Chapter Seven

Health, Nation-Building and State Capacity

Introduction

The preceding two chapters have outlined the historical and political-economy of health in Myanmar, and described the operation of the public health sector. This chapter looks in more detail at three examples of how the state and health intersect, particularly focusing on areas where health is directly impacted on by the primary political considerations of the regime. Each of the three examples involves attempts by the SPDC to build up the capacity of the public health sector, either without compromising higher political priorities of the regime, or as a method of strengthening central state power. The first section looks at the promotion of health-related GONGOs as part of the military’s strategy to use controlled mass organisations to widen its political support base and thus increase social control, and illustrates how unregulated public space, including grassroots development organisations, is suppressed. The second part examines how the regime is endeavouring to expand its influence in the border regions. In the ceasefire areas, socio-economic development is utilised as a nation-building tool; however, in the areas still under conflict, denial of the most basic elements of life for the civilian population is used as a weapon of war. Finally, case-studies contrast the implementation of two Department of Health programs to illustrate how different aspects of health are affected by political prerogatives. The first is the Expanded Programme on Immunisation, which is politically popular and relatively straightforward, and therefore has been one of the success stories of the Ministry of Health. The second is HIV/AIDS, where SLORC/SPDC’s attitude has been quite different. A combination of denial of the extent of the
HIV problem and *ad hoc* measures to deal with it, has failed to make a significant impact on the progress of the epidemic.

**The Role of Government-Organised Non-Government Organisations: Supplementing the State**

To compensate for the neglect of the public health sector, the government encourages the development of the private health sector, as well as upholding the concept of ‘community volunteerism’ as a central tenet of health policy implementation. Apart from the volunteer health workers, community volunteerism refers to a small group of state-sponsored NGOs. These organisations are carefully vetted and closely linked to the state, and therefore fall into the category of government-organised non-government organisations.

The principal GONGOs involved with health services, as mentioned above, are the Myanmar Maternal and Child Welfare Association, the Myanmar Red Cross Society, and the Myanmar Medical Association (already discussed in the previous chapter). These organisations provide an extensive supplementary role to the government bureaucracy, as described by government officials and the former president of MMCWA (interview 30, Yangon: June 2000; interview 37a, Yangon: June 2000). First, they are allocated an institutionalised role to participate in government policy development and planning on each level, and are privileged in allocations of state support. In addition to influence at a national level, they are the only formal organisations other than the bureaucracy that are permitted to play a major role at the grassroots level. This is obvious when their networks are utilised for the high-profile National Immunisation Days and National Sanitation Weeks.

The MMCWA is based on the maternal and infant welfare societies that originated during the colonial period, but was established in its present form in April 1991. It was set up through an initiative by the Ministry of Health, to bring the maternal and child welfare associations throughout the country into one high-level organisation (MMCWA n.d.: 1). Under a regime that does not tolerate autonomous community organisations, this required SLORC to enact the *Myanmar Maternal Child Welfare Association Law* of August 1990 (Law 21/90).
This law was amended in 1993 (Law 12/93), in order to increase the number of central committee members. The Association started its operations by establishing maternal centres, on land donated by the government. This has expanded over the last decade to include maternal health centres – 71 in 2000 – and micro-credit, childcare, literacy, nutrition, HIV-AIDS prevention, childcare and health education programs. New programs include sex education for adolescents and health care for elderly women. The headquarters complex in Yangon includes a vocational training school, early childhood development centre, and breast cancer screening facilities (interview 30, Yangon: June 2000).

Most of these programs are run in part or full with the Department of Health and other GONGOs, as well as UN agencies and INGOs. For example, a report of family planning activities says of the birth spacing program,

The government and MMCWA work together both in data collection, training, implementation, monitoring and evaluation of service delivery. MMCWA’s involvement in all levels of the programme promotes the coverage and outreach of the services. It can provide service to under served areas and population groups working in collaboration with basic health workers such as lady health visitors, midwives and auxiliary midwives. The programme gains momentum and becomes more efficient and effective because of the co-operation between government’s heath services and MCWA (MMCWA 1994: 13).

The external agencies are strongly encouraged by the government to work with GONGOs as their local implementing partners, although not all choose to.

The Myanmar Red Cross Society works in a similar manner, but concentrates on first aid; disaster preparedness for response to floods, fires and earthquakes; an orthopaedic program for amputees; an ambulance service; dissemination of the Red Cross principles and international law, for which it works closely with the International Committee for the Red Cross; and health promotion programs, which include HIV/AIDS prevention, iodised salt promotion and safe blood donation (MRCS 2000). It is closely supported in its work by the delegation of the International Federation of the Red Cross (International Federation of Red Cross and Red Crescent Societies 2002). Unlike the MMCWA, the MRCS was established in 1920 (originally as part of the
Indian Red Cross), and operated throughout the socialist era. At that time, it was described as ‘the only semi-government organization in the Union of Burma’ (Bo 1984: 79). In 1984, it was operating in 314 townships, under the supervision of the People’s Councils (ibid.).

On the surface, the MMCWA and MRCS seem to have a capacity equal to or greater than the Department of Health. Both the MMCWA and the MRCS have large networks of volunteers, who are organised in a hierarchical structure that mirrors state organisation. With substantial infrastructure and resources, and a hierarchy of volunteer personnel plus high-powered patrons, these organisations claim to cover almost every township in the country. In both cases, a strong central executive committee actively monitors the organisation down to the local level, as well as participating in state health planning at national level committees. The MMCWA is run by a 53-member central council, which includes eleven executive committee members. The president for 2003 to 2006 is Dr Khin Win Shwe, and the two vice-presidents are Dr Kyi Soe and Dr Tin Lin Myint. It has often been noted by foreign sources that Dr Khin Win Shwe is the wife of Secretary-1 of the SPDC, and Dr Kyi Soe is the director-general of the Department of Health Planning. However, these links to political leadership are of no surprise to anyone in Myanmar, who understands it as a common practice in a system where the regime has built its support on patronising a small, closely-connected elite. The regime would not tolerate a high-level organisation run by people without military connections. The members of the central executive committee claim an interactive role, giving lectures to members in the various regions, and intervening when the state/division committees are not performing adequately (interview 30, Yangon: June 2000).

The MRCS was, as of 2002, being run by Dr Kyaw Win, who is a former director-general of the Department of Health. Every three years, a National Convention is held that partially elects the 37-member Central Council. The

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1 The organisation was formalised by the Burma Red Cross Act of 1959.
2 The presidency is an honorary position; Dr Kyaw Win is retired from the bureaucracy (interview 42, Yangon: July 2000).
Central Council then elects the ten-member executive committee, which is responsible for the daily administration of the MRCS. In addition, committees are formed to run the five programs: Red Cross Ambulance Brigade, First Aid Training, Junior (School) Red Cross, Disaster Preparedness and Relief, and Information and Dissemination. Below the central level, supervisory committee at the state/division (a total of seventeen, including three in the Shan state), district, and township levels run the activities of the organisation. The total membership is over 280,000, of which approximately 165,000 is made up of Red Cross Brigade members; the rest consists of 26,500 life members, 17,200 ordinary members, and 73,000 from the school Red Cross (MRCS 2000). Each township is organised around a brigade, which is meant to consist of 500 members. The brigade members are the manpower of the Red Cross, for both disaster relief and participation in Department of Health programs such as immunisation and HIV/AIDS awareness (interview 42, Yangon: July 2000). Most of these members are young men. The MRCS (2000) claims that ‘at present it is one of the most popular youth organization[s] among the youth of Myanmar’.

The life and ordinary categories of membership are based on donations; such members do not participate in the MRCS activities. Life members contribute Kt300, while ordinary members give Kt5 per year. Each brigade undertakes fundraising activities – often in the form of small businesses – in order to meet the requirement of self-sufficiency (interview 42, Yangon: July 2000).

The MMCWA operates similarly, with supervisory committees for each state or division, and township associations in 321 townships. Overall, it claims to have more than 14,000,000 members (approximately 28 per cent of the population) (MMCWA 2000: 1). Each level is responsible for obtaining donations and recruits, and many services try to maintain a revolving fund, where people are asked to donate what they are able for the services they have received. The MMCWA is a popular recipient of donations from businesses and individuals at a national level, as well as some international donations (interview 30, Yangon: June 2000). The government donated most of the land

As in the government system, the most significant policy-implementing body is the township committee, which supervises branches at village and ward level, and in factories (numbering 8619 as of 2000), as well as coordinating with the township PDC and health department. For example, a profile of the MMCWA in Pakokku Township indicates the high status of the Association, and the significant patronage it receives from local power-holders. The committee consists of two patrons, including the township medical officer, and twenty-three members. The total MMCWA membership in the area is reported as over 3,500. There are twenty maternal clinics in the area, and regular immunisation, nutrition and health education programs. These activities are supported by the township authorities and the commander of the locally-based light infantry division, as well as through regular visits from the vice-presidents (MMCWA n.d.).

However, this does not indicate how the MMCWA operates in some of the more remote regions, or how much of the membership below the town elite genuinely identify with the Association. Apart from some anecdotal evidence, popular attitudes toward the MMCWA are difficult to assess. It can be said, though, that this form of top-down ‘grassroots’ development would not be considered unusual in Myanmar culture (see Chapter Five).

