN Agencies, International Organizations and NGO/INGOs were reviewed and analyzed.
- It is clearly observed that there are many programme of activities that will benefit both sides and contribute to the well being of the communities in Myanmar.
- It is also observed that UN Agencies, International Organizations and NGO/INGOs that have been providing assistance for the socioeconomic development of Myanmar should be systematically coordinated and guided so as to achieve more effective and efficient outcomes.
- Myanmar welcomes the assistance being provided by these organizations. Myanmar side will cooperate and give support for the successful implementation of these cooperation programmes and projects.
- Aiming at efficient, smooth and systematic implementation of the activities to bring about more effective results, I would like to explain the Programme Guidelines for carrying out the cooperation programme.
- The Programme Guidelines cover the Objectives, Proposal for Basic Cooperation Agreement, Proposal for the Project, Proposal for MOU and Implementation Arrangement.
- The objectives of the Programme Guidelines are as follows:
 - To enhance and safeguard the national interest
 - To prevent the infringement of the sovereignty of the State
 - To cooperate without any string to the State

- To provide guidance to be on the right track, render necessary assistance as well as cooperate and coordinate with the view to contributing the socio-economic development of the Nation

Initial Coordination

- The initial coordination among UN Agencies, International Organizations and NGO/INGOs with respect to cooperation programme will be carried out by the Ministry of National Planning and Economic Development.
- The line ministry will be responsible for the implementation of the respective projects.

Proposal for Basic Cooperation Agreement

- The Draft Basic Agreement for cooperation to be signed between the Union of Myanmar and the UN Agencies, International Organizations and NGO/INGOs shall be submitted to the Ministry of National Planning and Economic Development.

Proposal for the Project

- Any proposed project to be implemented in cooperation with UN Agencies, International Organizations and NGO/INGOs shall be submitted by these organizations to the Ministry of National Planning and Economic Development.
- The project proposal which is to be implemented in Myanmar shall be in line with the objectives of the Programme Guidelines. If the proposal is not in line with the objectives of the Programme Guidelines, consultation shall be made with the concerned Ministry to revise the proposal.
- If NGO/INGOs submit the project proposal which involves more than one Ministry, the Ministry which receives the proposal will scrutinize and transfer it to the Ministry of National Planning and Economic Development.

Proposal for Memorandum of Understanding (MOU)

- NGO/INGOs shall submit the Draft MOU, which is to be implemented in Myanmar, to the Ministry of National Planning and Economic Development after consultation with the concerned Ministries on the Draft MOU.
- Draft MOU which is to be implemented in Myanmar shall be in line with the objectives of Programme Guidelines. If the MOU is not in line with the objectives of the Programme Guidelines, consultation shall be made with the concerned Ministry to revise the MOU.
- If NGO/INGOs submit the draft MOU which involves multiple sector to the concerned Ministry, that respective Ministry will scrutinize and transfer the draft MOU to the Ministry of National Planning and Economic Development.

Implementation Arrangement

- Signing of Basic Agreement, Project proposal and MOU
 - The Basic Agreement between the Union of Myanmar and UN Agencies, International Organizations will be signed by the Ministry of National Planning and Economic Development on behalf of the Government.
 - The MOU/Project Proposal involving Overall Framework/Multiple Ministry/Multiple Sector, will be signed by the Ministry of National Planning and Economic Development.
 - If the MOU/Project Proposal is concerned only with the individual Ministry, that respective Ministry will sign the MOU/Project Document.
 - NGO/INGOs shall seek the approval from the concerned Ministry before signing any sub-contract covered by the MOU/Project Document.

- Registration and opening of the offices
 - NGO/INGOs shall register with the Ministry of Home Affairs and the opening of office will be allowed only after registration of organization.
 - At the time when NGO/INGOs open their offices they shall inform the Ministry of National Planning and Economic Development, Ministry of Foreign Affairs, Ministry of Home Affairs and concerned Ministries.
 - When NGO/INGOs close their offices, it is also required to inform the Ministry of National Planning and Economic Development, Ministry of Foreign Affairs, Ministry of Home Affairs and concerned Ministries.
 - NGO/INGOs may apply for extension of their registration in accordance with the existing procedure.

