BURMA HUMAN RIGHTS YEARBOOK 2007

CHAPTER 7

RIGHT TO HEALTH

"[States Parties recognise] the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health."

- Article 11 (1), International Covenant on Economic, Social and Cultural Rights

7.1 Introduction

The people of Burma continued to suffer very poor health in 2007. Although current and reliable statistics are difficult to obtain, reports from United Nations (UN) agencies, international and local non-governmental organisations (NGOs) indicate that the health of the Burmese population is among the worst in world. In February 2007, Charles Petrie, the UN Resident Coordinator for Humanitarian Affairs in Burma warned of *"an impending humanitarian crisis"*. His April 2007 report cited the *"growing inability of the social service provision structures to meet the essential needs of the population"*, and cautioned that the *"growing inability of existing health structures to confront the increasing rates of new and recurrent cases of HIV/AIDS, multi-drug resistant tuberculosis and drug resistant malaria will result in an inability to contain their progression within the general population".* His report also pointed out the *"alarmingly high"* mortality rates for infants, children under five, and mothers.[1]

The most recent official UN health statistics, which date from 2005, maintain that the mortality rate for infants is 75 (per 1,000 live births), while for children under five it rises to 106 (per 1,000 live births).[2] The maternal mortality rate is 3.8 (per 1,000 births) and the average life expectancy at birth is 59.9 years.[3] Furthermore, the probability at birth of dying before the age of 40 is 21 percent, while the probability of surviving to the age of 65 is 64.1 percent for women and 50.7 for men.[4]

Underlying much of this poor health is economic deprivation and instability (For more information, see Chapter 6: Deprivation of Livelihood). While the 2007/8 UN Human Development Report optimistically maintains that 21 percent of the Burmese population live below the poverty line; U Sein Htay, a leading Burmese economist has argued that this number is actually closer to 50 percent.[5]

According to Save the Children UK (SCUK), the average daily cost of a healthy diet exceeded the average daily income of the poorest people during 2007, while UN surveys have estimated that 90 percent of the population spends 60-70 percent of household income on food, allowing precious little for other household expenses, and leaving little margin of safety in case of sickness or loss of income.[6]

The situation is exacerbated by rampant inflation, for which estimates for 2007 ranged between 50 and 60 percent.[7] Meanwhile, the value of the kyat declined even further during 2007 as a result of high foreign debt, which sequentially raised firstly energy costs and consequently food and commodity prices.

According to UN data, malnutrition represents a very serious problem in Burma, with an estimated five percent of the population undernourished.[8] Child malnutrition is endemic with 15 percent of infants are born underweight, 32 percent of children under five are underweight for age, and 41 percent are under height for age.[9] However, the actual rate of malnutrition is in all likelihood far higher than that suggested by the UN. Credible reports from rural areas where UN agencies are not permitted access have maintained that child malnutrition in such areas is over 15 percent.[10] Moreover, Burma is reportedly the only country on the planet where the vitamin deficiency disease beriberi, caused by a deficiency of thiamine (vitamin B1), is a major contributing factor for infant mortality.[11]

Conditions are especially grave in the ethnic border states. Remote areas typically pose challenges to the delivery of healthcare in any country, but in Burma, a large percentage of the border areas are zones of continuing armed conflict, and the regime's Four Cuts Policy deliberately denies a standard of living adequate for health and obstructs civilians' access to medical care. (For more information, see Chapter 15: Ethnic Minority Rights). In June 2007,

the president of the International Committee of the Red Cross (ICRC), Jakob Kellenberger, made a statement that was uncharacteristically critical of the regime, maintaining that the SPDC was directly responsible for the *"immense suffering of thousands of people in conflict-affected areas"*, through the enactment of *"large-scale destruction of food supplies and of means of production"*, coupled with the imposition of movement restrictions that made it *"impossible for many villagers to work in their fields".*[12]

In Chin State, it has been estimated that as many as 40 percent of the population do not get enough food to live on.[13] Meanwhile, in parts of Karen State, it has been reported that only 25 percent of the population are able to acquire enough food to feed themselves and their families.[14] Many people in ethnic border areas choose not to live under the oppressive control of the SPDC and thus seek to avoid all contact with them. To accomplish this, thousands of people live as internally displaced persons (IDPs), many of whom reside in improvised dwellings in the forests, effectively evading military patrols but exposing themselves to malaria-bearing mosquitoes, a lack of food security, poor sanitation and a shortage of clean drinking water.[15] Human rights violations are widespread in these areas and are associated with increased levels of sickness and death. Data gathered by the Back Pack Health Worker Teams (BPHWT) has shown strong correlations between displacement and increases in rates of child mortality, child malnutrition, and landmine injury. Furthermore, extortion, theft and the wilful destruction of food supplies and livelihoods, all of which occur with alarming frequency in border areas, has also been shown to be associated with increased crude mortality, child malnutrition, landmine injury, and the presence of malaria parasites in the blood.[16] The SPDC provides little to no healthcare in these regions and local aid organizations such as the Karen Department of Health and Welfare (KDHW), the Back Pack Health Worker Teams (BPHWT), the Free Burma Rangers (FBR) and others attempt to make up the shortfall. It was reported that in Karen State in June 2007, seven adults and two children had died during the forced relocation of their village for lack of medical care after they became ill when exposed to the mosquitoes and heavy monsoon rains.[17] Moreover, the military systematically confiscates medical supplies; having prohibited the possession of medicines in some areas for fear that they could be given to armed opposition forces, regardless of whether or not the intention or means of doing so ever existed. Meanwhile, all access for humanitarian aid workers to conflict areas is denied.[18]

Uncontrolled exploitation of natural resources by the SPDC and by companies the SPDC has given resource concessions to has impoverished local people and put the quality and security of food and water at considerable risk.[19] In Hukawng Valley of Kachin State, local residents reported during 2007 that buffalo, cattle, and wild pigs had been killed by unidentified chemical agents used to protect crops by the Yuzana Company and by an unnamed Yunnan-based Chinese company.[20] Similarly, reports have emerged stating that unregulated pesticide, fungicide, and fertilizer use in the water gardens of Inle Lake further threatens the health of people who rely on the lake for drinking water and fish. An unnamed Burmese researcher familiar with the area reported that diseases of the throat and kidneys were common in the communities around the lake.[21] Meanwhile, in Minhlah village of Kale Township, Sagaing Division, the reliable reports have asserted that the military applied insecticide to rice in local villagers' fields, causing stomach problems in villagers who consumed it.[22]

In urban areas across the country, the regime's crackdown on protestors in September 2007 further served to exacerbate the already grave health conditions. Renewed restrictions on the movement of food interfered with the World Food Program's (WFP) feeding of 500,000 people, which included many children and HIV/AIDS and tuberculosis (TB) patients. Local authorities prohibited all movement of food out of Mandalay, impeding WFP operations in central Burma and northern Shan State. Disturbances in the port of Sittwe also limited food delivery to northern Arakan State.[23]

