

15th Annual Edition

BURMA

HUMAN RIGHTS YEARBOOK 2008



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CHAPTER 11
Right to Health

BURMA

HUMAN RIGHTS YEARBOOK 2008



11.1 Introduction

For the people of Burma, 2008 has been another difficult year. The difficulties related to lack of healthcare facilities continued, while other factors relating to poverty remained key influences on the health of the nation. The enduring story from Burma from 2008 was the humanitarian consequences of Tropical Cyclone Nargis, which hit the country on 2-3 May 2008. However, even at the beginning of the year, there were worrying reports and statistics emerging from Burma regarding the health status of the population.

In January 2008, the United Nations Children's Fund (UNICEF) released figures which showed Burma had the second highest child mortality rate in the world, with between 270 and 400 children dying on a daily basis, many from preventable causes.¹ By year end, the combination of the estimated 130,000 deaths due to Cyclone Nargis and the increasing HIV/AIDS crisis lead Médecins Sans Frontières (MSF) to describe the current situation in Burma as "*critical*", and also contributed to Burma being included in MSF's list of the ten worse humanitarian situations in the world.² While it has been estimated that approximately half of Burma's annual budgetary allocation goes towards military expenditure, less than half a percent of Burma's Gross Domestic Product (GDP) is allocated to healthcare.³ Burma's per capita spending on healthcare has been reported to be "*the lowest in the world*".⁴ As a direct result, deaths arising from easily preventable and readily treatable diseases are common. Burma also has the second highest child mortality rate in all of Asia, with ten percent of children dying before their fifth birthday; only Afghanistan's child mortality rate is higher.⁵

While the State Peace and Development Council (SPDC) military regime makes little to no effort to actively promote good health or to provide adequate healthcare, in some areas it actively prevents the population's access to healthcare through restrictions on movement and other human rights abuses. For example, in August 2008, it was reported that medical students were to be forced to take an exam on the current political situation in the country before being allowed to take up medical placements in hospitals. Presumably, those students who failed to toe the SPDC line would not have been permitted to commence their placements. Although this was denied by the SPDC, it was confirmed by lecturers at Rangoon's Medical Institute.⁶

Not only does the SPDC fail to provide healthcare and inhibits its delivery, in some cases it is actually the cause of the ill health. Forced labour is a serious problem, particularly in areas experiencing ongoing armed conflict. Typically, whenever SPDC army forces arrive in an area, they force locals to porter their supplies even if they are in poor health. For example, 40-year-old Mu Lin was already unwell when he was forced to porter for an unidentified SPDC army column for a week in Hopong Township, Shan State in April 2008. Despite complaining that he was feeling unwell and high a high fever, he was forced to continue carrying the heavy load that he was given. He was utterly exhausted by the time that he was released. A few days after returning home, Mu Lin heard that opposition forces might also be coming to his village to demand porters. Fearing that he would have to go again, he collected whatever possessions he could and fled to the Burma-Thai border with his wife and child. However, on the way, Mu Lin fell sick again, quite likely as a result of his weakened condition, and died before they could reach the border.⁷ (For more information, see Chapter 7: Forced Labour and Forced Conscription).

Serious concerns regarding the health of political prisoners also continued to be expressed throughout 2008. Burmese prisons are renowned for their poor conditions and lack of access to healthcare. According to a letter written by an unidentified prisoner in Buthidaung Prison in Arakan State, many prisoners have developed skin infections such as scabies due to poor sanitation facilities, while the inadequate diet has resulted in many prisoners also

contracting beriberi. The same letter also reported that scores of inmates in Buthidaung Prison had been treated with the same hypodermic needle, resulting in the spread of HIV among the prison population.⁸

In the wake of Tropical Cyclone Nargis, which struck the country on 2-3 May 2008, the health of many, particularly those in the coastal regions and the Irrawaddy Delta, was greatly affected. The refusal of the junta to either act themselves or allow in international aid agencies resulted in a deterioration in the situation and led to many unnecessary deaths, and has been classified by some commentators as a Crime against Humanity.

Despite worldwide concern and criticism regarding the situation in Burma, the World Health Organisation (WHO) has in fact been positive. In spite of the deplorable state of Burma's healthcare system, the disgracefully small budgetary allocation for the sector, and the near complete lack of political will of the SPDC to provide for the population, in September 2008, the WHO Deputy Regional Director for Southeast Asia, Poonam Singh, was quoted as having said that the junta was *"actually doing quite a lot to meet the health needs of the people"*.⁹ Unsurprisingly, such apologetic support for the regime by an international organization which consistently claims its neutrality shocked many Burma watchers at home and around the world.



