Chapter Five

The Politics of Health in Myanmar

Introduction

Although many people in Myanmar perceive health as apolitical, it is very much a socio-political issue. The historical context of each country – political, economic and cultural – has a huge impact on the nature of its health system. Economic factors determine a country’s ability to generate resources for health care; political factors determine the support, organisation and distribution of health services; and cultural factors affect the way that each community relates to a health system (Roemer 1977: 5-12). Along the same lines, Ashkar and Izhar (1994: 216) have written that ‘health care provision is simply a manifestation of society’s organisation and distribution of scarce resources in space’. Consequently, health sector problems are ‘a measure of social dysfunction’, reflecting ‘poverty, environmental contamination and inequity in the provision of health care in different regions’ (ibid.: 216-217). This chapter explores the political and economic context of health (while the cultural context will be addressed in Chapter Six), including factors internal and external to the regime that make state prioritisation of health politically infeasible. Specifically, it explains the context in which the distribution of state resources is determined. The following chapters look at the consequence of this distribution, attempting to provide a basis to measure the dysfunction and inequity of the state.

Health is a valuable sector through which to examine the state and state-society relations, because as it is a low priority sector for the regime, its administration is not subject to as much direct interference from the SPDC as more overtly political areas. This makes it useful to reflect the everyday side of
politics and administration in Myanmar, as well as the effects of economic and social transition. Roemer (1977: 10) makes the point that

in the larger political scene, [health care] is not a very critical issue involving power relations to the extent seen in policies on land ownership, industrial control, or foreign relations....Therefore, health programs are what some often call a convenient political football or, more accurately, the programs are highly sensitive to relatively small changes in the political balance of power.

The public health sector thus provides a valuable case study of the Myanmar state, as it is a reflection of the processes within the wider political system. Specifically, in this chapter I look at how the nature and role of the state has affected the health system, starting with a review of the historical evolution of the health system as the state has changed and adapted to new roles. Following that, I provide an overview of health and poverty in Myanmar under SLORC/SPDC, and an analysis of the political factors that influence it now, covering both the domestic and international context of health. It demonstrates how the effect of the illegitimacy of the regime on state capacity, described in previous chapters, impacts on the attempts of state authorities to achieve their goals in the health sector.

The health sector in Myanmar has always faced the same problems as those of other underdeveloped countries; these include ‘shortage of trained personnel, inadequate preventive and curative care for large populations, shortages of drugs and exorbitant prices’ (Akhtar and Izhar 1994: 216). However, these problems of state capacity have been exacerbated by the political incapacity of the state to focus on equity issues, as well as the impact of international sanctions against the regime (which will be detailed below).

The specific nature of the health system in Myanmar is affected by the role that the political leadership gives to the state. Prior to 1988 the state was centralised and interventionist, taking on responsibility for the welfare of the population, but not succeeding in meeting its obligations. The Pyidawtha campaign of U Nu’s government, and then the prominence of health and education policy during the socialist rule of the Revolutionary Council and the BSPP, were policies arising from the ideological commitment of the state to the delivery of health services. However, these governments were unable to
implement their ambitious programs because of lack of resources arising from more fundamental governance problems. As the following historical analysis demonstrates, the attempts of state leaders to undertake large-scale social development plans while preoccupied with concerns of state consolidation resulted in the incapacity of the state to develop the health sector in accordance with the importance that was placed on it in state ideology. Health services were dramatically expanded in the period after independence, but this expansion was not matched by increases in the quality of health services. The over-ambitious plans of Pyidawtha in the 1950s spread the capacity of the state too thin. Once these plans were abandoned, more modest development plans, and the efficiency drive of the Caretaker Government, seemed to presage the beginning of qualitative improvement. However, this suffered a set-back under the socialist regime. Although health spending under the Revolutionary Government and the BSPP increased almost every year until the mid-1980s, in real terms it remained at around 1 per cent of GDP. It was not so much the modest amounts spent on health that were the problem, rather that due to the ban on international investment and aid, virtually none of this amount consisted of foreign exchange currency. As a result, without the ability to import drugs and equipment, and to gain access to foreign training and innovations, standards and supplies in the public health sector rapidly deteriorated.

Nevertheless, even with the political impediments to providing health services, improvements in health status have been achieved in the past. In the decades following World War Two, most developing countries achieved a considerable decline in mortality rates. This was due to government interventions that took advantage of new technology for disease control campaigns, especially immunisation programs and malaria control, and public investments in sanitation, education and transport (Birdsall 1994: 380). This trend is evident in Myanmar, despite its neutralist, and later isolationist, policies. Many of the new programs and technologies were channelled through the agencies of the United Nations (UN), of which Myanmar has been a
member since it was formed. As a result, under-5 mortality\textsuperscript{1} decreased from 252 per 1000 live births in 1960 to 110 in 2000, and infant mortality rates dropped from 169 to 78 per 1000\textsuperscript{2} in the same time frame (UNICEF 2002: 14).\textsuperscript{3} Also, a UNICEF strategy paper (1999b: 5) remarks that ‘Myanmar is very close to achieving some important goals, particularly those relating to universal child immunisation, polio eradication and iodine and Vitamin A deficiencies’.

However, Myanmar has also followed the trend of underdeveloped countries that were unable to improve health status past this basic level. Adoption of a global policy to focus on improving primary health care (PHC) coincided with the debt crisis of the 1980s, which spurred structural adjustment policies in African and Latin American countries, aimed at reducing the role of the state. The ‘Washington Consensus’, characterised by the neo-liberal policies of the IMF and World Bank, promoted fiscal discipline, trade and financial liberalisation and widespread privatisation (UNICEF 2001: 63). Lacking a focus on equity, the consequence of this for health in many underdeveloped countries was that government responsibility for providing health care services was replaced with a philosophy of market-driven health services. International development agencies produced a number of initiatives designed to build up the role of the private sector and community contributions to relieve the state of part of its financial burden. The Myanmar government underwent the same transition more for domestic political reasons than because of the imposition of policy by multilateral funding agencies. However, the consequences have been the same.\textsuperscript{4} Although the international community has begun to acknowledge the detriment to societies of the focus on state efficiency and now advocating

\textsuperscript{1} Under-5 mortality and infant mortality rates are considered the most reliable index of human development, as they measure outcomes rather than inputs (UNICEF 2001: 21).
\textsuperscript{2} These estimates of the infant mortality rate fall at the conservative end of the range.
\textsuperscript{3} The period between 1950 and 1960 also showed a considerable improvement, as the infant mortality rate in 1950 was 304 per 1000 live births. In some towns that were filled with refugees from insurgent activity, the rate was much higher. Meiktila recorded an infant mortality rate of 821 per 1000 live births in that year (Maung Gale 1957: 18).
\textsuperscript{4} Health is not the only sector affected by the lack of government support. A report on the government’s activities in water supply and sanitation notes ‘[d]epartments working in this sector are over-staffed and under-resourced. Their productivity is severely constrained by the lack of funds available, particularly foreign exchange. It is stressed however that this is more a reflection on the low priority given to this sector by the government than a shortage of foreign aid’ (Cowater International Inc. 1993b: 2.4).
focused state intervention in development activities (see UNICEF 2001), the damage caused by state withdrawal from social development will not be easy to reverse.

Privatisation is not necessarily an undesirable trend. Controlled competition among private providers, and between the private sector and the state sector, can improve the quality and the availability of services. However, public goods cannot be left to the mercy of market forces without having a detrimental affect on equity. This is especially applicable in countries with impoverished populations. Health, education and other social services are public goods. Although, in many cases, health services are accessed on an individual level, the possible result of a literate and healthy population is undeniably a collective good. Yet, when the market is relied upon to provide financing, the services are structured to meet the needs of the provider, rather than the consumer (Abel-Smith and Leiserson 1976: 46). Unless private health services are strictly regulated by the state, consumers are disadvantaged by a limited ability to assess the quality of the services they receive, and when in urgent need, cannot shop around to find the best option (ibid.). In addition, Nancy Birdsall (1994: 378) points out that not only do most societies wish to ensure equal access to social programs, but private provision of these services does not account for the social benefits that society can derive from social services. Therefore, considerations of fairness and market failure necessitate the state’s involvement in social services (ibid.).

The SLORC’s break with socialism has had a number of consequences on state and society; for the public health sector, the government’s relegation of social development issues to a lower level of priority has been highly detrimental to the state’s ability to control the health sector. Currently, the Myanmar state is struggling with the ‘imperfect alternatives’ of state and market control. As it copes with economic transition, the state has given up sole responsibility for the delivery and financing of health care. Due to the

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5 Most of the other countries in the region are also moving towards greater privatisation, but, particularly in more developed countries, are attempting to compensate through social insurance schemes (Ramesh and Asher 2000: 104-110).
inability of the state to provide health services since 1988, the private sector has been allowed by the regime to rapidly expand to meet demand. However, private services are even less accessible to the majority of the population than public services, and are beyond the capacity of the state to regulate. Thus, in this period of transition, the Myanmar state has a limited ability to shape important groups and market forces that are changing the way that state and society relate. This means the ability of the political leadership to harness the state to fulfil goals in areas such as health is diminished.

The main difference between the health sector under SLORC/SPDC and its socialist predecessors is that health care is no longer a formal priority in the regime’s ideology. The previous chapter argued that instead of trying to use social development as a method to further state consolidation, since 1988 the regime has been following new strategies of nation-building based on a promotion of economic growth, which leaves few state resources for the development of health and other social services.

The economic transition, which epitomises the SLORC/SPDC’s political and economic strategies to further their goals, has exaggerated the changes in health policy. As such, the economic transition has resulted in a deterioration of health status that is common among former socialist countries where the state is adjusting to a new role (Orosz 1994: 276). These countries face the challenge of transforming a dual health system – a symbiosis of official state systems and a shadow private system – into a regulated public and private mix (ibid.: 285). Cuts in health expenditure, emphasis on cost-recovery systems, and development of the private sector have the common consequence, regardless of the country, of increasing inequity of access to health services and reducing the quality of health services (Asthana 1994a: 55-61).

The detrimental impact of the change in state ideology and the processes arising from economic transition on the health system have been accompanied by the political context of health, domestically and internationally (described

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6 At the same time, the regime’s lack of control does not translate as a positive factor, as public goods such as health cannot operate well without state intervention (Abel-Smith and Leiserson 1976: 33).
below), that arises from the legitimacy problems of the regime. In addition, the 
use of health as a political tool by those who oppose the regime, and by the 
regime itself, further reduces the ability of the state to improve health services. 
These three factors, some of which are directly attributable to the decisions of 
the regime, and some of which are beyond its control, significantly reduce the 
political capacity of the regime to prioritise health care.

**Historical Changes in Health Policy and Practice**

An examination of the evolution of public health care illuminates the 
factors that have shaped the health sector as it is now. Health has been 
identified as an area of individual concern over which the state has gradually 
exerted hegemony (Arnold 1993: Chapter Six). The usual sequence of health 
care development begins with the development of medical care for the elite on 
top of the traditional methods of care. Political insistence can lead to the mass 
development of curative care, and, as elites are threatened by epidemics, mass 
preventative care. As the inefficiency of separate curative and preventative 
services becomes apparent, an integrated health care system is developed 
(Taylor 1976: 289).

In Myanmar, as elsewhere, this process occurred under colonial rule. 
Generally, colonial medicine was characterised by ‘imperial arrogance’, and 
‘provided a pretext for the extension of state power into the everyday lives of its 
subjects’ (Owen 1987: 19). However, it laid the basis for acceptance that 
individual and community health status is the responsibility of government. 
The current expectation (of domestic and external political actors, if not the 
average person) that SPDC should be providing better health services to the 
population, and the SPDC’s attempts to meet this expectation, in rhetoric at 
least, has evolved from the actions of the colonial administration.