During and immediately following the protests, the SPDC actively restricted medical treatment in a variety of different ways as hospitals were ordered to deny treatment to those who had been injured in the protests. Moreover, patients were cleared out of hospital wards to make room for casualties, and some of those in desperate need of medical attention avoided hospitals for fear of being arrested.[24] Further compounding the issue, some medical personnel, and those responsible for the care of sick family members, were detained or forced into hiding.[25]

80-year-old *"Grandmother"* Ma Aye Noh displays a severe abscess which has formed on the side of her neck. Although her children have recognised the severity of the ailment, they say they have not so far been able to care for her or provide any treatment. *[Caption and photo: KHRG]*

The regime's absolute control over all State institutions, its considerable control of civil society actors, and position as chief economic policy maker, leave little room for individuals or organizations to escape the consequences of its policies, the majority of which are designed to benefit the military, at the expense of the civilian population.[26] A report by UN Resident Coordinator for Humanitarian Affairs in Burma, Charles Petrie, characterised Burma's suffering as the result of the regime's *"ill-informed and outdated policies, … lack of public expenditure"*, and *"uncompromising attitude to civil society groups"*.[27] In clear contrast to this, in the aftermath of the September protests, Senior General Than Shwe claimed that Burma's social and economic standards had improved, and that life expectancy had miraculously increased due to improvements in the State healthcare system, although just what these improvements were was not mentioned and remain to be seen.[28]

7.2 Access to Healthcare

Access to healthcare in Burma is limited by a range of factors. The first of these is the prohibitively small budgetary allocation for healthcare, which itself reflects the SPDC's general lack of political will to assist the general population. Such low levels of funding have created the dismally poor conditions in public hospitals. Meanwhile, the costs related to private healthcare in Burma are beyond the means of the majority of the population. The general lack of resources and the low pay provided to healthcare practitioners has also lead to widespread corruption, which has made access to medical care even more expensive and difficult.

The SPDC's constraints on, and active obstruction of humanitarian operations (For more information, see section 7.6: International Aid and Humanitarian Operations, below), and its regular detention and harassment of those seeking care have also all had their role in limiting access medical care in Burma. For the 2004 fiscal year, the UN reported that public health expenditure was a paltry 0.3 percent of GDP, while private health expenditure as considerably more at 1.9 percent of GDP, and that overall health expenditure was a trifling US$38 per capita. Though scarcely believable, the following year, in 2005, funding of public hospitals and dispensaries actually dropped to 0.2 percent of GDP, a figure much lower than the average for developing nations globally.[29]

Owing in part to Burma's grossly inadequate education system, in 2007 it was reported that there were a shortage of physicians and other trained health professionals, and most hospitals lacked staff, equipment, and medical supplies.[30] According to the UN Human Development Report, there were only 36 physicians per 100,000 members of the population, in which only 57 percent of births attended by skilled health personnel.[31] While the SPDC Ministry of Health's "Health Vision 2030" policy proposed the expansion and upgrading of Burma's public hospitals, in February 2007, Kandawgyi hospital and Kantharyar hospital, both of which are public hospitals, in Tamwe Township, Rangoon were closed suddenly with employees given no advance warning, no explanation, no compensation, and no assistance finding new employment.[32]

Some reports have maintained that, in some areas, such as in Shan State, patients are expected to provide the bandages, alcohol swabs, and medications needed for their operations.[33] Similarly, Myitkyina Government Hospital in Kachin State faced electrical shortages for at least a month during 2007, and charged surgery patients an additional 7,500 kyat (US$6) per hour to run a diesel generator during their procedures. Equally, pregnant women were also reportedly expected to supply candles and torches for use during their deliveries, and all patients receiving treatment at the hospital were required to pay extra money on top of their medical costs to keep the hospital supplied with medicine, equipment, and electricity.[34] In Arakan State, a pregnant woman died, allegedly because her treatment was delayed by doctors at the Buthidaung Government Hospital who were demanding more money than her husband could pay. No compensation was paid for her death.[35]

The Union Solidarity and Development Association (USDA), which, according to the SPDC is a popular social organization, but which in reality represents little more than the civilian face of the military and has been widely implicated for its involvement in political violence, supposedly administers a number of free clinics. However, in December 2007 there were reports that patients at the USDA clinic in Thanlyin (Syriam) Township, Rangoon were being charged 300 kyat for appointments.[36]

Local deficiencies in healthcare, which are especially acute in rural and ethnic areas, typically must be overcome by travelling long distances to larger centres for care. However, this often attracts many difficulties and should under no circumstances be considered an

acceptable solution. In areas experiencing continuing armed conflict, travel is often difficult, expensive and dangerous. In some cases, such as in many parts of Karen State, travel outside one's village is prohibited. Before travel is permitted in many of these areas, travel permits must be secured, typically through the payment of bribes, which when considered in combination with the cost of healthcare and the costs of travel can make such a prospect untenable.

On 1 March 2007, Daw Nu Nu Way suffered complications giving birth in her home village of Pa La Na in Kachin State. Her family and health workers from her village tried to take her to Myitkyina Township Hospital, but SPDC army soldiers from Infantry Battalion (IB) #29 who stopped her for two hours at a checkpoint along the way, preventing her from getting the immediate medical attention she required, which ultimately contributed to her death upon arrival at the hospital.[37]

A variety of healthcare providers exist alongside the woefully inadequate public system. In Rangoon, there are approximately 20 small private hospitals serve the very wealthy, who are the only ones able to afford the exorbitant fees they charge. In April 2007, the SPDC passed a new law creating a private health care policy body, and another one making overcharging by doctors punishable by five years' imprisonment, although, the effectiveness of these laws remains to be seen.[38] The enactment of these new laws suggests that private hospitals may be exploiting rather than alleviating the weaknesses of the public system. There are private clinics in other cities outside Rangoon, which during 2007; the poor and middle classes began to attend in increasing numbers for lack of trust in the public hospitals, or for where there are no public services available.

Meanwhile, a number of high-ranking SPDC officials and their families, apparently fully aware of the inadequacies of the Burmese healthcare system and its inability to do what it is supposed to do, travel all the way to Singapore to seek treatment in private hospitals. In January 2007, Senior General Than Shwe was hospitalized in one such facility in Singapore for a week, as was Prime Minister Soe Win in March 2007.[39] Indeed, the question begs to be asked: if Burma's healthcare system is as good as the SPDC would like to have us believe it is, why do they and their families seek treatment abroad?

