HIV/AIDS:
Taking Its Toll on Burma

In Her Own Words

The Health of Burma's Women and Children
THE ISSUES -

HIV/AIDS: TAKING ITS TOLL ON BURMA

The dramatic rise in intravenous drug users in Burma has contributed to an equally dramatic and tragic rise in the number of people infected with HIV/AIDS. In his recently published book, Dr. Chris Beyrer traces the history of the disease in Southeast Asia and looks at the efforts of government, international agencies and health professionals in addressing the problem within Burma's current social and political context. Meanwhile, as part of its National Health Plan, the State Peace and Development Council's Ministry of Health has outlined its strategy for combating the disease through prevention and treatment programs.

IN HER OWN WORDS

Previously thought of as a disease that effects only drug addicts and prostitutes, HIV/AIDS is now finding its way into Burma's mainstream. In this moving and telling account, a young Burmese woman, who until recently knew nothing of the illness, describes the devastating impact AIDS has had on her family.

THE HEALTH OF BURMA'S WOMEN AND CHILDREN

Women and children make up more than sixty percent of Burma's population, yet the health indicators for this group are among the lowest in the world. High infant and maternal mortality, malnutrition, and lack of access to adequate health services are problems plaguing the country. Such social factors as child labor, the trafficking of women and girls into prostitution, and the failure to educate health professionals contribute to the health crisis. The question remains: Does the will exist to improve the status of Burma's most vulnerable?
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BURMA DEBATE 3 SPRING 1998
HIV/AIDS: TAKING ITS TOLL ON BURMA
The following are excerpts from Dr. Beyrer’s recently published book of the same title. [Media Resources p. 42]

The book you have in your hands is something of an experiment. It has grown out of several years of work, at times exhilarating and at times deeply frustrating, on one problem: the swift and pervasive spread of HIV virus among the people of mainland Southeast Asia. It is not intended to be an academic text in my field — public health — though much of the information included is the result of research in public health, epidemiology, and prevention. What I’ve tried to do is exploratory, provisional, and personal. The result is as much, at times, a travel book as a medical one. A journey on the AIDS road, and one by no means complete.

"Burma: going to Myanmar, being in Burma"

Burma and Thailand share a land border almost 2,100 kilometers long, from the mountains of Thailand's far north to Burma's deepest south on the narrow and steamy isthmus of Kra. The Burmese and the Thais share long, entangled histories, old grudges and rivalries, and memories of great victories, occupations and defeats. They also share Theravada Buddhism, the Pali canonical language, and calendars and traditions rooted in the cultivation of rice. Yet it would be difficult to find two countries with more radically different modern histories. Thailand escaped European domination;
Burma did not — she was colonized by the British and ruled as part of the Indian Raj. In the Second World War, Thailand sided for a time with Imperial Japan, officially declaring war on the Allies in return for a comparatively moderate Japanese presence. Burma was one of the fiercest and most horrific theaters of the Pacific war, immortalized by the British The contrasts are stark and conclusions not difficult to draw. But coming to any kind of political resolution in Burma has proved devilishly difficult. The Burmese military, the Tatmadaw, is dominated by one ethnic group, the Burmans. Burma, however, is one of the most ethnically diverse nations in the world, with more than a dozen major ethnic groups and over 100 different languages or dialects. The complex forty-year Burmese civil war is also an ethnic conflict. Hatred and suspicion of the Burmese only deepens as the conflict continues, as roads to peace and reconciliation remain blocked. It was into this longstanding political and humanitarian crisis that HIV entered and found ample conditions for epidemic spread.

Freedom from Fear

The first HIV screening programs in Burma were initiated in 1985, under Ne Win. No cases were detected until 1988, when HIV cases were first found among injecting drug users in Rangoon. Thailand has also seen an early spread to drug users, in the same year, but Burma would prove to have a very different pattern of HIV. The difference had to do with the route of spread, for it was caused by addicts sharing injection equipment in both cases, but with radically different patterns of drug use. Another epidemic preceded the HIV epidemic in Burma, and this was one of heroin use.

Before 1988 there were pockets of heroin use in several of Burma’s larger cities. The bulk of opiate use, however, was opium smoking, and this was a traditional rural practice among several of Burma’s ethnic minority peoples. The mountainous regions of northern and eastern Burma have several ideal climates for opium growing. The opium poppy, Papaver somniferum, grows best in just such stony, moderate-elevation mountain soils. For decades some of the ethnic groups resisting the Burmese military had grown opium as a cash crop to fund their struggles. This was analogous to the ‘war-time’ economy of the Afghan Mujahideen, who also supported their struggle by growing opium in their mountains (to which the West turned a blind eye, since the Afghan struggle was against the Soviets).

Other ethnic groups were in more complex situations. Years of warfare against the central government had left peoples like the Shans without coher-
ent leadership. A chronic state of warlordism prevailed in the Shan states. These warlords were supported largely by opium revenues. Warlords like Khun Sa became famous either as 'narco-terrorists' or 'nationalist leaders,' depending on who was talking. There were purely criminal elements as well, groups for whom the war was an end in itself; the isolation and poverty of struggle served their need for secrecy in producing what had largely become by the 1980s the largest opium crop in the world. Poor and isolated Burma, off the geopolitical map, became the world's single largest supplier of heroin, producing as much as 40-60% of the global supply. This reality was not lost on the US, or the drug enforcement agencies of the West, but they were remarkably ineffective in dealing with Ne Win, the SLORC, or the ethnic groups to curb production. The limited evidence available suggests that before 1988 Burma was a major heroin exporter, not a consumer. This was soon to change.

The National AIDS Program of the Union of Myanmar did not attend the Eleventh International Conference on AIDS (held in Vancouver, Canada, in July 1996) but they had submitted papers, in abstract form, which were published in the meeting proceedings. One bears some scrutiny. It is abstract Tu.C.2547.

RAPID ASSESSMENT STUDY OF DRUG ABUSE IN MYANMAR
A Ministry of Health & UNDCP Co-Sponsored Project

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Background: Myanmar society prohibits drug use, but acknowledges it to be a problem. In 1988, heroin use dramatically increased. IDU [Intravenous Drug Use] has since become a major public health problem associated with high HIV prevalence.

Objectives: To assess the nature and extent of drug abuse in Myanmar; To create a database to support a Drug Demand Reduction Program.

Method: Used multiple sources and UNDCP guidelines; involved 36 high and low risk townships. Conducted case studies on 2277 IDUs in treatment units (DDTUs) and 937 users in 33 prisons. Also taped interviews, small group discussions, informal conversations and observations involving 186 key informers, 672 users, and 32 small groups.

Results: Drug abuse prevalence varied from 1.7% to 25% of township populations studied. Of 1333 addicts registered in 1994, 77% were heroin addicts, 22% opium addicts. 84% of DDTU patients and 65% of drug offenders reported using heroin, followed by opium (18% and 22% respectively). Users in DDTUs ranged from 12 to 77 years; 88-99% were male. Analyses considered ethnicity, marital status, education, occu-
pation, drug preference, reasons for initiating drug use, duration of use, [frequency] of use, mode of use, forms/dosage and expenditure on drugs, familial trends, legal involvement, consequences of use, AIDS knowledge, and reasons for seeking treatment.

The World Health Organization helped the National AIDS Program to measure HIV rates among Burma's addicts in 1994. The result showed the highest rates ever reported among addicts worldwide.

The abstract is the haiku of science writing. You have extremely limited space in which to summarize your concepts, methods and findings. There is a world of information in abstract Tu.C.2547, if we unpack it carefully. The great pity is that we don't have the paper, and this is because the researchers (who clearly undertook a massive investigative project) who did the work were not allowed to attend the Vancouver meeting. The same thing happened at the Asia-Pacific meeting the year before, and at the Yokohama International AIDS conference the year before that: no representation from Myanmar, all talks cancelled, their poster walls blank. I did meet one delegate from Myanmar in Vancouver, a hospital official who knew little about AIDS and cared less, but assured me that SLORC was really a very concerned and good government. (A typical party functionary being rewarded for his allegiance with a trip overseas.) Whoever did the work you've just read, however, was something else entirely — this is some of the most detailed information on drugs to come from the government. Listen to the haiku and you can hear the drumbeats of catastrophe.

Title first: UNDCP is the United Nations Drug Control Program, whose methods have been adapted here. This is the 'rapid assessment' component, an epidemiologic tool to get a handle on the amount of drug abuse in a city, state, or country. Myanmar, of course, is the SLORC name for Burma; to accept the name is to accept the legitimacy of the junta; if you call it Burma, the Burmese immediately know where you stand. So UNDCP is working with the SLORC. Fair enough; their mandate is drug control. But there is a standing UN resolution calling for the restoration of democracy in Burma and for the transfer of power to the elected government.

In the 'Background' section, we have the first acknowledgment on the part of the government that the 'dramatic increase' in heroin use occurred in 1988, the year they crushed the democracy movement and assumed state power. They also acknowledge that heroin use has become a major public health problem. The association referred to in the phrase 'with high HIV prevalence' is, however, an understatement. Another UN body, the World Health Organization, helped the National AIDS Program to measure HIV rates among Burma's addicts in 1994. The result showed the highest rates ever reported among addicts worldwide: 74% in Rangoon, 84% in Mandalay, and 91% in Myitkyina, capital of the remote Kachin State on the Chinese border. Note that Rangoon (Yangon in SLORCese) is on the southern coast of Burma, Myitkyina at the northernmost tip, and Mandalay roughly midway between the two. The virus is everywhere.

'Objectives. To assess the ... extent of drug abuse.' Given the astonishingly high rates of HIV among addicts, their number is essential to estimating how many Burmese already have HIV, but the second objective is more interesting: to create a database for a Drug Demand Reduction Program. This sounds, to those familiar with the jargon, suspiciously like the US programs, always promised and yet to be delivered, to work on the 'demand' side of the drug equation, the intense craving of users for their drugs, as opposed to the 'supply' side, the narcotics industry that is typically seen as the
foreign enemy (Pablo Escobar, Manuel Noriega, Khun Sa, the Corsican Mob, and so on). But we hear no more about this program.

As to 'Methods', 36 high- and low-risk townships were studied. This indicates the scale; it was a large undertaking. We don't know how low and high risk were defined, but we do know something about townships in Burma. The junta has been relocating tremendous numbers of people and communities. These relocations, usually forced, have been done to move people off land for development projects, to get the poor out of the cities and into satellite towns where they are more easily controlled, to clear villages and settlements away from sites of historical interest for the tourist trade. For example, the premier tourist attraction of upper Burma, the magnificent ruined capital of Pagan, has been cleared of its surrounding communities. The residents of old Pagan have been resettled, out of sight of tourists, in a dry, inhospitable area about 20 km away. These new towns are something like the townships and Bantustans of the old South Africa regime. They are often places of stark poverty and despair. The depth of this despair will become clearer when we get to 'Results'.

Do 33 prisons sound like a lot? And 937 users in these prisons? And then we have 2,277 IDU (injecting drug users, so we are talking about needle-users here) in DDTU, which we have to assume means something like Drug Detoxification Treatment Units. It is not spelt out here, but we know something about the alarming conditions in some of these treatment units from Burmese who've escaped to Thailand. Firstly, there is no treatment. Detox is cold turkey, without methadone or other medications to treat the symptoms of withdrawal. Secondly, these are not voluntary units, but are on a prison model. Many are 19th-century jail facilities. The central one in Rangoon has undergone its first major improvement after photos of addicts shackled to beds reached the world's press — it now has running water. Conditions outside the capital may in some cases be even worse.