**Pre-Colonial Health Care**

Before the British colonised Burma, formal health care was 
institutionalised, although not controlled by the state. It was provided by 
indigenous medical practitioners who were trained in the medical tradition of
Ayuveda. This is an ancient Indian system of medicine that was developed in the sixth century during the spread of the influence of Buddhism, based on a scientific study of surgery and anatomy. The doctors were patronised by the sangha, which ran a system of special monasteries that served as medical schools, called pwe-kyaung. Training involved an extensive course of theory and practice, for as long as five years. The doctors, known by the title of thama, could choose to gain royal recognition through an exam. If successful this entitled them to wear court dress, to go by the more prestigious title of thamadaw, and, sometimes, to be allocated a village to ‘eat’. A report drawn up by the colonial government (but not published until after independence) stated that, despite the benefits, gaining royal patronage was not a popular option as it also obliged the thamadaw to participate in the state’s frequent military campaigns (Committee of Enquiry into the Indigenous System of Medicine 1951: 4-10).

In the pre-colonial era the sangha was a powerful institution, and its near monopoly over the medical services, along with education and other matters, was an indication of its hegemony over society. However, part of King Mindon’s reforms in the mid-nineteenth century to modernise and rationalise the state was the suppression of the pwe-kyaungs during the first half of the eighteenth century. After this, the training of thamas was done by apprenticeship (ibid.: 13).

Access to Ayuvedic doctors was restricted to the elite; the majority of the population relied on local healers (Dunn 1976: 149). The informal village healers were of varying training and skill, often of specialist categories such as bone-setting or midwifery. As the state became more rationalised, the healers outside of state influence came to be known by the derogatory title of ‘quacks’ (Leslie 1976). This process occurred in Burma towards the end of pre-colonial rule, and was consolidated by the colonial state.

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7 State officials were often paid by being assigned a village from which they had rights to expropriate a share of the produce (Taylor 1987: 26-27).
8 Leslie (1976: 3) argues that ‘the complex and redundant system of learned and humble practitioners, of full-time and part-time practitioners, of generalists and specialists, of naturalist
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Imperial Medicine

Although King Mindon restricted the religious patronage of the thamas, the colonial state was responsible for deinstitutionalising the Ayurvedic medical tradition in Burma, and depriving its practitioners of status and credibility. Western medicine was the only system given authority by the state, and as a result practitioners of Ayurveda joined the ranks of the ‘quacks’. The political deconstruction of the monarchy and the sangha by the British administration after the annexation of upper Burma in 1886 had the effect within the sphere of health services of dividing the thama into a variety of sects. Without official patronage, their social standing was said to have declined (Committee of Enquiry into the Indigenous System of Medicine 1951: 13). A colonial medical officer, Lieutenant-Colonel Ba Ket of the Indian Medical Service (IMS), described the practitioners of non-Western medicine as ‘chiefly composed of self-styled se-sayas, charletons, fortune-telling and mystagogic Phongyis and amateurs’ (ibid.: 34).

The laissez faire nature of the colonial state was challenged by an epidemic of plague soon after annexation in 1886. It became clear that the state could not ignore health matters, because epidemics of highly infectious diseases, such as plague and cholera, could undermine the colonial agenda (Furnivall 1956: 363). Epidemics not only posed a risk to the indigenous population and interfered with ‘productivity’, but also caused high mortality rates in the European population (ibid.). Therefore, in 1886 a centralised body called the Health Services Administration, headed by a sanitary commissioner, was set up to prevent communicable diseases. The initial development of health services in the colonial state was part of the attempt to improve the ‘economic efficiency’ of society from the 1880s, which included the gradual increase of state resources for the development of communication, agriculture and schools (Taylor 1987: 75). According to F.S.V. Donnison (1953: 42), the expansion of the colonial state’s welfare activities was enabled by the increase and supernaturalist curers, was ideologically simplified by the distinction elaborated in the texts between quacks and legitimate practitioners’.
in Burma’s state revenue when the opening of the Suez canal in 1869 spurred a growth in rice trade. Further, he argues that the creation of specialist departments was necessary to free up general administrative officers to concentrate on law and order problems (ibid).

David Arnold (1993: 9) asserts that under colonial rule, ‘Western medicine was intimately bound up with the nature and aspirations of the colonial state itself’. This is backed up by Furnivall’s examination of the colonial government’s welfare policies, which revealed that while the emphasis of state medicine was on preventing and containing endemic diseases, such as smallpox, cholera and beri-beri, and on curative care, it was not primarily for altruistic reasons:

though policy may be inspired by humanitarian zeal for human welfare, the spread in western medicine is dominated in practice by economic factors. The Government must provide first for its European staff and for natives in its own service, civil or military, for convicts in jail and for the requirements of criminal administration, and for Europeans engaged in economic development. Efficiency and numerous other demands on public revenue require that such services should be rendered at as little cost as possible (Furnivall 1956: 359).

In 1889 the administration’s curative and preventative health services were separated, under the Inspector-General of Hospitals and the Inspector-General of Public Health Services. Beneath them, health services were organised on the district level, run by Civil Surgeons (senior doctors) and District Health Officers (UNICEF/WHO Joint Committee on Health Policy 1980: 46). For economic reasons, medical personnel were imported, in preference to training locals. Like the rest of the civil service, most of these were from the IMS. The focus of the colonial medical department was hospital

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9 According to Owen (1987: 19), colonial medicine ‘suggested that diseases such as malaria and cholera, which had often devastated Europe itself, were primarily associated with climate rather than socio-economic conditions; it reversed earlier tendencies towards mutual borrowing, which had implied there was something to be learned from Asian medicine; it tacitly denied the role of poverty and malnutrition in causing disease, thus relieving the colonial government of responsibility; it justified racial segregation (‘the first law of hygiene in the tropics’); and it provided a pretext for the extension of state power into the everyday lives of its subjects’ (ibid.).

10 However, the colonial government had difficulty in recruiting subordinate medical staff, and opened the Burma Government Medical School in 1907 to train Burmese as hospital assistants (Ireland 1907: 736-737).

11 In 1906, only 4 of the 39 civil surgeoncies (senior medical positions) were held by Burmese (Ireland 1907: 737).
care, vaccination against contagious diseases and sanitation work (Ireland 1907: 738-742).

Until 1935, Burma was administered as part of India, and thus the health policy for India and Burma was the same (although influenced to a certain extent by local differences). Arnold (1993: 240) has written of state medicine during the colonial administration of India as ‘an imperial artifact’ that was alien to Indian attitudes and responses, and therefore ‘coercion…appeared as the dominant expression of Western medical activity’. In India, though, the state was unable to use Western medicine to displace the indigenous practitioners until the Western system eventually became internalised by the Indian elite. This was largely due to the fact that Ayurvedic and Unani systems of medicine were reformed and strengthened after the imposition of colonial rule in India (ibid.: 3). However, in Burma, colonial health policy was more successful in ignoring the extensive indigenous medical tradition that had existed before colonisation, and instead asserted an entirely different cultural medical practice that failed to gain the trust of the Burmese people (Committee of Enquiry into the Indigenous System of Medicine 1951: 34).

Generally, as the Western tradition of medicine was the exclusive source of state medicine, colonial medical services did not penetrate far beyond the urban areas. Also, as was common at the time, preventative care meant preventing epidemics, rather than the everyday causes of high mortality. In particular, a major activity of the Burma Civil Medical Department was vaccination (Ireland 1907: 739). The best medical care existed in the capital, Rangoon. Health activities of the Corporation of Rangoon were dominated by the containment of endemic diseases, through house inspections, vaccinations, anti-mosquito activities, and the running of a Contagious Diseases Hospital (Corporation of Rangoon 1939: 33-65). Some maternal and child care was available in the form of fifteen ‘lady health visitors’ (LHV), working under the supervision of two ‘lady medical officers’, and free milk distribution. In 1938, the infant mortality rate in Rangoon was 291.57 per 1000 live births (ibid.: 10-27), indubitably much lower than in the rest of the country. However, statistics rarely tell the whole story. The state hospitals and dispensaries that were open
to the poor accounted for only about one-quarter of the total. The remainder were either private, or catered specifically to people employed by the state (Ireland 1907: 735).

Meanwhile, most of the population continued to seek health care from indigenous medical practitioners in the villages, and ignored the government programs to improve health and sanitation. Furnivall (1957: p) says ‘when the sanitary inspector came to clean up their village, they would pay him a trifle to hold his nose and pass on to the next’. It was also common for officials to be bribed to not carry out the vaccination program (Guyot 1966c: 363). The villagers refused to accept the state control that the government’s preventative health care entailed, alienated by the impersonal efficiency of British administration (Furnivall 1957: p-q). As was the case in India, government officials were seen ‘more as coercive than as persuasive agents’ (Guyot 1966c: 362-363).12

Towards the end of the colonial period, access to health services was slowly being extended. The total number of hospitals and dispensaries in 1937 was 294 (Sodhi 1938: 2). This consisted of state public hospitals and state hospitals for police and other civil servants. Private hospitals also existed, some aided by the government and some non-aided, as well as ‘local fund’13 hospitals (ibid.: 7). Together, these are reported by the government to have treated over 3,523,000 patients in 1937 – at the time, 22.9 per cent of the population.14 In contrast to Furnivall, the Inspector-General of Civil Hospitals speculated that the growing number of patients treated each year was due to the growing popularity of Western medicine (ibid.: 7).

However, the capacity to expand public health services was limited by the enormous cost of administrating the state. In 1938-9, less than one-quarter

12 The public’s negative perception of state health services was not helped by the fact that the civil surgeon was also the superintendent of the district jail (Guyot 1966c: 363).

13 Local fund hospitals were entirely dependent on funds from local boards or municipalities, although they sometimes were supplemented by private donations or assistance from the government in the form of grants of medical supplies, or partial salary for the medical officer (Ireland 1907: 734).

14 The population of Burma in 1937 was 15,360,000 (source: www.library.uu.nl/wesp/populstat/Asia/myanmarm.htm).
of government expenditure was allocated to health, education and economic development, with the remainder being used for administration of the state (Taylor 1987: 112). Donnison (1953: 45) points out that the one of the main reasons that the colonial health departments failed to make an impact beyond the European and urban-dwelling populations was the limitation of funds. This contributed to widespread corruption, 'from the lowest menials who would extort their few annas before bringing a bed-pan to the bedridden, to the doctors who would reserve the more sought-after drugs for their private paying patients'. Combined with cultural barriers – the majority of the health sector staff being Indian – and lack of faith in Western medicine, these costs deterred the rural masses from utilising the colonial health services.\footnote{Roger Jeffrey's (1991: 103) analysis of colonial health care in India, presumably relevant to Burma which was administered as a province of India, argues that the colonial government cannot be blamed for its failure to extend health care to rural areas, as the task would have taken more capacity than the colonial state had, depending on 'factors outside its control as well as the constraints imposed by the nature of that government'.}

Equality and Mismanagement in the Post-Colonial State

The Japanese Occupation, while still an imposition of external authority, gave the Burmese the opportunity to run their own administration. However, social services were disrupted by the war, which devastated the economy and the country’s infrastructure. After independence, the public health sector was reoriented to a socialist style of welfare. As in India, by this time the Burmese elite had internalised the British concept of health administration and Western-style medical practice into their conception of a modern state. In 1948, the administration of preventative and curative health care was reintegrated into the Directorate of Medical and Health Services. However, key parts of the health sector, such as Women and Child Welfare, and Child Health Services, were set up as separate directorates. This resulted in inefficiency through overlapping activities (UNICEF/WHO Joint Committee on Health Policy 1980: 47). In addition, as the Burmanisation of the civil service and expansion of development plans caused a shortfall in manpower, a large number of medical personnel from India had to be contracted for the short term (Guyot 1966c: 393).
At the time, an inefficient administrative structure was hardly the greatest of the state’s problems. A big hindrance to implementation of health was the insurgent operations against the state, which were at their height during the first few years of independence, and exacerbated the difficulties of reconstructing the country after the devastation of World War Two. In 1950/51, the government was spending one-third of public expenditure on defence and police, and only around 2.5 per cent on health services (with education receiving 5 per cent of expenditure) (Tisinger, Hernandez et al. 1951: 50).