This photograph, taken in November 2008, shows Naw Mary Wah as she was receiving treatment from a local Karen aid organization after failed suicide attempt. Earlier in the month she had attempted to kill herself by overdosing on quinine tablets which are typically used for the prophylactic treatment of malaria. Two months prior, she had lost her husband after he had stepped on a landmine while crossing a road. The blast did not kill him outright, but blew off most of his leg. After lying on the road in agony for some time, he eventually took his own life by shooting himself with his own hunting rifle. [Photo: © FBR]

11.2 Access to Healthcare

As in previous years, investment in healthcare by Burma's ruling military junta was close to non-existent, with MSF estimating that only 0.3% of the nation's Gross Domestic Product (GDP) was spent on healthcare.¹⁰ This paltry amount translates to just US\$0.70 per person and represents the lowest budgetary allocation for healthcare in the world.¹¹ Meanwhile, neighbouring Thailand was said to spend an estimated US\$61 per capita on healthcare.¹²

Access to healthcare is limited throughout Burma; however, certain groups have a tendency to suffer more than others. Inevitably, the availability of healthcare is far lower in rural areas than it is in inner city areas. One clear consequence of this uneven distribution of healthcare is the high rates of malnutrition identified among several of the country's ethnic minorities. For example, one report from October 2008 showed that in one particular area of Chin State, all 300 villages scattered throughout the region had been neglected by the authorities and possessed no healthcare facilities. It was reported that a medical team visiting the area had to send 23 people to hospital as emergency cases and voiced concern about the health of the local population.¹³

Following the advent of Tropical Cyclone Nargis, the health situation in certain rural areas that were particularly hard hit by the cyclone deteriorated significantly (For more information, see Section 11.5: Natural Disasters below, as well as Chapter 10: Cyclone Nargis – From natural disaster to human catastrophe). On 11 June 2008, it was reported that the people of 14 villages in the Dedaye Township, Irrawaddy Division had yet to receive any medical assistance. This meant that almost six weeks after the cyclone had struck the region, there were still dead bodies uncollected and people with serious injuries such as broken shoulders and ribs who were as yet still to receive any sort of assistance.¹⁴

While the SPDC claims to have improved healthcare facilities throughout the country, the reality is somewhat different. Though new clinics have been built in various different ethnic and rural areas, for instance in parts of Karen State, they are often the result of the forced and uncompensated labour of the local population. Moreover, once built, many village clinics stand unused as they are often left unstaffed and provided with no supplies.¹⁵ Such projects are typically carried out by the SPDC purely so that they can say they are building clinics and providing for the health concerns of the population. Following the completion of any new clinics, high-ranking SPDC army personnel often visit the site for the obligatory photo opportunity, which often later appear in the State-run press as evidence of all the ways in which the SPDC is benefiting the nation. However, after their photographs are taken, the officers depart and little to no further assistance is provided to the clinic. Many such clinics remain empty and on occasion, even permanently locked.

Meanwhile in urban areas, public hospitals are underfunded, fraught by corruption and are often unable to treat the most seriously ill. Many of the private clinics that could treat these patients are not only expensive but also often turn away patients they fear may die in the interest of protecting their reputations, even if these patients were able to pay. This was reported to have occurred in parts of Mon State in February 2008.¹⁶

Meanwhile, it has been reported that in Kyauktaw of Arakan State, Military Operations Command (MOC) #9 has extorted additional fees from individuals who visit a local clinic for a checkup. The clinic in question was allegedly set up as a free clinic by MOC #9, however, patients not only have to pay a consultation fee and for any medications that they require, they are also expected to bring gifts should they want to receive an adequate examination.¹⁷ Stories such as this sadly are not uncommon in Burma.

That said, there were numerous reports throughout 2008 of medical professionals doing their best for their patients across Burma despite the difficult circumstances they face. For example, in Arakan State in October 2008, a doctor saved the life of a woman requiring complex gynaecological surgery which would normally need modern operating facilities despite the very basic facilities he had access to.¹⁸ Similarly, in the cyclone-hit Bogale Township in Irrawaddy Division, one nurse, Moe Moe, was in her clinic when the cyclone struck on 2 May 2008, but managed to save her medical instruments which proved invaluable in the aftermath of the cyclone.¹⁹



A young internally displaced Karen boy, shown here as he was receiving medical treatment from an FBR medical team in southern Nyaunglebin District in March 2008. [Photo: © FBR]

Maternity Provisions

As with all other forms of healthcare in Burma, maternity provisions are poor in all areas of the country. The junta claimed that throughout 2008, it worked to extend maternal healthcare throughout the country, with plans to see a skilled midwife in every village.²⁰ As with many other claims made by the SPDC, it remains to be seen whether they will realise their commitments. Increased maternal care is much needed in Burma. According to the WHO, there is on average only one skilled midwife for every 5-10 villages, resulting in the majority of births being attended by unqualified auxiliaries if at all.²¹ The WHO estimates that the maternal mortality rate in Burma is 383 per 100,000 live births, one of the highest in the region.²² In the wake of Cyclone Nargis, it was feared that these figures would rise still further as a result of pregnant women living in poor conditions and the destruction of any maternal healthcare provisions. However, since that time, numerous NGOs have worked to set up clinics in the Irrawaddy Delta to help improve the situation.²³

