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Harvard School of Public Health/François-Xavier Bagnoud Center for Health

Burma and Cambodia: Human Rights, Social Disruption, and the Spread of HIV/AIDS

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Source: *Health and Human Rights*, Vol. 2, No. 4, HIV/AIDS and Human Rights. Part I: The Roots of Vulnerability (1998), pp. 84-97

Published by: [The President and Fellows of Harvard College](#), on behalf of [Harvard School of Public Health/François-Xavier Bagnoud Center for Health](#)

Stable URL: <http://www.jstor.org/stable/4065188>

Accessed: 16/06/2014 10:45

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Abstract

The debate around the issues raised by HIV/AIDS and human rights has largely focused on the protection from rights violations of individuals or groups affected by the disease. The relationship between political and social conditions where human rights abuses are frequent and the spread of HIV infection has been less studied. Two countries in Southeast Asia, Burma and Cambodia, are currently undergoing serious and uncontrolled epidemics of HIV; both are marked by political cultures of state violence and corruption, chronic civil war and insurgency, and widespread human rights violations. This article attempts to investigate associations between rapid HIV spread and political and social crises, using Burma and Cambodia as case studies. The climate and context of rights abuses are seen as significant factors of national vulnerability to the epidemic spread of HIV/AIDS.

Le débat concernant le rapport entre VIH/SIDA et droits de la personne s'est surtout concentré sur la protection des droits des individus ou des groupes touchés par la maladie. Le rapport entre les conditions politiques et sociales dans lesquelles les atteintes à ces droits sont fréquentes et la propagation de l'infection VIH a été moins étudié. Deux pays en Asie du Sud-Est—la Birmanie et le Cambodge—sont à l'heure actuellement touchés par graves épidémies de VIH incontrôlées; dans les deux cas on se trouve en présence de cultures politiques marquées par la violence d'Etat et la corruption, un état chronique de guerre civile et d'insurrection ainsi que par la violation généralisée des droits de la personne. Cet article, s'appuyant sur les cas de la Birmanie et du Cambodge, s'efforce d'explorer les rapports entre la propagation rapide du VIH et les situations de crises politiques et sociales. Le climat et le contexte de violations des droits de la personne y sont considérés comme des facteurs de vulnérabilité nationale face à la propagation d'une épidémie du VIH/SIDA.

El debate sobre los temas de VIH/SIDA y derechos humanos se ha concentrado hasta ahora en la protección de la violación de los derechos de individuos o grupos afectados por la enfermedad. La relación entre las condiciones políticas y sociales en los que los abusos de los derechos humanos son frecuentes y la propagación de la infección de VIH se ha estudiado en menor medida. Dos países del sudeste asiático, Birmania y Camboya, sufren en la actualidad epidemias de VIH graves y descontroladas. Las dos están marcados por una cultura política de violencia de Estado y corrupción, guerra civil crónica e insurrecciones, así como por la extensión de las violaciones de los derechos humanos. Este artículo intenta investigar las asociaciones existentes entre la propagación rápida del VIH y las crisis políticas y sociales, utilizando los casos de Birmania y Camboya. El clima y el contexto de abusos de los derechos humanos se consideran como factores significativos para la vulnerabilidad nacional ante la propagación de la epidemia de VIH/SIDA.

BURMA AND CAMBODIA: Human Rights, Social Disruption, and the Spread of HIV/AIDS

Chris Beyrer

AIDS-related human rights activism, sharing the orientation of the mainstream human rights movement, has focused on visible and purposeful governmental acts that jeopardize individual privacy, liberty, and protection against discrimination. Human rights obligations stemming from the right to health care, to social assistance, or from the necessity to improve the enjoyment of human rights through international cooperation have been neglected.¹

An early slogan of AIDS prevention campaigns in the United States was "AIDS does not discriminate." Unfortunately, this is only partly true. AIDS *does* discriminate; it is now clear that HIV spreads fastest where social life is chaotic, poverty endemic, and rights violated.² This is particularly true in the world's poorest and most strife-torn nations, and it is true for the poor of rich nations—for example in the United States, where HIV continues to settle in pockets of poverty and social disruption.³

The debate around the issues raised by HIV/AIDS and human rights has largely focused on the protection of individuals or groups affected by the disease from rights violations.^{4,5} The relationship between political and social settings in which human rights abuses are frequent and the spread of HIV has been less studied. Is there evidence to suggest that the social disruptions that arise from civil strife may make some nations or groups particularly vulnerable to the spread of HIV/AIDS?⁶ If so, HIV/AIDS prevention and control programs may need to address the prevailing human rights situ-

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ation in countries torn by national, ethnic, or political conflicts if control is to be achieved. Avoiding these issues in HIV/AIDS programs may lead to program failure.