It has been reported that in spite of the deplorable state of the public health system, the military has its own independent medical system. Though little information is available about this parallel system, it is known that there are well equipped hospitals in Naypyidaw that are exclusively for the use of military officers.[40]

In border and conflict areas public healthcare is virtually non-existent. The majority of villagers in these areas must rely on traditional herbal remedies, many of which prove ineffective in treating the problem, or services provided by armed opposition groups, independent relief organizations who from time to time are able to travel into conflict areas, or on clinics in neighbouring countries.[41]

The regime prohibits all international humanitarian access to all such conflict-affected areas. In April 2007, U Soe Tha, the Minister for National Planning and Economic Development reportedly gave assurances to the Assistant Secretary-General for Humanitarian Affairs that access would soon be given to these areas, however, no such admission has yet been permitted.[42] Karen, Karenni, and Shan States where armed conflict continues and the greatest number of internally displaced persons (IDPs) live in hiding, are among the worst affected by these restrictions. Local independent humanitarian aid organizations such as the Free Burma Rangers (FBR) and the Backpack Health Worker Teams (BPHWT) send medics and supply caravans into remote areas to provide care, and though these groups are among some of the most effective groups on the ground, the demand is too great for their limited resources and areas which are heavily militarized cannot be reached.[43]

Those living in Karen State and who are able to travel also have the option to cross the border into Thailand where they can get treatment at the public hospital in Mae Sot, Tak Province or at the Mae Tao Clinic (MTC) which is also in Mae Sot.[44] On the opposite border in July 2007, Indian traders from Manipur in India's northeast sponsored a number of medical clinics that provided free health check-ups to Burmese communities in villages situated along the Burma-India border, while the Shija Hospital and Research Institute near Imphal, the state capital of Manipur, offered free cleft palate surgery to Burmese citizens.[45]

The limited availability and poor quality of medicines available in Burma further limits the healthcare available. The chairman of the Myanmar Pharmaceuticals and Medical Equipment Entrepreneurs Association (MPMEEA), Dr Maung Maung Lay, has estimated that between 10 and 15 percent of medicines available in Burma are fake.[46] Inferior quality, the wrong medicines, or tablets containing less medicine than advertised can actually be worse than useless. In addition to diverting scarce financial resources, diseases such as malaria or tuberculosis can develop immunity to drugs if they are exposed to lower or less potent medications.[47] According to the *New Light of Myanmar*, Burma has five pharmaceutical factories within its borders, which provide 40 percent of domestic drug supply. In 2007, a sixth drug factory was built at Pyin Oo Lwin in Mandalay Division, though limited information is available on the products created at this, or any of the five other factories, their quality, and their anti-counterfeiting measures.[48]

A Free Burma Rangers humanitarian relief team proving medical aid to IDPs at Papun District, Karen State in December 2007. *[Photo: FBR]*

7.3 HIV/AIDS

More than 20,000 people die of AIDS in Burma every year. HIV prevalence trends in Burma suggest that the epidemic peaked in 2000 and in 2007 was believed to be in decline, although the disease burden remains very high and prevalence among children is still on the rise.[49] The WHO has estimated that HIV prevalence in Burma during 2007 stood at 0.67 percent, based on data from previous surveys and projections from past trends, however, in the absence of recent data, it remains unclear just how accurate this estimate is.[50] Researchers at the 8th International Congress on AIDS in Asia and the Pacific in August 2007 estimated that in 2007 there were 230,000 adults and 6,000 children living with AIDS in Burma alone, of which 13,000 cases have been classified as new infections. HIV prevalence among pregnant women was estimated at 1.5 percent in 2007, down from 2.5 percent in 2000.[51] Among intravenous drug users, HIV prevalence is believed to have stabilised at approximately 40 percent, after fluctuating from 62.8 percent in 1992, 34.4 percent in 2004, and 43.2 percent in 2005.[52] In 2005, the year of the most recent UN survey data, an estimated 1.3 percent of the Burmese adult population, or 339,000 people, were reported as living with HIV, making Burma the third-highest HIV burden in the South-East Asia region.[53] Also in 2005, HIV prevalence among commercial sex workers in Rangoon was 29.6 percent, and in Mandalay 34.3 percent.[54]

While the UN has praised the regime's progress in controlling HIV/AIDS,[55] at the beginning of 2007 the WHO warned of the risk of a massive spread of disease amongst intravenous drug users, sex workers and the gay community in Burma and in neighbouring countries.[56] Usage of and addiction to heroin is an increasing problem for neighbouring Thailand, India, and Yunnan Province in China.[57] Burma's poor cooperation with its neighbours impairs effective control of drug smuggling, addiction, and HIV transmission. However, frequent reports of the SPDC's complicity in the production and trafficking of drugs may offer an explanation for their lack of enthusiasm on this matter.

HIV education projects among local communities have increased in recent years, but the regime's budget allocation for these efforts remains appallingly low, and cultural barriers, along with draconian and discriminatory laws that declare the possession of condoms to be evidence of prostitution, make the teaching safe sex extremely difficult.[58]

Access to treatment programs is also very limited with as many as 60,000 AIDS sufferers in need of antiretroviral drugs (ARV) unable to access them.[59] The reasons for this are numerous. Many people living with HIV in Burma are simply not aware of that important fact. Burma suffers from an acute shortage of laboratory facilities where the necessary diagnostic blood tests can be conducted. Besides which, the average Burmese citizen, the vast majority of who live below the poverty line, cannot afford the costs of such tests anyway. Many of those living in rural areas often don't know that treatment exists, and even if they did, and were able to afford them (however unlikely a supposition that this may be), they would still have to travel to one of the larger urban centres to receive the treatment, which requires no only money, but also travel permits. Moreover, in such urban centres ARVs are only administered by a small handful of public hospitals, by the Artsen zonder Grenzen (AzG; the Dutch branch of MSF), and by HIV/AIDS support services offered by the NLD.

In January 2007, hospitals in Rangoon ran out of ARV, and shortfalls in public hospitals were such that they began referring patients to the services offered by the NLD.[60] Such activities are mistrusted by the SPDC, who apparently fear that the NLD may be using these services to develop political clout by rising to the challenge where the regime is failing.[61]

In addition to the expense of travel and medical care, patients must pay for the ARV treatment. However, the August 2007 fuel price rise, which in turn drove food and commodity prices up (For more information, see Chapter 6: Deprivation of Livelihood), similarly forced an increase of over 20 percent in ARV prices, pushing the cost of a one month's treatment course up to 37,000 kyat from the 30,000 kyat it had been previously.[62] In Burma many HIV sufferers die simply because they cannot afford the high costs of treatment.[63]

Daw Phyu Phyu Thin, right, at work with HIV/AIDS patients in Rangoon. *[Photo: Irrawaddy]*

SPDC army soldiers with HIV/AIDS are typically denied treatment because, according to an SPDC army medical officer, the army refuses to acknowledge the disease as a major problem, in spite of soldiers being at a high risk of contracting the disease because blood transfusions in the army are not tested for HIV.[64]