It is believed that communities in Eastern Burma, where an estimated half a million people have been displaced by continuing armed conflict and associated human rights abuses, suffer some of the worst maternal health in the entire country.²⁴ The situation is exacerbated by the poor living conditions and general health of the population, resulting in high levels of poor nutrition, anaemia and malaria, which increase the risk of complications during pregnancy and delivery. In this area, only 1 in 20 births are attended by a skilled midwife, increasing the maternal mortality rate to 1,000 per 100,000 live births, almost three times the country average. Meanwhile, infant mortality is 91 per 1000, compared with the national average of 76 per 1000 live births.²⁵

Abortion is illegal in Burma, and can often lead to life-threatening situations for poor women. Many women are employed in low-paying jobs with little security and a pregnancy would most likely result in loss of their job; a situation that they could ill-afford. While Burma's domestic laws stipulate that women are entitled to 45 days of paid maternity leave, in practice this rarely happens and women are far more likely to lose their jobs altogether. Despite contraception being available in Burma, it remains beyond the means of most women. Even the cheapest means of birth control costs 700 kyat per month, while sterilisation is illegal for women under 35 years of age.²⁶ Meanwhile, many women are reluctant to buy condoms for there have been reported cases of women being arrested and convicted for protestation purely for being in possession of condoms. Due to its illegality, obtaining an abortion from a qualified medical professional can cost as much as 50,000 to 100,000 kyat which, considering that the average wage of an unskilled worker is only around 1,500 kyat per day, such a procedure is far beyond the means of most. The only option, therefore, is a “backstreet abortion” conducted by unskilled individuals at a cost of 5,000 to 20,000 kyat. Such procedures can result in life-threatening complications, the most common of which is blood poisoning, but even in such peril many women are reluctant to seek medical help out of fear of being prosecuted for the crime of having an abortion. Those convicted can face up to three years in prison.²⁷

Pharmaceuticals

During 2008, pharmaceuticals were Burma's seventh largest import item, most of which reportedly came from India. This has led to local companies struggling to compete.²⁸ The almost complete collapse of the Burmese healthcare system has left the country vulnerable to counterfeit medications, which can be incredibly dangerous, if only through their ineffectiveness. According to an article published by the Kachin News Group (KNG), counterfeit artesunate tablets, used for the prophylactic treatment of malaria, were found at one stall in the central market in Kengtung, Shan State. They were tested at a laboratory at the United States Center [*Sic.*] for Disease Control and Prevention in Atlanta, Georgia, and were found not to contain any of the crucial active ingredient required to fight the disease, thus making them ineffective.²⁹ Considering that *Plasmodium falciparum* malaria, widely recognised as the most deadly strain which can often lead to coma and death, is widespread throughout Burma, the production and trade of counterfeit drugs can cost lives. (For more information, see the section on “Malaria” below).

The case of artesunate is but only one example; there is a wide range of counterfeit drugs available on the Burmese market which claim to treat a variety of ailments. The absence of adequate or affordable healthcare in Burma lead many people to take the risk of using such counterfeit medications, many of which prove to be little more than ineffective placebos.

In October 2008, the KNG reported another incident on the Sino-Burma in which local people were forced to purchase medicines from Northern Regional Military Command (*MaPaKa*) Commander, Major General Soe Win, who was known for having previously distributed medicines which had passed their expiry date.³⁰

There have also been reports of smuggling of drugs into Burma, presumably as a cheaper alternative to the imports being brought into Burma from India and China. Again, this is not particularly surprising given the state of Burma's ailing healthcare system. At different times throughout the year, there were reports of several police raids being carried out on seemingly-legal businesses and clinics in Arakan State. For example, in November 2008, police raided a neonatal clinic and had reportedly seized contraband birth control tablets and injections.³¹ Similarly, a few months prior, in September 2008, local police conducted another raid on a medical dispensary during which they had reportedly seized medicines

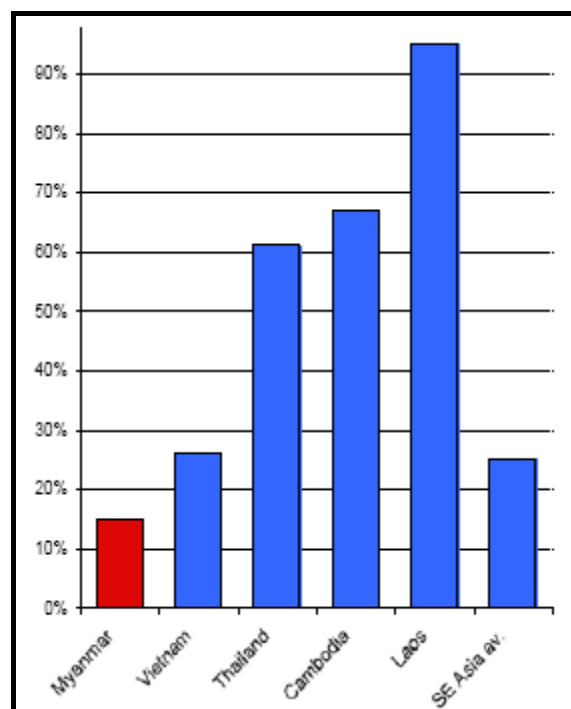
valued at an estimated 600,000 kyat. The reasons for these raids are unclear, particularly as the latter was selling genuine medications made in Burma and had a license to do so. The owner was arrested and detained for ten days despite having paid 400,000 kyat to police. The owner had already lost approximately one million kyat over the incident and could not afford the additional 200,000 kyat being demanded by the police to have the medicines returned. It was believed that the owner, who is a member of the Muslim Rohingya community, had been targeted by the authorities purely so that they could extort money from.³²