Thus, in examining the role of the GONGOs, it should be recognised that elite-directed development is common, and accepted, in Myanmar. The military government finds this a suitable institutional culture for societal control, and has taken it to an extreme by promoting only the organisations it considers acceptable. However, while the community generally accepts top-down activities imposed by the government, it is doubtful whether such activities truly penetrate to the grassroots.
In some cases, members of the GONGOs can make good use of the opportunities their positions allow them to take up.\(^3\) Because of this, some of the UN agencies and INGOs see a capacity for the MMCWA to develop into a more independent organisation (UNICEF 1995: 13; World Vision Myanmar 1996: 13).\(^4\) The MMCWA has been recognised by the WHO South East Asian regional office, which gave it an Award for Primary Health Care Development, in September 1998.\(^5\)

On a superficial level, the GONGOs allow the SPDC to achieve a basic requirement of state capacity, namely a more comprehensive administrative apparatus, and the appearance of grassroots control. Some of the GONGOs, including the MRCS, are reported as being trained by the government as auxiliary security organisations (EIU 1997: 16-17; interview 7, Yangon: March 2000). A government publication explicitly states that

For the emergence of a peaceful, modern and developed new nation, Red Cross brigade members have to discharge their original duties and in addition stand by as a reserve strength. On 4 November 1997, the original Red Cross Brigdes [sic] were upgraded to branch level which consists of five brigades throughout the country to augment the State Law and Order Restoration Council strength (Myanmar Ministry of Information 1999: 415).

While the GONGOs are criticised by many foreign observers for being controlled by the government, the reality is that the government never intended these organisations to operate autonomously. In a society where community organisations are tolerated only when they act as auxiliaries to government departments, the high level patronage of the MMCWA and MRCS seems to obligate them to serve the ends of the government in return. At the same time, both the government and the GONGOs make efforts to separate their images for public relations reasons, particularly on the issues of funding. For example,

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\(^3\) Also, it has been pointed out that local-level GONGO members are often also community leaders, health workers, and even NLD supporters (Purcell 1999: 88).

\(^4\) The author of a World Vision Myanmar study points out ‘the enormous potential, and willingness, of local NGOs to assist in meeting health, socio-economic, and environmental needs, at community level’ (McConville 1995: 3).

\(^5\) The WHO country representative at that time, Dr Klaus Wagner, said that the MMCWA received the award because of ‘strong commitment to PHC development; concern for equity, particularly for the disadvantaged and underserved; commitment to broader health development as an integral component of socio-economic development; replicability of the approach within the socio-cultural environment on the country; and sustainability of the
the MMCWA annual report emphasises the ‘support and guidance’ of the government, and ‘cooperation’ and ‘assistance’ of the ministries (MMCWA 2000: 1-3).

In terms of community perception, however, GONGOs are generally perceived as part of the state, especially as there is much overlap between public health personnel and GONGO membership. There also appears to be a significant element of coercion in their operations (interview 20, Yangon: March 2000; interview 27, Yangon: May 2000; Skidmore 1998: 129), although details are not easy to determine. This seems to involve pressure to join, as members that both donate money and participate in the activities. For example, it has been said that some members in a town in the Shan state were obliged to go to Mandalay on their own resources to attend a training session (interview 2: December 1999). Such coercive top-down organisation has long been common to governance in Myanmar, and many people’s experience of the GONGOs is similar to their experience of state sectors, which primarily solicit labour and donations; GONGOs are thus often seen as formal institutions, to be tolerated and if possible used for gain (interview 20, Yangon: March 2000; interview 27, Yangon, May 2000).

The government’s promotion of GONGOs, at the expense of other, less regimented forms of grass-roots development, reflects the way in which health development activities are used to integrate social control into every aspect of life. It also reflects the low capacity of the state sector. These auxiliary organisations, which are privileged by the government but raise their own funds, are important to supplement the capacity of the Ministry of Health to implement policy, and achieve the penetration of the state into grassroots activities. In doing so, however, the structures and institutional culture of the GONGOs produce the same barriers to societal embeddedness that is faced by the state.

programmes’ (Information Sheet No. A-0628(I), Yangon, 28 September 1998). This assessment was based on reports submitted by the MMCWA.
Health in the Border Areas

The promotion of GONGOs to fulfil the government’s social service obligations is one illustration of the regime’s perception that a certain type of social development promotes state consolidation. The operation of the public health service in border areas is another, and is often explicitly presented as a path to that goal.

Government publications often put forth the view that the extension of health institutions and infrastructure also serve the purpose of strengthening national cohesion. For example, a 1996 paper by the then director-general of the Department of Health states that

as the health of each family, community and state is developed, a good foundation for national consolidation is laid. The full significance of health is having a sound body together with a noble spirit and the capabilities for a cooperative endeavour toward national consolidation’ (Hla Myint 1996: 131).

It is for reasons of national consolidation, or perhaps more precisely, the maintenance of the ceasefire agreements, that SLORC/SPDC have interpreted ensuring equality of access to health services specifically as the method to support the expansion of government health activities into the border regions that were previously inaccessible to the government. It is only when the government is talking about its priorities for health in the border regions that the concept of health as linked to the development of the country and of the nation-state is conceptualised. For the rest of the country, health matters do not appear to be considered vital to anything but good health. This dichotomy reflects the regime’s perception that providing social development as part of ceasefire agreements contributes to security, whereas in the more secure parts of the country, more straightforward methods of social control can be utilised.

This is not to say that the need to expand health facilities into the border areas is not important on other grounds. Although most insurgent organisations had parallel administrations that were responsible for social

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6 Diverging a little, Hla Myint (1996: 132) also says that ‘bringing those squabbling indigenous races back to the warm family circle of the Union of Myanmar, with forgiveness and broad-mindedness may also be considered as a way of building up the health of the country’ (Author’s italics).
services, the major demand on resources was military. Following the first few ceasefires, a UN needs assessment mission found that

the need for immediate humanitarian aid is apparent...both infant and maternal mortality rates are very high. Within the period of a year, approximately half of all deaths in these regions are from among the “under-five” population, although they make up only less than 15% of the total population (UNDP 1991: 12).

Another report stated that ‘an appallingly low level of health and sanitation’, was contributed to by a huge ignorance of water-borne diseases, endemic malaria, and chronic malnutrition,⁷ since most of the households were not self-sufficient in grains, and reduced their food intake during the lean months (FIDH 2000: 10).

Great regional disparities were apparent, although most of regions with recent ceasefires or fighting still going on were found to have extremely high levels of malnutrition. In 1991, the Rakhine state was the worst off, with the highest infant mortality (at 114/1000 live births) and the highest under-5 mortality rate (213/1000), as well as protein energy malnutrition (PEM) prevalence of 32 per cent, of which 9 per cent were in the severely underweight category. The Kachin state was the next worst off, with infant mortality of 113/1000, under-5 mortality at 207/1000 and PEM of 21 per cent.⁸ At this stage, despite the Expanded Programme on Immunization, 82 per cent of the Kachin population had not been immunised (UNICEF c.1991: 18-27). The regime recognised that these conditions had to be addressed, and that doing so presented an opportunity to expand the reach of the state. The program to do this, initiated in 1989, is the Programme for the Development of Border Areas and National Races. To achieve the government’s commitment to develop long-neglected regions, made in the early ceasefire agreements, the Ministry for Progress of Border Areas and National Races was formed in 1992, (later renamed the Ministry for the Progress of Border Areas and the National Races and Development Affairs, and commonly called NATALA). NATALA is the

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⁷ The report does not outline what the assessment methods were.
⁸ The estimates of infant mortality rates in a government study in the same year ranged from 27 per 1000 live births in the Yangon division to 113 per 1000 in the Shan state, and a staggering 292 per 1000 in the Chin state (Åung Tun Thet et al. 1991: 9).
implementer of the program, which was outlined in the *Master Plan for the Development of Border Areas and National Races* (1994). The first of the five objectives of the *Border Areas and National Races Development Law* of 1993 is to develop the economic and social work and transport and communications of the national races at the border areas, in accordance with the aims which are non-disintegration of the Union, non-disintegration of the national solidarity and perpetuation of the sovereignty of the State’ (Myanmar Ministry of Information 1999: 29).

As mentioned in Chapter Three, NATALA is not a line agency, but coordinates the other ministries at a central level to fulfil the objectives of the program. Thus, the Department of Health must implement its activities in the border townships through NATALA.⁹

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⁹ NATALA undertakes development activities in the following areas: Kachin Special Region (1), Kachin Special Region (2), Kokang Region, Wa Region, Shan Region, Kachin North East Region, Palaung Region, Kyaingtong East Region, Homein/Mong Htaw/Mong Hta Region, Maw-pha Region, Pa-O Region, Kayah/Kayan Region, Rakhine Region, Chin Region, Naga Region, Kabaw Region, Kayin Region, Tanintharyi Region and Mon Region (Myanmar Ministry of Information 1999: 351).
Figure 7.1: Map of Border Area and National Races Development Programme Regions, April 2000


The Work Committee for the Development of Border Areas and National Races coordinates the implementation of the program. This is a high-level committee chaired by General Khin Nyunt, and consisting of ministers and senior bureaucrats. It consists of eighteen sectoral sub-committees that implement their respective projects, with the Management and Finance Sub-committee operating as a coordinator. The sub-committees are chaired by the deputy-ministers of the respective ministries, while regional work committees are chaired by the regional commanders, regional supervision commanders, or
military operation chiefs in their respective areas of authority (Thein Han 1996: 223). How the overlapping central and regional authorities are coordinated is not explicit, but the committees chaired by the regional commanders would not doubt take precedence. At the same time, as this is a high profile program, it is closely supervised by the members of the SPDC, who make frequent visits to projects.

**Figure 7.2: Implementation of Border Areas and National Races Development Plan**

![Diagram of implementation process]


The Border Areas Programme was initiated in 1989, but the main projects began in 1993/94 with a three-year short-term plan. This has been followed by a five-year medium-term plan, intended to construct the socio-economic infrastructure through public investment. The aim of the second five-year medium-term plan is to strengthen the infrastructure with encouragement of private investment.