However, the control of the central government had stabilised by 1953, when, with technical advice from the World Health Organization, the administration of the whole health sector was combined into the Directorate of Health Services. This consisted of four deputy-directors respectively responsible for hospitals and dispensaries, public health, maternal and child health and school health, and laboratories. The Directorate also consisted of a number of other posts under and parallel to the deputy-directors (UNICEF/WHO Joint Committee on Health Policy 1980: 47). In addition, health policy focused on large-scale campaigns to combat malaria, leprosy and tuberculosis.

This particular administrative reform was part of a fundamental policy change. Health services were being reoriented towards the aim of social equality, which particularly meant establishing access to public health services in the rural areas. The key feature of this policy was the establishment of rural health centres (RHC), each with four sub-centres, to cater to the population in fifteen village tracts (about 15,000 to 20,000 people). The first rural health centre, the Aung San Demonstration Centre Health Unit and Training Centre, was established in 1951 in the Insein district, just out of Rangoon, as a pilot scheme. In addition to training public health workers and research, the purpose of the Centre was ‘[t]o demonstrate proven and established health

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16 For example, a report on health conditions immediately after independence said: ‘Due to insurgents activities in the rural areas, the vaccination staff of Monywa District had to be withdrawn in the early part of the year of 1949’ (Maung Gale 1957: 9).
practices not yet universally accepted in Burma and yet known to be capable of contributing materially to the health and welfare of the citizens of Burma’ (Ko Ko 1958: 1). To staff the RHCs, the first batch of medical auxiliaries was posted. They consisted of a health assistant to run the RHC, assisted by a ‘lady health visitor’, midwives, and vaccinators. This was the first time that health centres had been established in rural areas. Additionally, the ‘local fund’ hospitals were nationalised (ibid.: 48).

When the immediate insurgent threats had receded, the government was able to pursue more normal governance matters. It sought to reshape the state to better fit the socialist ideals of its political leaders, especially through the Pyidawtha program, which was described in Chapter Two. The goals of the health section of Pyidawtha were to lower various mortality rates, wipe out diseases, and ‘ensure full health for our people’ (Government of the Union of Burma 1952: 107). On another level, it was to counter the detrimental effects of the restricted and elite-oriented colonial health system – the neglect of rural areas and inadequacy of facilities in urban areas. At the time of the Pyidawtha conference in 1952, there were only 294 hospitals and dispensaries in the country. In terms of manpower, there were 552 doctors and 404 nurses employed by the state, with a further 700 doctors and 650 nurses in private practice. For public health, there were 19 doctors and 3 nurses, supported by 200 midwives, 140 lady health visitors and 209 public health inspectors. These numbers were considered extremely inadequate, especially considering that Burma at the time was said by the government to have the highest death rate in the world (ibid.: 102-103). 17 The aim of the Pyidawtha plan was to achieve improvements in the health sector through a combination of curative and preventative care: emphasising health education, disease prevention and environmental sanitation, while building new hospitals and modernising the existing ones. It was planned to have 401 hospitals in operation by 1960, 380 of

17 The government publication did not offer evidence to back up this claim, although in this case the rhetorical effect is more significant.
health standards in general rose during the Pyidawtha period, but two problems common to other welfare programs remained. One was the poor distribution of benefits; doctors were concentrated in the major cities, where a profitable private practice could be carried on. The other was a performance gap between input and output.

Nonetheless, despite the poor planning and mismanagement of the Pyidawtha program, health services were expanded to rural areas, and the infant mortality rate and the crude death rate declined (Ko Ko 1957: 8)(see Figure 5.1). By the end of the period of parliamentary democracy, the government had built 28 hospitals, established over 400 RHCs, 345 maternal and child health centres and other specialised facilities, conducted a large scale malaria-spraying campaign, and ran training programs to expand the numbers of health staff (Walinsky 1962: 364-365). Walinsky says that ‘[t]he scope and size – if not the quality – of the welfare facilities and services provided during the development period were nothing short of remarkable’ (ibid.: 364).

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18 Walinski (1962: 105) wrote of the Pyidawtha health program: ‘this well-thought-out and essential program was undertaken with only a limited notion of the nature of the capital costs that would be required over a period of time, and without any reliable estimate of the impact which the large numbers of additional personnel contemplated would make on the Government’s current budget’.

19 The expansion of health services and personnel was matched in the education sector. Public expenditure tripled over the 1950s, and the expansion of schools and teachers enabled an increase in enrolments from 666,000 in 1953 to 1,764,000 in 1959-60 (Walinsky 1962: 365-366). The huge increase in numbers of teachers was achieved through two-month ‘emergency training’ courses, which were run from 1952 to 1955, and again in 1958 (Oo Khin Hla 1992: 4). But while this was necessary to staff the new schools being built under the education plan, it initiated a policy of favouring quantity of teachers over quality.
It was the failure of social policy, as much as political infighting, that gave Ne Win’s Caretaker Government the opportunity to reform administrative practice so effectively. A government publication, *Is Trust Vindicated?*, chronicled the ‘outstanding achievements in the Medical and Health Services during the period of tenure of the Government headed by General Ne Win’ (Director of Information 1960: 474). While in power from November 1958 to February 1960, the Caretaker Government tackled mismanagement and inefficiency in the health sector. Measures taken included: remodelling, extension and modernisation of Rangoon General Hospital, improvements in administration of that and the Central Medical Stores Depot, and construction of seven hospitals and forty-nine RHCs. There were also increases in the numbers of doctors, nurses and paramedical staff in government employ; doctors were sent to rural posts that previously could not be filled. The Caretaker Government also claimed substantial increases in attendance at RHCs and improvements in the performance of polyclinics in Rangoon, maternal and child health centres, and training institutions (*ibid.*: 474-488). This period produced an administrative efficiency previously not experienced in the country, but, as in the colonial period, coercion was a notable element in

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20 It should be noted that all statistics on mortality and morbidity in Burma until the 1980s were derived from hospital records. This enabled the government to report an infant mortality rate of 40 per 1000 live births in 1982 (O’Brien, Mays et al. 1985: 9). When midwives began collecting data directly from households, it became apparent that infant mortality rates and other death rates were much higher than had previously been reported. (*ibid.*).

21 The Caretaker Government maintained capital expenditure on development programs at the same level as the previous government. The main difference was that instead of financing them
policy implementation. In health, as other sectors, the militarisation of administration was able to briefly compensate for institutional weakness.

**Health and the State under Military Rule**

The Revolutionary Council did not continue the Caretaker Government’s directions in health policy. Whereas the AFPFL’s health policy was more socialist than the Caretaker Government’s efficiency-oriented reforms, the Revolutionary Council was much more progressive than either, implementing a complete nationalisation of health services in order to achieve universal health care. This meant that social development became an even greater priority of the state (at least rhetorically), and the main motivation of health policy was to achieve principles of equality and social justice, with an emphasis on addressing the urban/rural gap in services. As Taylor points out, the socialist government attempted to use social development instead of religious patronage to create legitimacy (Taylor 1987: 359). Of course, these principles were not radically different from the goals of U Nu’s regime, but the manifestation of policy implementation was. *The Burmese Way to Socialism*, says,

> The Revolutionary Council believes that...social services such as Health...shall flourish in direct proportion to the tides of socialist success like the lotus and the water’s height, and will accordingly work towards this end (Revolutionary Council 1962).

Indeed, the quality of health services was a good indicator of the success of socialism, although not in the positive manner that was intended. The participatory and non-exclusive concepts of Primary Health Care, a global policy promoted by WHO from 1978, fitted with the socialist ideal that the BSPP wanted to promote. Yet the implementation of PHC suffered from the same systemic problems that plagued ‘the Burmese Way to Socialism’ as a whole, namely the regime’s emphasis on control and the consolidation of the military state at the expense of the socialist ideology that was ostensibly the foundation of military rule.

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through foreign loans, as the AFPFL did, the Caretaker Government accepted foreign grants (Walinsky 1962: 260-261).
Health care reform, as with agricultural policy (see Chapter Two), was aimed at securing the support of the masses for the new political order. The first major reforms in the health sector, designed to achieve universal health care, were the abolition of the private wards in hospitals in 1963, and then the nationalisation of private hospitals in 1966. The Directorate of Health Services was reorganised in 1965, along with other government ministries, in an attempt to decentralise governance. The administrative regions of the country were reduced from fourteen to six, and an extra level was set up in the bureaucratic hierarchy at the division level. However, the township remained the main unit of local administration, represented in the health sector by the township medical officer (TMO), who was ‘responsible for execution of all the functions of the Health Department’ (Ko Ko 1965). The reforms also included the introduction of the station health unit, beneath the township level, which comprised a 16-bed hospital (mostly upgraded from a rural health centre), a station health centre and four to six RHCs (ibid.). A senior bureaucrat wrote at the time that:

Mobilising all available resources, the new organisation was moulded with the sole aim of extending its frontier to the workers and farmers in the country, embracing them all. The new setup also envisages a completely integrated health service from the top most to the lowest rung. It plans to practise preventative and social medicine with the base at the hospital. There will be unification of health services of Burma proper and the States; there will also be merging of health services of central government and Local Body Administration. The new organisation will offer best opportunities for centralisation of planning, with decentralisation of responsibility and authority (ibid.).

However, in 1972 the old fourteen administrative divisions were restored when the Security and Administrative Councils were reorganised in preparation for the new political system. The unwieldy secretariat system was also abolished.

After ten years, the Revolutionary Council’s quest for universal health care had made some progress. The number of hospitals had increased from 288 in 1964 to 427 in 1974 (Health Statistics Division 1975: 26-27).22 Smallpox was

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22 The share of capital expenditure in the health budget increased under the Revolutionary Council, from Kt1,891,000 (and Kt52,874,000 recurrent expenditure) in 1961-62 to 4,627,000 (and 59,335,000) in 1962-63, the year the Revolutionary Council took power. However, after capital
eradicated in 1970, as part of the global effort. Government researchers reported drops in the crude death rate, and in maternal mortality and infant mortality, and a corresponding rise in the health consciousness of villagers (although without detail of how this was measured) (Kyaw Sein et al. 1983: 2).

A study of a village in lower Burma in 1980 noted that health and sanitation conditions had improved since 1960, and villagers were more likely to utilise the government hospital and dispensary, if they could afford it (Mya Than 1987: 79). However, it was also obvious that providing universal health care in a declining economic system was untenable. Government expenditure on health increased eight-fold between 1963-64 and 1987-88, in order to compensate for population growth and maintain expenditure at around 1 per cent of GDP in the entire period (Aung Kyaing and Naing Oo 1988: 40). But this was not enough to cover the expanding activities of the state, arising from the government’s desire to monopolise health care delivery, and the development of new health care and disease prevention activities by international organisations.

Overall, health services suffered because the regime’s emphasis on principles of social equity in its political ideology was outweighed by the emphasis on independence and self-sufficiency in government policy. The implementation of social development policies was undermined by another key element of socialist policy, an isolationist foreign policy. The military’s efforts to shut out external political and economic influence on the state included restrictions on foreign investment and humanitarian aid. These factors, along with the extreme application of socialism in the early 1960s that abolished the private sector and distorted economic production and services, led to rapid impoverishment. Health services declined as supplies were not replenished and buildings not maintained. After the first few years of the nationalised health system, maintenance and facilities in the hospitals declined. Patients often had to provide their own bedding, and either rely on their families for

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expenditure peaked at Kt15,016,000 (compared to 85,901,000 in recurrent expenditure) in 1966-67, the share of capital expenditure gradually declined each year, as the health budget went to maintaining the health system as it was (Health Statistics Division 1975: 67).
meals or a give a ‘donation’ to the hospital to provide them (interview 59, Yangon: September 2000). The quality of medical training declined to the extent that the British General Medical Council withdrew recognition of medical qualifications from Burma in 1973 (A Correspondent in Rangoon 1984: 30).