Now let us consider the 'Results'. 'Drug abuse prevalence varied from 1.7% to 25% of township populations studied.' This took considerable courage to admit. If, in any part of the country, 25% of a township population is using heroin, you have an unprecedented addiction problem. This is 1 in 4 people. This means every family, every household. If most of the addicts are men, as we find out a few sentences later, then this also means something like half the men in some townships are using heroin. And remember, the HIV rate in addicts in Myanmar is the highest in the world. Look at the age range in the treatment centers, 'from 12 to 77 years...'. Another act of courage. This is not a normal heroin and opium use population. Twelve-year-old heroin addicts are rare in any country; 77-year-old addicts are unheard of. This age range suggests populations and communities where heroin addiction is as common as drinking coffee or tea. And then we see that 88-99% of addicts were men. This is not unusual, but it does show that 1-12% of addicts were women, and 12% is high in Asian countries,
A student veteran of the 1988 movement now living in exile had this to say about heroin and the junta:

_If you put up a poster about democracy at Rangoon University you get 15 years in jail. If you hold a meeting to discuss human rights you get 15 years in jail. But if you sell heroin in the college dormitory, nobody will bother you._

**Out of control**

Heroin addiction does not necessarily lead to HIV infection: needle-sharing does. When the SLORC assumed state control and began their systematic repression of the 1988 movement, they closed the country as Ne Win had done in 1962. Foreign investors mostly stayed away (with the exception of China and some Thai military investors who bailed the SLORC out of its initial financial shortages). There was very little medical equipment available, and what there was largely went to the army. Furthermore, having injection equipment in Burma is illegal (as it is in parts of the US, the so-called paraphernalia laws). The outcome of these events and shortages was the development of a uniquely Burmese heroin culture revolving around the tea stall. Every hamlet in the country has tea stalls, traditional places for people to gather, drink volumes of Burma's strong black tea, discuss the events of the day (except political ones). Because needles were, and are, so scarce in some parts of the country, the tea stalls became local injection stations. Addicts go as often as they need through the day or week to get their heroin doses from professional 'injectors,' working in the backs of the stalls, or somewhere nearby. These injectors often have only one or a handful of needles; these are used until they are too dull to pierce the skin, and then sharpened with nail files for further use. Hence the extraordinarily high rates of HIV among these users. (Other diseases can also spread this way: a short list would include malaria, tetanus, syphilis, and hepatitis B, C, and D.)

In rural areas addicts also make their own crude injecting equipment, and these 'works' are frequently shared as well; homemade needles are sometimes made from ballpoint pens, or carved from bamboo splits.

The syringe and medical equipment shortage has not been limited to illicit use of these items. The medical system is also grossly undersupplied, especially in the civilian sector and outside the big cities. The underground Federation of Trade Unions of Burma has collected testimony from nurses working in the public hospitals in the 1990s, which paints a frightening picture of medical practices in the country. Surgical equipment is re-used until it is useless. Disposable gloves are rewashed until they’re in shreds. Rubbing alcohol, a common disinfectant, was in such short supply in 1994 that nurses were diluting it ten to one with water; it would smell like disinfectant to patients, but it would not be of much use. The NAP admits that only 65% of blood is screened before...
succumbed quickly to infections. A Burmese doctor working in a government hospital in a provincial capital told me what she had to offer her patients when they were diagnosed with AIDS: Tylenol when she had it and extra rations of rice.

Since most addicts are men, it takes little imagination to see how quickly HIV could spread from the injecting community to women. Another UNDCP study found that over 80% of male addicts in Myitkyina were sexually active, and 98% had never used a condom. Indeed, of the 350,000-400,000 HIV infections estimated to have occurred by 1995, the NAP reported that 175,000 of these were among pregnant women attending antenatal clinics. Since the number of pregnant women in a population is much more easily estimated and ascertained than the number of heroin addicts, this huge number is probably fairly accurate. If the transmission rate from mother to infant is roughly the same in Burma as in her neighbours, and we have no reason to think it would be different, between 42,000 and 58,000 infants have been born with HIV in Burma since 1988.

Condoms were illegal until 1993. They are an unknown item to most Burmese, who have had only the IUD for contraception for decades. Condoms are legal now, but expensive. A packet of 10 from Japan costs 1,200 Kyat. The average monthly salary of a government worker is about 1,000 Kyat. You can also get black-market condoms made in Korea but sold in Russia (with instructions in Cyrillic). These are cheaper, at 750 Kyat for a dozen, but to buy them would still mean not eating for 2-3 weeks. In remote areas condoms are something the educated have heard of, but rarely seen.

What about medical care for people with AIDS? The first report in the medical literature on clinical AIDS cases in Burma was published in 1993. These were patients seen at Yangon General Hospital between 1991 and 1992. Most were IDU and most were men. Nearly all presented not with the usual opportunistic infections seen in developed countries, but with tropical infectious diseases like salmonellosis and tuberculosis, a clinical pattern akin to underdeveloped regions of Africa. A recent article on clinical care for people with AIDS found that treatment was essentially non-existent, and patients
and place. Burma is a place in the heart where democracy lives, Aung San Suu Kyi assumes her elected seat as head of state, and reconciliation starts. Myanmar is an illusion of power akin to Mussolini’s Era Fascisti, an illusion armed to the teeth, Buddhist Fascism, a seemingly unimaginable concept. Will Burma rise out of the realm of aspiration and be a nation again? This is the question at the heart of Myanmar; one cannot survive the political existence of the other. As for the two states of mind, both do exist now. The tensions between them divide the society like a mountain of razor wire, a barbed and bloody tangle.

The power of the Generals is everywhere and nowhere. Aung San and his daughter are also everywhere and nowhere. The battles are fought symbolically, in the heart and in the spirit, but the cost of capture is only too physically real. And they are wasting everyone’s time. I have met officials who can’t do anything about the AIDS situation because permission has not been granted. Talented civil servants scurry about their shabby offices like mice, waiting for the call, the fax, the message, that will let them do their jobs. Civil servants cannot send faxes; they can only wait to receive them. Only the Generals send.) The Generals cannot be bothered, they cannot be cajoled; it is dangerous to reason with them. Their power is arbitrary, capricious, violent and absolute.

...In upper Burma I met a doctor working in a hospital. He is a lovely guy: bright, committed, and brave. He is starved of medical news and information on HIV, and longs to share his work. We talked in the tacky VIP room above a local bar — his choice — a place supposed to be ‘okay,’ meaning secure. He told me that in 1994 his superiors became alarmed at how many AIDS cases and deaths he was reporting. He was told to stop being so ‘thorough.’ His own practice has become almost entirely AIDS care. He is one of only two physicians in this town who treat people with HIV infection. Most of his patients have three things in common: they’re young, they’re addicts or ex-addicts, and they’ve worked in the jade and ruby mines in Shan or Kachin states. This doctor thinks the mines have been crucial in the spread of HIV. He explained that in the rainy season the mines have about 5,000 people. When the ground dries out, the numbers swell into the hundreds of thousands. People come from all over the country to work in the mines. It is dangerous and most don’t do very well, but a handful do, and that’s the draw. Heroin dealers are everywhere, as are cheap brothels; women migrate seasonally to try to earn some money as well. SLORC runs the best concessions; the poorest people sift through their waste water looking for shards. When the rains come again, the miners go home, taking HIV to every nook and cranny.

This doctor thinks the SLORC is not directly involved in the sex or heroin trades in the mines, but that there are corrupt people in the junta who are involved, and that their activities are tolerated because of kickbacks. The Generals simply do not care very much about ordinary people.

Health reform, like reform of virtually every other sector in this tragic country, will not move forward as long as the political process remains deadlocked. In October 1996, Aung San Suu Kyi attempted to hold another party Congress. The military surrounded her compound, and arrested over 1,300 people. The Generals still do not come to the negotiating table. Burma’s agony continues; the triple epidemics of heroin use, HIV, and tuberculosis rage on.

In November 1996, a Dutch journalist visiting the Shan states discovers that people with HIV infection are being isolated in leper colonies. The leprosy patients are terrified of the people with AIDS, as are those with HIV infection of those with leprosy. This is reported to be a temporary measure. The journalist was also taken to see a new complex under construction, already surrounded with barbed wire. SLORC is preparing camps in rural Shan state for women coming back from Thailand with HIV. There is a name for places like this: concentration camps.

An internationally-recognized public health expert, Dr. Chris Beyrer is a physician and epidemiologist. He is currently Director of the Johns Hopkins Fogarty AIDS International Training and Research Program and also serves as Consulting Epidemiologist for the U.S. Department of Defense HIV/AIDS Research Program and Consultant to the Thai Red Cross, Program on AIDS.
AIDS has become a global health crisis. At present a total of 168 countries have reported HIV infection to WHO [World Health Organization], and like all countries in the world, Myanmar is having to face with the problem of AIDS. The community as well as the individual person infected with this deadly virus will encounter medical, social and economic problems. At present, medical and social problems are more apparently seen in most communities where AIDS have appeared. As the HIV infection spreads into the 15 to 40 years age group certain communities and villages are bound to suffer from the economic consequences of AIDS along with the medical and social problems. The long incubation period of AIDS is masking the potential impact of this deadly disease. In the coming years as more and more of those previously HIV infected individuals come down with AIDS, the disease impact will be more visibly felt in the coming years in Myanmar.

HIV/AIDS is now appearing in all the different social classes in the country. It is also currently seen in high risk behaviour groups in all parts of the country and is starting to spread into the low risk population groups.

The fight against AIDS has been given top priority by the Government of Myanmar and the importance of dealing with the problem in a multisectorial approach has also been well recognized. Participation of NGOs in AIDS control activities is being encouraged and in the coming years it is hoped that they will play an important role in the fight against this dreadful disease.
SITUATION ANALYSIS

Up till the end of 1992, HIV testing has been done only for blood donor screening, adhoc surveys and for sentinel surveillance purposes. No voluntary testing is available in the country on a widespread basis.

Prior to 1992, data regarding HIV/AIDS in Myanmar was obtained mainly through surveys conducted in certain areas where activities relating to high risk behaviours are seen to be occurring. The sentinel surveillance programme was started in March 1992 in 9 towns and was extended to 19 towns later.

The HIV epidemic was first observed among the IVDUs [Intravenous Drug Users] in Myanmar, but based on the findings now, it is seen that the epidemic is spreading from the high risk population groups into the low risk groups. It indicates that sexual transmission becomes a major mode of transmission now.

As of 1995 March, 570 AIDS cases were reported. The majority of AIDS cases are being reported from Yangon but reports are now coming in from Kawthaung, Kyaiungton and Dawei. The majority of the cases are between the ages of 30 to 39 years.

Out of a total of 14 states and divisions, HIV infections have been detected in 5 states and 7 divisions. Chin State and Kayah State are the only remaining areas where HIV has not been detected as yet. This is because the high risk groups in these states have not been examined for the presence of HIV.

OBJECTIVES

GENERAL OBJECTIVES

The general objectives of the AIDS Prevention and Control Programme are:

• to prevent infection with HIV,
• to reduce the personal and social impact of HIV infection,
• to mobilize and unify national and international efforts against AIDS.

SPECIFIC OBJECTIVES

The specific objectives of the AIDS Prevention and Control Programme are laid down as follows:

• The general community as well as the high risk groups are to be given health education to improve awareness of the consequences of HIV infection.
• Provision of safe blood supply is to be improved especially in HIV endemic areas.
• HIV infection through needles, syringes, surgical equipment is to be prevented to avoid spread of infection between patients and health care providers.
• Sentinel surveillance is to be expanded to other townships to obtain more information on epidemiological situation of HIV infection in the country.
• Management and counseling services of HIV/AIDS cases are to be carried out at all levels of health care delivery in the country.
• Cases of STD are to be detected early and given appropriate treatment to reduce the risk of HIV transmission.
• Community leaders, volunteers and health care providers are to be trained for health education activities at the community level and individual level.