The main activity of the Department of Health in the border areas (through the health sub-committee) is infrastructure construction. This is the dominant expression of ‘health service delivery’, and is regularly reported in terms of numbers: the 1999 annual report from the Ministry of Health stated that over the decade since the border areas program was started, 41 hospitals, 91 clinics, 8 RHCs and 30 sub-RHCs were built, at a cost of Kt200.4 million.
(Myanmar Ministry of Health 1999: 70). This constituted over 40 per cent of the new hospitals constructed in the country, overall, although a number of the hospitals already existing in the central areas are reported as being upgraded. In 1989, there had been only eight hospitals and six dispensaries in the border areas. (*ibid*.: 68).

Yet while hospitals, dispensaries and RHCs are being built, the government still has the problem of getting health personnel out into the remote regions, and getting them to stay there. It is not uncommon for a doctor, upon arriving for a post in a remote area, to immediately request a transfer, or for basic health staff to simply refuse to attend a RHC they have been assigned to, especially if it is a long way from the township centre, and instead to be found working in the hospital (interview 20, Yangon: February 2000). To a large extent, this problem is ‘cultural’, with health personnel from different parts of the country being assigned to places where the language, religion and social norms are very different.\(^\text{10}\)

To address this, the government has lowered the standards for entrants from remote areas into training programs for health staff, for example considering applicants to midwivery training with an 8\(^{\text{th}}\) standard level education rather than the usual 10\(^{\text{th}}\) standard,\(^\text{11}\) and admitting applicants from special regions without entrance exams (Hla Myint 1996: 135). Civil servants who are posted to remote border regions from central Myanmar receive double salary (Myanmar Ministry of Progress of Border Areas and National Races and Development Affairs 1994: 85).\(^\text{12}\)

Yet, as Lieutenant-Colonel Thein Han (1996: 230) stated frankly, ‘there has been little concrete progress in health care’. As well as the major difficulty of getting health staff to take up assigned posts in the border areas, and then to stay there, he listed the ‘short supply of medicine, health facilities, up-to-date

\(^{10}\) A UN report also found that ‘there is a tremendous gap in terms of language, culture and communication between the population in the existing traditional system and modern medical facilities’ (UNDP 1991: 13).

\(^{11}\) Tenth Standard is the highest level of the secondary education system.

\(^{12}\) Other incentives to induce doctors to work in remote areas are choice in the area of the next assignment, and greater access to advanced study of medical specialities (Mattock and Abeykoon 1993: 45).
medical tools and equipment and [adequate] statistics’ (*ibid.*). Consequently, many of the people living near the Thai/Myanmar border rely on Thai health facilities.

An assessment towards the end of the initial short-term plan, by the director-general of the Department of the Progress of Border Areas and National Races and Development Affairs, listed a number of problems that had hindered the implementation of the program. These included,

lack of definite demarcations for some project areas, lack of interest on the part of department personnel and local authorities, local populace, in some regions lack of technical know-how in regional development planning and lack of precise statistics and data’ (Thein Han 1996: 225).

Although these issues apply across the country, the impact of the Border Areas Development Program, and the health status of the population, differs according to region, depending on whether military operations are still going on, the strength of the ceasefire organisation, and other political issues.

In the Wa special administrative regions, widespread addiction to opium and heroin, with drug injecting interrelated with HIV infection, has added to health problems. The political ramifications of the narcotics industry have led to the areas administered by the UWSA being classed as special development priorities. Being among the first to agree to a ceasefire with the government, the UWSA was one of the first groups to receive the benefits of the government’s new strategy. Because it has control of the narcotics trade and is a powerful and valuable ally to the regime, development efforts have been maintained more thoroughly than in other ceasefire areas. Finally, because the narcotics produced in this region cause major drug problems in the rest of the world, UNODC has taken the opportunity to start a major program there. The UNODC/Wa Project (formally called the Wa Alternative Development Project) is a joint program between UNODC, NATALA, CCDAC, UWSA, and the Chinese government. It is based on sustainable grassroots development, and infrastructural extension. The health component aims to improve health and nutrition, reduce demand for illicit drugs, and establish a sustainable primary health care program (United Nations International Drug Control Program 1999). The Department of Health and the Wa Health Department are involved
in the program. However, conflicting priorities among these powerful actors has interfered with the program’s implementation. In particular, the UWSA Security Brigade has interfered with the work the civilian administration is involved in, and higher officials in the UWSA prove difficult to work with (interview 56, Yangon: September 2000). While this program is important for the government, in securing a valuable ally, and important for UNODC, as an opportunity to maintain a presence in one of the major heroin producing regions of the world, the elite of the UWSA are rich and powerful, and seem more concerned with extending their business and military activities than with development activities.

It is a different situation in the Kachin state, in the far north of the country, where insurgencies ceased in 1993 when the KIO agreed upon a ceasefire with the government. Being of less strategic importance than the Wa areas (mainly because, unlike the Wa, it is not located on major trading routes, or in narcotics production areas), once the fighting stopped, the government had less need to follow through with its development promises. The agreement was for the KIO and the government to implement programs jointly, but representatives of the KIO claim that the KIO has been undertaking development programs alone (ROKA c.1998).13

The KIO-administered areas are divided into the General Headquarters, and five divisions (Eastern, Northern, Western and Southern and the Sadung Special District). In 1996-1997, health facilities operated by the KIO to serve the civil population consisted of one 100-bed hospital at the headquarters, two 50-bed, and two sixteen-bed hospitals. There were also fourteen Refugee Health Centres, and nine Rural Health Centres. To staff these, there were twenty-eight doctors, thirty senior medics and 119 nurses (ibid.).14

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13 Non-government organisations such as the Kachin Baptist Convention also undertake development projects. However, a project report indicates difficulties in dealing with the overlapping authorities, and of inspiring the confidence of people living under a fragile ceasefire treaty to undertake long-term development projects (Kachin Baptist Convention 1999).

14 None of the health facilities is located in Southern Division, which is the Kachin sub-state within the Shan state.
Generally, the KIO health system is run on a similar basis to the government health system, and suffers much the same implementation problems, such as a lack of financial and human resources, and an overemphasis on capital expenditure and curative care (interview 22, Yangon: March 2000). Other townships in the state come under the government health service, although the remoteness of many of the regions makes operations more difficult than in the central areas of the country. Many of the roads become impassable in the rainy season, hindering the delivery of supplies, the work of medical personnel, and transportation of the sick to the township hospital. This is unfortunate, as the location of large mining areas in the Kachin state make the need for proper health services more essential than in some of the other parts of the country. The jade mining town of Hpakant has become a centre for HIV/AIDS, which spreads throughout the rest of the state, and then nationally, via the mobile population of seasonal labour (see below for more detail).
In the areas still under conflict, such as in the Kayah state, where a ceasefire agreement was signed between the KNPP and the government in 1996 but broke down soon after, the health crisis goes beyond mismanagement and lack of resources. A recent report summarised the situation:

What is generally acknowledged is that the health status of the population in Karenni is poor. This is linked to: the high level of poverty in the state; chronic conflict and insecurity; general deprivation characterised by inadequate income levels; a general lack of education and knowledge; lack of access to health care; poor housing; lack of access to safe water and sanitation; and lack of control over the reproductive process (BERN 2000: 81).

In areas where the military conflict still goes on, large parts of the population are internally displaced – either by fleeing from the fighting, or by forced relocation of villages to camps by the government in order to cut off support to the insurgents. The Housing Construction Work Committee of NATALA and the Department of Housing Settlements and Housing Development, which includes responsibility for health facilities, administer the relocation sites. The sites started out as areas of land with little or no shelter, facilities or sanitation. Refugees who escaped into Thailand reported that relocation resulted in high levels of morbidity and mortality, and that the burden of providing shelter was placed mainly on the local community (ibid.: 79).

In the Kayah State, over 25,000 people were displaced in 1996-98 (ibid.: 50). Those displaced lack access not only to health services (which are located in urban areas, and seriously understaffed), but to the basic necessities of food, water and land, which have been restricted for military reasons. The area is also one of the regions worst affected by malaria (ibid.: 6-7). Many villagers hide in the jungle rather than submit to forced relocation, and rely on tubers as basic foodstuff, which are mildly poisonous if not prepared properly (and cause dehydration from diarrhoea and vomiting which is difficult to treat because of lack of water, nutritious food and basic medicines). Of people hiding in the jungle, and at the relocation sites, it is estimated by insurgent and local civilian sources that ‘deaths from basic dehydration...in combination with malaria, dysentery and infection from a host of parasites...have killed more than half of the people who were living in the jungle in the Mawchi area’ (Karen Human
It has also been reported of the sole hospital in the relocation site at Shadaw that the doctors who are meant to be based there instead stay in Loikaw, the capital of the state, and visit only every few months. Although this hospital is designated as a township hospital, it does not have any medicines. For medicines or emergency treatment villagers must find some way to travel to Loikaw (ibid.: 9-10).

Another factor that exacerbates health problems in conflict areas is that the few external agencies working in the country are not permitted to set up programs there. As of 2000, only some local religious organisations and UNICEF were working in the Kayah state (BERN 2000: 7). However, the UN agencies and most of the INGOs are present in many of the other border regions: in the towns bordering Thailand and China, which are major centres of HIV infection, and areas of the Kachin, Chin and Rakhine states, where the government health services are perceived as particularly inadequate to cover health needs that are exacerbated by large internal and cross-border migration.