The BSPP and Primary Health Care

Although the concept of primary health care was initiated in Burma in the 1950s, its formal adoption as the key policy to implement the government’s goals for social equality occurred in 1978, after WHO’s Alma Ata Declaration proclaimed it as the method to achieve the global goal of ‘Health For All by the Year 2000’. The aim of the Primary Health Care approach is to concentrate sparse resources on low-level but widespread health interventions. This is achieved through networks of basic health staff who require only limited training, but can reach much more of the population than traditional health staff like doctors and nurses. Instead of spending on curative care, particularly hospitals, primary health care is based on preventative actions against fundamental causes of mortality and morbidity. The eight basic principles of Primary Health Care, which the government has defined as its PHC approach since it embraced the ‘Health For All 2000’ goals are: health education, an adequate supply of safe water and basic sanitation, maternal and child care (including family planning), immunisation against the major infectious diseases, promotion of food supply and proper nutrition, treatment of common diseases and injuries, communicable disease control, and provision of essential drugs (Mya Oo 1997: 174).

Formal long-term health planning was revived under the BSPP. The People’s Health Plan (PHP) I, which began in 1978 and ran until 1982, was

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23 This was followed by the People’s Health Plan II (1982 to 1986) and People’s Health Plan III (1986-1990). The original policy intended to take it up to People’s Health Plan V, finishing in 1998. By this stage the requirements of Health For All 2000 were expected by the BSPP government to have been met.
based on the Health For All goals, as well as the Twenty Year National Plan for Economic Development (1973-1993).24

The health system under the BSPP was conceptually a continuation of the Revolutionary Council’s policy. Organisationally, the BSPP’s policies laid down the basic structure of the health system that had been evolving since the early 1950s, and has remained mostly unchanged since the 1970s. Likewise, the cultures of health administration, and most of the management problems that emerged then, remain. A study in 1985 concluded that ‘a major weakness, if not the foremost…is the lack of organized, objective-oriented management at most levels in the health care system’ (O’Brien, Mays et al. 1985: 65). Despite changes in health policy by the BSPP, the implementation difficulties remained, as the fundamental impediments were still not being addressed. Even at the beginning of the large policy commitment to Health For All, insufficient money was being spent on the social sectors. In 1978, health expenditure remained at 1 per cent of GDP (Burma Ministry of Health 1983: 4). The capacity of the state was already run down and not capable of meeting such ambitious political commitments.25

In order to implement primary health care as WHO defined it, the BSPP introduced volunteer health workers to take health services deeper into the community. These were community health workers and auxiliary midwives, set up to work out of sub-rural health centres under the supervision of midwives. The PHC concept also included giving formal training to traditional

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24 The Twenty-Year Long-Term Plan ‘set economic ratios for the entire nation for production, consumption, and investment as well as ratios which ought to be established between different sectors of the national economy, and finally that the Ministries concerned are to be responsible for determining ratios with different sectors and for formulating relevant detailed programmes of work through thorough co-ordination with the departments and regions concerned’ (BSPP 1985: 47). It was to be implemented through five four-year short-term economic plans.

25 The socialist state’s efforts to achieve free, universal education fared no better than the quest for universal health care. Although government statistics showed improvements in enrolment rates and teacher-student ratios over the following decade, the school system was characterised by high drop-out rates after the first year of primary school, problems with the curriculum and examination systems, and a need to improve the quality and quantity of teacher training (UNICEF 1976: 11-16). Many of these problems stemmed from the socialist government’s efforts to expand education, even though expenditure declined continuously after 1965, resulting in an extensive but low-quality system (Steinberg 1981: 97). By the 1980s, 71.5 per cent of children were dropping out of the primary education system, almost half of those after the first year. Only 10 per cent of students completed primary education in the allocated five years (Williams 1990: 8).
birth attendants, elderly women of the village who performed midwife duties in return for non-financial remuneration. The village tract people’s council was made responsible for selection, recruiting and administrative supervision of the volunteer health workers, although RHC staff were responsible for technical supervision (O’Brien, Mays et al. 1985: 21).

However, the volunteer health workers did not receive the supervisory support that was intended to go with their positions. Again, this came back to the management problems of the health system and, indeed, governance problems in the political system as a whole. A mid-term evaluation of the PHP I, while claiming that 86 per cent of the six main projects had been performed, listed a variety of problems ranging from lack of supervision and inadequate organisation structures to shortages of technical and clerical staff, lack of interest and motivation, and lack of facilities, equipment and transport. In addition, there was poor coordination at all levels and lack of intra- and inter-sectoral coordination (Burma Ministry of Health 1983: 5).

Furthermore, during the implementation period of the PHP I, only 30 per cent of total current expenditure on health went to PHC activities. About 70 per cent of expenditure was still going to hospital services, in particular to pay salaries, and therefore, despite PHC being the major goal of health policy, primary care remained resource-deprived and mismanaged (UNICEF/WHO Joint Committee on Health Policy 1980: 38). The population per RHC averaged 19,295 across the country, but was as high as 28,308 people per RHC in the Mon state (Kyaw Sein et al. 1983: 17). In addition, 69.7 per cent of the population lived more than an hour’s walk from a health care centre, the distance that Ministry of Health researchers considered to represent accessibility (ibid.: 20). Where RHCs did exist, many were negatively affected by overburdened staff and shortages of equipment (O’Brien, Mays et al. 1985: 20).26

26 Health coverage was concentrated in the 209 townships in the central parts of the country under government control. The remaining 109 townships were in the periphery of the state, mostly under control of insurgent groups (Myanmar Ministry of Health 1993: 3). The ceasefire agreements between the government and many insurgent organisations since 1989 have had a major impact on the ability of the state to expand health services.
Of course, despite the limitations of the BSPP’s health sector, access to health services did expand during the socialist era. One indication of the pace of primary health care development is in a study of 47 RHCs conducted in 1987. Twelve of these were built during the 1950s, 16 in the 1960s, 12 in the 1970s, and the remaining 7 between 1980 and 1986 (Training Division 1987: 20). However, given the importance of health in official government, the progress made was modest, hindered by the regime’s preoccupation with challenges to its authority.

By the end of PHP II, a UNICEF consultant wrote that:

The commitment to PHC by the political authorities can be increased. People’s Health Plan has not been widely disseminated to potential collaborators and to the community, hence intra/inter project coordination has remained weak and little support has been extended by the non-health sectors. Delays in staff and facility expansion have been major constraints hindering further progress of PHC activities…township health departments have not been adequately strengthened to cope with the multitude of responsibilities assigned to the TMO (UNICEF 1985: 17).

The socialist state could not undertake the economic and administrative reforms necessary to achieving its goals in the health sector, and therefore was unable to implement its policy, even with considerable utilisation of mass organisations. This was a serious failure of the state, not just because of the cost to health status, but also because health and education policies were the main contributors towards performance legitimacy. Although, ‘in macro terms, between 1962 and 1980, significant advances were made in the development of education, health and other services designed to raise living standards….it is not possible to know to what extent the population credits the state with these improvements’ (Taylor 1987: 359-360). It is probable that these improvements were not sufficient to generate performance legitimacy for the state.

In the mid-1980s, the increasing impoverishment of the country made any advances in the implementation of PHC policy even more unrealistic, and the state found it more difficult to maintain its hegemony of social services. For example,

Hospitals, like schools, are not completely free, and individuals seek to use private medicine and education facilities whenever possible. The state thus devotes a good deal of attention to trying to limit the activities of private schools and of doctors, who, working privately, can earn large incomes (Taylor 1987: 360).
Chapter Five

The private service industry flourished throughout the socialist era in response to need, but towards the end it became particularly difficult for the government to control. In 1981 a UNICEF/WHO report stated that in Burma, ‘private medical expenditure is the major component of total health care cost and accounts for some four-fifths of the country’s…expenditure on health care’ (UNICEF/WHO Joint Committee on Health Policy 1981: 55). The response of the government was to halve the intake of students into medical schools in 1984, claiming that the output of medical graduates was too high for the health system to absorb (A Correspondent in Rangoon 1984: 31).

In fact, the extreme centralisation of the economy did not last beyond the 1960s, and the government relied on significant community contributions to carry out its health activities. For example, in Hwambi Township more than one-third of the cost of two health centres built between 1974 and 1979 was borne by the community (UNICEF/WHO Joint Committee on Health Policy 1980: 41). By 1985, the Ministry of Health and other government agencies contributed only an estimated 34.2 per cent of total expenditure on health. Foreign aid accounted for 11.8 per cent of expenditure, while 54 per cent of expenditure of health came from private households and charitable donations (Aung Kyaing and Naing Oo 1988: 44).

During the last few years of BSPP rule, the spending priorities of the socialist government were not very different from those of their successors. In 1988, just before the SLORC coup, over half of expenditure on state administrative organisations went to what a UN report defines as ‘non-productive sectors’ (such as administration, finance and defence), while ‘human capital development sectors’ (including health, education, labour and social welfare) received 24.4 per cent of total expenditure, and ‘productive sectors’ (agriculture, industry, construction, trade and so on) received 22.1 per cent. In addition, as the budget allocations were based on low capital allocation, and most of the recurrent expenditure went to wages and salaries, it was calculated that less than half of these budget resources benefited the poor. The report, written in 1992, concludes that ‘this is the main reason why poverty prevails in Myanmar’ (Fredriksen and Jourdan 1992: 54).
As Figure 5.2 demonstrates, there were large increases in health expenditure during the period of the *Pyidawtha* plan, declining slightly in the late 1950s. Under socialist rule, spending had declined, and remained at a similar rate throughout that period. Capital expenditure increased sharply during the early 1980s to implement the Health for All program, but could not be sustained.

**Figure 5.2: Spending on Social Services as a Percentage of Government Expenditure, 1949/50 to 1988/89 (selected years)**

Despite a greater policy commitment to social equity, the socialist state had no more capacity for service delivery than the current state, and the condition of the public health service was not much better than it is now. Under both socialist and non-socialist regimes, the health sector has suffered from economic policies that are perceived as central to state-building, but have the (unintentional) consequence of weakening the state’s capacity to deliver even basic social services. However, more checks against economic policies detrimental to the development of the state existed under parliamentary democracy, which, though far from perfect, was slowly becoming more moderate in its planning. Under military rule, however, all such checks have been eradicated.
It is arguable that poverty has increased even more since the beginning of the SLORC era. Although the capacity of the health sector under bankrupt socialist rule had already declined considerably by the 1980s, the problems in the health sector have been exacerbated by the increased economic and political incapacity of the state to focus on social development that has resulted from economic transition and related political changes. Within the region, only Cambodia, Laos and Bangladesh exceed Myanmar’s low level of development. Table 5.3 compares Myanmar’s key development indicators with those of countries in the region with varying levels of development.\(^{27}\) When comparing

\(^{27}\) In the region, apart for the very low-income countries of Cambodia and Laos, only Indonesia shares comparative government neglect of the health sector. See Achmad (1999) and Corner and Raharjo (1995).

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### Table 5.3: Comparative Regional Statistics on Health and Development

<table>
<thead>
<tr>
<th></th>
<th>Medium Human Development</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Malaysia</td>
<td>Thailand</td>
</tr>
<tr>
<td>Human Development Index rank</td>
<td>59</td>
<td>70</td>
</tr>
<tr>
<td>Life Expectancy at Birth (years) 2000</td>
<td>72.5</td>
<td>70.2</td>
</tr>
<tr>
<td>Adult Literacy Rate (% age 15 and above) 2000</td>
<td>87.5</td>
<td>95.5</td>
</tr>
<tr>
<td>Combined Primary, Secondary and Tertiary Gross Enrolment Ratio 1999</td>
<td>66</td>
<td>60</td>
</tr>
<tr>
<td>GDP per Capita (PPPUS$) 2000</td>
<td>9,086</td>
<td>6,402</td>
</tr>
<tr>
<td>Improved Water Sources (%) 2000</td>
<td>n.d.</td>
<td>20</td>
</tr>
<tr>
<td>Health Services (%) 1990-98*</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td>Adequate Sanitation (%) 2000</td>
<td>n.d.</td>
<td>4</td>
</tr>
<tr>
<td>Under Weight Children Under 5 (%) 1995-2000</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1000 live births) 2000</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Under-5 Mortality Rate (per 1000 live births) 2000</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>Maternal Mortality Rate (per 100,000 live births) 1985-1999</td>
<td>41</td>
<td>44</td>
</tr>
</tbody>
</table>

Myanmar with India and Cambodia, which share similar HDI rankings, and Laos and Bangladesh, which have much lower rankings, Myanmar’s indicators are erratic in levels of development. Myanmar generally rates better in levels of adult literacy, access to safe water and health services, and infant and maternal mortality rates. In terms of life expectancy, enrolment ratios and access to adequate sanitation, it is merely on par with its less developed counterparts, and in some cases, has worse ratings. In particular, the high level of under-5 mortality rates in Myanmar is only surpassed by Cambodia – both these countries have a higher disparity between infant mortality rates, and under-5 mortality than Laos and Bangladesh, presumably because in the lower developed countries most deaths occur in the first year of life.