According to the *Myanmar Times*, the Myanmar Medical Association (MMA) announced plans in December 2007, to hold HIV/AIDS education fairs in Rangoon and in Pegu (Bago), in collaboration with the UN Population Fund (UNFPA), and with the participation of the SPDC Department of Health's National Aids Program, and NGOs, including UK-based Marie Stopes International (MSI).[65] Meanwhile, the military, the police, and civil officials, all of whom are subordinate to the SPDC, have continued to actively obstruct individuals and local NGOs distributing educational materials and giving care and counselling to people living with AIDS. Self-help groups, which in other more liberal countries are ale to organize patients for mutual support and practical assistance, are rare in Burma, because of SPDC repression the social stigma still attached to AIDS, perpetuated by that repression.[66]

As noted above, the NLD was active in conducting HIV/AIDS education and support services during 2007, which it has combined with its campaigns on human rights education and political advocacy.[67] Phyu Phyu Thin is a leading Burmese HIV/AIDS activist, who, since 2002, had coordinated the NLD's HIV/AIDS support program, and run a centre in Rangoon providing antiretroviral treatment, counselling, and made arrangements for housing and referrals to international aid agencies.[68] However, she was arrested and imprisoned from 21 May 2007 until 2 July 2007 after she and more than 40 others met to pray for the release of Daw Aung San Suu Kyi. Following her arrest, 11 HIV-positive supporters staged protest vigils demanding her release, for which they were also arrested and detained for three days at the Waybargi Infectious Diseases Hospital on the outskirts of Rangoon.[69]

The regime has also obstructed other attempts at HIV/AIDS education and treatment. A Burmese NGO worker who had met with local residents in Mon State in early 2007 to discuss an HIV/AIDS education and prevention project was ordered to appear at the local police station and accused by the TPDC chairperson of failing to first consult them about the project, despite the project having already been under implementation for two years.[70]

In another case, Ko Tin Ko, who is HIV-positive himself, was arrested and detained by police in Rangoon in April 2007, for distributing educational leaflets that he had written about HIV/AIDS and the difficulties AIDS sufferers face in travelling to Rangoon for antiretroviral treatment.[71] In February 2007, he had attempted to form an HIV/AIDS awareness centre in Pakokku, Magwe Division, but his efforts were frustrated by the police who ordered him to shut the program down.[72]

7.4 Other Infectious and Communicable Diseases

Tuberculosis

According to the World Health Organization, Burma holds the unenviable position of being on the list of 22 "High TB Burden Countries", with an estimated 40 percent of the population being infected.[73] During 2007, the SPDC Ministry of Health estimated that 100,000 new tuberculosis (TB) patients develop each year, with approximately half of this number being infectious.[74] The UN, meanwhile, is less conservative in its estimates, who maintain that there are closer to 130,000 new infections each year.[75]

Tuberculosis in its inactive form does not cause illness; however, a weakened immune system brought on by other diseases or through poor nutrition can bring about active tuberculosis, which can turn deadly.[76] According to the UN Joint Program on HIV/AIDS (UNAIDS), between 60 and 80 percent of people with HIV also suffer from TB. Tuberculosis is one of the biggest infectious disease killers of AIDS sufferers, and as such proper treatment of TB can be considered a life-saving treatment for those in this position.[77]

Correct treatment for TB is known as "Directly Observed Therapy" (DOTS) in that prescribed antibiotic pills are taken under direct observation by health workers, to ensure that the antibiotics are not sold for profit, or misused to treat other afflictions. According to the United Nations Human Development report, 95 percent of all detected cases of active tuberculosis are under DOTS treatment, where 84 percent of this number (80 percent of the total) are successfully cured under DOTS.[78] Ineffective or incomplete treatment, as can occur among poorly monitored and impoverished populations, such the internally displaced, can lead to the rise of drug-resistant strains of TB. Such strains are difficult and expensive to treat, and unfortunately are reportedly becoming an increasing problem in Burma.

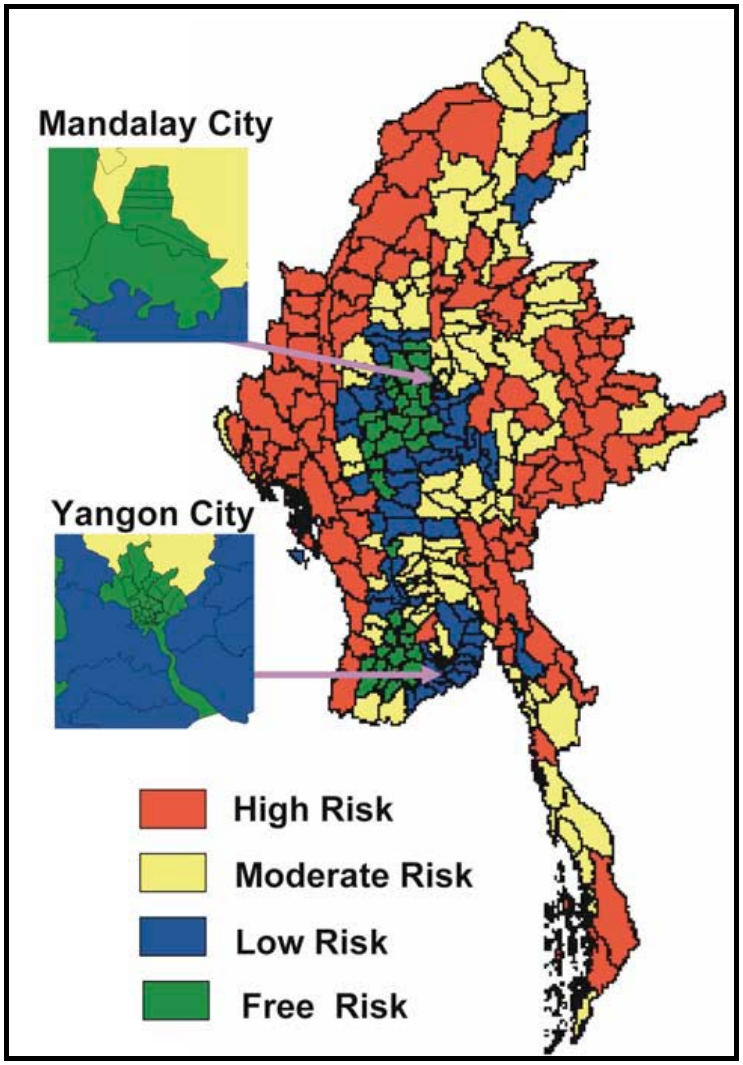
In May 2007, Medecins Sans Frontieres (MSF) reported treating 15 cases of multi-drug-resistant tuberculosis in an unnamed refugee camp in Thailand along with two further cases of *"extensively-drug-resistant"*, one of which was reported in a refugee camp, while the other was observed in a Burmese migrant worker in Thailand. It was suspected that other refugees and migrant workers may b unknowingly carrying this highly resistant strain.[79]