The Rakhine state is no longer under active military conflict, but is still a highly sensitive security region, and therefore remains firmly under militarised administration. This centres on the Rohingyas, a Muslim ethnic minority in the north of the state. None of the governments of Myanmar has been comfortable with the Rohingyas, who are perceived as ‘foreign’. An operation against them in 1978 forced over 200,000 people to flee over the border to Bangladesh. Many of these were repatriated by the United Nations High Commission for Refugees (UNHCR), but after the SLORC came to power the region became even more militarised, and another mass migration occurred in 1991-1992. Once again, many of the Rohingyas have been returned through the UNHCR. The situation remains repressive. A human rights report claims that ‘the Burmese authorities…do their best to bring the Rohingyas to a point of utter social and economic precariousness’ (FIDH 2000: 17). The Rohingyas suffer restriction of movement, requiring a license to temporarily leave their village that can take two months to be processed and requires extensive bribes (ibid.: 21). This restricts the opportunity for small-scale trade, and also means that unless they are lucky enough to have a sub-rural health centre in the village, access to the
government health infrastructure is effectively denied. Health services in Rohingya villages are almost non-existent, particularly due to a lack of staff. Buddhist health staff often refuse to be posted to the remote, Muslim areas, and Rohingya generally are not able to gain access to training in government medical and public health education programs (ibid.: 27), as most are unable to prove their citizenship under the current law.

However, the northern Rakhine State has one of the highest levels of external agency programs in the country. It is part of UNDP’s poverty alleviation Community Development for Remote Townships Project, and several INGOs operate small-scale projects. This is because the situation in Rakhine is one issue on which the regime has been unable to ignore international pressure, as some of their closest allies, Malaysia and Indonesia, do not take kindly to persecution of Muslims.

The security situations and power structures in the other border regions have much the same detrimental impact on the health of their populations. This, even more than the lack of government health infrastructure, is responsible for the large disparities in health status between the states and the divisions. The ethnic states have fewer health facilities, and greater incidence of preventable disease and malnutrition. This must be taken into account when looking at national averages. Overall, the government’s blatantly political use of social development as a tool of nation-building in the border areas, to either reward its allies or punished its opponents, further complicates the problematic delivery of health services to the population in Myanmar.
Table 7.4: Selected Health Statistics across Regions (1997)

<table>
<thead>
<tr>
<th>State/Division</th>
<th>Fully immunised children (%)</th>
<th>Under-5 Children who are moderately or severely underweight (%)</th>
<th>Households with access to safe and convenient water supply (%)</th>
<th>Households with sanitation coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>77.3</td>
<td>38.6</td>
<td>66</td>
<td>45.2</td>
</tr>
<tr>
<td>Wa/Kokang*</td>
<td>39</td>
<td>37</td>
<td>61</td>
<td>27</td>
</tr>
<tr>
<td>Shan (East)</td>
<td>43</td>
<td>40</td>
<td>63</td>
<td>46</td>
</tr>
<tr>
<td>Kayah</td>
<td>48</td>
<td>39</td>
<td>37</td>
<td>34</td>
</tr>
<tr>
<td>Kayin</td>
<td>55</td>
<td>39</td>
<td>62</td>
<td>42</td>
</tr>
<tr>
<td>Chin</td>
<td>58</td>
<td>45</td>
<td>64</td>
<td>61</td>
</tr>
<tr>
<td>Pa-O region*</td>
<td>60</td>
<td>40</td>
<td>69</td>
<td>53</td>
</tr>
<tr>
<td>Shan (North)</td>
<td>63</td>
<td>33</td>
<td>58</td>
<td>27</td>
</tr>
<tr>
<td>Kabaw &amp; Naga*</td>
<td>63</td>
<td>26</td>
<td>36</td>
<td>19</td>
</tr>
<tr>
<td>Shan (South)</td>
<td>66</td>
<td>35</td>
<td>57</td>
<td>38</td>
</tr>
<tr>
<td>Kachin (border area)*</td>
<td>72</td>
<td>23</td>
<td>71</td>
<td>48</td>
</tr>
<tr>
<td>Rakhine</td>
<td>73</td>
<td>53</td>
<td>60</td>
<td>16</td>
</tr>
<tr>
<td>Yangon</td>
<td>76</td>
<td>33</td>
<td>84</td>
<td>72</td>
</tr>
<tr>
<td>Ayerarwaddy</td>
<td>77</td>
<td>42</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td>Mandalay</td>
<td>78</td>
<td>36</td>
<td>68</td>
<td>52</td>
</tr>
<tr>
<td>Mon</td>
<td>79</td>
<td>39</td>
<td>69</td>
<td>52</td>
</tr>
<tr>
<td>Kachin</td>
<td>82</td>
<td>21</td>
<td>68</td>
<td>64</td>
</tr>
<tr>
<td>Chin (border area)*</td>
<td>82</td>
<td>35</td>
<td>64</td>
<td>69</td>
</tr>
<tr>
<td>Sagaing</td>
<td>84</td>
<td>32</td>
<td>62</td>
<td>20</td>
</tr>
<tr>
<td>Bago</td>
<td>87</td>
<td>44</td>
<td>82</td>
<td>44</td>
</tr>
<tr>
<td>Mon &amp; Taninthayi (border area)*</td>
<td>93</td>
<td>37</td>
<td>63</td>
<td>45</td>
</tr>
<tr>
<td>Magway</td>
<td>93</td>
<td>44</td>
<td>56</td>
<td>53</td>
</tr>
<tr>
<td>Taninthayi</td>
<td>93</td>
<td>40</td>
<td>54</td>
<td>37</td>
</tr>
</tbody>
</table>

* Areas covered by the Border Areas and National Races Development Plan

Program Case Studies: the Expanded Programme on Immunisation and AIDS Prevention and Control

The Expanded Programme on Immunisation

As well as regional disparities in the operation of the public health sector, and of the intrusion of non-health state priorities into health, specific programs run by the Department of Health receive vastly disparate treatment, mainly in terms of how favoured they are by the regime. The Expanded Program on Immunisation, one of the keystones of primary health care, is a good example of what the regime sees the health sector as being able to
contribute to the state, and how significant achievements can be made by the public health sector when the political backing is present. The effort and prominence given to these annual mass mobilisation efforts is far from typical in terms of administrative capacity, central-local and central-regional relations, and the welfare activities of the state. This program aims to immunise all children against the major childhood diseases. Like the opening of a new bridge, it provides a showcase for the regime’s claim to performance legitimacy, with achievements such as 95 per cent immunisation coverage across the country for polio (Information Sheet No.B-1347, Yangon, 28th April 2000). The program includes cooperation with the United Nations – UNICEF donates the polio vaccines – in pursuing a major international health goal. It involves community participation, as members of the GONGO are mobilised as the volunteer workforce. Finally, it is an achievable and relatively inexpensive health intervention.

The program aims to immunise children under one against six communicable diseases (diptheria, pertussis, polio, tetanus, measles and tuberculosis), and pregnant women against tetanus. The activities are integrated into the regular work of the basic health staff, specifically being the responsibility of the midwife working out of a rural health centre, urban health centre or station health unit, assisted by volunteer health workers. The NHP (1996-2001) recognised the need for close supervision of the program from above, and community involvement from below, particularly mentioning the need for support from local authorities, USDA, MMCWA, MMA and MRCS (Myanmar Ministry of Health 1996: 108-112).

It is clear that the EPI programme has saved the lives of thousands of our children. At the same time EPI is cost effective. By addressing the project to immunizable childhood diseases, mortality and morbidity among the children of Myanmar would be reduced so as to ensure future productive force of the country, quantity as well as quality of services would be greatly enhanced (ibid.: 112).

15 The immunisation program is similarly popular in other countries. For example, it was a favourite of the former President of Indonesia, Soeharto. While most health programs in Indonesia are hindered by low implementation capacity, programs with direct elite support were much more successful in mobilising resources (Achmad 1999: 17-18).
EPI was initiated in 1978, under People’s Health Plan I, as a joint program of the government and UNICEF. At the beginning, it was aimed at prevention of diphtheria, whooping cough, childhood tuberculosis and tetanus. Over the four years of PHP I it operated in 104 townships. By 1985, it covered 176 townships. During the socialist period, EPI was integrated into the basic health system, as a priority program. ‘Every month one whole week’s working time of BHS staff in the EPI townships are [sic] devoted to outreach programmes for the community’ (UNICEF 1985: 6). At this stage, it was run solely by the Ministry of Health, and included farmers and workers in the target group for tetanus immunisation, in order to protect production levels (ibid.).

In 1986, townships set up to operate the program were given a target of achieving 80 per cent immunisation coverage. By 1990, this had been achieved in 210 townships. At this stage, 31 per cent of the population in remote border areas was unreachable, and EPI was chosen as the first health program for these areas because of its cost-effectiveness, its perceived high value, and to serve as an ‘entry program’ for other health programs (UNICEF c.1991: 4). At the beginning of SLORC rule, the achievement of EPI was being hindered by four major constraints: ‘1) security problems, 2) unreliable or no electricity supply for the cold chain,\(^{16}\) 3) transportation difficulties, and 4) a shortage of human resources’ (UNICEF 1995: 37). Subsequently, the security restrictions were addressed by the ceasefire arrangements, and the cold chain extended to a certain extent by solar refrigerators, but transportation to get the vaccines beyond the township centres, and the human resources to implement the program, were major problems in the mid-1990s (ibid.).