A Karen relief team distributing medical supplies to internally displaced villagers in Papun District of Northern Karen State in August 2008. For many villagers living in conflict areas, teams such as this one are among some of the only sources of aid that IDPs receive. *[Photo: © KHRG]*

11.3 HIV/AIDS

The HIV/AIDS situation in Burma is one of the worst in Asia and has deteriorated to the extent where Médecins Sans Frontières (MSF) has labelled it as one of the ten worst humanitarian situations in the world.³³ Statistics released by the United Nations Joint Programme on HIV/AIDS (UNAIDS) showed that between 240,000 and 360,000 people out of Burma's population of approximately 50 million are HIV positive.³⁴ Approximately 25,000 people lost their lives to AIDS-related illnesses in 2007 and according to MSF, just 20 percent of those requiring Anti-Retroviral Therapies (ARTs) are receiving them, with most of these being delivered through MSF. On average, ARTs cost US\$29 per month in Burma. With the average wage of just US\$1.2 per day, this is far beyond the means of most Burmese.³⁵ Of the 76,000 people estimated to be in need of immediate care, during 2007, MSF treated approximately 11,000. Meanwhile, the SPDC provided care to only 1,800 and spent only US\$200,000 to combat the HIV/AIDS crisis, despite the need to spend an estimated US\$18 million just to treat those currently in need of ARTs.³⁶ As a result of this extreme lack of funding, many patients must wait for a significant amount of time before receiving any form of treatment, while others die tragically while still waiting. In October 2008, it was reported that at one clinic in Rangoon, as many as 50 patients were seen queuing each morning in the hope of getting access to free ARTs. However, according to one doctor working at the clinic, only ten percent of patients ever receive ARTs; the remaining 90 percent die before they get the chance.³⁷



This chart summarizes the findings of a study conducted by MSF on the percentage of Anti-Retroviral Therapy (ART) coverage, current to the end of 2007. The results from Burma (shown in red) are compared against similar findings from other neighbouring countries in Southeast Asia. [Table: © MSF]

Although public awareness of HIV/AIDS in Burma is gradually increasing, throughout 2008 there was still a significant lack of knowledge and stigma often inhibited its prevention and treatment. In February 2008, a film about people living with HIV won the best picture award at Burma's equivalent to the Academy Awards, possibly indicating a change in attitudes

towards public awareness of the disease.³⁸ However according to the *2007 Asia Epidemic Update Regional Summary*, when asked, only 50 percent of Burmese adults could provide three methods of HIV transmission, while in some areas there is a belief that the virus can be transmitted by mosquito bites.³⁹

A high proportion of those who are HIV positive are youths, with those under 24 accounting for almost two thirds of those living with the virus.⁴⁰ According to MSF, a significant reason for the high HIV/AIDS prevalence in Burma is the high level of intravenous drug use among young people. It is thought that many young people use drugs due to a sense of hopelessness in the country. A report by the Kachin National Organisation (KNO) has alleged that in Myitkyina, Kachin State, as many as eight out of every ten youths will at one point have used intravenous drugs, and this often would have involved the sharing of needles.⁴¹

Sex-workers are another group at increased risk of contracting HIV. Due to the endemic poverty in Burma and lack of well paid jobs, many women are drawn to sex work in the cities in order to support their families and pay for education and medical bills for their children, parents and siblings. These women are particularly vulnerable and are at increased risk of contracting HIV both through sex and drug use, to which they are more likely to resort.⁴²

Of the 400 prisoners held in Myitkyina jail, in February 2008, approximately 90 percent were diagnosed as being HIV positive. A former political prisoner blamed these high levels of HIV infection on the poor basic healthcare provisions inside the jail.⁴³ In November 2008, it was reported that two years prior, in October 2006, jailed poet and member of the opposition National League for Democracy (NLD), Aung Than, had contracted HIV in Insein Prison in Rangoon Division while receiving treatment for a prostate problem. According to reports, “a member of the hospital staff who was not a doctor” forcibly injected 36-year-old Aung Than with a used needle despite his protests. It is not clear what the needle contained, but it is believed that it had been used on another inmate who had HIV. Soon after the incident, Aung Than began displaying symptoms such as “repeated fevers, skin ailments, and frequent colds”, first sparking fears that he had contracted HIV. His requests to be tested were all denied. His fellow detainees, some of which included medical practitioners, have reported that his symptoms were typical of someone with AIDS. At the time of the original report, two years after the incident, Aung Than was still yet to receive treatment or be released from jail.⁴⁴

11.4 Other Infectious and Communicable Diseases

As in previous years, the broader Burmese population continued to suffer from infectious and communicable diseases during 2008 and in many cases the levels of these diseases were higher than in other countries in the region. Among the primary reasons which gave rise to this are poverty, which results in a lack of clean drinking water, a lack of adequate sanitation facilities, malnutrition, a lack of vaccinations, and a lack of political will on the part of the SPDC to adequately address these issues.