Malaria

Malaria is the leading cause of death and sickness in Burma. The UN has estimated that 700,000 people each year suffer from malaria, not only because the disease is endemic to many parts of the country, but also owing to inadequate protection against the disease. The simplest form of protection against malaria is obtained through the use of insecticide-treated mosquito nets (ITNs); however, many do not have access to such a simple yet vital line of defence, which, according to the UN results in 700,000 new cases each year.[80] Total nation-wide prevalence of the disease is difficult to determine, but recorded deaths from malaria in Burma are higher than in any other country in all of Asia. In March 2007, the SPDC Ministry of Health reported that malaria morbidity dramatically declined from 24.5 per 1,000 in 1989 to 9.3 per 1,000 in 2006, with mortality declining from 10.4 to 3.1 (per 1,000) over the same period.[81] Official statistics should always be considered to be questionable, with these figures being no exception. In 2003, the WHO, working along official channels, recorded 2,016 cases of malaria in Karen State. Meanwhile, the Mae Tao Clinic (MTC) just across the border in Mae Sot of Tak Province, Thailand reported 5,000 confirmed cases, while the Karen Department of Health and Welfare (KDHW) and the Backpack Health Worker Teams (BPHWT) had reported treating 27,000 cases among internally displaced populations in the

state.[82] An independent study published in September 2007, estimated the prevalence of malaria in contested regions of eastern Burma to be approximately 10 percent.[83]

The Thai Ministry of Public Health, which maintains 800 malaria treatment units along its border with Burma, reported 2,995 malaria cases among Burmese migrant workers in the first half of 2007, which had resulted in 12 deaths.[84]



Malaria Risk Areas in Burma. *[Source: WHO]*

Dengue

Dengue is a flu-like illness caused by a virus transmitted by the bite of the *Aedes aegypti* mosquito. The disease can be fatal in children, especially in the haemorrhagic fever strain that is caused by repeated infection.

No vaccine exists to treat dengue, so control of mosquito populations forms the basis of prevention. Unplanned and unregulated urban development, poor water storage, and unsatisfactory sanitary conditions increase the breeding habitats of the mosquito, which has led the WHO to describe dengue as a *"man-made problem related to human behavior"*.[85]

In the first half of 2007, warmer weather and unseasonable heavy rainfalls brought a steep rise in dengue infections throughout South East Asia, chiefly in Indonesia, Thailand, and Burma, though reported totals for the region at year-end were less than in 2006.

In August 2007, the SPDC Ministry of Health reported the deaths of *"about 100 children"* resulting from dengue thus far for 2007. In July 2007 alone, 32 children had reportedly died of the disease, the majority of who were under five. This number represents a worsening situation when compared to the 130 fatalities from dengue for the whole of 2006.[86] Furthermore, in August 2007, the WHO reported 98 deaths from 8,445 cases to July 2007, compared with 6,711 cases in the same period the year before. The major cities of Rangoon, Mandalay, and Moulmein, all of which *"have undergone rapid urbanization in the last few years"*, reported the highest number of cases, however, this statistic may also reflect the lack of access that international organizations have to most parts of the country.[87]

In June 2007, at the beginning of the rainy season, the emergency ward of Rangoon General Hospital was *"filled by children"* suffering from dengue.[88] The following month, in July 2007, doctors at Rangoon Children's Hospital reported that each day, 150 to 200 children had presented with dengue, and that the hospital didn't have the resources to treat them, ultimately resulting in as many as five deaths a day.[89] Dr Than Win, from North Okkalapa Township in Rangoon told reporters that *"the strain of the disease prevalent in patients this rainy season appeared to be stronger than those in previous years and that the numbers of children dying were unprecedented"*.[90]

Private clinics were also reported to have been crowded with dengue cases, with a Rangoon resident reporting that patients were queuing outside hospitals for treatment, and that due to overcrowding, SPDC-administered hospitals were admitting only the most serious cases.[91] However, in a country where over a hundred die from dengue each year; largely due to a lack of adequate and affordable healthcare, all cases should be treated as serious. Similarly, an unidentified doctor at a private clinic in Minhla Township of Pegu (Bago) Division reported in July that his clinic was receiving 10 cases of dengue a day.[92] Private clinics and hospitals in Mon State had also reported being full of patients with dengue in May 2007, and that some patients had been asked to leave before they had fully recovered in order to make room for new patients.[93] Reports emerged that one or two people had died of dengue each day at Moulmein Hospital. Local villagers in Ye Township, Mon State said that fatalities were under-reported because health workers go to lengths to conceal them, for fear of being blamed by higher authorities.[94]

Following the outbreak, Daw Myint Myint Soe, the Mon State Chairperson of the Myanmar Maternal and Child Welfare Association (MMCWA), an SPDC-organized and controlled women's rights organization, visited Than Ka Lond village in Kyaik Mayaw Township, Mon State in June 2007 to ostensibly check on the status of malaria cases, in what was little more than an overt photo opportunity and public relations stunt. It was reported that the Village Peace and Development Council (VPDC) had extorted a sum of approximately one million kyat from local villagers to cover the cost of her visit.[95] The report failed to mention why they were checking on cases of malaria following an outbreak of dengue, or what they could have done should they have found any.

In the first half of 2007, the SPDC Ministry of Health reportedly launched a dengue education campaign in Rangoon, but some residents claimed that authorities had failed to educate the community about the dangers of dengue. Daw Thet Nwe, whose three-year-old daughter, Ma Thazin Wai, had died from dengue in late July 2007, organized a community outreach program with a group of neighbours who distributed educational pamphlets published by UNICEF about the risks of dengue. The group maintained that they felt they had to do this to make up for the failure of the authorities to do so. Daw Thet Nwe was quoting as having

said, *"We didn't know the right way to deal with the fever and ended up losing our baby girl … if we had seen the leaflets earlier we could have prevented her death"*.[96]

Avian Influenza

In November 2007, Burma announced its first reported human carrier of avian influenza in a seven-year-old girl in a village in Kengtung Township, Shan State.[97] Separate outbreaks of avian influenza, which is also known as bird flu or H5N1, occurred in poultry farms around Rangoon in February, March, June, and July, and in Mon State in July, in eastern Pegu in October, and in eastern Shan State in November and December.[98]

In response to the earlier outbreaks the regime claimed that it had sealed off disease areas, tested birds for disease, disinfected areas, closed fowl meat depots, prohibited transport of fowl and sale of birds or their eggs, culled birds, and urged farmers to use new farm equipment and to prevent crows from entering their farms,[99] and pet-owners to keep their animals from eating birds.[100]