The Ministry of Health reports that by extension of the cold chain, the program was expanded to another 35 townships in 1992, a further 32 in 1993, and 24 more in 1994. Implementation of EPI began in the remaining seventeen townships in 1995 (Myanmar Ministry of Health 1999: 4). The 1997 Multiple

\(^{16}\) A cold chain is ‘the unbroken relay of transport and storage, which must maintain vaccines at the right temperatures from the point of manufacture to the point of use’ (Price 1994: 147). The
Indicator Cluster Survey reported a national average of 77 per cent of target children (12 to 23 months at the time of the survey) were fully immunized against the six vaccine-preventable diseases. However, the average concealed wide gaps in coverage between urban and rural areas, and regional disparities (Department of Health Planning 1999b: 19). The percentages of fully immunised children ranged from 39 per cent in the Wa/Kokang region, 43 per cent in the eastern Shan state, and 48 per cent in the Kayah state, to 93 per cent in the Magway and Taninthayi divisions (see Table 7.3).17

Then, in 1996, a crash immunisation program began in the form of annual National Immunisation Days (NIDs), and a commitment to meeting the global goal of eradicating poliomyelitis by the year 2000. All children under five are given the polio vaccine, while all children under one receive the other antigens (UNICEF 1995: 41). It is these days in particular that demonstrate what the immunisation program represented to the regime. Under the leadership of the WHO regional office, the NIDs were planned to start in 1998. However, to bring Myanmar into line with other countries in the region and make it possible to reach the 1990 goals, the government instead conducted the first NID in February/March 1996, in Shadaw township of the Kayah state. In December 1996 and January 1997, the second NIDs covered remote townships in Shan, Kachin, Chin, Kayah states and Upper Sagaing Division. By the third NID, in December 1997 and January 1998, the crash programme was being implemented to some extent in all townships in the country (including the Wa areas for the first time) (UNICEF 1998b: 15-16). As a result, immunisation coverage for the six preventable diseases is reported to range from 77 to 91 per cent (Myanmar Ministry of Health 1999: 69). Simple measures such as these can have a major impact on mortality and morbidity rates.

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17 It is possible that the high percentages in Taninthayi is a consequence of the infrastructural expansion in the region that occurred during the building of the two gas pipelines to Thailand, and indicates a large state presence in this otherwise peripheral region. In addition to government services, the oil companies operating in the area run localised development programs.
The NIDs assume almost military proportions. The report on the December 1998 NID stated that:

This year’s poliomyelitis eradication activities target approximately 5.8 million under-five children, which is a task of enormous proportions. Myanmar have thus organised meticulously at the central, state/division, district, township and village levels in order to manage the activities. Accordingly, down-the-line instructions have been circulated...so that full support will be given to health personnel by administrative authorities....activities will be carried out simultaneously all over the country including remote border areas (Information Sheet A-0727, Yangon, 13 December 1998).

Indeed, in the remote border areas, it does become a military operation, with Tatmadaw personnel delivering health personnel and equipment to remote areas, and in some cases administering vaccines themselves.\textsuperscript{18}

The Japanese government pays for measles vaccines. UNICEF supplies the other vaccines, along with assistance in training and implementation (Bianco 1996: 3). UNICEF is gradually transferring responsibility for the maintenance of the cold chain to the Department of Health, although it still covers 80 per cent of the cost (UNICEF 1995: 42). The 1996-2000 Master Plan of Operations describes the implementation structure: the main responsibility lies with the Ministry of Health, but national and international NGOs are also involved, as well as private practitioners. Other parts of the government are involved in the logistical matters: the General Affairs Department, the Immigration and Manpower Department, Road Transport, Myanmar Airways, Myanmar Railways, and NATALA; the Ministry of Education is involved with relevant health education through the schools (\textit{ibid.}: 42).\textsuperscript{19}

However, having the immunisation program integrated into the health system hierarchy means that, despite the relative simplicity of the program, as well as the political support, it is subject to the usual implementation problems.

\textsuperscript{18}The former director-general of the Department of Health reported: ‘Children of people living in remote areas beyond the reach of ordinary transportation have been able to receive vaccination against polio because military helicopters and airplanes rendered assistance in transporting not only refrigerators and vaccines but also doctors and nurses to these areas which were normally inaccessible. In some especially inaccessible areas, the Tatmadaw men themselves went and provided the vaccines’ (Hla Myint 1996: 139).

\textsuperscript{19}The former regional director of UNICEF, Kul Gautam, has criticised the contribution of the Myanmar government to the program, saying that ‘much of the progress is being achieved through external support. The government itself is not allocating enough funds’. In contrast, he cites the poorer country of Bangladesh, which is now able to procure a significant amount of vaccines without external help (\textit{Reuters}, Bangkok: 16 March 2000).
The 1985 review of the EPI program reports problems of lack of supervision, arising from a lack of transport facilities and manpower, and inadequate travelling allowances (UNICEF 1985: 12).

Many of these problems remained in 1998, when UNICEF’s mid-term review of the 1996-2001 program (1998: 16) stated that technology has been correctly transferred to the basic health staff and the quality of immunization was generally satisfactory. However, there is still room for improvement in many aspects, linked to training, management, monitoring and supervision.

The achievements of EPI are presented in terms of numbers, detailing townships under the program and children who have received a polio vaccine. But the operation of the program is much more complicated. As well as technical challenges, low levels of acceptability and accessibility by the community are common barriers to the success of an immunisation program (Price 1994: 147).

In the case of Myanmar, there are doubts as to how well the cold chain that keeps the vaccines alive during transportation is maintained, as well as problems in getting mothers to bring their children back for multiple vaccines (interview 6, Yangon: February 2000; interview 20, Yangon, March 2000). Many women are too burdened looking after the household and their livelihood to take children several times to be immunised (Bianco 1996: 4).

Outside of the NIDs, the implementation of the program rests with the lowest level of the health sector hierarchy. For example, a UNICEF publication featured the story of Daw Marlene, a midwife who delivers vaccines on the road between Bhamo and Myitkyina, in the Kachin State. Every month she spends four to five days delivering vaccines wrapped in ice packs, often covering about 100 miles on almost impassable roads on her bicycle (Bianco 1996: 1-2). Such dedication does not seem to be typical of government-employed midwives. During the rainy season, it would be impossible.

Mark Nichter’s (1990: 196-208) analysis of vaccinations in South Asia highlights the misperceptions and resistance caused in the community by an attitude that a vaccination campaign is like a military campaign, which requires little participation from the community apart from their presence. Some of the problems arose from the lack of knowledge by health workers of the vaccines they were administering, lack of trust in the intentions and quality of government health services, and beliefs that children were protected from the diseases by traditional remedies.

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**HIV/AIDS Prevention and Control**

UNAIDS (2000: 130) estimates that at the end of 1999, there were 530,000 people living with HIV/AIDS (PLHA) in Myanmar, as well as 48,000 deaths from AIDS in that year and 43,300 cumulative AIDS orphans. This places the HIV prevalence rate among adults at 1.99 per cent of the population (ibid.). However, UNAIDS revised its estimate to down to 400,000 PLHAs in 2001 after a joint estimation workshop with the government (UNAIDS 2002).  

The UNAIDS estimates are cause for alarm, but may still be understating the situation. In four townships where World Vision work is targeting high-risk populations, anecdotal evidence suggests that at least one person dies of AIDS every day (Chandler 1998: 254). Researchers from the Johns Hopkins Bloomberg School of Public Health estimated that there were 687,000 PLHAs in Myanmar in 1999, or 1 in 29 adults; this produces an HIV prevalence rate of 3.46 per cent of adults (Beyrer *et. al.* 2003). As a result, the International Crisis Group asserts that ‘Myanmar stands perilously close to an unstoppable epidemic’ (ICG 2002a: 1). The geo-strategic repercussions of the HIV epidemic have also been noted by John Dwyer, president of the AIDS Society of Asia and Pacific, who stated: ‘Burma is the epicenter of the epidemic in Asia’ (cited in Beyrer and Hnin Hnin Pyne n.d.)

This situation represents more than a health crisis. The impact of the HIV/AIDS epidemic on the African continent, which predates the epidemics in Asia by a decade, has demonstrated the detrimental impact that an AIDS epidemic has on a country’s development. It is difficult to quantify the impact of the HIV/AIDS epidemic on Myanmar so far, due to the lack of reliable statistics even for basic health indicators. However, the UK Department for International Development, DFID, has estimated that by 2010 the impact of HIV/AIDS in Myanmar will have increased child mortality by ten per thousand (80.3, instead of 70.1 without HIV/AIDS), reduced the growth rate by 0.2 per cent, and reduced life expectancy from 62.8 per cent in a scenario without

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21 The change in estimates may have been linked to the criticism UNAIDS received for its 2000 epidemiological report on Myanmar, which the International Crisis Group reports set UNAIDS activities in Myanmar back considerably (ICG 2002a).
HIV/AIDS to 58.8 per cent (DFID 2000: 3). Further, because HIV infection causes unusually severe illness and premature death in the most productive segment of the population (those aged 15 to 50), it has social and economic consequences that go beyond the medical aspects of the disease. For example, the Institute of Economics in Yangon found that in the border town of Kawthaung, in the far south of the country, the average total cost of AIDS to the household of migrant and transport workers infected with HIV was calculated at seven times the household’s monthly income (Institute of Economics 1997: iii-iv). The same type of study in three areas of the eastern Shan state found that the average cost to the household was seventeen times the monthly income. The situation is often made worse when the wife is infected, and then passes the infection on to children perinatally. According to the report, ‘[t]he cost of illness was borne mainly by household savings, although the community contributed and some assets were sold off’ (Institute of Economics 1997: iii-iv).

The average household income in the Eastern Shan State is higher than in Kawthaung, due to the easier access to Thailand in the north, which offers increased earning opportunities. However, the greater access also makes the residents of the Eastern Shan State more vulnerable to HIV infection (ibid.: ii). Both of the towns used in the study have a higher average income than the rest of the country, and are high-risk groups for HIV infection.

A 1996 UNICEF report says that

In Myanmar, the principal factors contributing to the rapid spread of the epidemic include changing socio-economic patterns; a general lack of knowledge about HIV/AIDS and reproductive health among the general public; the presence of sexually-transmitted diseases and limited access to diagnosis and treatment; and limited access to productive measures such as condoms (UNICEF-EAPRO 1996a: 18).