HIV/AIDS research and prevention strategies have largely focused on the behaviors of individuals and the vulnerabilities of groups at risk of contracting HIV.^{7,8} The classic unit of analysis has been the individual and her or his risks of acquiring HIV infection. Trends in risk groups are deduced from the behaviors associated with HIV seroconversion and extended to larger populations. This approach has its strengths (rigor, precision, ease of analysis) but also profound limitations. Epidemiology should guide and focus preventive efforts. If political and social factors hinder prevention efforts or facilitate the spread of HIV, these issues should logically be part of research efforts and intervention programs. Such factors are seldom considered in publications in the medical literature on public health.⁹

Southeast Asia

Southeast Asia is one of the regions most severely affected by the HIV pandemic, despite relatively late introductions of the virus.¹⁰ Only sporadic cases were identified in Thailand, Burma, and Malaysia until the late 1980s. However, by 1990-1991, Thailand had seen explosive spread of HIV in heterosexual populations, and Burma had an equally devastating epidemic of HIV among its large population of injecting drug users (IDUs).¹¹ Starting in approximately 1992-1993, Cambodia underwent a similar rise in HIV rates among sex workers and their clients.¹² In 1996, Thailand had an estimated 750,000-900,000 cases of HIV infection, Burma approximately 500,000, and Cambodia (with a population of only seven million), between 50,000-90,000.¹³ Public health responses in Thailand have been impressive, and their effect increasingly well documented.^{14,15} Evidence has shown that rates of new infection, incident sexually transmitted diseases, and HIV risk behaviors have declined sharply.¹⁶ However, these tremendous gains have not happened in either Burma or Cambodia, Thailand's western and eastern neighbors. To understand the ongoing spread of HIV in these two countries, political, social and human rights analyses are crucial. In both

countries, human rights violations play key roles in the explosive spread of HIV.

Burma: Continuum of Conflict

Burma has endured a low-intensity civil war almost continuously since independence from Britain in 1949. The country has been under military rule since the 1962 *coup d'état*. General Ne Win's "Burmese Way to Socialism" isolated and impoverished the country and eroded the health care system of what had once been among the most medically advanced countries in Asia.¹⁷ The military junta has been repeatedly criticized by the United Nations (UN) for widespread human rights abuses and severe restrictions of civil liberties. There have been repeated civilian and student uprisings against the Ne Win régime, and its successor, The State Law and Order Restoration Council (SLORC), all of which have met with brutal state repression.¹⁸ The last major uprising in 1988 did, however, result in general elections in 1990. These elections were won, with a large majority, by the National League for Democracy (NLD), led by Nobel Peace laureate Daw Aung San Suu Kyi. However, the junta has refused to honor the elections, and has jailed, driven into exile, or otherwise attempted to silence the elected leaders of the country.¹⁹ Despite the 1995-1996 signing of several cease-fire agreements with ethnic groups fighting the junta, Burma remains at war. The human rights situation in 1996-1997 has continued to deteriorate.²⁰

The first HIV screening programs in Burma were initiated in 1985.²¹ No cases were reported until 1988, when the first HIV-infected injecting drug users were found in Rangoon.²² While poorly documented and little studied, enough information is available to suggest that HIV has since spread in both urban and rural areas, among most of Burma's many ethnic groups, and among populations thought, until recently, to be at relatively low risk, such as clients of prenatal clinics and volunteer blood donors.²³ The Myanmar National AIDS Program (NAP), using estimates derived from their HIV sentinel surveillance data, estimated 350,000-400,000 infections nationwide by 1995; the World Health Organization (WHO) estimate is slightly higher (a thorough population census has not been conducted in Burma since

independence; as of 1995, the population was generally estimated at 43 million).^{24,25}