Though vaccinations are widely considered to be one of the most cost-effective forms of public health, the Burmese junta provides no childhood vaccines for its citizens. The few vaccination programs operating within the country are conducted by international NGOs. For example, UNICEF provides up to 90 percent of all vaccinations in the country, yet despite their best efforts, these programs do not reach all children. Many parts of the country remain off-limits to international organizations and sadly, it is within many of these areas that the most vulnerable populations live.⁴⁵

Beyond the specific diseases discussed below, there were outbreaks of a number of other diseases in 2008. For instance, in November 2008, there was an outbreak of measles among an internally displaced population in Karen State. Measles is easily prevented through vaccination, but few children in Burma receive the necessary vaccinations. By the time the outbreak had been brought under control, 512 people had been taken ill and four had died.⁴⁶ Meanwhile, in March 2008, there was an outbreak of chickenpox in Buthidaung Township, Arakan State which had killed four children, all aged two to three years old. Deaths from chickenpox are almost unheard of in most countries of the world where adequate vaccination programs and healthcare facilities exist, but in Burma, poverty and malnutrition, along with poor healthcare, can often lead to complications and ultimately to deaths.⁴⁷

Tuberculosis

According to MSF, Burma has one of the highest levels of Tuberculosis (TB) infection in the world, with an estimated 80,000 new cases every year.⁴⁸ TB is highly infectious, but can lay dormant in carriers for many years. Its effects are most serious for those with weakened immune systems, for example those who are malnourished. It is also the most common killer of AIDS patients; therefore, the relationship between HIV/AIDS infection levels and TB infection levels in Burma is extremely important. A representative of the International Organization for Migration (IOM) reported that many people infected with TB do not go to hospitals and attempt to treat themselves at home with traditional herbal remedies and other such treatments which typically prove to be ineffective.⁴⁹

In 2008, an independent study which relied on data obtained from the health screening of ethnic Shan migrants working in Thailand showed TB to be the most common communicable disease diagnosed. The study also revealed that significantly lower numbers of Burmese migrant workers complete the treatment programme compared with Thai citizens who contract the disease.⁵⁰

Malaria

Globally, it is estimated that a million people die of malaria every year, and according to MSF, it is Burma's leading cause of death, leading Burma to account for half of all malarial deaths in all of Southeast Asia.⁵¹ There are massive discrepancies in the estimated prevalence of the disease. While in June 2008, the WHO conservatively estimated there to be approximately 500,000 cases per year, malaria specialist, Dr Frank Smithuis the MSF head of mission in Rangoon, was quick to dismiss this, estimating that the number of malaria cases in Burma each year to be nearer 10 million.⁵² As with many other communicable diseases, the high mortality rates for malaria in Burma is believed to be due to both the overall poor health of local communities, which in turn are a result of poor living conditions, and the almost complete lack of healthcare services and budgetary allocation. While MSF has been committed to tackling the malaria epidemic for some years, its 30 clinics treating around 200,000 people per year still leave many untreated, although from the figures above it is difficult to say if it is hundreds of thousands or millions who are going without treatment. As with other aspects of healthcare, those in remote areas are most at risk. One report published in November 2008, maintained that almost the entire population of one village in Kachin State were infected with malaria.⁵³ While, in December 2008 it was reported that 23-year-old refugee Abdul Malek had died of jaundice and malaria in a refugee camp in Bangladesh after having receiving only paracetamol and antibiotics, which would be ineffective for malaria.⁵⁴

Following Cyclone Nargis, there were fears that a culmination of factors could result in a serious outbreak of malaria in the affected Irrawaddy Delta region. The influx of salt water into the delta created an ideal breeding ground for the mosquitoes that transmit it. Many animals were also killed leading to concerns that mosquitoes would be more likely to try to feed on humans thus transmitting malaria.⁵⁵ Thankfully, however, these fears do not appear to have been fully realised as there were no reports throughout the rest of the year of any serious outbreaks in the area. (For more information, see the section dealing with "Cyclone Nargis" below).