The United States Food and Drug Administration (FDA) praised the regime's response to the March outbreaks as *"quick and effective"*, as did the UN Food and Agriculture Organisation (FAO), although conceded that the SPDC would require further help on the issue.[101] The regime maintained that it had actively surveyed for disease outbreaks, sought and accepted assistance from other countries,[102] and cooperated with international organisations such as the WHO, the FAO, and USAID[103] in controlling the outbreaks, and with neighbouring countries in preventing movement of fowl across borders. In March 2007, the U.S. Government, which gives virtually no aid to the regime and has been one of its most ardent critics, supplied $600,000 worth of laboratory testing equipment.[104] According to some reports, the regime reported bird flu cases to the international community, a departure from its usual secretiveness,[105] although other reports emerged of some concealing of outbreaks.[106]

The health infrastructure of Burma is so weak that, in the words of one unidentified UN official, an outbreak of avian influenza *"would be close to impossible to contain"*.[107] In spite of this, the regime has done little to nothing to correct this basic vulnerability. The response to outbreaks has been restricted primarily by the limited capacity and lack of political will of the SPDC's veterinary and public health apparatus. In March 2007, the FAO noted that the source of the February outbreaks that had occurred in four townships around Rangoon remained unknown, and that the regime needed stronger surveillance, laboratory capabilities, animal health services, and public education, and to assist develop these, gave US$1.4 million to aid the regime's effort in these areas.[108]

In many cases, especially in rural areas, local residents reported that word of the dangers of avian influenza had not reached their area or that the junta had simply not made any public announcements, and that chickens were still being sold alive in markets and in restaurants.[109] Likewise in the June outbreaks, the Livestock Breeding and Veterinary Department (LBVD) failed to inform poultry farmers for ten days after the initial reports, probably out of fear of international condemnation for their failure to control the situation.[110] Again, in October 2007, the regime censored news of yet another outbreak in Thanatpin Township in Pegu Division.[111] In many areas, as expected, the outbreaks caused a decline in demand, and rather than stopping trade in chickens, the lower market prices simply shifted consumption of chicken to the poor who previously were unable to afford the high costs of meat.[112] In other areas, merchants sold chicken clandestinely at inflated prices.[113]

Reports also emerged of members of the junta-affiliated Myanmar Red Cross and auxiliary fire brigades accepting bribes from poultry farmers to avoid having to cull their birds, or to enforce the culling only at small farms and leaving larger farms, who would have been able to pay much larger bribes, alone.[114] A veterinarian involved in the response had said on condition of anonymity that the measures taken were grossly inadequate and that because the authorities had offered no form of compensation to the owners of the destroyed birds, people either evaded the culling or were impoverished as a result of it[115]

Diarrhoea

Waterborne diseases causing gastrointestinal symptoms, diarrhoea, dehydration, and then death are responsible for 50 percent of infant morbidity in Burma, and in a shocking statistic that is unforgivable in the 21st century; diarrhoea itself is the second most significant cause of death in children under the age of five.[116]

According to the *UN Human Development Report 2007/2008*, 78 percent of the Burmese population uses an *"improved"* water source (defined as being safe to drink) and 77 percent use improved sanitation. When children become sick, only 48 percent of them receive the appropriate medical care of rehydration and continued feeding.[117] These statistics provided by the UNDP, however, seem highly optimistic. In reality, these figures are likely to be far lower. The UNDP reportedly has works to improve sanitation and water supply, but diarrhoea remains widespread, and many of the most vulnerable populations live in areas beyond the reach of UN agencies such as UNDP.[118]

On 1 November 2007, there was reportedly an outbreak of diarrhoea in Bawli Bazaar of Maungdaw Township, Arakan State, believed to have been brought on by a sudden change in weather conditions. Many persons afflicted with the illness were admitted to the medical clinic in Bawli Bazar, however there was little that could be done for them, owing to the *"scarcity of oral saline and other much needed medicines"*. Between 6 and 8 November 2007, four patients died as a result of the diarrhoea that they suffered from. The names and ages of the deceased were:

1. Robiya, 7;
2. Salma Khatun, 25;
3. Hasina, 20; and
4. Sokina, 26.[119]

Typhoid

Typhoid is another potentially fatal waterborne disease with a high prevalence in Burma, owing largely to poor sanitation. On 8 April 2007, a 12-year-old Ahmed Khobir from Aley Than Kyaw village in Maungdaw Township, Arakan State died after contracting typhoid. The boy reportedly suffered with the disease at home in the absence of any medical care for two weeks before being taken to Maungdaw Hospital where he died a week later. Following the boy's death, his village doctor had told journalists that, *"There is not good practice of personal hygiene among our people. In open food serving places, we share same glasses and cups for drinking water and tea, which are readily contaminated. We mostly drink un-boiled water"*.[120]

Responding to the crisis of an enduring lack of safe drinking water in Arakan State, the United Nations Development Project (UNDP) reportedly dug a number of wells in affected areas throughout Maungdaw Township in June 2007, however, as with many issues in Burma, demand far outweighs the supply and these wells are able to only reach a fraction of the population in these areas.[121]

Rabies

Rabies is a disease that while eradicated in many parts of the world, still endures in Burma. An outbreak of rabies was reported in both Dimawhso and Loikaw Townships of Karenni State, in January 2007, and again in Dimawhso Township in April 2007. In a knee-jerk response to the first outbreak in January, local authorities in both townships had ordered all domestic dogs killed, regardless of whether they were rabid or not. Three children were reportedly in critical condition after contracting the disease after being bitten by a dog during the April outbreak in Dimawhso Township.[122]

Polio

Since 2005, UNICEF and WHO personnel have reportedly worked in conjunction with the regime and Bangladeshi authorities on a large-scale polio immunization program, and as a result of this program, the SPDC maintained in 2007 that at least 95 percent of children under the age of five have now been vaccinated.[123] However, these statistics, like all official figures provided by the regime, should be viewed with some scepticism.