In particular, internal seasonal migration on a massive scale has been identified as a major factor in the rapid spread of the epidemic (UN Theme Group for HIV/AIDS in Myanmar 1998: 3).

The seasonal migration throughout the country consists of workers who provide labour for mining, forestry and construction projects, as well as transport drivers who work the trade routes from China, and girls who are trafficked to Thailand and China to work in brothels. A particularly notorious
site is the jade mining town of Hpakant in the northern Kachin State. Each year, seasonal workers expand the population of this town from 50,000 to between 500,000 and 800,000 (AHRN 1998: 101). Away from family and community networks, with large amounts of disposable income, many of these workers rapidly fall into injecting drug use and regular visits to sex workers, where unsafe sex is common. In ‘shooting galleries’, a hit of heroin is available for less than US 50 cents, usually using a common syringe (interview 32, Kachin state: June 2000). The effect of such a culture became rapidly apparent when HIV prevalence among injecting drug users (IDUs) in Myitkyina had reached 90 per cent by 1993 (UNAIDS/WHO 1998: 5). When these workers return home, the infection is spread to their wives, and then to their children through mother to child transmission during pregnancy, labour and breastfeeding.22

Official statistics show that in 1999, 57 per cent of sex workers and almost 89 per cent of IDUs in Mandalay were infected with the virus (Myanmar AIDS Prevention and Control Project 1999). The high rates of infection among high-risk groups are accompanied by substantial infection rates in the general population. A major turning point in the nature of the epidemic was recognised in 1995 when the sentinel surveillance results showed a sharp increase in seroprevalence among pregnant women and blood donors (UNICEF-EAPRO 1995: 6). This meant that HIV had become a mainstream disease, spreading from groups at high-risk of infection to the general population.23 UNAIDS statistics, based on government sentinel surveillance testing of pregnant women in 20 locations in 2001, showed 5.5 per cent in Muse (on the Chinese border), 5 per cent in Kawthaung (a coastal town on the Thai Border) and 6 per cent in Pyay (a large town North-West of Yangon) testing positive (UNAIDS 2002: 13). Among tuberculosis patients tested in 15 locations in 1997, over 10 per cent tested positive in Kawthaung, Myitkyina (Kachin

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22 For further information on the spread of the epidemic in different parts of the population, see Southeast Asian Information Network (1998: 5-14). For the link of vulnerability to HIV infection with drug addition, see the Centre for Harm Reduction (2002)

23 Men Who Have Sex With Men (MSM) is not included as a category in the sentinel surveillance surveys, although surveys of MSMs by the Mandalay Health Department have found rapidly increasing HIV prevalence rates between 1993 and 1996 (UN Theme Group for HIV/AIDS in Myanmar 1998: 5).
State) and Taunggyi (Southern Shan State), while 18 per cent tested positive in Kyaingtung, in Northern Shan State.

The policy development and the implementation of HIV/AIDS Prevention and Control Programme have been very different to those of the immunisation program. HIV/AIDS prevention strategy and management is a very difficult and cost-intensive health intervention, relying on long-term behavioural change and expensive treatments. The assumed social implications of the disease also make it highly sensitive and politicised.

The regime’s initial attitude towards HIV/AIDS was a mixture of denial of the extent of the problem and a strong rhetorical commitment to dealing with it, and this is telling of contradictory actions by different levels of the government. The HIV/AIDS Prevention and Control Programme has been hindered by the conservative nature of the regime, which is reluctant to acknowledge that there is widespread prostitution and injecting drug use in the country. For most of the SLORC/SPDC rule, the regime’s rationalisation has been that since extramarital sex and illicit drug use are not part of the country’s culture, the epidemic cannot be widespread (Aung Zaw 1999: 12). Rather, it has maintained that the numbers have been greatly exaggerated by outsiders in order to ‘attack’ the government. For example, in July 1999 the Minister for Immigration and Population delivered a World Population Day address in which he said:

Myanmar would like to state firmly that the sources of HIV/AIDS are not from our country....The Government [has] laid down necessary health policies and programmes to control it. Due to these measures, instances of HIV/AIDS remain relatively low and allegations of an AIDS epidemic raging in Myanmar are without foundation (Information Sheet No. A-0981, Yangon, 12 July 1999).

The regime’s attitude to HIV/AIDS produced a ‘paralyzing policy ambivalence’, where, ‘called upon to respond, government officials have felt caught between notions of national ideals and moral standards, and the actual behaviours and practices of its citizenry that may be at odds with these’ (UN Theme Group for HIV/AIDS in Myanmar 1998: 1).

Yet although the government’s denial of the HIV/AIDS epidemic during the 1990s was a great a hindrance to controlling the disease, this does not mean
there was no action on the matter. The action taken by the Myanmar
government on HIV/AIDS during the 1990s reflects, first, the erratic nature of
policy making, and second, that different degrees of action can be taken in the
different levels of government. The official response to the discovery of the first
HIV positive case in the country in 1988\(^ {24} \) was relatively rapid. A technical
committee that dealt with HIV screening of high-risk groups had already
existed for three years. By 1991, over 74,000 people in high-risk groups had
been sampled, and 2.9 per cent of these were found to be HIV positive. In 1992,
the government began regular sentinel surveillance surveys of seventeen sites
around the country.

In addition, to deal with the first confirmed case of HIV, a two-year
short-term plan was implemented, and the National AIDS Committee was
formed in 1989. This committee is a multi-sectoral policy development body,
chaired by the Minister of Health, and operating with six technical committees
(UNAIDS 1997: 2). Two medium-term plans (MTP) for AIDS Prevention and
Control operated from 1990-1993 and 1994-1997, developed with assistance
from WHO and UNDP. The first MTP was concerned with developing guiding
principles and a plan of action, based on prevention of transmission, care and
counselling, and management and multi-sectoral initiatives. The second MTP
was based on developing a broad framework for the National AIDS Programme
(NAP) (UNICEF-EAPRO 1995: 7), which was set up as an implementing body,
and incorporated into the STD Control Programme in the Department of
Health. Subsequently, policy has been developed as a part of the National
Health Plan, but with less specific policy priorities and programs (UN Theme

HIV/AIDS was the third priority of the 1996 to 2001 National Health
Plan. The social and economic connotations of the epidemic for the country
were acknowledged in policy documents long before the leadership admitted

\(^{24}\) It is worth noting that China’s first case of HIV infection was identified in 1989 in Ruili (The
Financial Times, 24/3/01), a town on the Sino-Myanmar border that is a transit point in the
trucking and drug trafficking routes down through north-eastern Myanmar.
that an epidemic existed. In 1994, the National AIDS Programme stated in its annual report that

given the current rate of increase in the prevalence of HIV infection in Myanmar, it is anticipated that the number of persons with AIDS will rise sharply within the next 5-10 years….The epidemic will, consequently, result in the overburdening of existing health infrastructures as well as economic and social burdens on the family, the community and on society as a whole due to the loss of income and labour supplies, and the need to provide physical and psychological support and care for sick family members (Disease Control Programme 1994: 7-8).

The most prominent element of the early part of the HIV/AIDS prevention campaign was the billboards spread across the country, reading ‘AIDS = Death’. These have had the result of spreading awareness about the existence of the disease, but also of greatly increasing its stigmatisation. In a January 2001 interview with the *The Myanmar Times* (15-21 January 2001, Vol 3(46)), Secretary-1 claimed credit for this campaign, and in doing so demonstrated the realities of policy making in Myanmar. He said:

In the early days, Health Ministry officials said that to put up posters saying that AIDS is fatal gives too harsh a message, that it will cause psychological trauma to those suffering from it. But I personally felt that many more needed to understand the warning clearly, so I insisted that they put this on all posters: that AIDS kills, no cure, no hope.

It seems that increasing awareness by the regime of the political and economic implications of the HIV/AIDS epidemic in the mid-1990s actually increased the freedom to take official measures against the epidemic. The *Thintbawa* magazine published an article on HIV/AIDS in Myanmar in 1995, which was passed by the censors almost untouched. The then-editor believed that happened because at the time the international community was not so vocal about AIDS in Burma, but it became a sensitive issue after it received more international attention (Irrawaddy Publishing Group 2001).

This view seems to correlate with the change in the SPDC’s perception of the epidemic. In 1995, when it was becoming apparent HIV infections were established in the mainstream population, a UN report estimated that half a million people in Myanmar would be HIV positive by 2000; this report is said to have greatly alarmed the regime. As with anything the regime is unable to control, it reacted by suppressing it. Having met every year or so since it was formed, the National AIDS Committee was not convened again until 1998.
Apparently, this was because a former health minister did not want HIV/AIDS to dominate the health agenda (ICG 2002a: 4).

Further, it has been noted that policy and program documents qualitatively declined from the early 1990s (Wrigley 1999: 41).\(^\text{25}\) This could reflect a combination of government denial and realisation that the original strategies outlined during the Medium Term Plans were too ambitious in the cultural and political context.

Government denial was exacerbated by societal denial of responsibility. One of the greatest problems of preventing HIV/AIDS is that by the time it becomes visible within the community, the epidemic is already far advanced, so that successful prevention would require people to change behaviour before it is apparent there is a need to do so, and for government officials to plan for and commit resources to a long-term, unseen disease (Barnett and Whiteside 2000: 10).

A survey in the townships covered by UNDP projects found that 89.1 per cent of men and 69.4 per cent of women were aware of AIDS, with their knowledge mainly coming through friends, television and radio. ‘They know what AIDS is, and most of them have seen AIDS patients, how they suffered and how they died’ (UNDP/UNOPS/ENVIPRO 1997: 3).