TARGETS
AIDS Prevention and Control Programme has an objective to expand the coverage of implementation in all the townships in Myanmar and to give priority to those places where HIV/AIDS is spread readily.

The target for the control of HIV is to prevent increase in the prevalence of HIV infection so that sero-prevalence among IUDU and male STD patients will not be more than the current rate of 61.75% and 8.2% respectively.

STRATEGIES
The following strategies have been laid down to combat the HIV/AIDS epidemic in Myanmar.

PREVENT SEXUAL TRANSMISSION OF HIV
The prevention of HIV through sexual means depends upon the change in sexual behaviours and this is to be achieved through provision of information and education and by means of early detection and proper treatment of sexually transmitted diseases.

PREVENT BLOOD BORNE TRANSMISSION OF HIV
The prevention of blood borne transmission of HIV is to be achieved through provision of safe blood and blood products, prevention of HIV transmission in the health care setting by promoting universal infection control measure, [reduction of] the use of drugs (narcotics) especially by injection and by provision of information and education to drug addicts so as to change their risk behaviour, proper sterilization of all skin piercing equipment and screening of donors for organs and semen donations.

PREVENT PRENATAL TRANSMISSION OF HIV
The prevention of perinatal transmission of HIV is best achieved through prevention of sexual transmission of HIV to women and by providing HIV infected women of child bearing age proper education, counseling and family planning services so as not to bear a child.

PROVISION OF PROPER CARE AND CLINICAL MANAGEMENT
Services for the care of persons infected with HIV or ill with AIDS is to be provided and these services should be appropriate, accessible and continuous. Health care providers should strive to ensure that humane care is being provided and that quality of care [is] at least equal to that provided for other diseases.

PROVISION OF COUNSELING SERVICES
Counseling services are to be made available to HIV infected individuals as well as to those individuals in the community with high risk behaviours. Through proper counseling it is hoped that the mental and social problems faced by HIV infected individuals will be reduced if [they] could not be solved. Information regarding ways to prevent the spread of HIV infection to other non-infected individuals could also be given through counseling.

PROVISION OF SOCIAL AND ECONOMIC SUPPORT FOR AIDS PATIENTS
A person with AIDS will be having repeated bouts of illness which would require hospitalization and proper nursing care at home after being discharged from the hospital. Social support for these persons as well as their families is crucial and at times it could mean more to the patient and his family than the medical management.

Isolation and quarantine should have no place in the fight against AIDS. Economic support for AIDS patient is to be provided to those in need. This is to be carried out with the help of the various community based voluntary organizations.

ACTIVITIES
HEALTH EDUCATION
Health education activities targeted for the general community as well as the specific educational activities targeted towards high risk individuals and
HIV positive/AIDS cases are to be implemented in all the townships in the country. In townships where HIV epidemic is seen to be high, special health education activities are to be carried out intensely so that the population is specifically made aware of the dangers of this dreadful disease.

These activities are to be carried out by the staff of the basic health services. Support from non-governmental organizations are also to be obtained for the health education efforts especially at the village levels.

Peer educational programs are also to be used in the education of IVDUs and various categories of sex workers.

- **Health education for the general public**
  Health educational talks targeted towards the general public are to be conducted in every township. This activity is to be carried out by the Township Health Department. Collaboration and support from the respective Township AIDS Committee, Sexually Transmitted Disease and Skin Diseases Control Teams and the Health Education Teams at the state and divisional levels are to be obtained whenever possible.

  In townships where AIDS is a major problem, health educational talks are to be held in all villages within the township at least once a year utilizing the various categories of health workers stationed in that township.

- **AIDS education in schools**
  Health educational talks on the prevention of AIDS are to be conducted for the 9 and 10 standard students in each township. This activity is to be undertaken by the Township Health Department as well as the School Health Teams. Inclusion of AIDS education into the health education curriculum of school children is to be undertaken with the collaboration of the respective sectors from the Education Department.

- **AIDS billboards**
  Erection of AIDS billboards to create awareness on AIDS are to be done by the Township Health Department in collaboration with the Township AIDS Committee.

- **AIDS education/information materials**
  Distribution of AIDS education/information materials are to be made through health care institutions as well as through other non-governmental organizations working at the community level.

- **Individual educational talks**
  Educational talks on the prevention of AIDS are to be given to those individuals engaged in high risk behaviours on an one to one basis. This activity is to be carried out by the staff of the Township Health Department and Community Leaders whenever the opportunity arises. Community leaders as well as volunteers from non-governmental organizations are to be used in this activity.

- **Peer educational programmes for IDUs and Sex Workers**
  Peer education programmes are to be established for injecting drug users, youths and sex workers with the aim to change their risk behaviours.

- **Condom promotion and distribution**
  The use of condoms [is] to be promoted by means of educational pamphlets and mass media. Condoms are to be distributed to HIV/AIDS cases, and also to the sexually promiscuous individuals through STD clinics, counseling services, Drug Treatment Centers and various health outlets present at the townships where HIV infection rates are high.

**ENSURING SAFE BLOOD SUPPLY**

- **Screening of blood donors**
  Potential blood donors are to be screened for at risk activities which could have exposed them to HIV, so as to reduce the likelihood of blood being collected for transfusion during the window period. Donor deferral information pamphlets are to be made available at all blood donation centers so that donors [may] be provided with the necessary information and on their own defer donating blood.

- **Recruiting voluntary, non-remunerated regular blood donors**
  The use of professional blood donors should be discontinued and discouraged and the recruitment of voluntary non-remunerated regular blood donors should be promoted in every hospital. Blood donor recruitment activities should be carried out in the various townships so as to ensure that a pool of potential donors, who are at least not known to belong to any of the high risk population groups are readily available should the need for blood arise.

- **Screening of blood**
  In townships where HIV epidemic is seen to be wide spread, all blood used for transfusion are to be screened. This activity is to be expanded in a phase by
phase manner in the coming years till all blood and
blood products in the country are screened for HIV.

• Rational use of blood

With the high prevalence of hepatitis B and the
looming danger of the transmission of HIV through
blood transfusion, blood should be used only in con-
ditions where it is absolutely necessary.

PREVENTION OF HIV INFECTION THROUGH NEEDLES,
SYRINGES, SURGICAL EQUIPMENT AND OTHER SKIN
PIERCING EQUIPMENT

• Universal infection control measures

Universal infection control measures are to be
implemented in all health care facilities so as to limit
the spread of infection from an infected patient to
another patient, from infected patient to health care
provider and lastly from infected health care provider
to patient.

Proper sterilization of syringes, needles, surgical
equipment and other skin piercing equipment [is]
also to be undertaken in all health care centers in the
country.

• Information on proper sterilization

Distribution of information materials to increase
awareness regarding the need for proper steriliza-
tion is to be made. This information is also to be tar-
geted to those people who are engaged in tattooing
and acupuncture.

SENTINEL SURVEILLANCE

In order to monitor the spread of HIV infection
within the country, a sentinel surveillance system
has been set-up in 19 towns situated in 7 divisions
and 5 states. Expansion of the surveillance system to
other towns [is] being been planned, taking into
account the epidemiological situation of the spread
of HIV infection in the country. Prioritization of
control activities carried out in the various town-
ships are to be based on the sentinel surveillance
findings.

MANAGEMENT OF HIV/AIDS CASES AND PROVISION OF
COUNSELING SERVICES AT VARIOUS HEALTH CENTERS

• Management of HIV/AIDS cases

Management of HIV/AIDS cases [is] to be pro-
vided in all hospitals and health centers in the coun-
try. Referral of cases from the township levels [is] to
be done if needed to the state and divisional hospitals.

• Counseling services

Services for counseling of HIV positive individ-
uals and the provision either pre-test or post-test
counseling for those individuals taking a HIV test is
to be provided at the various health facilities where
HIV testing is done or where HIV/AIDS cases are
being cared for.

EARLY DIAGNOSIS AND TREATMENT OF SEXUALLY
TRANSMITTED DISEASES

Sexually transmitted diseases have been known
to greatly increase the risk of HIV transmission.
Providing early diagnostic facilities and treatment
reduces the risk of HIV transmission and it also pro-
vides opportunity to inform and educate individu-
als engaged in high risk behaviours. Necessary sup-
port to the Sexually Transmitted Disease and Skin
Disease Control Programme is to be provided by the
AIDS Prevention and Control Programme.

Training courses for basic health workers for early
recognition, diagnosis, provision of initial treatment
Poster reads: AIDS can be transmitted through
• Sex with infected persons
• Injecting drugs
• Contaminated instruments
• Transfusion of infected blood
• Infected mothers to their newborn babies

and also for proper referral of cases needing special care are to be conducted at the township levels.

TRAINING OF HEALTH CARE WORKERS AND COMMUNITY LEADERS

Training workshops for health workers and community leaders are to be conducted with the aim to promote health education activities at the community level.

• Training of Basic Health Workers

Health workers from the township health departments are to be trained for AIDS prevention and control activities. A total of 150 townships are planned to be covered during 1996.

• Training of community leaders and NGOs

Training for community leaders in AIDS education activities [is] to be conducted in 50 townships during 1996. NGOs who will be working in the field of AIDS will be provided with training support depending on their area of interest.

RESEARCH

Research in the field of AIDS is to be conducted with the aim to promote and support AIDS prevention and control efforts in the country.

INTRA AND INTER-SECTORAL COORDINATION

Intra-sectoral collaboration is to be made with the STD and Skin Diseases Control Project, Drug Abuse Control Project, Laboratory Services, Hospital Care Programme and the Central Health Education Bureau. The existing manpower in these sectors [is] to be utilized so that AIDS control measures [can] be effectively and efficiently implemented within the short period of time. The AIDS Prevention and Control Project is to provide specific support to these sectors for their AIDS prevention and control activities and case management efforts.

Collaboration is also to be carried out with other sectors under the Ministry of Health especially in the field of research (DMR) and in the training of paramedical health workers (Department of Health Manpower). Inter-sectoral collaboration with other ministries is to be promoted with the aim to enhance AIDS prevention activities in these respective ministries.

The AIDS Prevention and Control Project is to collaborate with non-governmental organizations also, aiming to promote community based health education measures and AIDS care. Technical and financial support for non-governmental organizations working in the field of AIDS is to be provided by the AIDS Prevention and Control Project.

The AIDS Prevention and Control Teams at the state and divisional levels will be responsible for the coordination and collaboration of AIDS control measures carried out by the various sectors.

COMMUNITY INVOLVEMENT

Community leaders and volunteers from non-
governmental organizations will be involved in educational talks on the prevention of HIV/AIDS, given to those individuals engaged in high risk behaviours. Active participation of community members will be needed to prevent HIV infection through sexual transmission and through unsterilized needles. The community leaders and representatives from NGOs are to be trained to promote health education activities targeted towards different social and ethnic groups.

MONITORING AND EVALUATION

MONITORING

The monitoring of the AIDS Prevention and Control Activities is to be carried out by the AIDS Prevention and Control Programme at all levels of administration. Activities to be carried out at the township level are to be monitored by the respective township health department and also by the state and divisional health department. As part of this monitoring process quarterly reports are to be submitted by the AIDS Prevention and Control Programme.

Sentinel surveillance of HIV infection is also to be carried out in selected towns covering both the high risk as well as the low risk groups. From the high risk groups, 100 samples are to be chosen from intravenous drug users, commercial sex workers, male and female STDs. Blood donors, new military recruits and pregnant women coming to ante-natal clinics are to be included in the low risk groups. Sentinel surveillance is to be carried out twice a year during the months of March and September.