How and why has this public health disaster occurred? Burma is one of the world's largest producers of illicit opiates, exporting as much as 40 to 60 percent of the world's heroin.²⁶ Since 1988, when the SLORC assumed power, Burma has also become a major heroin consumer.²⁷ Currently, the NAP estimates that approximately 1 to 2 percent of adult men and 0.5 percent of adult women are heroin users.²⁸ In an earlier NAP estimate, deemed too politically sensitive by military censors, it was reported that 4 percent of adult men were involved in this behavior. The United Nations International Drug Control Programme (UNDCP) estimated in early 1994 that 60 to 70 percent of all IDUs in Burma were HIV-infected.²⁹ The reported rates of HIV prevalence were high among IDUs in several large cities: 74 percent in Rangoon, 84 percent in Mandalay, and 91 percent in Myitkyina, the capital of Kachin state on the Chinese border.³⁰

In Burma, heroin is relatively cheap, highly pure, and widely available. This has led to the development of a "tea-stall" culture of heroin use. Addicts get their daily doses from professional injectors who work in back rooms in the stalls, injecting up to 50 addicts a day. Needles are re-used until they are too dull to pierce the skin. In rural areas, IDUs also make their own crude injecting equipment, and these "works" are frequently shared as well.³¹ Nonprescription use or possession of needles and syringes is illegal, and punishments can be harsh.³² These can include incarceration, forced labor, and "cold turkey" drug detoxification. Drug "treatment" is based on a prison model, with mandatory incarceration for possession, and methadone not available to incarcerated populations.³³

HIV spread among IDUs has not been limited by geographic borders. The province of Yunnan, which borders the Kachin and Shan states of Burma, has the highest reported HIV prevalence rate in China.³⁴ In the border district of Ruili, across from Kachin state, 62 percent of IDUs were infected with HIV in 1994. The majority of these drug users were ethnic Kachin and Wa, the predominant ethnic groups on the Burmese side of the border.³⁵ A similar situation exists on Burma's border with India. The state of Manipur is experi-

encing one of the most explosive HIV epidemics in India.³⁶ In Burma, the Chin state did not begin testing for HIV until late 1995, but these combined border epidemics of heroin use and HIV suggest regional threats to health.

The political crisis in Burma has had other effects on the spread of HIV. Ongoing civil war in Burma's ethnic areas, particularly in the large Shan state, has led to widespread human rights abuses against ethnic Shans, including the military use of both male and female civilians for forced labor (usually as porters).^{37,38} The brutality and high mortality (from poor nutrition, exhaustion, beatings, and infectious diseases, particularly malaria and diarrheal diseases) of forced portage has driven large numbers of Shan men and women to seek refuge and employment in Thailand. The loss of men, either to insurgent groups or as porters, has left large numbers of Shan women without husbands, brothers, and fathers. Reports of rape by SLORC troops are common,³⁹ and Shan women and girls are heavily recruited into the Thai sex industry.⁴⁰ In northern Thailand, up to 40 percent of brothel-based sex workers are Shans.⁴¹ These women are reported to have HIV prevalence levels of 40 to 60 percent.⁴² As illegal immigrants to Thailand, they are at extreme disadvantage; fear of arrest and deportation can contribute to their inability to seek STD and HIV care and education. Many are illiterate; most have a limited knowledge of the Thai language. Human rights abuses including slavery, rape, and physical abuse against these Shan women have been documented in Thailand.⁴³ Yet they continue to come to Thailand, as do perhaps 500,000 other illegal Burmese workers, reflecting the level of poverty and violence in their own country.⁴⁴ While low education levels and lack of access to HIV prevention campaigns contribute to this high HIV risk, the root cause of their vulnerability and exposure to the virus can be attributed to the social chaos of their homeland.

Loss of the country's health professionals through arrest, incarceration, or emigration is another outcome of the political situation which profoundly impacts the response to the HIV epidemic. Individuals with university-level education have suffered particularly, as students (notably medical and nursing) were major supporters of the 1988 democracy movement.⁴⁵ Student activists in this movement were im-

prisoned in large numbers, many were killed outright, and those who escaped arrest were forced into exile in Thailand and India, where many remain today.

Junta control of all educational materials and all media is another factor contributing to the high rates of HIV infection. Mass media campaigns under SLORC include some AIDS messages. But these are largely limited to billboards proclaiming that "AIDS Kills." Preventive measures and harm reduction messages are virtually absent. All educational and reading materials, including HIV/AIDS prevention materials, are banned in Burma's extensive prison system. SLORC does not allow nongovernmental organizations (NGOs), whether indigenous or other, to operate without its approval. The scarcity of NGOs makes HIV/AIDS control and care all the more difficult in Burma. Lastly, it is a given that empowerment of at-risk groups and of affected communities is central to HIV/AIDS control.⁴⁶ Empowerment, however, is a threat to totalitarian régimes such as SLORC. This is particularly the case since empowerment of local communities was one of the core themes of Burma's democracy movement, which overwhelmingly defeated the junta in the 1990 elections.