Rarely in Myanmar do statistics reveal the true picture. The fact that Myanmar’s purchasing power parity is significantly lower than all countries in the region, including Laos and Bangladesh, casts doubt on the true level of access to health services. As Chapter Six reveals, one of the greatest barriers to health care is people’s ability to afford it. The accuracy or representativeness of the statistics also needs to be questioned. The examination of the education system in Chapter Six throws doubt on the level of adult literacy claimed by the government, and Chapter Seven shows how the relatively low national statistic for malnutrition (as measured by underweight children under 5) is undermined by large regional disparities. The maternal mortality rate is a result of projections from old statistics and more recent partial studies. Indeed, the large difference between Myanmar and its counterparts in this area suggests that the true rate may be much higher. The UNICEF website publishes a revised statistic on maternal mortality for 2000 at 360 per 100,000. Moreover, while the other countries of South Asia and Southeast Asia have improved their ranking in UNDP’s human development index in the last two years, Myanmar’s has declined from 125 to 127 (UNDP 2000b, 2002).

Two main factors affecting budget allocations have changed: first, the abandonment of socialist economic policy, which has led to government policy that emphasises the contributions of the private sector as an alternative to
government spending; secondly, the decline of political capacity to channel the resources of the state into poverty alleviation.

These issues are reflected in SLORC/SPDC’s allocations of public funds. In 1989/90, just after the change of regime, public expenditure on health as a share of GDP was 0.6 per cent. By 1998/99, it had declined to 0.1 per cent (EIU 2002a: 22). In the opinion of the UN Working Group (1998: 30), ‘the consequences of these cutbacks in health expenditure are largely responsible for the deceleration in health attainments’.

As Figure 5.4 demonstrates, Myanmar’s public spending on health and education is significantly lower than its ASEAN counterparts. With combined health and education spending at 1.4% of GDP, it is half of the next lowest social spender in the region, Indonesia (at 2.2%), and notably lower than the less developed countries of Cambodia (3.5%) and Lao PDR (3.3%). Myanmar also contrasts with the rest of the region in spending more on defence than health and education combined.

![Figure 5.4: Public Expenditure on Health, Education and Defence in Selected Countries](image)

At this point it might be asked whether it if fair to expect the Myanmar state to be responsible for the health of its citizens? In many respects, the poor capacity of the public health sector is not different from that of most developing countries, where mismanagement of resources, manpower problems and bureaucratic bottlenecks are common.

However, in Myanmar the state has taken the responsibility for social development upon itself in the process of centralisation, and tied it to legitimacy issues. Historically, this has occurred by integrating health services
into the development of the state. In more recent times, the state has taken aboard the international expectations of state responsibility for promoting social development, which are primarily determined by the standards and priorities of multilateral institutions like the WHO. The state is once again expected to play a major role in reducing morbidity and mortality, within WHO’s lofty policy objectives of ‘making health central to human development, and developing sustainable health systems to meet the needs of people’ (WHO 1998c: vi). Good governance is considered an essential element of meeting these objectives, through ‘dynamic leadership, public participation and support, a clear sense of purpose and adequate resources’ (ibid.: 8).

When the SLORC brought the country out of its isolation, it did so with the explicit aim of being identified as a good global citizen, and being seen to conform to the international norms for social development has been a major element of this desired image. Consequently, SLORC/SPDC has committed Myanmar to numerous international and regional health or health-related conventions, including the Convention of the Rights of the Child (CRC). Generally, this commitment leads to related policy development. In the case of the CRC, this was followed up by the enactment of The Child Law and the establishment of the National Committee on the Rights of the Child in 1993.28 Further, this commitment to social development has been affirmed domestically, in the government’s stated social objective: ‘Uplift of health, fitness and education standards of the entire nation’, which is proclaimed in every newspaper and publication, as well as on billboards around the country. Thus, while health is not a key part of government ideology as it was prior to 1988, the regime has taken the obligation upon itself by including health

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28 UNICEF describes the adoption of the CRC by the international community as ‘a watershed’, which ‘presented a coherent vision of children’s rights and how society should provide for them - expressed in terms of a legal document that asked national governments to sign up to those terms and thereafter be held accountable to them’ (UNICEF 2001: 35). Other international initiatives which the SLORC/SPDC have committed to include the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), goals outlined at the World Summit for Children, plus international initiatives on Health for All, Sanitation for All, Universal Salt Iodisation and Polio Eradication.
improvement as one component of the transition to a modern and developed nation.

**Poverty and Health Crisis in Myanmar**

For most countries, impoverishment is also related to structural inequity of the global economy. As already mentioned, in the case of Myanmar, mismanagement by the government has been the most significant cause, as the military regime of Ne Win deliberately shut the domestic economy off from the world for almost three decades, and then the actions of his successors spurred sanctions that have distorted the input of international investment and aid. It is significant for Myanmar’s development that, due to its self-imposed isolation, it has never undergone a structural adjustment program of the World Bank or IMF, and did not experience the full impact of the debt crisis that preceded these programs. However, results are the same: rising unemployment, fall in real wages, landlessness and urban migration, cuts in public expenditure, and emphasis on cost recovery that makes public services inaccessible to the poor (Asthana 1994a: 55).

Poverty is the root cause of the majority of deaths from preventable disease. A synergistic cycle of malnutrition and infection are the cause of most mortality in developing countries, especially among children (ibid.: 56). Health indicators for Myanmar show a country that has barely begun to undertake a health transition away from very high mortality and morbidity rates arising from preventable diseases.\footnote{A health transition encompasses both the changing patterns in the causes of death (from infectious diseases and nutritional and reproductive health problems among populations with high mortality rates to chronic and degenerative disease in populations with low mortality rates), and the social and behavioural changes that parallel epidemiological change (Murray and Chen 1994: 3-6).} UNDP’s *Human Development Report 2002* conservatively estimates that infant mortality is 78 per 1000 live births, although other estimates take it as high as 105 per 1000 (Chandler 1998: 249; UNICEF 1998a). It is worth noting that UN estimates of Myanmar’s health indicators, such as infant mortality and under-5 mortality, dropped significantly in recent
years as the UN agencies began accepting the results of government studies, instead of projecting their own figures from government statistics.

If a child survives the first year, the risk of mortality remains high, with an under-5 mortality rate of 110 per 1000 live births (UNDP 2002). Estimates of the maternal mortality ratio range from 230 per 100,000 live births (ibid.) to as high as 580 per 100,000, almost half of which is due to complications from abortions (UNICEF 1998a). The high maternal mortality rate is one consequence of the differential effects of underdevelopment on men and women, which means women carry a greater burden of the health crisis. Gender differences in levels of health, and accessibility and utilisation of health services, contribute to this (Lewis and Kieffer 1994: 123-124). A combination of the risks of reproductive health, low social status and poor environmental conditions make the most powerless members of a society the ones most affected by the synergy of poverty and ill-health (Price 1994: 139-140).

After childhood, the quality of life is quite low, and threatened by frequent disease attacks (Kloos 1994: 205). Fifty-two per cent of the population do not have access to health services (UNDP 2000b), and 32 per cent do not have access to safe water (UNDP 2002). Although more people have gained access to improved water sources in the last decade, a 1993 report indicates two trends: that most improved water sources are provided by the private sector or community sources, and that there is an urban bias (Cowater International Inc. 1993b: 4.13).³⁰ Despite the myth perpetuated by the SPDC that no one goes hungry in Myanmar (AFP, Yangon: 19 August 2001), government data shows that 38.6 per cent of children under five are moderately malnourished, while

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³⁰ According to the report, most of the water supplied by the government is untreated river water (Cowater International Inc. 1993b: 4.13). Cowater International notes that ‘village water supply is predominantly constructed, owned and paid for by the villagers themselves. Government share in financing the construction of rural water supply system is mostly limited to handpumps, motorized pumps and stand posts which represent 3.2% of overall rural protected water supply coverage’ (ibid.: 4.16). Water supply in the major urban areas is better, with a protected water coverage rate of 54 per cent in Yangon, and 61 per cent in Mandalay in 1993 (ibid.: 4.17).
12.6 per cent have malnourishment in the severe category\textsuperscript{31} (Department of Health Planning 1999b: 28).

There is high incidence of preventable disease, especially malaria, which causes 3,000 deaths each year (UNICEF 1999a: 7) as well as recurring illness\textsuperscript{32} and the rates of tuberculosis and leprosy are among the highest in the world. In 1998, Myanmar ranked seventh amongst leprosy-endemic countries, with a prevalence rate of 2.74 per 10,000 (WHO 1998b). In addition, WHO has listed Myanmar among the 22 countries that account for over 80 per cent of the world’s tuberculosis burden (WHO 1998a). Especially alarming is the rapidly expanding HIV/AIDS epidemic, which will be examined in detail in Chapter Seven.

These poor health conditions reflect the poverty that affects most of the population. A UNICEF report (1999a: 6) states that ‘the vast majority of deaths and illnesses are due to inappropriate or insufficient care and knowledge, most frequently stemming from insufficient resources on the part of households and the national authorities’.

Many households can barely meet their survival needs. In 1996, an INGO estimated that the average monthly income for the rural population is Kt2000, and Kt3000 (at the time, US$12.5 and US$18.75 respectively) for the urban poor that live mainly in the resettlement suburbs on the outskirts of Rangoon and Mandalay (World Vision Myanmar 1996: 3). The majority of sex workers, street children and vendors come from these suburbs (interview 51, Yangon: August 2000; interview 54, Yangon: September 2000).\textsuperscript{33} The bulk of this, an average of 71 per cent of monthly household income, is spent on food

\textsuperscript{31} Although these percentages are already high, Chandler (1998: 250) points out that they are probably understated as the government midwives who are responsible for collecting the data are usually too busy to weigh most of the children in the villages to which they are assigned. It is estimated that only one in every five villages is covered.

\textsuperscript{32} A major causal factor for the high transmission of malaria is large-scale, short-term migration within the country, as the poor rural population searches for seasonal work. Malaria reduces productivity and earning potential, thus exacerbating the conditions of poverty that make people susceptible to transmission. The disease is a large socio-economic burden on the country (Murti 1998: 1-5).

\textsuperscript{33} In 1989, the government forcibly removed inner-city squatters to suburbs on the outskirts of the main urban areas. It has been estimated that the population affected by the resettlement was 1.5 million, or 4 per cent of the population at the time. More than half of the relocations
Even that is often insufficient. Many households living in the poor urban areas are surviving on day-to-day vending or construction work, and may be able to eat only once a day (Clawson and Keller 1999: 7-8). Anecdotal evidence shows that many families ‘will drink rice water for nutrition, and drink tea at night to stave off hunger pangs. It is not uncommon for families to eat meat only two times per week’ (Chandler 1998: 249). Children are kept out of school to contribute to the household income, illness inevitably leads to indebtedness, and the burden on women is intensified as financial difficulties drive many men to alcoholism, gambling and abandonment of their families (see Clawson and Keller 1999: 7-9). Some families are forced by their poverty to sell their children as domestic servants to wealthy families, or into prostitution (Boyden 1991: 4). Dr Jocelyn Boyden (1991: 4) explains that many young girls ‘entered prostitution at the behest of their parents or to help them financially. Prostitutes may be the sole breadwinner in the family, sustaining drug-addicted fathers who are unable or unwilling to work’. Prostitution can also result from illness in the family. Most of the prostitutes in the border town of Kawthaung are from the urban slums of Yangon, and had recently lost a parent (Chandler 1998: 261).