Dengue Fever

Dengue fever continued to be a serious problem in Burma in 2008. As with malaria, it is transmitted by mosquitoes, but unlike malaria the dengue carrying mosquitoes are generally active during the day. This makes it far more difficult for people to protect themselves from being bitten and there is no vaccine. Dengue manifests itself as flu-like symptoms of severe fever, rash, headaches and joint pain.⁵⁶ It is particularly dangerous for children and the elderly.⁵⁷ In July 2008, there were reports that 3,000 people in Burma had thus far been infected with dengue that year, but no further information was provided as to the number of fatalities which resulted.⁵⁸ The worst outbreaks of dengue normally come later in the year during the height of the rainy season. There was a further report at the end of July 2008 of an outbreak in Monywa Township in Sagaing Division which had killed an unspecified number of children, with locals saying that health services were not adequate to deal with the outbreak and had been overrun.⁵⁹

As with malaria discussed above, there were fears that Cyclone Nargis had left behind favourable conditions for the mosquitoes that transmit dengue, raising concerns of an epidemic in cyclone-hit areas. The WHO and UNICEF worked with local organizations to try to reduce the risk by destroying breeding areas, primarily through spraying insecticide and larvicide into stagnant pools of water left behind by the cyclone.⁶⁰ Fortunately, these measures would appear to have had the desired effect, as no major outbreaks in the cyclone-hit areas were reported later in the year. However, ten Taiwanese aid workers reportedly contracted dengue after volunteering in the area and were expatriated and successfully treated in back home in Taiwan.⁶¹

Diarrhoea and Dysentery

As waterborne diseases, diarrhoea and dysentery are both problems in poorer areas which lack adequate sanitation facilities. Although easily cured where good healthcare is in place, in poorer areas, lives, particularly those of children, are often lost to this easily treatable disease. Diarrhoea is also easily prevented; it has been estimated that by having access to proper latrines, rates of diarrhoea can be reduced by up to 40 percent; however, only 25 percent of Burmese have such access.⁶² There was an outbreak of dysentery and diarrhoea in a number of villages in Maungdaw Township of Arakan State during August and September 2008. The deaths of two people, 35-year-old Rohima Khatoon and 12-year-old Shom Jeeda, were reported at the end of August 2008. Many more were affected and a team of doctors from Maungdaw reportedly travelled to the affected villages to assess the situation. The doctors suggested that malnutrition was a key cause of the outbreak.⁶³ By mid-September 2008, there had been more deaths in several villages in the area.⁶⁴ In October 2008, the Maungdaw Township Health Officer made an appeal to the authorities for help. There were no more beds in the hospital and the area was in urgent need of doctors and medicines. There were also concerns about the levels of malnutrition, particularly in children. There were no official reports as to the total number of fatalities, but local health workers reported that more than fifteen children had died during the outbreak.⁶⁵

Wherever malnutrition and a lack of fresh water are found, diarrhoea and dysentery are typically not far behind. Both diseases are particularly rife in refugee camps. In July 2008, two children reportedly died of diarrhoea in the Kutupalong refugee camp in Bangladesh. Poor sanitary conditions, a lack of adequate food and absence of medical care all contributed to outbreaks of diarrhoea, dysentery, malaria and pneumonia within the camp.⁶⁶ In November 2008, a further outbreak of diarrhoea was reported among the refugee population in the Nayapara refugee camp, also in Bangladesh. One baby girl was reported as having died, while several others were being treated. A relative of the baby girl reported that her death was a result of poor medical care. Other refugees reported having to stand in long queues to obtain medicine. Some reported having to join the queues from as early as 3:00 am, with only about half of those queuing eventually getting any treatment.⁶⁷



A Free Burma Ranger medic providing medical and dental treatment to internally displaced villagers in Karen State during 2008. *[Photo: © FBR]*

Cholera

Cholera is another waterborne disease which often affects those living in poverty. As with diarrhoea and dysentery, it can be easily prevented through drinking purified water and using adequate latrines; however in Burma in 2008, it continued to take many lives unnecessarily. Left untreated, cholera can kill as many as one out of every two people infected.⁶⁸ An outbreak in Kachin State in October 2008 reportedly killed 21 people after the stream that the villagers used for drinking water had flooded and become contaminated. However, it would seem that the intervention of the SPDC-affiliated Kachin Independence Organization (KIO) prevented the disease from spreading further and saved many lives. According to reports, the KIO had sent a medical team into the area and prohibited travel and quarantined the affected area to prevent the spread of disease to neighbouring areas. The SPDC also reportedly sent a medical team from Myitkyina to the worst affected area for two weeks to assist the efforts of the KIO.⁶⁹

As with other waterborne diseases, there were fears after Cyclone Nargis hit that there will be an epidemic of cholera in the area. There were in fact reports of outbreaks of cholera in the area, but these were not only in line with figures reported in previous years, but also were only to be expected for a region dominated by a large river delta soon after being struck by a tropical cyclone. The WHO was reported to have distributed water purification tablets after the cyclone, which it claimed had prevented many deaths.⁷⁰

Foot-and-Mouth Disease

Although foot-and-mouth disease does not affect humans, it is highly infectious among farm animals and has a high fatality rate. This can have a devastating effect on already poor farmers and lead to a loss of livelihood, which in turn could have adverse health effects. The only reported outbreak of the disease in 2008 was in Irrawaddy Division, which had already suffered extreme devastation in the wake of Cyclone Nargis. It was estimated that approximately 200,000 farm animals died in the cyclone, but the number lost to foot-and-mouth disease after the storm had passed remains unknown. The loss of more livestock could destroy the livelihoods of many farmers already struggling to survive.⁷¹ In 2003, an agreement was signed between Burma, Thailand and Malaysia to reduce the spread of foot-and-mouth disease across national borders.