While Burma, as a "least-developed" country, will clearly need international assistance to cope with its escalating HIV/AIDS burden, the political crisis in the country is likely to remain a major obstacle to HIV/AIDS prevention and care. Politically "blinded" attempts to deal with the epidemic in Burma are unlikely to succeed, given the political, social, and economic sources of this public health tragedy.

Cambodia: The Costs of Social Chaos

Cambodia has one of the fastest growing HIV/AIDS epidemics in Asia.⁴⁷ The epidemic seems largely attributable to sexual transmission and to spread through blood, blood products and medical procedures.⁴⁸ The Cambodian National AIDS Prevention Committee estimates that roughly 2 percent of Cambodian adults are HIV-infected.⁴⁹ HIV prevalence among blood donors in Phnom Penh rose from 0.076 percent in 1991 to 3.62 percent in 1994.⁵⁰

Despite one of the largest UN efforts ever undertaken, and considerable international donor and NGO support, Cambodia is still at war.⁵¹ The Vietnamese defeat of Pol Pot in

1978 generated a Khmer Rouge insurgency that has continued to threaten Cambodian governments. Currently, more than two-thirds of government revenues are spent on the war.⁵² In addition, the country has had to contend with the return of nearly 400,000 refugees, many of whom have been unable to return to their homes due to fighting, land mines, or both. Human rights abuses continue, including the killing of opposition leaders, journalists, and social activists. In an environment of poverty, massive internal displacement, breakdown of social institutions, and destruction of extended family networks, HIV is spreading rapidly.

Cambodia's 6 to 10 million land mines are responsible for the maiming and killing of up to 400 persons each month.⁵³ Land mine injuries lead to emergency surgery, often requiring blood transfusions. However, the blood supply is far from safe, and incompletely tested; much of it is still bought from high-risk professional donors.⁵⁴ Compounding these risks is the fact that few individuals have been trained as health professionals since the murder of most of the country's health professionals by the Khmer Rouge in 1975-1978.⁵⁵ Cambodia, like Burma, has lost many of the people it now desperately needs to rebuild, heal, and provide HIV prevention, treatment, and care.

In addition, trafficking of Khmer women and girls into the sex trade is reportedly increasing.^{56,57} HIV prevalence among these women is high and condom use is uncommon. According to the Cambodian Human Rights Task Force, the forced prostitution, physical abuse, rape, and murder of these women are also sharply on the rise.

There is evidence that the presence of the United Nations Transitional Authority in Cambodia (UNTAC) contributed to the spread of the HIV epidemic in Cambodia. Local authorities have been quick to blame UNTAC for the rise of HIV infections, though this is probably an oversimplification. Yet there is no doubt that the large number of international peacekeeping forces (mostly all young men) dramatically increased the demand for sex services. The infusion of cash from these forces into local economies after years of poverty and isolation was undoubtedly a great attraction for many women (and brothel owners, managers, and traffickers) to enter the sex trade. NGOs working with women in the sex trade before

and during the UNTAC period, report that sex workers, on average, doubled their nightly number of customers from 5 to 10 during the UN mission.⁵⁸

Soldiers from some of these countries undoubtedly came to Cambodia infected with HIV. Yet others *left* Cambodia with HIV infection. Studies of returning infected UNTAC soldiers in Uruguay and the United States have shown that most had subtype E of HIV, which is found primarily in Southeast Asia and Central Africa.^{59,60}

Overall, the outcome for the Khmer people has been a disaster. Khmer culture generally does not accept women who have been sex workers back into society. The large number of women who entered the trade during UNTAC now have few options but to continue. With Asian business activities increasing in Cambodia, a new wave of clients has arrived to replace the soldiers. Most of the sex venues in the city now have signs in the Chinese, Japanese, Korean, and Thai languages.⁶¹

These activities are not limited to Phnom Penh. Aid workers with Médecins Sans Frontières working with sex workers in the river port town of Siem Riep (population 12,000) estimate that about 400 women are selling sex on any given day. Condom use is low, and most women have no choice but to accept clients who refuse to use condoms. The International Red Cross is also active in Siem Riep, assisting more than 38,000 returning refugees. Many have become internally displaced persons, with fading hope of returning to their homes and past occupations. The women and girls of this population are highly vulnerable to brothel traffickers. Red Cross staff reported that HIV prevention is low on the province's list of priorities. In descending order of importance, priorities are: food, securing housing, avoiding land mines, finding a job in the still marginal economy, and the end of the war. HIV prevention (buying condoms, for example) can seem a luxury, given this daunting list of unmet, basic needs.