This pattern is common in transitional societies, as a decline in social and cultural values undermines ‘traditional’ social cohesion. Within a few years of the start of economic transition, the negative impact on vulnerable parts of the population was apparent. A UNICEF report on children in especially difficult circumstances in Myanmar noted ‘[e]conomic conditions in particular have eroded support structures and threatened traditional values, exposing children to exploitation, abuse and separation from their families’ (ibid.: 3).
In the remote border regions, where slash-and-burn agricultural methods are common, the situation can be even more desperate, because the harvest is often marginal and will not produce enough rice to last through the year (interviews 33, Kachin state: June 2000). In the Wa regions, a major factor contributing to the widespread cultivation of opium is the extreme impoverishment of most rural households, which have rice for only four to six months of the year (Welsh 1993: 3). In the early 1990s, a quarter of the population in this region was described in a UN report as living in abject poverty, defined as the inability to afford minimum nutrition standards and other basic necessities required to live decently. Female-headed households dominate the poorest strata of society (Fredriksen and Jourdan 1992: 19). The central plains, where most of the Burman ethnic group live, appear to have some of the poorest of the poor in the country. The same report found that the dry zone states (Sagaing, Mandalay and Magwe) have a ‘most alarming’ poverty incidence, with 56 per cent of the rural population earning 19 per cent less than the poverty income threshold, and the remaining population earning two to four times less (ibid.: 24). Generally, most rural households barely earn enough to cover living expenses, while households with less than 4.5 acres to cultivate live below subsistence level (Thawnghmung 2001: 131). Statistics indicate that more that 40 per cent of the population lives below the poverty line in some parts of the country, with a national average of 23 per cent (IMF 1995: 30-31). Forty per cent of the population is landless (Steinberg 2001b: 46). Moreover, unlike the rest of the region, where poverty is concentrated in rural areas.

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37 David Tegenfeldt (2001: 113) points out the situation in these regions is complex and varying, and ‘populations in certain rural areas which are emerging from thirty years of war describe their situations as becoming relatively better than before, while many in these same areas and in other areas of the country find themselves sliding into a progressively worse situation – one in which they are struggling to meet their basic needs’.

38 Despite the growth in power and riches of the UWSA, the life of the average person living in the Wa special administrative region remains extremely impoverished (interview 19, Yangon: March 2000; personal communication: January 2002).

39 Calculated at two-thirds of GDP, to account for the large influence of the informal economy.

40 The average wage in rural areas of the dry zone and delta was 100-150 kyats per day in 1998, which would buy about half of the daily rice requirements of a typical family. Thus, according to David Dapice (1998a: 7), ‘[a] family with two healthy workers together earning K250 a day with work every day can just buy rice and very little extra food but no clothing, school fees and supplies or medicines’.
areas, in Myanmar the urban and rural poverty rates are much the same (IMF 1995: 31).

Except for a very small percentage that has benefited from the economic transition, real income per capita for most of the population has not risen much since the mid-1980s (Dapice 1998a: 1). A major reason for this is that yields from agriculture – the mainstay of the economy and most of the population’s livelihood – have not increased in pace with population increase, despite the introduction of multi-cropping practices and expanded irrigation. This has been exacerbated by forced quota sales of paddy to the authorities at a low price, the state monopoly on the export of rice, and the lack of formal credit sources (ibid.: 3-8). Also, the government no longer provides subsidies on fertilizer, and the high cost farmers must pay for it adds to the disincentives and constraints that lead to low yields (Taylor 1998a: 2-5).

Farming families are often unable to supplement their incomes, because there is little opportunity for wage work in rural areas, and environmental depletion has reduced their ability to gather extra food sources from forests and rivers. Even in the fertile delta area, there is an increasing scarcity of fish, crabs, firewood and vegetables, as well as great difficulty in finding sources of fresh water (Dapice 1998a: 9).

Thus, it is not surprising that the typical villager’s development priorities have been observed to be, first, ‘income security, and improvement of their

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41 The introduction of multiple cropping in 1992 did contribute to a rise in living standards for some cultivators, enabling them to purchase goods such as tractors, televisions and motorbikes. However, like urban residents, rises in income for farmers have been offset by rises in the consumer price index. The prices of fertiliser, pesticides, and other essential items have risen higher than paddy prices. As a result, most farmers are no better off than in the socialist era (Thawnghmung 2001: 269).

42 The 1993 Agricultural Census found that 68 per cent of households are rice cultivators, but only 36 per cent undertake double-cropping. Furthermore, only 2 per cent of households use a tractor, with most using ploughs and sickles (Dennis 1999: 5-6). However, these statistics may be out of date, as the census was conducted only one year after double-cropping was introduced.

43 Agricultural credit from the government is fairly inaccessible, and once obtained, only covers around 10 per cent of plantation and harvesting costs. As a result, most farmers rely on private loans, which carry a much higher interest rate (Thawnghmung 2001: 169).

44 Poverty is exacerbated by some cultural and social practices. One is the burden on all households, regardless of income, to contribute to religious and social activities in their community (Thawnghmung 2001: 135-140). Another major financial drain is the popularity of the Thai lottery, in both urban and rural areas. Thawnghmung reports that better-off residents
incomes so that they may be able to afford improved social amenities. Following that priority, they wish to have improved access to adequate supplies of clean water for drinking and other domestic uses, as well as water for their livestock and for certain of their crops’ (Agrodev Canada Inc. 1995: 17). After food and income security, education is the main priority (interview 61, Yangon: September 2000; interview 67, Yangon: October 2000).

It is the high incidence of poverty in Myanmar that makes the lack of public health services such a great problem. As many families exist so precariously, they have no leeway to deal with the cost of illness, in terms of either direct costs or lost earning opportunities. Therefore, ‘the burden of illness on individuals, families, communities and eventually on the country seems to be escalating at a higher velocity than expected’ (UNDP 2000a: 3).

Because poverty and poor health status are so closely related, food security is a major component of addressing health problems. The regime is very sensitive to the political effect of rising food prices on urban dwellers, and uses a variety of methods to keep the prices of staples as stable as possible. But the burden of subsidising the cost of food in urban areas is placed on rural dwellers, as is the unofficial burden of supporting local military units. With these responsibilities, many farmers end up without enough rice from a harvest to feed their households for the year, let alone to provide income for other necessities.

Although the poor health indicators cannot be attributed solely to government policy, they show the great need for concerted government attention. However, that widespread poverty in the country is largely attributable to government policy is reflected in the considerable gap between what the government claims it is doing and what is actually being achieved, which is revealed in Chapter Six.

\[\text{in one village would spend an average of Kt2000-4000 on each round of the lottery, which is run fortnightly, while poorer residents would spend around Kt50-300 (ibid.: 143).}\]
\[\text{45 However, Lintner (2000: 184) reports that community leaders in northern Myanmar see drug addiction and HIV infection as the most pressing social problems in their villages.}\]
\[\text{46 One of these is the introduction of tax-free markets in Yangon in 2000. The markets have proved very popular, but are unable to meet demand.}\]
The International Community and Health in Myanmar

The security agenda of the regime is not the only factor that hinders social development. One of the key factors in reducing the political capacity of SLORC/SPDC has been the impact of external sanctions. The irony is that although the SLORC/SPDC has made a concerted effort to court international respectability, it has received less international aid and assistance than the BSPP, which maintained a policy of isolation and made no effort to convince the international community that it was moving to an acceptable ‘democratic’ political system. In 1987, the overall trend of technical assistance by external agencies was decreasing, although contributions to the health sector remained steady. Between the programmes of UNDP, WHO, UNICEF and the ADB, and bilateral aid from Japan, the Netherlands, and USA, aid for the health sector alone was around US$30 million annually (WHO 1989: 27).

Political and economic sanctions that have been applied against the government since 1988 to pressure the regime towards political liberalisation, including denial of funding and humanitarian aid from multilateral agencies and bilateral donors, mean that external sources of funding have greatly declined. Already not a large amount by international standards, Overseas Development Aid (ODA) dropped sharply after the coup in 1988, when most donors pulled out and UN agencies froze operations. By 1993, when some donors had restarted assistance, total external assistance to Myanmar (covering all sectors) was US$109.5 million, the largest share of which went to Investment Project Assistance. In 1993, ODA for the health sector was US$10.7 million (UNDP 1995a: 14-16). Although bilateral donors like Japan gradually resumed a limited program of humanitarian aid, and more INGOs started operating in the country, the overall amount of external assistance remains very low. The

47 Japan is the most significant official bilateral aid donor, accounting for 80 per cent of ODA, delivered through debt relief, grassroots projects, technical assistance and humanitarian aid (ICG 2001b: 17). In addition to Japan, India, Malaysia, Thailand and Singapore contribute loans and grants for technical assistance and grassroots development projects (Matthews 2001). Other foreign embassies fund small-scale grassroots projects through discretionary funds. In 2001, Australia moved to resume its direct aid program through a project aiming to increase the capacity of the Department of Health to address child nutritional problems (see Media Release, Australian Minister for Foreign Affairs: FA147/24 September 2001).
Chapter Five

The budget of the UN agencies is declining. In 1996, ODA inflow was US$56 million, which made up 2 per cent of GDP (UNICEF 1999a: 26). This has increased marginally, standing at US$76 million by 2000 (ICG 2002b: 32).

The low level of aid severely restricts humanitarian assistance. In August 2001, the heads of nine UN agencies based in Yangon took the unusual action of sending a joint letter to the heads of their respective organisation headquarters, appealing for increased ODA and humanitarian assistance, saying that ‘[t]he current peripheral or piecemeal assistance provided to Myanmar is not adequate to reverse or even slow down certain negative trends’ (The Myanmar Times, 13-19 August 2001, Volume 4(76)). The letter quoted recent figures on ODA, saying that the total annual ODA to Myanmar was only US$1 per capita, compared to US$35 in Cambodia, and US$68 for Laos (ibid.). Figure 5.5 further shows the meagre amount of ODA received by Myanmar, compared to other countries in the region.

Around thirty INGOs run health programs in Myanmar, an absurdly small number compared to other countries suffering from a humanitarian crisis, such as Cambodia, where the number of INGOs is in the hundreds. Since donors are very sensitive to international opinion on Myanmar, INGOs are able to obtain funding to run only comparatively small programs. Despite the existence of a health crisis in Myanmar, characterised by a former UNICEF country director as the ‘silent emergency’,48 the amount of external humanitarian aid it receives is limited by the political situation to an extent that is otherwise seen only in war zones or countries under much more comprehensive international sanctions (interview 72, Yangon: October 2000).

48 This phrase refers to the fact that despite evidence of extremely high infant, under-five and maternal mortality rates, as well as a high rate of severe malnutrition, a rapidly expanding HIV/AIDS epidemic and very low access to health facilities and adequate water sanitation, ‘the silent emergency has gone largely unnoticed by the international community’ (Carriere 1997: 225). On the domestic front, ‘A government in charge of a country with a natural resource base as rich as Myanmar’s, dominating as it does nearly all political and economic activity with pervasive controls over virtually all aspects of its people’s lives, cannot deny responsibility’ (ibid.: 219).
The United Nations and INGOs: propping up the health sector

In the cases of both the BSPP and SLORC/SPDC, regardless of policy, the UN agencies, along with a handful of INGOs and some bilateral agencies, have effectively upheld the health system. Since the capacity of the public health sector is effectively non-existent for much of the country, the UN and INGO programs have a disproportionately large impact on the health sector. Without the cooperation of the UN agencies, the Department of Health, the government’s primary implementer of health policy, would lose the support vital to achieving the small amount it currently does.