However, misunderstanding and prejudice are common. The survey also noted that although most of the respondents knew that the main sources of infection are commercial sex work,\(^\text{26}\) unclean syringes and blood transfusions, the misperceptions that HIV can be contracted through sharing food and appliances, and so on, remain. This means that people living with HIV/AIDS, and often their families, tend to be ostracised. Over half of the survey respondents thought that infected people should be forced to live outside the

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\(^{25}\) This is reflected in the closely related UN programs. Reviews of UNICEF Mekong project activities found that ‘Early project documents called for highly targeted interventions into geographic areas and among target group populations seen to be most vulnerable or at-risk to impacts of the HIV/AIDS epidemic. The more recent documents refer more generally to goals of improved reproductive health and STD control, as well as UNICEF-wide goals encompassed in Healthy Living and Life Skills programs’ (Wrigley 1999: 41).

\(^{26}\) The common perception that sex workers are a major source of HIV infection is not entirely correct. Rather, the risk arises from having unsafe sex with an HIV infected person, including sex workers.
village (ibid.: i-ii). The study also showed a high distrust of health facilities; although brothels are seen as the primary source of HIV infection, hospitals, private clinics and health centres are also perceived as a major source of infection (ibid.: 11). This is quite correct, as although the government requires all blood products to be tested for HIV, the high cost of doing so means that it is rarely done (interview 7, Yangon: February 2000).

The negative attitudes to HIV/AIDS in society needed to be targeted by a coordinated and targeted awareness campaign. While the regime denied that HIV/AIDS was a mainstream health issue in Myanmar, this was not possible. In this context, the Ministry of Health’s (1996: 154) strategy to manage HIV/AIDS in the country was to ‘prevent infection with HIV; to reduce the personal and social impact of HIV infection; to mobilize and unify national and international efforts against AIDS’. Specifically, this included health education for the general community and high risk groups, ensuring provision of safe blood supply, infection control measures in health facilities, counselling services and clinical management of HIV/AIDS, expansion of sentinel surveillance, early treatment of STDs, and training for community leaders and organisations to deal with the social and economic costs of HIV/AIDS infection (ibid.: 154-156).

At the implementation level, international agencies were closely involved. In the early 1990s, WHO was the principal international agency assisting the government on HIV/AIDS activities. The Global Programme on AIDS, the predecessor of UNAIDS, significantly contributed to the two Medium-Term Plans of the NAP with technical assistance and funding. WHO

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27 In addition, a National AIDS Programme report admits that ‘it is assumed that underreporting of AIDS cases is common’, because many do not come into contact with the health system, and doctors are uncomfortable reporting cases when they are not able to confirm clinical diagnosis through testing (Disease Control Programme 1994: 5).

28 In addition, the Ministry of Transport and the Ministry of Labour implemented HIV/AIDS prevention activities to target their employees and their families. However, for the most part, inter-ministerial cooperation on this issue is hindered by lack of resources and mechanisms for sharing information (Bagosao, Hankins and Rojanapithayakorn 1996: x-xi).
also implemented the UNDP HDI project, ‘Enhancing Capacity for HIV/AIDS Prevention and Care’.  

Like the EPI program, the Department of Health has worked closely with UNICEF in implementing the HIV/AIDS prevention program. UNICEF’s parallel program, implemented through the public health system and GONGOs, included prevention of mother-to-child transmission, capacity-building for basic health staff in STI management, and HIV/AIDS prevention training through schools (see www.unicef.org/myanmar). Members of MMCWA and MRCS were trained as facilitators and trainers (UNICEF-EAPRO 1996a: 19), reinforcing the use of state-sanctioned volunteers to supplement and support the government health system.  

At this time, UNICEF operated similar projects in all the countries in the region, but it seems that its program in Myanmar has actually been better received than in other places. A report to donors of the UNICEF East Asia and Pacific Regional Office Mekong Region STD/HIV/AIDS Project, which encompasses Cambodia, China, Lao PDR, Burma, Thailand and Vietnam, declared that

in countries with the most advanced pandemic and most reliable epidemiological data and projections – Thailand and Myanmar – UNICEF has already been programming for 3-4 years....in other countries sentinel surveillance data and the impact of the emerging pandemic have been very unreliable and unclear, limiting the national response and also that of UNICEF (UNICEF-EAPRO 1996b: 2-3).

The UN agencies’ advocacy efforts helped to keep space open for the National AIDS program to implement its activities. The international support for the Ministry of Health’s program was enhanced in 1997, when the UN

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29 The Myanmar government is also a participant in UNAIDS regional activities and the ASEAN regional programme, plus cross-border programs at Muse on the Chinese border, and Tachileik, Mong la, Kyaingtung, Kawthaung and Myawaddy on the Thai border (Information Sheet no. A-0871, Yangon, 11 April 1999).

30 For example, a MMCWA member describes the program in the mid-1990s: ‘In its national programme for training urban and rural women on STD/HIV and health, MMCWA seeks to enhance organizational, clinical, training and communication skills at the township level...the local chapters of MCWA and MRCS organize training for youth and women in decision-making, communication, and negotiation skills. The training addresses existing social norms regarding sexuality, the practice of safe sex gender relations, and HIV/AIDS discrimination issues’ (Nyo Nyo 1995). However, Wrigley points out that the inherent distrust of authority in Myanmar means that people in high-risk groups, which include those involved in illicit activities of prostitution and drug use, are not likely to participate in programs run by the GONGOs or government health workers (Wrigley 1999: 15).
Country Theme Group on HIV/AIDS was set up to facilitate collaboration and joint action by the UN agencies. The UN Theme Group consisted of representatives from the cosponsoring UNAIDS agencies in the country, UNICEF, UNDP, UNDCP (now UNODC), WHO and the government (UNAIDS 1997: 9). This group prepared and endorsed in November 1998 the ‘UNAIDS National Strategy to support HIV/AIDS Prevention and Care in Myanmar for 1999-2001’ (personal communication: April 2002). At the time, UNICEF anticipated that the adoption of this strategy would produce ‘a mandate to respond effectively to this emerging human and social emergency’ (Wrigley 1999: 6).

Yet, even with close international involvement, the political barriers to dealing with the epidemic were significant. A UNDP situation analysis and needs assessment report written in 1998 said that

The Myanmar government has not been slow to react, but the response has been overly constrained by a high-level policy ambivalence, the limitations of a medical model perspective, and by serious shortages of both technical and financial resources available to their programs (UN Theme Group for HIV/AIDS in Myanmar 1998: 1).

The usual barriers of censorship, understaffing and inability to make fairly basic decisions restricted the National AIDS Program. As with most other senior bureaucrats, the time of those who carry out the national HIV/AIDS program is dominated by meetings, training sessions and research, rather than strategy development (ibid.: 40). Although non-health ministries have undertaken workplace programs for their staff, most notably the Ministry of Transport and the Ministry of Labour, their efforts have been very ad hoc, and have not been sufficiently multi-sectoral. Even the UN agencies have suffered from ‘remarkable failure’ to share information, including for joint programs (ibid.: 36).

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32 The poor coordination of the UN agencies working in Myanmar stems from the unusual role of the UNDP, which is operating significantly differently from the other agencies (see Chapter Five), but still undertakes the traditional coordination role (Chandler 1999).
The political sensitivity of HIV/AIDS meant that, rather than targeting of high risk groups in the population, prevention programs ‘too often attract or are designed to cater to the lower-risk and less risk-seeking activities members of a given community’ (UN Theme Group for HIV/AIDS in Myanmar 1998: 24). In addition, despite the rhetoric of multi-sectoral approaches, there was little capacity to accept HIV/AIDS as a priority in non-health sectors such as drug control. This meant that the opportunity to gain control of the epidemic before it spread into the mainstream population was lost.

Therefore, over the course of the 1990s, HIV/AIDS prevention and control strategies were characterised by erratic and contradictory actions that failed to prevent the spread of HIV/AIDS. However, as the scale of the epidemic became more overwhelming and international pressure increased, the regime’s attitude seemed to change slightly, especially from the end of 2000.

Early indications that the regime’s attitude was changing came when the National AIDS Committee was revitalised and restructured in February 1998, and held its first meeting in three years, with the intention of convening every six months (Wrigley 1999: 21). One of the decisions made was to give state/division AIDS committees more authority to identify local needs for prevention strategies, although at the time their role was limited to World AIDS Day activities (UN Theme Group for HIV/AIDS in Myanmar 1998: 20). A request was submitted for UNAIDS to establish a country representative office, resulting in the first country programme advisor arriving in 1999.

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33 For example, the success of the Thai strategy was based on promoting condom use for high-risk groups (Ainsworth and Teokul 2000: 57).
34 The UNAIDS Epidemic Update in 2001 notes that ‘[i]n large parts of Asia and the Pacific, prevention programmes are poorly funded and resourced. Typically, small projects are scattered across countries and do not acquire the scale or coherence that is needed to halt the epidemic’s spread. Because many high-risk practices are frowned upon and even criminalized, there are serious political hurdles to prevention’ (UNAIDS 2001: 15). The notable exception to this trend in the region is Thailand, which runs a well-funded, comprehensive prevention program that has reduced annual new HIV infections from 140,000 to 30,000 in a decade. Cambodia’s prevention program has also been noted for its achievement in reducing HIV prevalence among pregnant women from 3.2 per cent in 1997 to 2.3 per cent in 2000 (ibid.).
35 For example, safe-injecting practices by IDUs are inhibited by the risk of being arrested on suspicion of drug abuse if in possession of a syringe or needle (Ba Thaung and Khin Maung Gyee 1995: 75). Heroin addicts are required to register with the authorities, and undertake a mandatory detoxification program (Asian Harm Reduction Network 1998). See Skidmore (1998: 268-299) for a description of drug use in Yangon, and a study of the Yangon Drug Rehabilitation Unit.
These moves were reinforced in July 1999 when the former Minister for Health, Major General Ket Sein, said ‘Official statistics show AIDS has now spread to all states and divisions. Therefore, it is required to step up the momentum in carrying out preventative and control measures’ (cited in Aung Zaw 1999).