Discussion

Burma and Cambodia do not share a common border, and their recent histories have been quite different. Yet they share political cultures marked by state violence and corrup-

tion, chronic civil war and insurgency, and explosive and recent epidemics of HIV infection.

While the sexual, behavioral, and drug-use risk factors of individuals play a major role in HIV epidemiology and prevention, the political and social realities that trigger HIV spread and hinder its control have received much less attention. Without some measure of social stability and respect for human rights, targeted interventions (e.g., promoting condom use) may not be effective.

Aside from the direct impact of civilian casualties during war, the social disruption of civil unrest can be fertile ground for more complex health effects. The number of countries where the spread of HIV has been facilitated by political repression, social disruption, and civil strife include Uganda, the Democratic Republic of Congo (former Zaire), Kenya, Rwanda, Burundi, and Haiti. Burma and Cambodia are now in this unfortunate category. The interaction of HIV, political instability, and human rights abuses in these settings should not be surprising; social resources for public health are limited in these countries even in peacetime. Moreover, the governments of these countries are all too often incompetent, corrupt, or both, and persecution against minority groups, intellectuals, journalists, and educated elites are commonplace. Yet in the extensive HIV/AIDS literature these political realities are too rarely included in discussions of epidemiology, national vulnerability, and barriers to prevention.⁶² Studies are more likely to report that in a war-torn African country, the lack of male circumcision has facilitated HIV spread. They are less likely to report that government censorship has eroded a free press, that rape of women is widespread and largely unpunished, or that donor funds for health programs have been squandered by corrupt or inept officials. Measures of risk in public health literature typically focus exclusively on the behaviors of individuals, even in settings where social systems are patent obstacles to risk reduction.

Development assistance and technical support have helped poor countries contend with HIV/AIDS. These programs, however, have also supported problematic régimes and leaders, principally by lending international legitimacy to régimes in power. Supporting such régimes inadvertently helps prolong the political and social situations that lead to

explosive HIV spread. The Burmese junta, which is actively seeking international legitimacy, recently defended its human rights record to the UN by listing the number of international agencies and NGOs working with them on HIV/AIDS programs, among others.⁶³ While researchers and prevention experts may struggle to establish ethical standards for their own projects in countries like Burma, there are larger ethical and human rights issues at stake. To support such a régime in any way, as Aung San Suu Kyi has stated, is unethical in and of itself.

The public health community *is* concerned with human rights. Notwithstanding, the focus of these concerns has traditionally been limited to the ethics of HIV testing and counseling, informed consent procedures, discrimination and confidentiality, forced or *de facto* isolation and confinement of HIV-infected persons, access to care, and the rights of research subjects. There is a large body of literature around these issues.⁶⁴ Yet without a wider examination of the human rights context of public health programs, these parameters may be too narrow to have little actual impact. In Burma, for example, citizens are denied freedom of speech, the right of assembly, the right of a free press, the right to vote, the right to organize independent nongovernmental organizations, and are not allowed to criticize the junta and its policies.⁶⁵ Arbitrary arrest, incarceration without trial, extrajudicial execution and torture by the current régime have all been documented.⁶⁶ Can the rights of people with AIDS be addressed in any meaningful way without taking into account the wider reality of human rights under this régime? To phrase the question differently: can a political body with such laws and policies be expected either to respect the rights of people with or without HIV/AIDS, or to enact effective HIV/AIDS programs?

A new paradigm for understanding the relationships between public health problems and political realities may be required if we are to address challenges like the spread of HIV/AIDS in countries in turmoil.⁶⁷ While humanitarian assistance and strict ethical standards for international involvement must remain priorities, a deeper integration of human rights and political realities into public health discourses and analyses is needed. At the 1996 Asia Pacific meeting on AIDS, a call was made to depoliticize AIDS. Perhaps the precise

opposite approach is called for: to recognize and attempt to respond to the crucial impact political and social realities have on the dynamics of this, and other, diseases. For many countries there may be no more effective HIV prevention program than the respect for human rights that begins to come with peace.

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