Several UN agencies are present in Myanmar; those most important in the health sector are UNICEF, UNDP and WHO, all of which began working in the country in the early 1950s. More recently, in 1999, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has opened up a country office. These agencies have different mandates, ways of functioning, and agendas, which are not always complementary (interview 74, Yangon: October 2000). This is exacerbated by the difficulties of working at the state level in Myanmar, which

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49 There has been no humanitarian aid from multilateral financial institutions under SLORC/SPDC.
50 The other agencies present, some of which touch on health issues, are Food and Agricultural Organization (FAO), United Nations Office on Drugs and Crime (UNODC), United Nations High Commission on Refugees (UNHCR), United Nations Population Fund (UNFPA), World Food Programme (WFP) and United Nations Information Centre (UNIC). Also, United Nations Office for Project Services (UNOPS), United Nations Human Settlements Programme (UNCHS), United Nations Economic, Social and Cultural Organization (UNESCO) and International Atomic Energy Agency (IAEA) work in the country through UNDP, as project implementers.
have led to changes in the traditional mode of operations of some of the agencies. As a result, ‘the UN system’s programme in Myanmar is in many ways unique. Most of its activities are downstream, that is, at people’s level’ (United Nations System's Operational Activities for Development in Myanmar 1997: 3). To address the problems arising from these different strategies, fourteen thematic working groups exist to coordinate the work of the agencies on important development issues (ibid.: 6).

The WHO country office has two major functions: strengthening of health policy, and direct technical assistance (WHO 1995b: 1). The first element involves collaboration with the government in developing health policy in accordance with WHO priorities. The technical assistance takes the shape of projects functioning directly through programs of the National Health Plan (NHP), which ‘represent specific technical inputs into the implementation of the NHP’ (ibid.: 1). This involves substantial direct financing of the Ministry of Health. For example, the 1994/1995 two-year budget to implement these projects was US$5.5 million. Other activities of WHO are the funding of two-year fellowships for Myanmar nationals, for study outside the country; procurement of essential drugs and supplies; funding of consultative reviews, and local training activities of medical doctors and technical staff. WHO is also the executing agency for some of the UNDP projects (ibid.: 2).

Outside the country office, WHO’s South-East Asian Regional Office (WHO SEARO) office is quite significant. WHO is one of the most regionalised of the UN agencies, and the regional offices have considerable control over allocation of the budget and determining programme priorities (Walt 1994: 137). Generally, country offices receive funding only to cover fellowships and study tours (although extra-budgetary funds from donors for particular programs bypass the regional office), and although they are closely linked with the Ministry of Health, tend not to participate in strategic planning and programming (ibid.: 137). In the case of Myanmar, Myanmar nationals working

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51 See Chapter Six for a fuller description of how WHO assistance impacts on government health policy and implementation.
in the regional office have a strong influence over decisions made at that level (personal communication: January 2002).

UNICEF has been operating in Myanmar since 1949, using a ‘broad-based integrated approach which emphasised community participation’ (Soe Saing 1990: 35). The country program consists of six programs to address the survival, protection and development of children. These are: health and nutrition, water and sanitation, basic education and child development, empowerment and capacity building, and child rights and protection (UNICEF 1995: 7-8). To implement the health and nutrition program, the agency works closely with the Department of Health as an implementing partner, providing technical and financial support, and runs programs that cover most of the country, particularly interventions such as the Expanded Programme for Immunisation (EPI). These concentrate on direct impact in communities, and emphasise maternal and child health and welfare. At a more informal level, UNICEF attempts to address the systemic problems in the Myanmar government that impede the implementation of its goals. This includes encouraging management reform and capacity building at the programming level (interview 13, Yangon: March 2000). Also, the Country Programme aims to ‘play a catalytic role in mobilising resources and building alliances for the effective implementation of the CRC’ (UNICEF 1999a: 8).

However, the ability of the UN agencies to address the health problems of the country is far from comprehensive. A UNICEF report explains that

[opublic overments that have been running since the early 1990s, such as immunisation, the control of diarrhoeal disease and respiratory infections, reduction of protein-energy-malnutrition through growth monitoring, breast-feeding promotion and nutrition counselling, are implemented throughout the country. The projects that were initiated by the 1996-2001 Master Plan of Operations, covering HIV/AIDS, women’s health and some nutrition activities operated in selected areas (UNICEF 1998b: 10). The 2001-2005 programs are based on area-focused townships (AFTs), where projects are implemented through an intersectoral approach. This is explained on the UNICEF Myanmar website: ‘For example, the school will be a point of convergence for education, health, nutrition, safe water, sanitation services and communication, re-enforced with community-based health services. Although the majority of programme activities will converge increasingly in AFTs, the high prevalence of HIV/AIDS and malaria, for example, and programme opportunities may see specific activities implemented in some non-AFT areas’ (www.unicef.org/myanmar).
more knowledge and skills acquisition, as well as the motivation to make and sustain additional efforts. They also need social and material support in order to do so (ibid.: 66).

The WHO and UNICEF country offices have taken on slightly different roles from those they generally assume, in an attempt to work effectively in the current political situation. However it is UNDP, the largest UN agency working in the country, which has made the greatest adjustments to the political context in Myanmar. One of the normal functions of UNDP in each country is to co-ordinate the work of the other UN agencies. UNDP played a major role in the health sector throughout the BSPP period, financing the ‘Umbrella Project’ from 1974, which mobilised resources to meet development needs, and used the World Bank and ADB (and later bilateral agencies) to implement technical assistance programmes. Umbrella II began in 1979, and the third phase ran from 1982 to 1987. At this time, UNDP worked in close partnership with the government, and could provide technical assistance in any priority sector requested by the government (Soe Saing 1990: 18). In the fourth Country Programme (1982-1986), direct funding amounted to US$76 million, of which US$7 million went to the health sector (ibid.: Appendix D).

The Country Programme V, running from 1987 to 1991, included a major focus on the development of social infrastructure, and several studies were undertaken on the administrative system. However, in 1993, the UNDP Executive Board in New York radically altered the way UNDP was to operate in Myanmar. At this time, strong pressure existed in the international community against working with the Myanmar government. The Executive Board’s decision 93/21 stated that

until a country programme is considered at an appropriate time, all future assistance from the United Nations Development Programme and related funds to Myanmar should be clearly targeted towards programmes having a grass-roots-level impact in a sustainable manner particularly in the areas of primary health care, the environment, HIV/AIDS, training and education, and food security’ (UNDP 1995b: 1).

This ruling ended UNDP’s more normal development assistance, through technical assistance and capacity building of the bureaucracy. Instead,
the Human Development Initiative began in 1994, as a two-year program of multi-sectoral grassroots development in fourteen selected townships, at a cost of US$25.6 million. At the end of this, UNDP claimed that approximately one million people had been assisted by the projects (UNDP c.1996: 6). In 1996, the Human Development Initiative–Extension (HDI-E), expanded the program to cover sixteen townships (plus the Quick Impact Projects (QUIPS) in the Rakhine and Chin states, making a total of 23), with a budget of US$52.1 million; this operated until April 1999, and has been followed by two further phases.

Myanmar is the only country in which UNDP operates the Human Development Initiative programs. Under the HDI, instead of giving government agencies financial and technical assistance for developing and implementing projects, UNDP undertakes the implementation directly. It appears to be a compromise between the highly political position of channelling aid through the Myanmar government, and the reality that UNDP is one of the few sources of resources for poverty alleviation in the country.

Focusing on the local community level, the HDI programs aim to ‘address human development and humanitarian needs of people in a sustainable manner and in carefully targeted geographical areas’ (UNDP c.1996: 6). Instead of attempting to cover the whole country, the programs are implemented in the focus townships through a multi-sectoral approach. This is based on four projects covering primary health care, water and sanitation, HIV/AIDS and basic education, and three projects focusing on environment and food security (ibid.: 16).

At the local level, the program is implemented by Myanmar nationals, mostly former United Nation Volunteers with development experience overseas (Agrodev Canada Inc. 1995: 17). Each township has an HDI office, the township project unit, which serves as a planning and coordination forum. It is

53 According to a consultant report, ‘[t]hese townships were selected on the basis of high incidence of poverty and overall low status of welfare, accessibility, presence of ongoing UN initiatives sharing the same goals as that of the HDI, and geographical diversity’ (Agrodev Canada Inc. 1995: 71).

54 This means that UNDP has not signed a traditional Country Cooperation Framework (CCF) with the Myanmar government.
chaired by the TPDC chairperson, whose support is vital to the project’s impact. A UNDP human development officer is appointed as secretary (Alliband and Hlaing 1997: 22-23). There is also an emphasis on capacity building of local agencies, such as national NGOs and community-based organisations (CBO), to empower them to be agents of their own development, and on encouraging the formation of village committees for specific development objectives.

The HDI’s specific health-related project is ‘Improving Rural Community Access to Primary Health Care’. Township health promoters manage the project, coordinating with the Department of Health’s township medical officer, and assisted by community health workers in the villages. The strategy of the project is to build the capacity of the grassroots infrastructure of the public health service, as well as encouraging sustainable community involvement in development. Village Health Committees (VHC) are auxiliary bodies that ‘plan, implement, supervise and evaluate village health activities’ (Improving Rural Access to Primary Health Care Project (MYA/96/001) 1999: IL#7.8). VHCs have long been a part of the government’s health policy, but generally are only formed with outside encouragement. In some places it is reported that under the HDI projects, ‘meetings are now becoming part of the routine community gathering, for motivating and mobilizing the community, sharing information among villagers and feed-back discussions’ (ibid.).

An external assessment of the initial HDI program argued that ‘considerable benefit has already accrued to the target rural communities’ (Agrodev Canada Inc. 1995: 3). This included a direct impact, through improvements in community social and productive infrastructure, and indirect impacts, through capacity building at the village level and local support agencies (ibid.: 2). For such an assessment to be made just over a year after the project began is a reflection not only of the fact that small measures could make a substantive difference, but also of the willingness and enthusiasm that exists in most communities to take advantage of such opportunities. The same has been observed in the work of INGOs. Both locals and foreigners working in community development have commented that the concept of participatory development needs to be taught to most communities, as they have never been
given the opportunity to make development decisions before. However, once given the opportunity and training to do so, most communities are found to embrace the concept successfully (interview 33, Kachin State: June 2000; interview 61, Yangon: September 2000). It was also noted in the HDI assessment that ‘there is a huge need for training at the community level in the sense of imparting knowledge to community members of how to better help themselves and their families improve their lives’ (Agrodev Canada Inc. 1995: 18).

In addition, an evaluation at the end of HDI-E concurred that communities, local government, project officers and the UNDP staff still retained a top-down methodology due to inexperience with the grassroots approach. For example, in the creation of village health committees in the Primary Health Care Project, ‘it appears to have been common practice under HDI for VHC membership to be selected primarily by Village Mid-wives in conjunction with V-LORC members’ (Alliband and Hlaing 1997: 6).

Thus, even with an emphasis on working at the grassroots level, operating large projects in such a system creates many other problems, such as inability to be able to protect national staff from political pressure (interview 20, Yangon: March 2000).55 Also, the different sectoral projects have not been well integrated, partly because there is no line agency that can act as a counterpart agency for the whole program (with the exception of the Progress of Border Areas and National Races Department in the border regions, see Chapter Seven). This lack of established processes is a hindrance to the work of all international agencies and businesses in Myanmar.

All of this is a reflection of the reality of implementing a grassroots development strategy in a system where the hierarchical political culture and the constant sense of insecurity produced by the unpredictable nature of governance discourages the basic elements of participatory development, such

55 Martin Smith (1996c: 116) points out that international agencies working in Myanmar must be cautious in how their work is presented not only in order to continue their work in the country, but to protect local employees from retribution by the government.
as bottom-up initiative and long-term planning.\textsuperscript{56} Genuine community participation tends to imply challenges to power structures at the national level and in traditional authority relations at the village level (Asthana 1994b: 187-188).