Ad-hoc surveys are also to be conducted in certain high risk population groups such as truck drivers and fishermen, to monitor the spread of HIV infection in these groups which are to be considered crucial for economic sector.

EVALUATION

Internal programme review is to be conducted once a year to evaluate the programme as well as to draw up plans for the coming year. The following operational and epidemiological indicators are to be used in evaluating the AIDS Prevention and Control Programme. These indicators are to be obtained through the sentinel surveillance system and also through special surveys conducted in certain population groups.

1. HIV infection rates among Intravenous Drug Users.
2. HIV infection rates among Commercial Sex Workers.
3. HIV infection rates among Male STD patients.
4. HIV infection rates among Female STD patients.
5. HIV infection rates among Pregnant women.
6. HIV infection rates among Blood Donors.
7. HIV infection rates among new military recruits.
8. Number of condoms distributed.
9. Proportion of men aged 15 to 40 years practicing safer sex.
10. Percentage of planned activities being implemented (ongoing) and completed.

It should be reminded that because AIDS has a long incubation period, the number of reported AIDS cases will be increasing every year for a period of several years, even though the new HIV infection rates are declining or have remained stationary.

BENEFITS

As a result of AIDS Prevention and Control Activities carried out throughout the whole country, awareness about AIDS is expected to be increased among the high risk population groups as well as in the general population. This increased awareness, along with the social and cultural support measures provided by the community working for a change among their members who are engaged in high risk behaviours, would provide the necessary stimuli for behaviour changes to occur. Because of the AIDS prevention activities it is hoped that less people will be coming down with HIV infections.

Through provision of counseling and AIDS care services, the impact of AIDS on the individual victim as well as on their family is expected to be lessened. Through the support of NGOs in community based health care programmes for AIDS patients, means for a continuum of care at home could be offered.

The economic cost of losing men and women at their prime time of life could be averted. An AIDS free healthy work force is to be regarded as a national asset for future economic development of the country. The massive hospital care cost which will have to be borne by the government as well as the community, could be exerted through measures aimed at preventing the spread of HIV infection.
IN HER OWN WORDS

THE STORY OF THE LONG-DISTANCE LORRY DRIVER'S WIFE

This interview was conducted in Rangoon. Both the name and origin of the woman interviewed have been changed to respect her privacy.

FROM THE INTERVIEWER

I first heard the word 'AIDS' at the beginning of 1988. All I knew about it was that it was a very serious disease with no cure. I had no idea that it would soon come to threaten the whole world. At first it was far away in some distant country and it was only when this dread disease had arrived quite close that I began anxiously to investigate it further. At the funerals of my friends the number of people who had died of AIDS was slowly increasing.

I wanted to gain a more practical understanding of AIDS than I could obtain from merely reading about it. So I went to the isolation hospital (the Hospital for Contagious Diseases) in Rangoon where AIDS patients were sent. There I met and talked to many AIDS sufferers who told me of the different ways in which they had contracted the disease, and revealed their innermost feelings as they faced a certain death. Among them was an ordinary housewife, not highly educated, leading a simple married life, who had been told she was HIV positive. I talked to her in the out-patients' department. She was slim and quite attractive, carefully and neatly dressed.

Her name was Khin San Myint. She was from the small town of Ok-kan not far from Rangoon. The eldest of four children, Khin San Myint left school at the age of fourteen to help her parents who were farmers, growing vegetables to sell in the capital city. She married when she was twenty-three and worked as a dressmaker after her marriage.
Q: So you have to come here from Ok-kan every day?
A: No, only once a week. It's not too bad, only a few hours by bus to get here. If I get up early at about six, I'm in Rangoon by ten.

Q: How old are you?
A: Thirty-five.

Q: What does your husband do?
A: He's a lorry driver — his parents' lorry. Like me he's the eldest. He has two sisters. He left school at fifteen. Since his parents own a lorry (which they use to transport goods) and being a boy he automatically became interested in working on the lorry.

Q: Where did you get married?
A: At my house, the girl's house, as is usual. As it was the first wedding for both families, we had a fine lunch with tea and cakes to follow and lots of presents.

Q: Where did you live after you got married?
A: I went to live in his house, as there weren't so many people in his family. And anyhow his parents depended on him as he was in charge of driving the lorry.

Q: Which places does he drive the lorry to?
A: To Shan State and to Mandalay, in fact all over the country, wherever the goods are.

Q: Did you continue with your dressmaking after you got married?
A: Certainly I did, even more than before. My husband was away most of the time and I didn't need to cook as his two sisters did it all, so I had plenty of time for sewing.

Q: Have you got any children?
A: Of course I have, two daughters. The elder is eleven and the younger is nine. They are doing well at school.

Q: How much does your husband earn?
A: Quite a lot. His parents give us two or three thousand kyat to put in our savings each time the lorry returns from a trip, as well as giving us free board and lodging. Each trip lasts about ten days, so we usually get about ten thousand kyat a month. [In Nov. 1997 this would have been about $34-35 a month at the prevailing unofficial exchange rate of about 280 to the dollar. By March 1998 the kyat had risen to 250 to the dollar.] I can keep the money I get from sewing and use it for myself. But I don't spend it. I save it up for my daughters. Everything was all right until this terrible illness started.

Q: And now your husband...?
A: He died six months ago.

Q: Oh, I'm so sorry. When did he first get ill? How did you learn that he had AIDS?
It began, his illness that is, more than a year ago. We didn't know what was wrong with him then. We thought it was just an ordinary illness. He kept on having fevers which took a long time to go down. We thought it was malaria because he used to travel all over the place.

It wasn't until he began to get big herpes-like blisters that our doctor told him to go to Rangoon to have a blood test to see if he had AIDS.

 Didn't that scare you?

No, I didn't know what sort of illness AIDS was. [N.B. This was in Nov. 1997]

And didn't your husband know?

He didn't know much about it either.

So what happened when he went to have a blood test in Rangoon?

He had to pay much more for that blood test than for an ordinary one; nearly two thousand kyat instead of about three hundred. At first it seemed to me too much money to pay just for a blood test but then I thought we had to know what was wrong with him if we were ever going to get the right medicine, so he had the test. We got the result straight away. They told us he had AIDS and that he should go at once to the isolation hospital. At first I was happy to think that the hospital would be able to treat my husband. But then the nurses explained to us about AIDS and we realized that he had this dreadful illness.

What did you both feel when you learned this?

I can't even describe it. So much bad news at the same time. All I can remember is hearing that he couldn't be cured and that he would soon die. They told me to have a blood test as well. My first thought was of my two young daughters. I prayed they'd be spared even if I'd caught the disease.

Where do you think your husband caught it?

(Said apologetically and very quietly) From — forgive the expression — a bad woman. You see, he's a lorry driver. Going all over the country, he's bound to have a bit of fun with other women when he's away. I know that. But he also told me that he'd gone to a doctor for an injection once when he wasn't well so he could have...
Got the virus from an injection like that, he said. I just don't know any more.

Q: Did you have a blood test?
A: Not straight away, not till after he died. I was afraid that if I was told that I had the disease as well I would be too miserable to nurse him properly. And there was always the hope that I was lucky and hadn't caught it.

Q: It has nothing to do with luck. As his wife, you were certain to catch it. The only way for you to prevent it would have been for you to — how should I put it — to use a condom when making love.
A: (Hanging her head in embarrassment) Oh, no, I couldn't.

Q: There's nothing to be ashamed of. Do you know what a condom is?
A: I didn't know before. I'd never seen one. But when he got ill the nurses from the hospital showed me — it was like a balloon. If I found one somewhere else I would have tried to blow it up like a balloon. When they told me what it was for, I didn't dare to look at it again.

Q: Did you leave your husband to be looked after in the isolation hospital?
A: At first I did. But seeing people dying almost every day frightened him so much that he didn't want to stay there any longer. He said he wanted to be looked after at home because he would very soon die if he stayed any longer in the hospital. So we came back to our own home. We bought the necessary medicines and our local doctor gave him some injections.

Q: Did the doctor use a fresh needle for those injections? Did you tell the doctor?
A: Yes, we did. I don't know about the needles but I don't think the doctor used a fresh one. I saw him sterilizing needles and using them again. I can't blame him, he only got fifty kyat for each injection he gave. A fresh needle costs ten kyat. Otherwise he'd make no profit after paying the cost of the medicine, even though he was using Chinese stuff. [i.e. not Western medicine.]

Q: Did your husband's family help to look after him? Did they know about this disease?
A: I don't really want to talk about them. People only show their true character when in real difficulty. At first only his parents and I and the local doctor knew about his illness. We didn't want other people to know.

Q: Why did you want to keep it secret?
A: Everyone's frightened of it. They despise people who have it. And besides, he was the only person in our town to have AIDS so we were ashamed. But seeing as his mother kept on weeping whenever she saw him, his two sisters soon realized what was wrong. They were terrified. They no longer saw him as the elder brother they had looked after all their lives. They wouldn't come anywhere near him and left home to live with some relatives. The relatives soon realized what was up and so they stopped coming to visit, too.

Q: But didn't you explain to them how the disease was passed on?
A: I did. Only by mixing blood. But they wouldn't believe me. They thought it could be caught by coming near the ill person.

Q: Didn't that make your husband very unhappy, that they stopped coming?
A: Of course, but he didn't say anything. He didn't even want me and his mother to come near him very much. And he told me to send our daughters to stay with my mother. But in spite of what he said I stayed with him all the time.

Q: Could he eat much food?
A: No, only a little bit. He kept saying he would like this or that but when I gave it to him, he couldn't eat it. By the end he couldn't eat anything at all. And he had diarrhea all the time. He suffered a great deal.
Q: How long was he at home for?
A: He only lasted about six months.
Q: He died quite quickly, didn't he?
A: It might seem quick to you but his sisters and his relatives thought he took too long to die. They weren't at all pleased when I went and asked a well-known local healer to come and treat him. Nor when I begged for a special potion from a monk which was supposed to be very effective. He was my husband after all. After he died, I did everything to set their minds at rest. I poured paraffin over his bed and his clothes and burnt them all. I sluiced the house down with hot water and buried the things he used to eat with.

Q: And then what did you do?
A: What do you think I did! I went straight to Rangoon with my two daughters to have our blood tested. And I was really happy that they didn't have HIV. As for me, I always thought I'd get it — the nurses had told me I would. But when I actually learned that the virus was in my blood I felt absolutely helpless. When people are very unhappy they often say they want to die, but the fear of death when it really faces you is like something you have never known before. But for the sake of my daughters I had to be strong. I had to look after them while I still had time. I thought I mustn't die too soon. So I went back to the isolation ward at the hospital and told the nurses. They gave me some medicine, told me what else to buy and told me to come back as an out-patient once a fortnight. We came back home and I told my parents-in-law what had happened. They said I should leave the children with them as they couldn't bear to be parted from their grandchildren. So I went back alone to live with my parents. The lorry my husband used to drive was sold off as his parents couldn't bear the sight of it.

Q: What did your younger sisters say?
A: Not much. They weren't very pleased but they don't dare to tell me what they really feel because I am their elder sister. I tried to set their minds at rest by keeping all my things very clean, washing everything with soap and hot water. And — excuse the expression — when I have to go outside to relieve myself, I dig a hole and then cover it up with soil.

Q: Are you still making clothes?
A: Yes, whenever anyone brings me something to sew I do it. Sewing takes my mind off my worries but...