- Appointment of staff
 - Regarding the appointment of international staff in the UN Agencies, International Organizations and NGO/INGOs in Myanmar, these Agencies and Organizations shall seek the prior consent from the Myanmar side.
 - Regarding the appointment of international personnel for the Representative's Offices in Myanmar, the Agencies and Organizations shall seek the prior consent from the Ministry of National Planning and Economic Development.
 - Regarding the appointment of international staff for the respective projects, the Agencies and Organizations shall seek the prior consent from the concerned Ministry.
 - The list of international and local staff working in Myanmar shall be provided to the Ministry of National Planning and Economic Development and the concerned Ministry.

- Internal Travel
 - The Ministry of National Planning and Economic Development will coordinate for the travel programme and necessary approval for the official(s)/mission from the headquarter of the respective organizations with which Ministry of National Planning and Economic Development signed the MOU/Project Document. Official(s) from the Ministry of National Planning and Economic Development will accompany them in the trip.

- If the MOU/Project Document is signed by the other Ministries, that Ministry will coordinate for the travel programme and necessary approval for the official(s) /mission from the headquarter and official(s) from Myanmar side will accompany them in the trip.
- If the official/personnel is from UN Agencies, International Organizations and NGO/INGOs in Myanmar, the Ministry responsible for the project will coordinate for the travel programme and necessary approval from the concerned authorities. Official(s) from Myanmar side will accompany them in the trip.
- Management
 - The relevant Ministry which has signed with the UN Agencies, International Organizations and NGO/INGOs will coordinate the matters on importation of equipment and motor vehicles for the project as well as the entry visa for the officials/mission from the Headquarters in accordance with the rules and regulations of the State.
- For the smooth implementation of the projects, the Central Coordination Committee will be formed. The committee will be chaired by the Minister for National Planning and Economic Development and the Minister for Foreign Affairs and the Minister for Home Affairs will be vice-chairmen. The members of the committee are the Deputy Ministers from the concerned Ministries and the Deputy Minister for the Ministry of National Planning and Economic Development will act as Secretary. The Director General of Foreign Economic Relations Department will act as Joint Secretary.
- The Central Coordination Committee Meeting will be held every three months. Special meeting will be held if needed.
- The meeting among Central Coordination Committee and UN Agencies, International Organizations and NGO/INGOs will be held every three months.
- The coordination at the central level will contribute to smooth and successful implementation of the project activities.
- The Ministries concerned will hold the coordination meeting with the respective Departments monthly (or) every two months.
- State/Division and Township Coordination Committees will be formed at the State/Division and Township level consisting of the head of the General Affairs Department as chairman and the members from the concerned Departments. The Secretary of the Committee will be the Planning Officer of the respective State/Division and Township Planning Department.
- The State/Division and Township Coordination Committees are responsible for coordination among NGO/INGOs as well as coordination with Departments and communities.

- Upon the arrival to the State/Division/Township, the team leader from the organizations which will implement the projects shall inform the State/Division and Township Coordination Committees.
- The UN Agencies, International Organizations and NGO/INGOs shall refrain from the activities not within the scope of work. If it is necessary to carry out the activities which are not within the scope of work, the respective organization shall seek the prior approval from the concerned Ministry.
- The UN Agencies, International Organizations and NGO/INGO shall provide monthly and quarterly reports to the Ministry of National Planning and Economic Development as well as to the concerned Ministries.
- If the proposed activities to be undertaken is substantive and is related to the another Ministry, the Scope of Work/Terms of Reference shall be revised officially and if the work is marginal, concurrence from the concerned Ministry will be required.
- Through close cooperation and coordination among the Ministries, UN agencies, International Organizations and NGO/INGOs in accordance with the Programme Guidelines, it will lead to smooth, systematic and efficient implementation of the project activities bearing better results.
- The organizations which would like to implement the cooperation programme in Myanmar shall comply with this Programme Guidelines.
- Many organizations currently working in Myanmar may not require to change substantially the way they are working now. However, if there are some practices which are not in line with the Programme Guidelines, the organizations shall carry out their programmes in conformity with the Programme Guidelines in consultation with the concerned Ministry. NGO/INGOs which have not yet registered are required to do so.
- There are many NGO/INGOs which have been implementing their projects without any difficulty in Myanmar. For these organizations, we would not like to see any inconvenience in their activities. Accordingly in the process of their works, they may continue to carry out project activities in line with this Programme Guidelines.
- In the event of special circumstances, the Ministry concerned will consider the situation with understanding in order to implement the project smoothly.