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Consequences of armed conflict for an ethnic Karen population

A long-running conflict between central Burma authorities and armed Karen opposition groups has driven some 100 000 refugees across the border to Thailand. An unknown number are displaced within Burma. From March, 2002, Nu Po camp (Tak Province, Thailand), one of seven Thai sites hosting Karen refugees (map), received an unexpected influx of refugees from the neighbouring Dooplaya District of Burma, a region containing about 60 villages of around 150–200 people each, grouped into four townships. Consistent accounts of violence and high death rates among these new arrivals, including allegations of direct attacks on civilians, prompted us to do an exhaustive mortality survey in refugees who had arrived in Nu Po camp since March, 2002.

The survey was approved by camp authorities, and all participants gave oral informed consent. Between Oct 11 and Oct 13, 2002, we used a prepiloted questionnaire to measure mortality and other population changes retrospectively during a recall period of 271 days from Jan 14 (Karen New Year) to survey date. Family heads were interviewed about differences in the composition of their households between the beginning and the end of this period, and about events accounting for these differences (births, deaths, separations, disappearances, etc). We defined families as groups living together in Nu Po camp. Causes of death were self-reported. An open, systematic question was also asked about the family's main reason for leaving Burma; responses were coded into categories predefined on the basis of information gathered from stakeholders in the camp.

We interviewed 244 families, all of whom came from Dooplaya District. A majority (184 [75%]) came from Kya In township; 46 (19%) families originated from Kawkareik township, and the remaining 14 from other townships within Dooplaya District. 1349 individuals had been living in these families in their home villages at the beginning of the recall period; of these, 238 stayed behind in the village, 105 left the family, 40 disappeared, and 31 died; 45 were born and 48 joined. Of the 1028 people who made it to Nu Po, 798 (78%) arrived between April and June; 74% reported travelling for 2 weeks or less and 8% took more than 1 month to reach the camp. The 31 deaths are equivalent to a crude mortality rate of 1·0 per 10 000/day (average population 1182). Five of the 45 babies born during the recall period died.

Violence caused 15 of the 31 deaths. Nine were due to gunshot, five to explosion, and one to beating. Three of those killed were women and seven were children younger than 15 years. All violence-related deaths occurred inside Burma. Medical causes accounted for the remaining deaths. 90 (37%) families mentioned "war or insecurity" (attacks on their village or neighbouring villages, fear of persecution) as their main reason for leaving Burma; 83 (34%) mentioned "forced labour" (both sexes and children seemed equally susceptible to this practice); and 53 (22%) "forced relocation" by troops to various displacement sites. 36 (15%) families spontaneously reported that their house had been set on fire, and eight villages were named as having been burnt down. 163 (67%) families stated that they had been interviewed for registration; however, only two (1%) could show a refugee card.

Our findings show high mortality due to violence in a population of Karen refugees who fled Burma, mainly because of military actions. The mortality rate (about twice the normal rate in less-developed countries) is probably underestimated, since deaths of people who stayed behind, left the families, or disappeared are not reported. Our findings also raise great concern about the living and security conditions of the people remaining in the villages, displacement sites, or in flight within Dooplaya District.

Unacceptable human rights abuses, including civilian killings, village burning, forced labour, and relocation, seem to be occurring in this area. Our survey thus confirms and quantifies previous reports about the consequences of armed conflict on civilian populations in Burma.[1–3] In Dooplaya District, civilians seem to be caught in the middle. Warring sides should allow for impartial humanitarian assistance to reach those in need.

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Medical assistance and refugee safety in contemporary conflicts

With the passing of World Refugee Day it is timely to consider the roles, obligations, and limitations on medical workers aiding refugees in southeast Asia's longest hidden war. In 1962, the Burmese military government launched a war of pacification against the people of Burma, which continues under the Burmese State Peace and Development Council. About 10 000 people have died every year for the past 40 years[1] with hundreds of thousands undergoing forced labour, relocation, and conscription and rape by armed forces on all sides of the conflict.

Francesco Checchi and colleagues' mortality survey (see page 74)[2] in Karen refugees from the Dooplaya District of Burma shows the severe effects of the conflict on ethnic-minority civilians caught in the war zone. The survey results highlight a few of the wider physical and mental health issues concerning refugees in the nine Thai-Burma border camps.[3] They complement other studies of the effects of the war on civilians, such as the systematic use of rape as a terror tactic by the Burmese military[4] and the consequent reproductive health crises, and injuries and deaths as a result of landmines, direct violence, infectious sexual diseases, and other diseases such as malaria, cholera, and AIDS.

Within Burma, the forced relocation of hundreds of thousands of people has created a large internally displaced population. These people have only the most rudimentary access to health care. The establishment of the Karuna Foundation medical clinics offering inexpensive health care and the creation of additional traditional medicine and village health posts are a small addition to basic health services. Such improvements have not, however, helped to ease Burma's current health crisis, since only 2% of the regime's budget is devoted to health care.

Changing and geographically variable health conditions mean that international health workers are faced with a complex and often chaotic situation. Rates of morbidity and mortality are high in the 40% of Burma that lacks basic health services, and forms of structural and indirect violence flourish in areas housing forcibly relocated populations. High rates of illegal abortion, rape, prostitution, sexual barter, and polygyny are consequences of a breakdown in social structure, employment, and extended living arrangements. Furthermore, the high migration rate of male workers in the relocation zones places young women, teenage girls, and widowed or abandoned mothers in vulnerable situations in which reproductive health care is inaccessible or unaffordable, and maternal mortality and sexual and infectious disease rates rise rapidly in comparison with non-relocated populations.[5]

The situation in Burma highlights the lack of international protection for internally displaced people if their own governments turn against them. Checchi and colleagues emphasise the particular complexities of the Burmese case, and indeed, the ambiguous lines of authority and status of the Karen refugees exemplify the worldwide problem of governments who are unwilling to ratify and implement international conventions governing the treatment (and definition) of refugees. Furthermore, UNHCR cannot provide safety and humanitarian aid to people fleeing war-torn countries unless the organisation is invited to do so by the countries in which the refugees settle.

Medical workers strive to be neutral actors, staying away from the politics of camp governance, and treating all those in need of medical assistance equally. It is unrealistic to expect them to be given unfettered access to war zones by warring parties, especially in heavily mined areas and areas where the lines of control change daily. Checchi and colleagues conclude that "warring sides should allow for impartial humanitarian assistance to reach those in need", but there is simply no way for this to occur unless the mandate of UNHCR is signed by more UN member nations. The need for protection of such liminal groups is hinted at in a UNHCR policy document that aims to provide external, as well as internal, camp security by maintaining as strong a presence as possible.[6]

Health workers do not want to appear to sanction or legitimise the use of violence by any groups, but they require access to civilians in war zones and the non-interference by warring parties of their treatment of non-combatants and internally displaced people. The nature of contemporary conflicts is such that they can best promote the safety and wellbeing of civilians by being politically engaged and witnessing, documenting, and treating war-related injuries. Political engagement involves a willingness to negotiate for access to civilians with camp authorities and stake-holders in war zones and refugee settlements, and international activism to push for more countries to become signatories to international humanitarian agreements, for internally displaced persons to be recognised as refugees in international law, and to enforce security and unfettered access to civilians in conflict zones.

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