The specific shift in the regime’s HIV/AIDS policy can be dated to January 2001, when General Khin Nyunt stated in an interview that HIV/AIDS is ‘a national cause. If we ignore it, it will be the scourge that will destroy entire races’ (Myanmar Times, 15-21 January 2001, Vol 3(46)). Being the strongest statement made on HIV/AIDS by a power-holder in Myanmar, this was interpreted by the international community as a retraction of the regime’s denial of the epidemic.

However, HIV/AIDS policy in Myanmar has never been a straightforward matter of political denial or otherwise. The regional director of UNICEF, Kul Gautam, subsequently expressed frustration at the ‘confused and contradictory signals on the HIV/AIDS situation’, and said that ‘any underestimation or belittling of the problem just delays more effective action’ (Reuters, Bangkok: 19 March 2000).

Since 2000 Khin Nyunt’s statement has been backed up by some substantial actions, which the UNAIDS director for Southeast Asia, Tony Lisle, described as an ‘absolute groundswell of change’ (San Francisco Chronical, 3 April 2003). Advances in policy (and practice) include a government-sponsored needle exchange program, and the screening of a soap opera developed by Population Services International on state-owned television that deals with HIV infection and condom use (ibid.). An extra layer of HIV/AIDS policy was added in 2000, when the government developed a four-year ‘Strategic Master Plan for the expansion of HIV/AIDS prevention and control activities’. Another indication of change is the government’s revision of its estimates of

However, high-level government statements on HIV/AIDS remained contradictory. In October 1999, the Deputy Minister for Health, Dr Mya Oo, said at an international meeting that Myanmar’s cultural values and traditions, such as the taboo against pre-marital sex, can significantly prevent the spread of AIDS (Information Sheet No. B-1109, Yangon, 15 October 1999).
PLHA in the country following a joint workshop with UNAIDS and WHO in 2002, from 33,000 to 180,000.\textsuperscript{37} In 2002, the high-profile Myanmar Business Council on AIDS was registered by the government to provide training for businesses on how to deal with HIV/AIDS in their workplace.\textsuperscript{38}

Although significant political and financial restrictions remain, these policy adjustments give bureaucrats and health workers in Myanmar greater scope to push the ‘boundaries’ in dealing with HIV/AIDS. This is an important element of policy implementation, especially for a sensitive topic such as HIV/AIDS. It seems that a large part of the program’s progress so far has been due to senior bureaucrats who are prepared to push the process ahead of official sanction (Wrigley 1999: 20-21). It has been noted that the staff of the National AIDS Programme has achieved a great deal despite the lack of staff and funding allocated to it (ICG 2002a: 5). In some cases, progress on project implementation in the border areas has been facilitated by approval from local military authorities, making possible more than was permitted by central authorities (interview 67, Yangon: October 2000).

Increased recognition of the seriousness of the HIV epidemic by the government and the corresponding need for significantly increased donor funding and coordination was backed up by further action from the international agencies present in Myanmar. The formulation of a Myanmar UN Joint Plan for HIV/AIDS 2001-2002 established a comprehensive framework for the UN response to the epidemic in Myanmar, and has been followed with a Joint Plan for 2003 to 2005.

Yet the increased opportunities for HIV/AIDS programs came at a time when international funding vital to the implementation of the National AIDS Program had decreased. UNAIDS was contributing only one-third of the amount that the Global Programme on AIDS was giving to the Myanmar program (UN Theme Group for HIV/AIDS in Myanmar 1998: 25).

\textsuperscript{37} Formerly, instead of projecting an estimate from the percentages in the sentinel surveillance surveys, the government instead based its estimate solely on the number of people identified as HIV positive in the survey (interview 72, Yangon: October 2000).

\textsuperscript{38} The International Crisis Group also lists other international interaction which indicates a trend of a more pro-active position by the government on the HIV epidemic (ICG 2002a: 8-9).
International funding is crucial, with over 50 per cent of the total annual expenditure on HIV/AIDS programs in Myanmar (US$2 million in 2000) provided by international donors (DFID 2000: 3).


The current framework for international support for HIV/AIDS prevention and care is based on the United Nations Expanded Theme Group on HIV/AIDS’ *Joint Programme for HIV/AIDS: Myanmar 2003-2005*, working in conjunction with the government’s Strategic Plan. The five objectives of the UN program are:

1. Individual risk of sexual transmission of HIV reduced;
2. Individual risk of HIV transmission among injecting drug users and their partners reduced;
3. Awareness of HIV/AIDS among the general population, particularly young people, increased;
4. Access and quality of care, treatment, and support for people living with HIV/AIDS increased; and
5. Essential elements of the enabling environment for an effective expanded national response strengthened.

39 In 2002, the UN Theme Group was expanded to include the government, donors and INGOs. Ten INGOs run HIV/AIDS programs in Yangon and Mandalay, and the border areas, serving as an implementation partner for UNICEF (see ICG 2002a: 6). Other groups in Myanmar society are involved in HIV/AIDS prevention activities, particularly religious-based community organisations.
Implementing partners for the objectives are eight government ministries, twelve INGOs, and nine GONGOs. Thus, as with most health policy, the international agencies are key drivers in facilitating implementation.

However, there is still a short-fall of funding to implement the plans; as of the beginning of 2003 the UNAIDS country coordinator, Eamonn Murphy, claimed that the program was missing US$30 million of the US$51 million budget needed for implementation (Broadmoor 2003).

The difficulties in securing sufficient funding reflect that despite the recent advances in HIV/AIDS policy, the political context of health continues to inhibit an effective response to the epidemic. The implication of this is that Myanmar’s level of development will not merely remain static, but will actually decline. The potential social, political and economic impact of the HIV/AIDS epidemic is such that it could greatly affect the nature of the state in five years or so. In relatively early stages, an epidemic can overwhelm health services. As it spreads through the population, key household and community members are lost, and a large number of children are orphaned. Later, the loss of human resources diminishes the ability of households, communities and districts to govern and provision themselves (Barnett and Whiteside 2000: 9). UNDP has found that for each one per cent of HIV/AIDS prevalence in a population, 2.2 years of progress in human development is lost. This is linked to regression in all the development indicators, as well as drops in GDP and foreign investment. The health care system is overwhelmed, both the private and public sector are affected by lost human resources, and GDP decreases as productive activity and growth slows. The manager of UNDP’s Regional Programme on HIV/AIDS and Development has said ‘[t]he epidemic is a direct measure of the failure of development’ (Brown 2001). For Myanmar, the advance of the HIV/AIDS epidemic occurred in a political environment where addressing the more difficult development problems was not on the agenda for most of the 1990s.

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40 As measured by UNDP’s Human Development Index.
Conclusion

As these three different aspects of health and the state show, the various components of the health sector have different implications and uses for state authorities. Although it is correct to say that, overall, the public health sector is neglected by the state, the case studies in this Chapter illustrate the complexities of policy development and implementation.

Certain health activities have side benefits for other state goals, and thus receive more resources and support from the political leadership. The government’s promotion of GONGOs as health charities not only provides an alternative source of health care to the community, taking pressure off the Ministry of Health, but also extends the state’s social control at the local level, through a seemingly innocuous and benevolent activity.

Of course, what the state intends and what happens can be entirely different. Instead of increasing state embeddedness within society, as the regime no doubt intents, the use of GONGOs to deliver social control through development merely reinforces community attitudes to authority (as discussed in Chapter Three). The community’s perception of the GONGOs as political organisations first and foremost means that their real penetration at the grassroots is negligible, and consequently reduces the effectiveness of their health-related activities.

Equally, the development of the border areas to promote nation-building is misguided strategy by the regime to improve state capacity, which is unable to overcome the inhibiting political context. The use of health to strengthen ceasefire agreements is regarded with cynicism by many of the ceasefire groups, whose communities have yet to receive any substantial benefits, as is the regime’s tactic of promoting equality of access to services for its allies, but elsewhere using denial of services as a tool of war.

The two case-studies illuminate how political incapacity interacts with weak state capacity in program implementation. The EPI program is an example of a situation where the policy is politically feasible, by contributing to regime priorities, but, as even with privileged sectors, weak state capacity contributes to significant implementation difficulties. The HIV/AIDS program
demonstrates a case of how policy fluctuates in response to conflicting agendas; the political and cultural obstacles to comprehensively responding to the epidemics, against the significant international pressure to do so, and, perhaps, growing awareness of the risk it poses to the country’s progress. The more pro-active policy on HIV/AIDS since 2000 indicates a growth in political capacity of the regime to address this issue, but it is unlikely to become a policy area the regime is comfortable with (as with EPI), and the contentious nature of HIV/AIDS places it at risk of policy set-backs.

Overall, although it is encouraging that the Ministry of Health has enough support to properly implement some of its activities, such as the Expanded Program on Immunisation, the danger is that the government’s selective support of politically-acceptable programs distorts the already low distribution of resources throughout the health sector, leaving potentially more urgent programs in the background, and contributing to the low capacity of the health sector. Furthermore, the politicisation of health discourages the population from utilising public health services.

Thus, the political, economic and cultural factors described in these last three chapters have shaped a public health sector that suffers from the politicisation of health issues, which results in under-resourcing, over-burdening, and lack of community support. This situation reinforces weak state capacity that prevents the state from being able to address the current health crisis, or the intrinsic underdevelopment of the country.