Q: Don't many people come to you with sewing orders now?
A: No, not any longer. As you can guess, the whole town is waiting to see if I caught the disease from my husband. They all stare at me when I go to the market wondering if I am getting thinner. So I try to dress better than before and make myself look as nice as possible. Some market-sellers even seem reluctant to serve me, so I just ignore them and go buy somewhere else. In the same way, the news has got around to my sewing customers and they have slowly stopped coming. Even my most regular customers waited to see how I was and only when they saw I looked quite well they brought their orders to me again. Even my own aunt looked so grim when I went to visit her that I have never gone there again.

Q: Do you come to the hospital in Rangoon regularly, every fortnight?
A: Yes, I haven't missed a single time. But people don't realize where I'm going — they think I'm going to the market. And I always take care to go nicely dressed. The nurses at the hospital tease me saying that I have found a new man.

Q: Really? And have you found someone else?
A: What an idea! I swear I haven't and it hasn't even occurred to me. I don't want to pass this illness to someone else or to make someone a
widower. And the most-important of all, I will never do anything to make my daughters unhappy.

Q • Your daughters don't know, do they? Do you see them everyday? Do you sleep in the same bed with them?

A • How could I possibly tell them? But I have thought about it a lot and just before I die I will tell my older daughter everything. So that she knows to be afraid of this terrible disease. They're very good girls and I see them every day. At school holidays they come to stay with me. There's something I should tell you. Once we were all three sleeping in the same bed — I can tell you this as a woman — suddenly my period started. When I woke up and saw the blood I got a fright because the girls were sleeping with their arms around me. I searched frantically all over their little bodies to see if there were any open sores or spots. I nearly went mad. I didn't find any and they were all right, but after that we never slept in the same bed when I had my period.

Q • It was a good thing to be so careful. You are very brave not to give up. You've been very strong. Try to carry on like this.

A • It's my daughters who give me strength. For them I will live as long as possible. Look what I've got in my bag which I take everywhere with me — so many different medicines, English, Burmese and a very special potion from a monk. I always take them regularly and I'm very careful not to catch cold when I wash. I never forget to worship the Lord Buddha and to say my prayers — He, too, may be able to help me.

Q • Yes, you're right. As human beings, all of us will die some day whatever age we may be. It may be in a car accident or by drowning or some other accident but we can't do anything about it.

A • Yes, but sometimes I can't help thinking that my husband and I never did anything bad to anyone. We just earned an honest living. We were simple country folk without much education and so we got this terrible disease. I don't think it was our fault I would like to ask Yu-ma Min [Lord of Death] why we have to die like this when we have done nothing wrong.
Two girls from my village went to work in Thailand.

They had never been there before.
A Thai man tricked them.
He said "Bangkok is very beautiful."
There are many tall buildings."
The girls followed him.
Their parents looked for them everywhere.
Their parents used all their money looking for them.
But they couldn't find them.

Bangkok is very big.

"The Buddha said Even if you carry your parents on your back will never repay your debt to them."

When the rains come our brothers enter the temple alone for the wrongdoings of our parents.
Make merit for their life to come.

Tied to the flesh by the karma of a female birth it is difficult to repay our parents.

Sons provide for the life beyond Daughters provide for this life.

They come from Thailand looking for children with passion not yet stirring.
Green like mangos not fully sweet.

They promise work and offer money to parents who do not know the world beyond.

Excerpts from a film by Ellen Bruno
They locked me in a room. I was alone. I was all alone there. When it was time to eat they'd unlock the door and give me rice. Mamasan watched me all day long to make sure I didn't escape. But I couldn't escape. I spoke no Thai at all. I couldn't speak a word. I was really young then. When he sold me I was only 12.
"For a long time the state of Myanmar’s children was perhaps one of the country’s best kept secrets. Decades of self-imposed isolation, fabricated statistics and the absence of social research and journalistic inquiry had created a false image of social developments... In fact, neither the outside world nor even the authorities inside Myanmar have an accurate or complete appreciation of the very serious conditions in the social sectors."

Possibilities for a United Nations Peace and Development Initiative for Myanmar
UNICEF DRAFT DOCUMENT, 1992

The above quotation perhaps best summarizes not only the status of Burma’s children but the dire state of public health in that country. Although Burma’s present economic and political situation is largely publicized, much less known is the effect the military regime’s policies have had on the health of the country’s population. The deterioration of the economy, decades of civil war, and a leadership more interested in maintaining its own privileges than in the welfare of the population, have had a dramatic negative impact on the health status of the Burmese people, particularly among women and children.
BY DR. CESAR CHE LA LA.
CHILDREN'S HEALTH

Let's begin by looking at Burma's infant mortality rate. According to UNICEF, the national infant mortality rate in 1996 was 105 per 1000 live births. This is significantly higher than other countries in the region: the rate in Vietnam, for instance, was 33 per 1000; 31 per 1000 in Thailand; and 11 per 1000 in Malaysia. To give a more global perspective, Cuba, which has among the best health indicators in Latin America and the Caribbean, had an infant mortality rate of 10 per 1000 that same year.  

Weight rates vary considerably among different areas. They can go from as low as 5.81 percent in the Shan State to 52.63 percent in Magwe Division.  

Malnutrition, particularly in children, is also manifested as lack of essential minerals and vitamins. Iodine deficiency, which is particularly dangerous among children since it can lead to learning and mental development problems, is a major public health issue in Burma. Goiter, due to lack of iodine, is present in approximately 28 percent of school children countrywide, and in some areas, such as the Chin and Kachin States, the rates are even higher. In addition, goiter is increasingly found in marginal low-income areas of Rangoon. 

Deficiencies of Vitamin A are widespread in Burma among both children and adults. Because it may damage the eyes and increase the risk of infections, Vitamin A deficiency is one of the most critical nutritional problems in children. Iron deficiency also provokes anemia, which is found in 30-44 percent of children between 6 and 16 years of age. Anemia increases susceptibility to infection and hinders school performance and physical activity.  

As in many other developing countries with lack of potable water and sanitation, major causes of children's morbidity and mortality in Burma are intestinal and respiratory infections, malaria, malnutrition and vaccine-preventable diseases. Diarrheal diseases in children under five account for approximately 18 percent of all deaths, and are the second most important cause of death in children in that age group. Mortality rates increase sharply when diarrhea is complicated with malnutrition or with other diseases.  

Because of poor sanitation, cholera outbreaks occur yearly, particularly during the rainy season. A new serotype of *Vibrio cholerae* (first identified in Burma in 1994) has provoked many cases, and since there is no immunity to this serotype, the disease causes relatively high fatality rates both in children and in adults. Preventing disease in children is even more complicated by the widespread lack of essential medications. Reportedly, medicines donated by international agencies are stolen by corrupt military officers and sold on the black market.  

A government effort — the Universal Child Immunization (UCI) program — which is conducted with UNICEF's support, aims at immunizing for infants who do survive, the picture remains grim. One million children are reportedly malnourished, 9-12 percent of them severely so. It has been estimated that children between one and three years of age receive only 71 percent of the recommended energy intake, and 76 percent of the recommended protein intake. Recent visitors to Burma have commented that the outward signs of malnutrition have become more and more visible in the satellite towns that surround Rangoon and in the capital city itself. 

The high rate of babies with birthweight below 2500 grams (estimated at 23.5 percent in 1991) is probably a reflection of the high malnutrition levels among pregnant women. As with infant mortality, low birth-weight rates vary considerably among different areas. They can go from as low as 5.81 percent in the Shan State to 52.63 percent in Magwe Division.  

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children against vaccine preventable childhood diseases. However, it reaches less than 60 percent of children nationwide, and an even lower percentage in particular areas. Achieving higher immunization rates has been hindered by security concerns, transportation problems, lack of electricity (essential for keeping active many vaccines) and shortage of health workers, particularly in remote areas.

Child Labor
In 1991, the Burmese military regime ratified the UN Convention on the Rights of the Child. Tragically, the realities for many of Burma's children stray far from the protections laid out in that document. As UNICEF has stated, "Across the country many children enjoy no childhood at all. They are simply put to work."

The difficult economic situation in the country compels many children to enter the labor force. According to the 1983 Census Report (the last Census taken in Burma), over half a million children under the age of 14 work. Working conditions for many children make child labor detrimental to their health and educational possibilities.

An ongoing study of working children in the urban informal sector indicated that approximately 30 percent of working children had dropped out of school, 8.5 percent had never enrolled and 2.9 percent were attending school, although not regularly. Among those children who go to the countryside looking for agricultural or construction work, most do not attend school and have no access to public health services.

Children and adolescents are forcibly recruited into the military, becoming unwilling victims or participants in Burma's armed conflicts. It has been reported that in order to make them more aggressive and willing to fight, they are often given alcohol or drugs before going into combat. As also happens with adults, children are used as porters, human shields or minesweepers.

A fairly recent phenomenon has been the outflow of young Burmese, particularly girls, into neighboring countries to find work. Driven by poverty and hopes of improving the material quality of life for their families, girls, some as young as twelve years of age leave Burma for Thailand or other countries with aspirations of becoming housekeepers or nannies, or securing employment in restaurants or shops. Too often these children end up on construction sites or in brothels where they are kept in slave-like conditions, unable to escape.

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A small survey of street children carried out in 1994 by the Young Women’s Christian Association indicated that the number of street children in Burma’s main cities (Rangoon and Mandalay) is estimated to be around 10,000. More than 90 percent are illiterate or have dropped out of school. Because in many cases they have been abandoned by their families and marginalized by society, these children have a lifestyle which is a threat to their health and well-being,... some go into prostitution, or survive through petty thefts or drug-related activities.

Women’s Health
Pregnancy and Childbirth

Women in Burma face considerable health problems due to poor living conditions, inadequate health services, and lack of basic education. Deficient health care is more evident in the ethnic minority regions, where constant relocation and the heavy losses of men’s lives have left women with the responsibility of providing for their children. For example, maternal mortality rates, which are an important indication of the quality of women’s health care, are 580 per
100,000 live births. Compare this to 80 per 100,000 for Malaysia and 10 per 100,000 for Singapore. Most maternal deaths in the country are due to induced abortion, largely conducted clandestinely, and to unsanitary conditions. These staggering rates make it imperative that access to basic reproductive health information and to birth spacing and contraceptive methods currently provided in only select areas of the country, be increased.

Although midwives are the main providers of health care to women in rural communities there is a shortage of them, particularly in rural areas of minority states. Only ten percent of the rural population has direct access to maternity care provided by a midwife.

The percentage of women of reproductive age who use modern contraceptives is estimated to be between 17 and 22 percent, with great variations from region to region; rates are even lower in border and remote areas. This is significantly lower than the goal of “30 percent by 1997” set by both UNFPA (United Nations Fund for Population Activities) and the Ministry of Health. Rather than using contraceptives (which have to be purchased privately in the market), women frequently resort to abortion to control family size. It is estimated that 14 percent of married women between 15 and 49 years have undergone abortions. This rate is much higher in the major teaching hospitals in Rangoon and Mandalay where the abortion rate is between 330 to 500 per 1,000 live births. Pregnancy and childbirth highlight particular health concerns for women, including iodine and iron deficiency and anemia. Lack of iodine in pregnant women can provoke neurological cretinism, congenital abnormalities, low-birth-weight babies, as well as miscarriages and stillbirths. Goiter (the most visible form of iodine deficiency) is a major public health problem affecting all segments of the population, especially women of childbearing age.

Anemia, particularly that caused by iron deficiency, is also prevalent among pregnant women. Women are at special risk of having this type of anemia because of their blood loss during menstruation, or when they have closely spaced pregnancies. In the latter situation, iron is transferred to the growing fetus before the mother has had time to replace the iron stores used up during the previous pregnancy. An estimated 60 percent of Burmese pregnant women, or over 700,000, are affected by this condition.