In August 2008, it was also reported that the Japanese Government had initiated an US\$829,000 aid project aimed at combating a variety of animal diseases in the country including, but not limited to, foot-and-mouth disease and avian influenza (H1N1). According to reports, the project will be carried out over three years and will include the establishment of two separate laboratories to work on the prevention of disease transmission.⁷²

11.5 Contaminated Chinese Milk Products

In September 2008, toxic melamine was discovered in a variety of Chinese milk products, particularly in powdered baby milk. Melamine is a chemical that can be used to artificially elevate protein levels, but is mainly used in plastics and can be harmful to humans if ingested. It is particularly harmful to young children, and can cause kidney stones, which in very young children can lead to death. In China, tens of thousands of children were affected and at least four children were reported to have died. Chinese milk products are all exported throughout Asia, leading to widespread concern across the region.

Chinese dairy products are widely sold in Burma as cheap Chinese-manufactured products have flooded Burmese markets. In September 2008, the SPDC reported that they were to destroy 16 tonnes of milk powder produced by Chinese companies and investigate if there were any other contaminated milk products in the country.⁷³ Towards the end of September, SPDC-affiliated health inspectors seized large quantities of Chinese dairy products for testing from the popular Mingalar and Nyaungpinlay markets in Rangoon.⁷⁴ However, it was not until almost a month after news of the contamination broke that the regime made an official announcement naming the products that they had found to be contaminated.⁷⁵ The affected products were removed from shop shelves and on 10 October 2008, the SPDC then banned the importation and distribution of the nine dairy products that they had found to be contaminated. A few days later a further seven products were also banned after also being found to be contaminated.⁷⁶

Despite this, however, there were concerns about the junta's response to the crisis. To begin with, their actions came nearly a month after the contamination was originally reported, and during that time, not only had the authorities not tested any products but they had also not warned the public of the possible dangers. Secondly, due to the widespread poverty of the general population, many families are not able to buy branded baby milk powder, but instead buy the cheaper repackaged baby milk powder at a cost of approximately 100 kyat in local markets. Furthermore, at the time there was absolutely no indication from the SPDC that they had any plans to inform the public about the risks of purchasing repackaged baby milk.⁷⁷ According to the *Mizzima News*, one grocery store chain in Rangoon introduced an exchange policy for customers to exchange contaminated milk products for safer alternatives.⁷⁸ Many consumers boycotted Chinese dairy products altogether out of fear of other products being contaminated. Unable to sell the products in their stores due to a lack of consumer confidence, many merchants reportedly began to offer Chinese milk products to their customers at heavy discounted prices. In spite of such savings, locals reported that it was only those who were ignorant of the dangers of the contamination who were buying the products as others were not prepared to take the risk.⁷⁹ Products continued to be tested at the end of October 2008, including several brands of "three-in-one" instant coffee, but no further products were reported to have been contaminated.⁸⁰ Despite the widespread availability of Chinese milk products in the Burmese market, there were no reports of any fatalities or illnesses arising from the ingestion of contaminated products.

11.5 Natural Disasters

Cyclone Nargis

Tropical Cyclone Nargis struck the Burmese coastline on 2 May 2008 and is believed to have killed more than 140,000 people. In total, an estimated 2.5 million people were affected by the devastation caused, and in some areas, particularly those areas situated within the Irrawaddy Delta, up to 95 percent of homes were destroyed.⁸¹ (For more information, see Chapter 10: Cyclone Nargis – From natural disaster to human catastrophe).

In response to the enormity of the disaster, numerous countries and international aid agencies lined up to provide relief for those affected. However, in spite of the sheer scale of the catastrophe, the immensity of the human cost, and the generosity of the international community willing to help, the junta both failed to act and also actively prevented the provision of aid to those in desperate need. The denial of humanitarian aid in this fashion is tantamount to a crime against humanity.

The initial concern of the international community quickly turned to outrage as it was feared that thousands more Burmese civilians would lose their lives through disease and hunger while offers of assistance were refused.⁸² Days after the cyclone, hundreds of thousands of people had received no aid whatsoever and reports began to emerge of people dying of hunger and dehydration. Bodies lay strewn in the streets and in streams near which survivors continued to live.⁸³ Reports also began to emerge of overflowing toilets and people drinking from stagnant water sources, a dangerous situation which could lead to outbreaks of waterborne diseases such as diarrhoea and cholera and provide a breeding ground for the mosquitoes responsible for the spread of malaria and dengue fever.⁸⁴ This sparked the very valid fear that the spread of disease could take many more lives than the original event.