In spite of these highly optimistic claims by the SPDC, in April and May 2007, wild polio virus was detected in three toddlers all aged between 15 and 23 months in Maungdaw Township of northern Arakan State. In response, the District Civil Surgeon of neighbouring Bangladesh to organized door-to-door surveys and immunizations at five points along the Naff River, where it forms the border between Bangladesh and Burma, to prevent the outbreak crossing the river and spreading into Bangladesh. Meanwhile, one village elder in Maungdaw *"confirmed that there is a polio diagnosed child in Maungdaw town but no action against polio [had] been taken on the Burma side"*.[124]

As a result of the SPDC's failure to act, in May 2007, a further seven children in Maungdaw Township were confirmed as suffering from the disease.[125] Following this, the WHO launched a renewed immunisation campaign for Bangladesh and Burma, with the stated goal of vaccinating some 2.5 million children in three rounds of immunisations in May, June, and July 2007.[126] Some of the children affected by the May outbreak had reportedly been taken across the border into Bangladesh in search of better medical treatment than was available to them in Burma, however such travel can be dangerous, owing both to the prevalence of landmines deployed along the border as well as strict movement restrictions imposed against the Rohingya who inhabit northern Arakan State.[127] Additional vaccinations were reported to have been conducted in northern Arakan State in November 2007 to counter this continuing prevalence of this disease, but little information on these additional programs has been made available.[128]

7.5 Natural Disasters

The SPDC has also failed to take measures to mitigate the adverse health effects of extreme weather. Unchecked deforestation has contributed to flooding and according to the UNDP; Burma has lost approximately 70,000 square km of forest every year from 1990 to 2005.[129] The regime's advance warning and emergency response to flooding is consistently poor, which often has resulted in epidemic and death. In May 2007, unseasonably early torrential rainfall caused flooding in several townships in Rangoon Division, and polluted water from latrines overflowed into the water supply, which made safe drinking water scarce.[130] Residents reported that advance warnings given by the Department of Meteorology and Hydrology were only published in the SPDC-controlled newspaper and besides which, arrived too late to be at all effective. Others claimed that municipal authorities failed to unblock drainage canals choked with garbage, and that the official response was uncoordinated, with local people in some areas left to organize their own rescue and recovery efforts. This was reported to have taken place in Thingangyun Township, where one housewife had reported that *"It [the water] is still up to the calf level. You can't live on ground level yet. … We are trying to salvage and repair the damages done by the floods. Rice and clothing shops are all ruined"*. One Rangoon resident reported that the SPDC had actually prevented people from carrying out rescue efforts.[131]

Also in May 2007, Tropical Cyclone Akash destroyed most of the homes in the fishing village of Ngapyegyaung in Pauk Taw Township, Arakan State, leaving 300 people without clean drinking water or adequate shelter. Relief supplies of blankets, mosquito nets, clothing and medicine were only supplied three months later, after the local Village Peace and Development Council (VPDC) alerted higher authorities to the diarrhoea outbreak afflicting the village. One teacher from the village later complained about the delay in the delivery of relief supplies, saying that, *"There is immediate distribution of relief to people affected by natural disasters all over the world, but we received relief goods after nearly three months. Here the government simply neglects the people"*.[132] However, the supplies delivered were inadequate. The cyclone also damaged rice stores and animal husbandry projects in villages in northern Rathedaung Township, resulting in food and rice shortages. Authorities not only delivered no aid to the area, but also maintained the policy that prohibits the transport of rice from one village to another throughout the region. (For more information, see Chapter 6: Deprivation of Livelihood).[133]

In late June 2007, Rangoon was hit by a tornado, with official reports of three deaths, five injured, and roofs ripped off 500 homes, however, as has been stated elsewhere, all such official reports are typically gross underestimations of the reality and as such should be treated with some degree of cynicism. South Dagon Township in Rangoon was reportedly one of the worst affected areas. Local authorities reportedly distributed supplies such as mosquito netting, cooking utensils, clothing, tarpaulins and four *pyi* (6 kgs / 14 lbs) of rice. However, this aid was not distributed evenly with many items reportedly being distributed by lottery, thus leaving hundreds without assistance. Those whose homes were destroyed were also given 4,000 kyat (approximately US$3) in compensation, although how this miserably small amount of remuneration was supposed to benefit those who just lost everything they owned is anyone's guess.[134]

In July 2007, heavy monsoon rains again caused flooding in Rangoon and throughout central Burma, leaving at least two dead and thousands homeless.[135] Residents had reported that local authorities had demanded an unspecified amount of money from them under the pretence that this money was to be used to *"tackle the issue"*, although little was done and the money extorted from the residents went straight into the pockets of local authorities. A week later drains were still blocked, water in homes was at knee-level, and mosquitoes were a severe problem, bringing with them a heightened risk of potentially life-

threatening diseases such as malaria and dengue.[136] One resident claimed that officials of the Yangon (Rangoon) City Development Council (YCDC) refused to open a water passage door in front of the Mya Yamone Housing Development, which would have reduced flood waters in nearby homes, because the council-members reportedly had *"close ties with the owners"* of the property.[137] Meanwhile, UNICEF responded to the disaster by distributing medicine, clothing, cooking utensils, and water purification tablets.[138]

Heavy rains also lashed southern Arakan State in early July 2007, which on 6 July 2007, brought with it a record rainfall of 34.5 cm (13.6 inches), which, according to official statistics represents the highest recorded rainfall in Burma in a single day. The Arakan townships of Thandwe, Taungup, and Gwa were reported as being among the worst affected by the rains, with some inhabited areas reportedly submerged under six feet (180 cm) of water. Residents reported drastic food and water shortages, to which the authorities responded by opening a few emergency shelters but provided no emergency supplies.[139] A resident of Gwa, where one man was killed and more than 20 were injured when homes were washed away, said that ten days after the flooding, the authorities still had not visited the area to assess the damage and make plans for recovery efforts.[140] Meanwhile, in Thandwe Township, where at least three people were killed, UNICEF reportedly responded with the distribution of water-purification kits, oral rehydration salts, clothes, soap, cooking utensils, mosquito netting, and tarpaulins for shelter.[141]

Buildings in South Dagon Township, Rangoon Division, damaged by a tornado which swept through the area in June 2007. *[Photo: Irrawaddy]*

7.6 International Aid and Humanitarian Operations

The grave health situation in Burma has over the years prompted other countries, UN agencies, and international non-governmental organisations (INGOs) to contribute funding for healthcare, or to run educational programs, immunisation campaigns, clinics, and relief operations themselves. Aid contributions have, however, been limited by concerns about such funds being misappropriated by the military rather than received by the people in need, and concerns that the regime will spend more on the military if it can rely on international donations to meet its medical expenses.[142]

The United States (US), for instance, has long had a policy of giving minimal aid to Burma. The European Union (EU) has a similarly sanctions-oriented policy, and the United Kingdom (UK) has in recent years given less to Burma than it has to any other developing nation on a per capita basis. Meanwhile, the neighbouring ASEAN countries have provided Burma with little aid.[143] Japan, however, is Burma's largest humanitarian aid donor and has a long history of involvement with Burma, which until 1988, also provided Burma with loans for infrastructure projects.[144] China gives significant economic and political support to the SPDC, but owing to the lack of transparency of from both parties, the actual amount and nature of the support is difficult to discern.[145] In 2005, total amount of development aid given to Burma from the international community was reported to have been valued at US$144.7 million.[146]