There is a shortage of midwives, who are the main providers of health care to women in rural communities, particularly in rural areas of minority states. Only ten percent of the rural population has direct access to maternity care provided by a midwife. UNICEF (which has compiled some of the most complete health statistics in the country), has provided substantial support in an attempt to enable midwives to meet the basic health needs of people at the community level. In spite of these efforts, however, 32 percent of Burmese women deliver their babies without the assistance of a trained health worker.

Malaria, Leprosy and Tuberculosis

The prevalence of malaria is particularly high in border areas, and among children and women of reproductive age. Malaria, when it is associated with malnutrition, goiter and severe anemia, can lead to high rates of pre-term deliveries, as well as to low birthweight babies.

Burma has adopted a malaria control strategy aimed at preventing mortality and reducing morbidity which was developed during the WHO (World Health Organization) Ministerial Conference on Malaria held in Amsterdam in 1992. The improvement of better diagnoses and treatment of malaria patients is stressed over the previous strat-
egy of eradicating by active case findings and widespread spraying with insecticides.

Efforts at eradicating the disease are complicated by the migration of labor into high malaria transmission areas, and by the resistance of some species of the Anopheles mosquito to frequently used insecticides. Other constraints in combating the disease are the lack of diagnostic facilities at the peripheral level, and the absence of reliable epidemiological and entomological information.

The presence of drug resistant tuberculosis has been demonstrated in Burma. Tuberculosis is the most frequent opportunistic infection among AIDS patients in the country. Approximately 10 percent of the people in Burma are carriers of the virus for hepatitis B.3

**Discrimination against women**

Although Burma has not ratified the 1981 Convention of the Elimination of All Forms of Discrimination Against Women, it was a signatory to the 1952 UN Convention of the Political Rights of Women. In the last few years, several international agencies have denounced the Burmese regime for its discriminatory practices against women and neglect of their health. The veracity of these charges, however, has been repeatedly denied by the government. Among the most serious accusations are summary arrests, rape and extrajudicial executions carried out by government soldiers on military operations in ethnic minority regions of the country.

Many of these cases have been documented by international human rights organizations such as Amnesty International and Human Rights Watch/Asia.

There is evidence of the forcible conscription of women, including girls, pregnant women and the elderly, into forced labor on government construction projects, and their use as porters in the war areas. It is estimated that during the 1991 dry season offensive, for example, over 10,000 civilians — among them 3,000 women — were forced into porterage by SLORC troops. According to accounts, women porters have been gang-raped, and those who have tried to flee were shot dead. Frequently, SLORC military commanders order women, regardless of their marital status, to come to their posts for questioning, where they are raped at gun point, sometimes in the presence of their husbands and children. In the documentary film, *Burma Diary* by Jeanne Hallacy, an ex-SLORC soldier revealed how, when reaching a village, they gathered the women and thrust sharpened bamboo poles into their vaginas.

**Women, prostitution, and AIDS**

Women in Burma are often handicapped in their search for work because of their poor educational levels. Although government figures show only a disparity of around 15 percent in the national literacy
rate between men and women, those rates can be substantially higher in ethnic minority areas. Community leaders estimate an 80 percent illiteracy rate among women from some border areas and in many remote mountain regions, girls are often never able to attend school and consequently lack basic skills. In order to survive these conditions, some women have been forced to resort to prostitution, primarily outside their own country. Although the total number of Burmese women working as prostitutes is difficult to estimate, their number has increased significantly over the past decade. Many are from rural families, and have no formal education. It has been estimated that between 25 and 35 percent of women who work as prostitutes in northern Thailand are from Burma's Shan State in the eastern region of the country, an area of considerable social unrest. The documentary film Sacrifice by Ellen Bruno highlights the personal accounts of several young women, many of them from Shan State who were unknowingly brought into the sex trade when they were as young as twelve or fourteen years old.

Women from Burma engaged in prostitution in Thailand are part of the estimated 800,000 to 2 million women presently working as commercial sex workers in that country. Along the Thai-Burma border, agents recruit women with false promises of providing them with employment or legal resident status in Thailand or force them into prostitution under threats to their lives. Family members or friends who accompany the women to the border receive payments of between US$400 to US$800 from the recruiting agent. This payment then becomes a debt that the women must repay through sexual servitude. These women are completely dependent on their captors who force them to work long hours and make it impossible for them to refuse customers. In most brothels, health care and birth control education are minimal or non-existent. An investigation carried out by the Women's Rights Project of Human Rights Watch/Asia found that only in six out of nineteen brothels where the women they interviewed had worked, did the prostitutes have routine contact with health care workers. And this contact was mainly for the provision of birth control methods and to test for sexually transmitted diseases. They found that many other serious illnesses normally go untreated.

When pregnant, women are forced to abort illegally or to continue serving clients even late into pregnancy. Many brothels are surrounded by electric fences and armed guards to avoid escape.

When pregnant, women are forced to abort illegally or to continue serving clients even late into pregnancy. Many brothels are surrounded by electric fences and armed guards to avoid escape. The recruiting agent, brothel owners and pimps often conduct their activities with the agreement of the local police or government officials. In addition to women from Burma, Thai agents also recruit women from Laos and China.

Conditions in the brothels are abhorrent. To quote a report from one of Bangkok's leading newspapers, The Nation, which covered a police raid on brothels in the southern Thai city of Ranong: "Each of the cubicles, measuring two by two-and-a-half meters, contained a cement bunk where the girls were forced to prostitute themselves. Hidden doors, concealed by secret passageways where the girls could be hidden in case of raid.... The stench of the place was terrible. There were no proper toilets. It was a hell hole." Many prostitutes are totally uninformed about the risks of contracting AIDS. In a study among those attending a training school created under the 1949 Prostitution Suppression Act, 98 percent had no knowledge of AIDS or how it could be prevented. Because of the circumstances in which Burmese women practice prostitution (forced labor, involuntary and often unprotected sex with brothel clients, rape) their rate of HIV infection is much higher than in Thai prostitutes.
Although the Thai government is aware of the dangers facing Burmese prostitutes living in Thailand, and is concerned about the effect this situation has on the sex tourism industry, it has been slow to react. In that regard, it has systematically failed to investigate and prosecute police and military officers involved in the illegal sexual trade of women and girls coming from Burma.

As Vitit Muntarbhorn, associate professor of law at Chulalongkorn University in Bangkok explained, "... many governments ... tried to stem the tide of prostitution but much has also resulted in lip service. More often than not, they seem to wait for a catalytic incident ... before pushing the authorities to take action, and where action is taken the fervor dies down after a period."

In Burma, AIDS is no longer limited to high risk groups, but is increasingly affecting the general population, including women and children. UNICEF statistics on a border town in the Shan State show that between 6.0 and 10.6 percent of pregnant women who registered at public Maternal and Child Health Center (MCH) clinics were HIV-positive. Women are particularly vulnerable to HIV infection because of unprotected sexual relations with infected male partners, use of tainted blood in transfusions needed after childbirth because of anemia or poor antenatal care, and the large number of women working as prostitutes in Thailand and Burma.

Reproductive tract infections (RTIs), particularly those associated with sexually transmitted diseases (STDs), have been shown to increase by 10 times the risk of contracting an HIV infection. Presently in Burma, public STDs clinics are underutilized because of lack of medications and the social stigma.

The Politics of Health

The health of Burma's people cannot be isolated from the political situation in the country. Politics has multi-faceted impact — from health research and service delivery, to the status of health professionals. Ruled by a regime that does not allow a free flow of information, the ability to conduct reliable research in Burma or to educate the people on health issues can be extremely difficult. Both non-governmental organizations and international agencies have commented on the difficulties in obtaining accurate data or obtaining access to certain segments of the population to conduct their own surveys.

Although the Burmese military is trying to impose a veneer of normalcy in the country, opposition to its rule has not ceased. In recent years, the military regime has opened the economy and eagerly sought foreign investment, while at the same time keeping a tight control on domestic political expression, in the hopes that protests would wane and the main opposition party, the National League for Democracy (NLD), would be marginalized.
A State Department human rights report also describes how, in August 1988, government troops surrounded a hospital, stopped the free flow of patients and medical personnel, and obstructed medical care for injured demonstrators.®

Dr. Maw Zin, a medical doctor, was arrested by the Burmese regime in 1990 for political activities and is currently serving a 20-year term in Rangoon’s Insein Prison.

Also in 1988, riot police attacked demonstrators on the campus of Rangoon University, approximately 100 among who were injured. Soldiers reportedly blocked ambulances and restrained emergency workers from picking up the wounded, who were driven by the riot police to Insein Jail.

Health professionals are among the estimated 1,000 political prisoners currently held in Burma, according to Amnesty International.® Special targets of the military are doctors who are vocal in their opposition to the Burmese regime. Still under arrest or missing are eight physicians whom were elected members of parliament, three of who were given 25-year prison sentences for attending secret meetings.

One physician, Dr. Aung Khin Sint, who received a literacy award in 1972 and three World Health Fellowships, was arrested on August 4, 1993, for distributing leaflets that opposed restrictions imposed on the National Convention. He was released on February 4, 1995, rearrested on July 23, 1996, and is still in prison. No sentence has been given, nor are family visits allowed.

Also under detention is Dr. Khin Zaw Win, a dentist and former UNICEF worker. He was arrested on July 4, 1994 and sentenced to 15 years' imprisonment for “spreading false news” and other offenses. [Apparently, the reason for his detention is his political participation and his contacts with foreigners.] According to the New Light of Myanmar, he helped the UN’s Special Rapporteur to Myanmar spread “fabricated news” about the situation in the country.

Smear tactics are commonly used by the Burmese regime to discredit those in opposition. In 1989, U Win Tin, vice-chairman of Burma’s Writers Association and a member of the NLD central committee, was arrested on false charges of having been involved in an illegal abortion. He was accused of harboring the partner of a woman who had undergone an abortion. However, while the young couple and the doctor who conducted the abortion have since been released, U Win Tin was sentenced to 11 years imprisonment under the 1950 Emergency Provision Act. In March of 1996 he received an additional five years, together with other prisoners who had been accused of anti-government activities while in prison.
Most prisoners in Insein prison are without adequate medical attention, in conditions which often amount to cruel, inhumane or degrading treatment. Amnesty International has identified 20 detention centers around the country where prisoners are brutally interrogated. Last October 23, Burma's military government acknowledged that U Kyaw Din, a member of the National League for Democracy party, died of acute pulmonary edema while serving a two-year sentence at a prison hospital. NLD records show that six well-known party members have died since 1988 while in custody.

In an effort to suppress political dissent, universities have been closed by the regime for over seven of the past ten years. And since the most recent student demonstrations in December 1996, the doors to higher education have remained continually shut. This has caused havoc on efforts to educate future health professionals. According to diplomatic sources in Rangoon, there are currently no medical students matriculating. Moreover, a recent dictate by the regime requiring all medical interns to serve a mandatory three years of government service after licensing has discouraged the best and the brightest from pursuing careers as doctors. To further deplete the pool of qualified physicians, in a major "downsizing" campaign by the Ministry of Health this past year, hundreds of physicians were "removed" from service and their licenses revoked.

IS THERE A CURE?

The economic situation and the health status of the population continues to deteriorate. According to the International Monetary Fund, in 1996 the country's foreign-exchange reserves were only US$183 million — its lowest level since 1988. While the trade gap increased in fiscal 1995-96, rice exports went down by almost two-thirds, and the total imports almost doubled the value of exports. The value of the Burmese kyat has almost doubled in a year, and the government's effort to attract tourists to the country has failed. The recent financial crises in Southeast Asia could exacerbate an already dangerous economic plunge.