It was reported that two weeks after the cyclone had hit, only 86 visas had been granted to international aid workers, although even these few were denied access to the worst affected areas.⁸⁵ The handful of aid workers allowed in had to work with those who had already been working in the country to coordinate the aid operation. Many such local aid workers had lost family members in the cyclone as well and were already traumatised by their experiences. Yet, in spite of this, they were not able to mourn the loss of their loved ones as they were then forced to work tirelessly so as to help as many as they could while the junta still refused the international offers of help.⁸⁶ In one reported incident, aid workers were actually blocked by police officers from reaching the survivors they were trying to help.⁸⁷

After three weeks had passed and with no shift in the junta's position, there were a growing number of voices, both within Burma and around the world, calling for the UN Security Council to take action or even to force the SPDC to accept aid and allow the international community to help.⁸⁸ It was estimated that as much as 50 percent of the limited existing healthcare facilities in cyclone-affected areas had been destroyed, and the fact that people had limited access to food and sanitation made them all the more vulnerable to disease.⁸⁹ In addition to disease, there was also the risk of cuts and other injuries sustained during the storm becoming infected, which without treatment could have quickly become life-threatening.⁹⁰

Doctors operating in Irrawaddy Division reported primarily treating patients with cuts and flesh wounds, diarrhoea and respiratory diseases, and though many thousands of people in the region were treated, the number of patients who had contracted infectious diseases thankfully remained lower than had initially been feared.⁹¹ Meanwhile, a number of cholera outbreaks were reported to have occurred in some of the relief centres set up to accommodate the displaced, such as the one at Labutta, however, the frequency of cases was said not to have been significantly greater than in previous years.⁹²

There were also legitimate concerns for those who were already ill prior to the cyclone, in particular those suffering with TB and HIV/AIDS whose treatment, if indeed they were receiving any, could be disrupted. Such people were also more vulnerable to contracting other diseases, particularly as a result of the poor living conditions and the destruction of sanitation facilities.⁹³

Eventually, after several diplomatic visits to Rangoon by representatives of the United Nations, the junta relented and many millions of dollars in relief and hundreds of aid workers flooded into the country. Fortunately, in spite of the initial fears of outbreaks of disease, these appear never to have come to fruition and a second wave of deaths from disease did not materialize. However, regardless of the aid agencies eventually being allowed entry into the country, by mid-June 2008, some six weeks after the event, the UN estimated that a million people in need had yet to be reached.⁹⁴ By the end of August 2008, it was reported that there had been no further large-scale outbreaks of disease which could be attributed to the cyclone.⁹⁵



This photograph, taken in the Irrawaddy Delta region in late October 2008, shows the severity of the devastation left behind by Cyclone Nargis and the resultant living conditions that families continued to survive under. [Photo: © Charles Metzger]

Famine

Parts of Chin and Arakan States continued to be plagued by a famine which began in 2006 with the flowering of the bamboo. This rare phenomenon takes place only once every 50 years as the bamboo comes to the end of its life cycle. When this happened, however, it brought a plague of rats which fed on the flowers and whose fertility then increased as a result. Once they had consumed the bamboo flowers, they then went on to feed on villagers' crops.⁹⁶ The effect of this on the already-impooverished region was devastating. Villagers have estimated that around 40 percent of their rice crops had been destroyed, which, in turn, resulted in rice prices in local markets increasing by 75 percent.⁹⁷ The last time that the bamboo came into flower back in the 1950s, an estimated 15,000 people died from starvation and through the diseases spread by the rats. By June 2008, it was estimated that approximately 20 percent of Chin State's population of 500,000 were suffering from hunger and malnutrition, leading to warnings from aid agencies that the famine was reaching a critical point.⁹⁸

As the year progressed, the situation became increasingly serious. Doctors warned that malnutrition and starvation in the population was leading to an increase in disease through their weakened immune systems.⁹⁹ There were reports which maintained that in some areas; in particular in a number of villages in Thangtlang Township, Chin State, diarrhoea, cholera and skin conditions had become endemic, with numerous deaths being reported.¹⁰⁰ In June 2008, it was reported that in Sittwe, the capital of Arakan State, a father, unable to find enough food to feed his family, had poisoned his two young children before taking his own life rather than watch them die slowly from starvation.¹⁰¹

Despite the severity of the situation, the SPDC offered virtually no assistance to the people of Chin and Arakan States. It was not until much later in the year, in November 2008, that the junta offered a token aid delivery to a few villages. That which was provided was inconsequential when compared to the enormity of the demand. It is likely that the only reason that anything was offered at all was so that the regime could claim that they were doing all that they could to help the people. Most Chin people were being helped through the famine by Chin living abroad sending supplies back to their families or communities.¹⁰² Meanwhile, throughout the crisis, rather than helping the people, the military continued to impose fines, unofficial taxes and wholesale movement restrictions, while also forcing the local population to perform forced and uncompensated labour, all of which only added to the severity of the famine and the hardships faced by the civilian population.¹⁰³



It is believed that 140,000 people lost their lives to Tropical Cyclone Nargis, while an estimated 2.5 million were adversely affected. Sadly, scenes such as this one were not uncommon in the wake of the cyclone as thousands of bodies lay strewn across the streets and littered streams and beaches. This photograph, taken in Bogale Township, Irrawaddy Division, in May 2008, shows the bodies of at least eight people who were killed, some of whom were children not yet even in their teens. *[Photo: © Delta Tears]*

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