In 2007, the pattern of international aid provided to Burma changed somewhat. The US Government, breaking from their usually firm stance of non-engagement, provided technical assistance in response to repeated outbreaks of avian influenza outbreaks (for more information, see the section dealing with Avian Influenza above), and after the bloody suppression of protests in September 2007, announced plans to help facilitate the work of humanitarian agencies (while at the same time strengthening existing sanctions against the regime).[147] The British House of Commons International Development Committee visited the Burma-Thailand border in April 2007 after which they called for a quadrupling of aid, all of which was to be directed through local NGOs and community-based organisations (CBOs) operating on the Burma-Thailand border to avoid enriching or otherwise supporting the regime.[148] The British Department for International Development (DFID) initially took no action on the recommendations, but late in the year announced plans to double aid to Burma from £8.8 million in 2007 to £18 million by 2010.[149] The European Union also announced plans to increase the level of aid that they sent into Burma, with the proposal of US$15.5 million in humanitarian aid for vulnerable populations in border areas, and a further US$2 million for health and livestock projects across the country.[150] Similarly, in January 2007, an ASEAN briefing paper declared that:

> *"If the government of Myanmar would let us, we are willing to play a role in alleviating the humanitarian problems faced by Myanmar, such as HIV/Aids, tuberculosis and malaria, internal displacement due to conflict between government forces and insurgents, and poverty".*[151]

In 2006, a group of six international donors founded the Three Diseases Fund (3D Fund) in response to the withdrawal of the UN-initiated Global Fund.[152] The Fund was devised to target HIV/AIDS, malaria and tuberculosis (TB); the three diseases which lend themselves to the name of the Fund, and in April 2007, the 3D Fund began projects in Burma, reportedly under the *"guidance"* of the Work Coordination Committee, headed by SPDC Health Minister Dr. Kyaw Myint.[153] In the 2007/8 fiscal year the 3D Fund reportedly gave US$4 million towards healthcare projects in Burma, which is expected to increase to US$5.7 million in 2008/9 fiscal year.[154]

Meanwhile, in February 2007, the United Nations allocated US$1.35 million from the Central Emergency Response Fund (CERF) towards humanitarian programs in Burma and to programs for Burmese refugees living in Bangladesh (For more information, see Chapter 17: The Situation of Refugees).[155]

The violent crackdown on peaceful demonstrations in September 2007 renewed the international reluctance of continuing to provide aid to the regime with many donors once again restricting aid to the junta (For more information, see Chapter 11: The Saffron Revolution – The 2007 Pro-Democracy Movement). In response to the intentional killing of Japanese photojournalist Kenji Nagai, who was shot in the back at point blank range, the Japanese Government announced that it would stop all aid to Burma except that on purely humanitarian grounds that directly helps the Burmese public, thus cancelling US$4.7 million in aid.[156] For the 2006/7 financial year, Japanese aid was valued at US$11.5 million (1.35 billion yen). Japan also provided technical assistance to the SPDC, which, when considered alongside the humanitarian aid, brought the value of the total aid package to US$25.5 million (three billion yen).[157] In 2007, Japanese aid included US$1.1 million to WFP operations, with a specific focus on vulnerable populations in Shan and Arakan States and Magwe Division, and a further US$179,000 for malaria education, prevention and control.[158] The aid cuts in 2007 echoed previous responses to the SPDC's excesses. In 1988, Japan reduced aid in protest of the SPDC's violent crackdown that year, and again in 2003 in response to the renewed house arrest of Aung Sun Suu Kyi and the attack on her convoy near Depayin in Sagaing Division on 30 May 2003.

The United Nations, which has generally pursued a strategy of engagement with the regime, openly spoke out in opposition to the human rights situation inside the country, condemning the SPDC for its actions. In October 2007, Charles Petrie, the UN Resident Coordinator for Humanitarian Affairs in Burma criticised the junta for its deplorable human rights record, in response to which the SPDC stated that he was no longer desirable in the country, and refused to renew his visa in November, which in effect forced him from the country.[159]

While the regime allows UN agencies to operate in the country, albeit under extreme limitations and with very limited access, in general the SPDC has proven unwilling or unable to cooperate with UN agencies and international NGOs, and has created a *"a difficult and complex environment"* for them to attempt to work within. Numerous UN agencies, including the FAO, WFP, WHO, UNICEF and others, have been reported to have faced restricted access to populations in need and interference with the delivery of food, healthcare, and development assistance. Furthermore, the regime coerced these organizations into working with SPDC-affiliated groups such as the USDA, denied UNHCR access to border areas, deliberately provided inaccurate socio-economic surveys and prevented INGOS from collecting their own data. The regime has further prevented humanitarian staff from travelling freely and has repeatedly obstructed the timely provision of goods and services.[160] (For more information, see Chapter 10: Freedom of Assembly, Association and Movement).

The ICRC, which by long historical tradition attempts to maintain dialogue, found the constraints imposed upon them by the regime impossible to work under, and in June 2007 issued a rare and uncharacteristic public denunciation of the regime. The statement, made by the ICRC president, Jakob Kellenberger, levelled accusations of *"numerous acts of violence … including murder"* against the SPDC which *"violate many provisions of international humanitarian law"*, and asserted that the ICRC *"uses confidential and bilateral dialogue … however this presupposes the parties to a conflict are willing to enter a serious discussion"*.[161] The ICRC further accused the military of repeated and routine human rights violations in conflict and ethnic areas, allegations which the regime immediately denied without investigation, and in turn then accused the ICRC of *"clandestine relations with insurgent groups"*.[162]

Moreover, between 1999 and 2005, representatives of the ICRC had visited hundreds of detainees, made recommendations that resulted in important improvements in water supply, accommodation, and healthcare, and supplied nearly half the medical supplies received by those detained within Burma's appalling prison system. Soon after Prime Minister Khin Nyunt being removed from office in 2005, the Ministry of the Interior (MoI) imposed the condition that a member of the USDA accompany the ICRC during all of its interviews with detainees. The ICRC deemed the principle of confidentiality to be fundamental to its mandate, thus rejecting the SPDC's suggestion, and since that time has not conducted any further prison visits inside Burma. Still facing a stalemate in March 2007, the ICRC closed its two field offices in Mon and Shan States.[163] The SPDC refused to budge on the issue and kept up its restrictions despite the protests of the EU, and in June 2007, the ICRC closed its Taunggyi office, leaving only two offices in the entire country.[164] In November 2007, an ICRC spokesperson said that despite these difficulties the ICRC had no intention of leaving Burma, and appealed to the regime to allow them to visit the thousands detained for their part in the September 2007 protests.[165] Unsurprisingly, this appeal fell on deaf ears.

Following the September crackdown on peaceful and unarmed protestors, the UN country team operating inside Burma issued a statement urging all parties to address the underlying causes of the September crisis. The statement read that *"while acknowledging the efforts made by the government of Myanmar [Burma] to build schools, clinics, hospitals and roads, the UN system in Myanmar [Burma] nevertheless sees every day that in this potentially prosperous country basic human needs are not being met"*.[166]

A relief worker from the Free Burma Rangers treating villager in Papun District, Karen State. *[Photo: FBR]*

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