Under these conditions, what is the hope that the health of the nation can improve? Some suggest that the answer lies in increased humanitarian assistance by the international community. Having evaluated dozens of such projects throughout the world, I can speak to the merits of such projects, but their effectiveness depends largely on whether the conditions necessary to implement them exist.

A government must set health care as a priority in an atmosphere that allows transparency, direct access to populations most in need, independent research, reliability of data, and public health education campaigns that are carried out without impediment. Health indicators in a country devastated by war, such as Vietnam, could quickly improve because there was the political will by the nation's leaders. Unless there is a dramatic change in government, health conditions in Burma will continue to deteriorate for the foreseeable future.

REFERENCES

Dr. Cesar Chelala is an international medical consultant who has conducted health-related missions for several UN and international agencies in over 40 countries worldwide. He is a member of the International Advisory Board of Physicians for Human Rights and co-winner of an Overseas Press Club of America award.
IN BRIEF

ROUND TABLES

WASHINGTON, DC — A Washington Roundtable featuring Kent Wiedemann, Chargé d’Affaires at the U.S. Embassy in Rangoon was held on May 27. Mr. Wiedemann shared his perspective on recent developments in Burma and provided an update on U.S. policy.

The guest speaker for the June 1 Roundtable was Dr. Alan Smith of the Burma Ethnic Research Group. Dr. Smith is the co-author of a recently published report, Forgotten Victims of a Hidden War: Internally Displaced Karen in Burma. Jana Mason, a policy analyst at the U.S. Committee for Refugees, also briefed the group on her recent visit to Thailand and Burma.


NEW YORK — The New York Roundtable co-sponsored a briefing entitled: The Role of Women in Burma. Guest speakers included Naw May Oo, president of the Karen National League; Ohmar Khin, representing the Burmese Women’s Union; and Betsy Apple, a lawyer from Earthrights International and author of School for Rape: The Burmese Military and Sexual Violence.

The New York Roundtable is a periodic meeting of organizations and individuals interested in Burma. For more information contact Burma/UN Service Office by phone: (212) 338-0048 or fax: (212) 692-9748.

NEW ENGLAND — The New England Burma Roundtable is an informal group of individuals and organizations working to promote human rights and democracy in Burma. Meetings are held the second Monday of every month. For information contact Simon Billenness of Franklin Research & Development Corporation by phone: (617) 482-6655 or fax: (617) 482-6179.

SAN FRANCISCO — The Bay Area Burma Roundtable is held the third Wednesday of every month. For more information contact Jane Jerome by phone: (408) 995-0403 or e-mail: jjerome@igc.apc.org.

SEATTLE — The Burma Interest Group is a non-partisan forum attended by representatives of NGOs, business, academia and other interested parties that meets monthly to discuss Burma related topics. For more information contact Larry Dohrs by phone: (206) 784-6873 or fax: (206)784-8150.

LONDON — The Burma Briefing is a periodic meeting of NGOs working on Burma. For information contact Edmund McGovern by phone: (44-392) 876-849 or fax: (44-392) 876-525.

HONG KONG — Information on Burma Roundtables can be obtained by contacting the Asian Human Rights Commission by phone: (852) 2698-6339 or fax: (852) 2698-6367.

BRUSSELS/PARIS — The NGO communities in France and Belgium host periodic roundtables in Paris and Brussels. For more information on this European forum contact Lotte Leicht of Human Rights Watch by phone: (32-2) 732-2009 or fax: (32-2) 732-0471.

VANCOUVER — A Burma Roundtable has been formed in Vancouver to coordinate activities and discuss developments in Burma. For more information on the monthly meetings contact e-mail: celsus@axionet.com.

INSIDE WASHINGTON

BURMA FILM SCREENED ON CAPITOL HILL

Sacrifice: The Story of Child Prostitutes in Burma, a new documentary film by award-winning producer Ellen Bruno, was shown June 10 on Capitol Hill. Co-sponsored by the National Asian American Telecommunications Association (NAATA), several non-governmental organizations, the National Coalition Government of the Union of Burma (NCGUB) and in conjunction with the Congressional Human Rights Caucus, the Congressional Asian Pacific American Caucus and Congressional Women’s Caucus, the event featured guest speakers Ellen Bruno and Dr. Chris Beyrer, internationally-recognized HIV/AIDS researcher from Johns Hopkins University.

STATE DEPARTMENT HOLDS BURMA MEETING

The Bureau for International Narcotics and Law Enforcement Affairs (INL) of the U.S. Department of State hosted a two-day meeting (May 28 and 29) on the current political, economic and narcotic situation in Burma. Panelists included journalist Bertil Lintner; former U.S. Ambassador to Rangoon, Burton Levin; Dr. Sheldon Simon, Professor of Political Science at Arizona State University; and Kent Wiedemann, Chargé d’Affaires at the U.S. Embassy in Rangoon.

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INSIDE WASHINGTON (CONTINUED)

CONGRESS HOSTS BIRTHDAY CELEBRATION FOR AUNG SAN SUU KYI

The Congressional Human Rights Caucus, in conjunction with several non-governmental organizations and the National Coalition Government of the Union of Burma, commemorated the June 19 birthday of Aung San Suu Kyi with a cultural program held at the Rayburn building. Greetings were extended to the Nobel Laureate by various organizations and members of Congress including Congressman Tom Lantos (D-CA); Congressman Benjamin Gilman (R-NY), Chairman of the House International Relations Committee; and Congressman Dana Rohrabacher (R-CA).

CONGRESSMEN PROTEST SENTENCING OF NLD MEMBERS

In a May 5, 1998 letter to Lt. Gen. Khin Nyunt, Congressmen Tom Lantos and John Porter, co-chairs of the Congressional Human Rights Caucus, voiced outrage over the "extraordinary prison sentences" recently handed down to several democracy activists inside Burma. The letter cited, in particular, the 25-year sentence imposed upon 60-year-old Daw San San, for the offense of speaking via telephone to a reporter from the British Broadcasting Corporation, as well as the 15-year sentence to NLD member U Aung and the death sentences issued to two student activists. The Congressmen called for the immediate release of these and other political prisoners and noted that: "The prosecution, imprisonment and possible execution of these individuals for the legitimate exercise of fundamental political rights is an affront to the values of civilized nations."

LETTERS TO THE EDITOR

Referring to your magazine BURMA DEBATE, Vol. V, No.1, Winter 1998, I would like to address the article on page 4, "General Than Shwe's Message." In that article you put a picture of smiling Than Shwe as though you respect him so much that the picture is fit enough for us to hang on the wall just like pictures of General Aung San.

What a shame!

The image in the picture is that of a lowly, inhuman, worthless, military murderer together with his blood-sucking herd behind him. You up-grade a feeble-minded Than Shwe to a level of greatness that this creature does not deserve by putting the devil's picture in such a large format. If you have to include pictures of such despicable animals, please use a 2 x 2 or, at most, a 2 x 4 inch size and substitute the false smile with his natural devil's face with fangs jutting out. (I could supply you with such pictures if you need them!)

Thank you for your attention.

Kyin Ho, M.D.
Fort Lauderdale, FL

You published a letter by former Colonel Chit Myaing directed at me in your Winter 1998 issue. I wish to refute only one of his assertions; although I recognize the risk of drawing another lengthy self-aggrandizing response from him.

If all the wonderful deeds the former Colonel credits himself with are true, then it is a great mystery why the Shan people have been and still are so terribly dissatisfied with Burmese military control of their territory. And while the former Colonel keeps listing his seemingly endless meritorious deeds, Sao Kya Seng, the Sawbwa of Hsipaw, just did them, without broadcasting his good work to the rest of the world.

Sao Kya Seng never took a penny of the Bawgyo Festival or any other pwe for himself. The proceeds from any century-old festival held in Hsipaw State went to the Hsipaw Sawbwa Foundation; the money was used exclusively for educational purposes, benefiting young people. Sao Kya Seng and I were not 'enjoying' ourselves with proceeds collected from the Bawgyo Festival while the former colonel was building a pagoda in Lashio — as he alleges.

How interesting that the former Colonel now remembers his aversion to Shan gambling festivals; I remember when he and his subordinates requested to hold such a festival in Hsipaw State to raise funds for the Burmese Army.

I will let history deal with the other statements made by the former Colonel about the role he and his friends played in the Northern Shan States. However, I wish to state that I do not need his condescending wishes to find peace of mind because I believe in the Dhamma.

Inge Sargent
former Mahadevi of Hsipaw
author of Twilight Over Burma

In an article printed in the state-controlled New Light of Myanmar newspaper [June 29, 1998], the regime warned that Aung San Suu Kyi could become another Ngo Dinh Diem, a former President of South Vietnam who was assassinated at the direction of generals in the South Vietnamese army during a coup in 1963.

Aung San Suu Kyi is a Noble Laureate and leader of Burma's non-violent movement for the restoration of democracy and peace in Burma. The military "government" which is threatening her life shot down thousands of peaceful, unarmed protesters in broad daylight, in front of embassies, in 1988, and it further refused to recognize the result of the 1990 May general elections. Daw Aung San Suu Kyi's party, the NLD (National League for Democracy) won over 80% of parliamentary seats.

In the last 48 hours, military intelligence agents also arrested Members of Parliament in Irrawaddy, Mandalay, Shan and Pegu Divisions and are swirling around party headquarters in Rangoon, where more arrests appear imminent.

The military regime has carried out ethnic cleansing actions against ethnic groups such as the Shan, Karen, Rakhine, Mon, and so forth. Ethnic women have been systematically and specifically targeted, and many hundreds, if not thousands, of ethnic women have become victims of government-sanctioned violence against women of the "enemy race."

I hope you will print this letter as a gesture of solidarity with the people of Burma, and will stand with the people against an illegitimate and illegal government that threatens the life of a highly respected and beloved Burmese leader, and one that has killed, raped, looted, maimed, tortured its own people with immunity and impunity — such atrocities are an everyday occurrence and continue even now.

Dr. Chao-Tzang Yawngwe
(on behalf of the Vancouver Burma Round Table)

(om behalf of the Vancouver Burma Round Table)

Coquitlam, British Columbia
JAPAN EXTENDS DEBT RELIEF TO BURMA

The Japanese government has decided to grant Burma's military regime another 2 billion yen grant in debt relief, only three months after a previous loan of the same amount. According to the Kyodo News Service, government officials signed an agreement on May 29, to give the latest grant, which matches the 2 billion yen in principal and interest recently paid by Burma to Japan under a special program aimed at helping least-developed nations by providing them with additional aid that equals the amount of debt repaid.

BUSINESS WATCH

CAMBRIDGE MASSACHUSETTS PASSES BURMA RESOLUTION

On June 8 the Cambridge City Council voted unanimously to pass a Burma selective purchasing resolution which states that: "as a matter of public policy the city of Cambridge declares that it will not purchase goods, services or commodities from any company or corporation that does business in the nation of Burma." Cambridge joins twenty-one other cities, counties and states with Burma selective purchasing legislation. The City Council also went on record in its support of the Massachusetts Burma Law, which restricts state contracts to companies doing business in Burma. The Massachusetts law is currently being challenged in the World Trade Organization.
stooges, who are axe-handles, it is effectively and successfully undertaking nation-building tasks.

A law has already been promulgated to ensure success of the National Convention and systematic transfer of power. It is the law No 5/96 of the government, promulgated on 7-6-97, entitled the Law Protecting the Peaceful and Systematic Transfer of State Responsibility and the Successful Performance of the Functions of the National Convention against Disturbances and Oppositions.

According to Section 3, Chapter II of the above law, individuals or organizations are prohibited from disturbing, destroying, obstructing, inciting, delivering speeches, making oral or written statements and disseminating in order to undermine, belittle and make people misunderstand the functions being carried out by the National Convention for the emergence of a firm and enduring Constitution and according to the Section 4 of the law, violators, on conviction, will be punished with imprisonment for a term of a minimum of 5 years to a maximum of 20 years and may also be liable to fine. Section 5 of the law prescribes that if any organization or any person on the arrangement or abetment of any organization violates any prohibition contained in Section 3, such organization may be—

a) suspended for a period to be specified,

b) abolished, or

c) declared as an unlawful association under the Unlawful Association Law.

Section 6 of the law prescribes that all funds and property of an organization against which action is taken under Section 5 may also be confiscated. The government has already announced that the constitution is not to be drafted by a single organization or a single person and that Hluttaw shall not be called unilaterally in the absence of a new Constitution.

In fact, Daw Suu Kyi is just a guest of Myanmar. Being a wife of a British, she has no right to stand for election even under the Elections Law enacted by Bogyoke Aung San, her father. After winning the Nobel Prize and others including dollars and pounds, her family has become a millionaire [sic]. The family has acquired a three-story building and a new limousine. Do not cause destruction to Myanmar to get more prizes and cash awards from the West. Do not disturb stability and peace in the country. Myanmar law and Myanmar public opinion can no longer tolerate traitorous acts.

The above excerpt is from the article "Don't do anything unforgivable" by Upay Kyaw, which appeared in the June 29, 1998 issue of Burma's state-controlled newspaper, The New Light of Myanmar.

"I ask you to use this booklet to learn about Burma. And I urge you to turn that knowledge into action. In South Africa, we gratefully learned that the people's voice raised is indeed a most powerful tool. It is time we raised our voices together to demand that our governments and the world community take effective action to bring respect for human rights and democracy to Burma."

— Most Reverend Archbishop Desmond Tutu, in his foreword to Burma: Country in Crisis.

Now available from the Open Society Institute's Burma Project, Burma: Country in Crisis, a resource guide that provides concise information and resources on important issues facing Burma today. Available online at: http://www.soros.org/burma/crisis.html

To order, contact:
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ETHNIC VOICES

This department is a new addition to Burma Debate to highlight concerns and stimulate discussion on topics surrounding ethnic views. Those interested in submitting material to be considered for possible publication should contact the editor by e-mail or fax (see page 2).

STATEMENT FROM THE CHIN SEMINAR
Ottawa, Canada, May 3, 1998

1. The Chin seminar, organized by the Chin National Front (CNF) and attended by 17 Chin compatriots including elected Chin MPs, respected intellectuals and freedom fighters from inside and outside Chinland of today's Union of Burma, was successfully held in Ottawa, Canada, on April 29 to May 2, 1998.

2. Chinland, a formerly free state, joined the Union of Burma under the Panglong Agreement. The CNF has refused a cease-fire agreement with the Burmese military regime, and to cut off support of the CNA by the Chin people. The Chinland movement became more aggressive and offensive in the western part of Burma.

3. The military regime discarded the 1947 democratic constitution which safeguarded the Panglong Agreement. Therefore we, the Chin people, consider ourselves as a free nation until and unless a constitution which guarantees our rights is proclaimed.

4. The problem of the Union of Burma started because of unequal treatment of the nationalities by the successive Burmese governments since independence. This unequal treatment has been increased by the military dictatorship especially in the areas where non-Burmans reside.

5. The military regime has convened a sham national convention with hand-picked delegates to prolong and legitimize the military dictatorship. This national convention deepens the national hatred and suspicions instead of solving the political crisis.

6. Since the military took over power, there are rampant human rights violations, religious and racial persecutions causing an exodus of Chin refugees to India as well as other countries.

7. The cease-fire arrangement between the military regime and some other armed nationality opposition groups cannot solve the present political crisis because of the absence of political dialogue.

8. In order to solve the political crisis of the Union of Burma and the refugee situation, we demand tripartite dialogue which has been called for by the United Nations as well as Daw Aung San Suu Kyi. This involves dialogue between the Burman Democratic Forces, the Burmese Military and the Non-Burman Democratic Forces.

9. Under genuine democracy and the right of self-determination in its fullest extent, we are willing to work together to consolidate unity among all nationalities in Burma to form a Federal Union.

THE CHIN PEOPLE: VICTIMS OF THE BURMESE ARMY'S LANDMINE

In addition to human rights abuses, religious persecution, and racial discrimination in Chinland, the western part of Burma bordering India and Bangladesh, the Chin people have been facing a life-threatening situation because of hundreds of thousands of landmines planted by the Burmese army since June 1997. The planting of these Chinese-made landmines has been carried out by the Burmese army LIB [Light Infantry Brigade] (36) and (379) in the border areas of Bangladesh-Burma, particularly in Pletwa township and the southern Indo-Burma border areas of western Kaladan river.

The reason behind the planting of landmines in Chin villages was clear; to wipe out the activities of the Chin National Army (CNA), an armed wing of the Chin National Front (CNF), and to cut off support of the CNA by the Chin people. The CNF has refused a cease-fire agreement with the Burmese military regime, even though the regime has offered to talk four times since 1994. Therefore, the CNF's movement became more aggressive and offensive in the western part of Burma.

The CNF's political aim and objectives are the restoration of genuine democracy in Burma and self-determination of the Chin people. The Chin people, who had an continued on page 43
MEDIA RESOURCES (CONTINUED)

over the past three years and the terrible toll they have taken in human lives, this report is aimed at raising awareness and encour-
aging a dialogue on security issues in the border region: that action
may be taken to ensure greater safety for refugees and border com-
munities in the future.

FORGOTTEN VICTIMS OF A HIDDEN WAR: INTERNALLY DISPLACED KAREN IN BURMA
April 1998
Burm Ethnic Research Group and the Friedrich Naumann
Foundation
P.O. Box 1965, Bangkok
Bangkok 10500
Thailand

An analyzing the data collected between November and
December 1997 from each of the seven districts of Kakhooi, this
report provides a summary of the conditions facing the estimated
100,000 — 200,00 Karen internally displaced persons (IDP) inside
Burma. The authors examine the extremely difficult conditions
inurgancy warfare and military occupation by the Burma Army
have imposed upon the Karen people.

BURMA: VOICES OF WOMEN IN THE STRUGGLE
A collection of writings
June 1998
ALTASEAN-BURMA
c/o Forum Asia
109 Suthisarnvinichai Road
Samsenok, Huaykwang
Bangkok 10200
Thailand
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This collection of writings recognizes the women of Burma:
Burman and non-Burman ethnic women in the struggle against
the military regime. With a foreward by Daw Aung San Suu Kyi and a
dedication to the millions of women throughout Burma who con-
tinue to survive, and the strong, committed women who are in
detention, this book marks a significant, concerted effort to bring
together the voices of the women of Burma from all over the globe.

BURMA MILITARY SECRETS:
Signals Intelligence (SIGINT) from the Second World War to Civil
War and Cyber Warfare
by Desmond Ball
P.O. Box 1141
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Thailand
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E-mail: ande@loxinfo.co.th

This book provides a unique view into important military
and political developments in Burma over the past half century
through one of the most secret and authoritative intelligence
sources, the signals intelligence (SIGINT). The author is a professor in the
Strategic and Defence Studies Centre, Australian National
University, Canberra, Australia. The 310 pp. book is available in
paperback for US$25.00, plus mailing charges. Enquiries for mail-
ing can be made by e-mail.

ETNIC VOICES (CONTINUED)

independent territory before the British annexation in 1895, co-founded the Union
government along with the Burman, Kachin and Shan. The 1962 military coup, how-
ever, forced them, as a last resort, to take up arms against the military regime. In fight-
ing the CNA, the Burmese army has faced great difficulties because of the CNA's use of
 guerrilla warfare and civilian support in the bordering areas. For this reason, the
Burmese army started planting landmines within Chinland.

Most of the Chin people depend heavily upon slash and burn cultivation and
breeding of livestock for their survival. Having never been warned by the Burmese
army about the landmines, many Chin people have been killed. In the same way,
their domestic animals such as cows, buffaloes and goats face the same fate. The vil-
lagers are unable to cultivate their fields, which is resulting in food shortages.

Hospitals, health care centers, and even physicians are absent in these persecuted
areas. There is no place for medical treatment for villagers at all. Even if a village is
in a village on a landmine, he is to face fines or torture. Another type of punishment
is relocation of villages or forcing many villagers to live together in one designated place
where the Burmese army is being stationed. For instance, the Marenwa neighboring vil-
lages were forced to settle together. Villages such as Punyinaw, Pagawa, Pokonaw,
Satangwa, Muiletwa, Aungkhai, Phuiletwa and Samang along the Kalethgyng river were
relocated in early 1998.

Landmines have forced the Chin people to take refuge in other countries. There
are about 3,000 Chin refugees in Bangladesh and more than 50,000 Chin refugees in
India. From April 16-18, 1998, U Ohn Kyaw, the Foreign Minister of Burma's ruling
State and Peace Development Council (SPDC), visited Bangladesh. The Bangladesh
government raised the issue of landmines along the Bangladesh-Burma border areas
in its meetings with the SPDC delegation. It is the hope of the Chin people that the
international community will take note of the situation that exists today in Chinland
and call on the SPDC army to account for its actions before many innocent civilians
are maimed or killed.

BRIEFINGS AND DEVELOPMENTS

UN DRUG HEAD MEETS SPDC
Pino Arlacchi, executive director of the United Nations Drug Abuse Control
and Crime Protection Organization traveled to Burma May 11-14 to meet with Burmese
officials. Accompanied by Richard Dickens, a representative of the UN Drug Control
Programme (UNDCP), Mr. Arlacchi flew to Shan State to look at anti-drug activities
after meeting with Secretary-1 of Burma's State Peace and Development Council
(SPDC) Lt. General Khin Nyunt, and Major General Soe Win, secretary of the
Myanmar Central Committee for Drug Abuse Control and Director General of the
Police Force. A proposed ten-year UNDCP project for the elimination of poppy cul-
tivation and the development of opium substitution crops was also discussed with
Burmese officials and ambassadors from the various embassies in Rangoon. The
UNDCP will be looking to donor countries to fund the project once it is finalized.

ILO CONDEMNS LABOR PRACTICES OF BURMA'S REGIME

At the annual meeting of the United Nations International Labour Organiza-
tion (ILO) held in Geneva in June, the Burmese regime once again faced con-
demnation by member states. The ILO, which is a tripartite body made up of repre-
sentatives from governments, workers and employers, raised the case of Burma for
being in violation of Conventions on Forced Labor and Freedom of Association,
conventions that have been ratified by that country. The 173-member UN organi-
zation cited the continued use of forced labor and the prohibition against the estab-
lishment of independent trade unions in the 'special paragraph' used by the group
to highlight the violations. A report by an ILO Mission of Inquiry into the
regimes non-compliance to these conventions is due out later this year.

BURMA DEBATE 43 SPRING 1998
Burma Debate is a publication of The Burma Project of the Open Society Institute.
Mary Pack, Editor

THE OPEN SOCIETY INSTITUTE (OSI) was established in December of 1993 to promote the development of open societies around the world. Toward this goal, the institute engages in a number of regional and country-specific projects relating to education, media, legal reform and human rights. In addition, OSI undertakes advocacy projects aimed at encouraging debate and disseminating information on a range of issues which are insufficiently explored in the public realm. OSI funds projects that promote the exploration of novel approaches to domestic and international problems.

The Burma Project initiates, supports and administers a wide range of programs and activities. Priority is given to programs that promote the well-being and progress of all the people of Burma regardless of race, ethnic background, age or gender.

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website: http://www.soros.org/burma.html