However, the value of grassroots programs in building the capacity of local government structures should not be underestimated. This is most significant in the work of INGOs, which, in spite of difficulties in satisfying the basic political and security concerns of both the government and donors, can have a disproportionate impact on the health status of a village. INGOs were invited into the country by SLORC to compensate for the loss of bilateral development aid. The numbers have been restricted by political sanctions on the country - twenty-eight INGOs were operating in the country by 2002 (ICG 2002b: 33), although several of these are present without MoUs (Tegenfeldt 2001: 109) – but the INGOs that did manage to secure funding and to successfully negotiate an MoU with the government\textsuperscript{57} became essential for the implementation of UN projects as UNDP took on a new development role.

INGO programs are concentrated in Yangon and Mandalay, specifically in the very poor townships on the outskirts of the cities; in a number of towns bordering Thailand and China, which are focal points of HIV/AIDS infection; and in Western and Northern border states.\textsuperscript{58} Their financial resources are small-scale, but because of accusations that INGO resources will be coopted by supporters of the regime, most of the INGOs are very careful to target their assistance directly towards the community, perhaps more so than in countries

\textsuperscript{56} For example, a UNDP (1998: 18) evaluation report notes that ‘[t]here is virtually no experience in Myanmar of the kind of participatory poverty-alleviating development, which [the project] is attempting to carry out’.

\textsuperscript{57} Roger Walker (1993: 26) explains how World Vision negotiated its MoU in the early 1990s, and summarises the delicate position INGOs must operate in, saying that World Vision ‘allowed for some flexibility without compromising on certain requirements for project integrity’.

\textsuperscript{58} A more extensive INGO presence exists on the Thai-Myanmar border, providing emergency assistance to as many as 120,000 Myanmar refugees in Thailand located in 17 refugee camps, who have fled from the conflict zones and political persecution (Mizzima News Group, 11 December 2000). Groups working on the border also provide cross-border care through ‘backpack health workers’ (Associated Press, 16 December 2001). An umbrella organisation, the Burma Border Consortium, coordinates the many NGOs working on the border.
where humanitarian aid is not so political.\textsuperscript{59} Also, while good relations with the Ministry of Health are vital, those INGOs which choose not to run programs with the assistance of GONGOs, or through public health facilities, are able to do so.

For example, an INGO that runs health programs in the Kachin State gave local women basic training in health education and first aid, providing a starting kit and support and supervision for the duration of the project. These women then fulfilled the role that the government’s volunteer health workers are supposed to carry out. In some villages, village health committees formed to support the volunteer health workers, and to expand the scope of the program. The INGO also gave villagers the opportunity to purchase bed-nets or latrine pans at a subsidised price, which were then transported to the village by the INGO staff. The components of the program were simple, but effective in villages where the voluntary health workers were able to educate the villagers about basic hygiene practices and malarial prevention. As the major causes of death arise from easily preventable diseases, some of the villagers commented that they noticed a decrease in mortality over the course of the project. At the time I visited, in 2000, the INGOs’ funding had ceased, but the villages in which the project had been a success were keen for further training and support to implement new projects that they had initiated. Unfortunately, the coverage of INGOs and UN agencies in the area was very limited. The villagers did not even consider approaching local government authorities for support (interview 33, Kachin state: June 2000; personal observations). See also Tegenfeldt (2001: 115-117).

Another exception to the norm of top-down development is a handful of very localised and informal organisations, initiated by a motivated individual or small group, which are able to achieve grassroots development. Community-based organizations work with the support of UN agencies or foreign embassy discretionary funds. Most of these organisations are a result of

\textsuperscript{59} Another indication that INGOs are sensitive to the problems of aid delivery in Myanmar is the moves by a number of the INGOs involved to develop a voluntary guideline of practice.
the survival strategies developed during the extended period of civil war in many parts of the country (interview 27, Yangon: May 2000), and given space to exist by the give-and-take that characterises the ceasefire arrangements (interview 28, Yangon: May 2000). Others are able to find loopholes in the system, or exist so informally that they can operate without being drawn into the state’s restricted definition of community organisation. Further, several religious organisations which have majority constituencies in certain regions are able to undertake community development projects with relative autonomy, existing somewhere between the GONGOs and the informal community-based organisations. Church-based charities are denied official NGO status by the government, but are allowed to operate fairly extensively and autonomously. Most of these charities are organised under two umbrella organisations with an established position in society: the Myanmar Council of Churches and the Myanmar Baptist Convention, as well as the YMCA. Where these organisations are not present, a tradition of Buddhist charity forms the main

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60 For example, the Metta Development Foundation is a quite unique organisation in the present system, being an officially registered NGO, but one of only a few that is considered autonomous from the government. Using opportunities opened up by the ceasefire between the government and the KIO, it was established in 1998 ‘to assist communities in Myanmar recover from the impact of decades of civil conflict’ (Metta Development Foundation brochure). It initially operated projects in the far north of Kachin state, but then extended to other parts of the country, with headquarters in Yangon. The Foundation’s development programs are based on the goals of ‘building community capacity, coordination of sustainable development projects and promoting community-controlled social and economic associations’ (Metta Development Foundation 2000: 2). It is very different from most other experiences of development in Myanmar, placing a strong emphasis on participatory action research to design projects, and the use of local resources and gender equality. The annual report states that ‘Metta operates with the full participation of local communities in all stages of planning and implementation, with special emphasis on mobilising local resources. Economic, cultural and environmental sustainability is considered a vital part of Metta’s work’ (*ibid.*).

61 One of the members of the Myanmar Baptist Convention, the Kachin Baptist Convention (KBC), has a major presence in the Kachin state. It was founded in 1910 by foreign missionaries, and now has a large and well-equipped headquarters in Myitkyina, with a staff of 30, and also runs a theological university. The majority of the population in the Kachin state is Baptist, and consequently the KBC is the dominant social organisation in the state. It is much more than a community-based organisation, and obviously has a good working relationship with government authorities. At the same time, it appears to be much more autonomous than the MMCWA or MRCS. Since the ceasefire, of which the KBC was a prominent facilitator (ICG 2001b: 19), the KBC has expanded into development activities, recently formalised by the creation of its Development Department in 1999. Villagers, usually the pastor or church youth, are selected by the local church and sponsored by the KBC to go to Thailand and the Philippines for training, and then return to their villages to run education, health, microcredit and reforestation projects. The development program is funded by donations from both local and international sources, and works in alliance with other NGOs (interview 35, Kachin state: June 2000).
The Politics of Health in Myanmar

social safety net, and is said to sustain a substantial number of impoverished families (Boyden 1991: 15).

The Politics of Humanitarian Aid

The UNDP Executive Board’s unprecedented decision in 1993 to change the way it operates in Myanmar is one reflection of the politicisation of humanitarian aid since the beginning of SLORC rule. Aid has always been a major prop for the government health system, and the sudden and massive decline in humanitarian aid since 1988 is indubitably a major contributor to the decline of the health sector over the last decade. Of course, there is considerable political justification for the decisions of bilateral and multilateral donors not to give humanitarian aid to Myanmar while it remains under military rule.62 One of the NLD members elected in the 1990 election described it succinctly, saying the problems do not stem from natural disasters, total war, lack of resources or overpopulation. Instead, ‘[t]he root-cause of the humanitarian crisis in Burma is long-existing poor governance: it is aggravated by the incompetence of the current regime, its lacking ability and will to initiate sound policy-making that would most assuredly improve living standards’ (Bo Hla Tint 1999).

The argument that the policies of the military regime are the root cause of the humanitarian crisis has been used to support the view that the only solution is to end military rule. The organisations that support a moratorium on humanitarian aid argue that it is impossible to solve the ‘symptoms’ of the crisis without strengthening the power of the regime that caused it. In particular, by enhancing its legitimacy and the political benefits the regime can gain by channelling the aid through its local supporters. However, the politicisation of the issue has meant certain realities of the situation have been overlooked. The argument that aid should be withheld was valid in the first few years of SLORC rule, when the regime appeared to be unstable and

62 For a range of arguments for and against humanitarian aid in Myanmar by INGOs, see Burma NGO Forum and Australian Council for Overseas Aid (1993), Steinberg (1999b) and Purcell (1999: 76-79). For an example of the current debate on humanitarian aid to Myanmar, see the
susceptible to international pressure. But after more than a decade, military rule is more firmly entrenched than ever, and the urgency of human suffering in the country has been increased by the impact of the HIV/AIDS epidemic. In such a case, as an INGO worker expressed it, addressing problems with the economy or widespread malnutrition can be deferred for a couple of years, but to ignore HIV/AIDS for even a short time could be catastrophic (interview 27, Yangon: May 2000).

The debate on whether to deliver humanitarian aid to Myanmar while under military rule arose from the NLD’s position of discouraging any form of investment, aid or loans to Myanmar until the event of a political transition. Although the NLD’s stand in favour of economic sanctions has remained strong, there is some confusion about exactly what their position is on humanitarian aid. To a certain extent, it appears that the general belief that the NLD is totally opposed to humanitarian aid is due to misunderstanding of the position by people outside of Myanmar. In particular, the position of the NLD is often confused with that of exile groups (personal conversation, Western diplomats, Yangon: September 2000), who advocate a ‘no aid’ position (Altsean-Burma 2002). As many positions on humanitarian aid are explained in terms of solidarity with the NLD’s call for no aid, this has had a significant impact on health issues in Myanmar.

The most detailed NLD position comes from a letter that Aung San Suu Kyi wrote to the Administrator of UNDP in 1996, which said

There is an absolute necessity…to work in close cooperation with the NLD which won more than eighty per cent of the contested seats in the elections of 1990 and remains to this day the only organization which effectively represents the will of the people….We would like to ensure that access to aid is not reserved for those who stand in favour with the authorities.

The letter made it clear that the NLD did not think the HDI programmes were meeting this criteria, citing examples of where the NLD members and others not in favour with the authorities have been denied access to the programs, and pointing to the close involvement of Township Law and Order

ICG report (2002b) and critiques of it by Dr Chao-Tzang Yawngwe (BurmaNet News (online), 23 April 2002) and Altsean (2002).
Restoration Council chairmen in HDI activities, ensuring that ‘the local authorities have a stranglehold on the selection process, the resource allocation and the implementation of the programme’ (Aung San Suu Kyi 14 January 1996). The letter ended by requesting that ‘formal provisions be made for [the NLD] to be closely and actively engaged in the planning and implementation of UNDP projects, including evaluation and monitoring in the field’ (ibid.).

The NLD position on humanitarian aid is conditional on the aid projects being ‘properly’ monitored, and not being channelled through GONGOs and local authorities. Aung San Suu Kyi maintains that without transparency, accountability and independent monitoring, humanitarian aid does not assist the people (Altsean-Burma 2002). Rather than increased funding, ‘good governance is the answer to Burma’s humanitarian problems’ (Aung San Suu Kyi, cited in ibid.).

While her assertions are certainly true, they are not realistic given that the political context makes it almost impossible to meet these criteria all the time, and that great need exists regardless of political sensitivities. Further, this absolute position does not take into account the way things get done within the country. Like the people of Myanmar, who have learnt to get around the restrictions of the government to some degree, some aid agencies can also achieve a lot by subtle advocacy and building support for development values within the communities in which they work, so that local authorities support, rather than hinder, their programs. Also, INGO programs – at least – are required by their donors to maintain transparency and accountability, and are often externally monitored. But, as explored earlier, this is more difficult for

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63 However, the position expressed by Aung San Suu Kyi in private and semi-private statements at different times has been contradictory, especially in regards to the presence of INGOs in the country. In an interview in 1999, Aung San Suu Kyi stated that ‘[w]hat we said about humanitarian aid is that we are not against it. But we want it properly monitored so that it is given to everybody and not just to those who are favoured by the authorities….And we’ve never said that all NGOs should leave Burma or not come in’ (Mitton 11 June 1999). Yet this statement seems to contradict an earlier interview, in 1998, where she suggested that INGOs should concentrate on assisting refugees on the border: ‘We don’t think the time is right to for NGOs to come in. It is very difficult, if not impossible, for NGOs to work without permission of the authorities….It is much more important to change the political situation in Burma’ (Purcell 1999: 93-94).
UN agencies. So, while an absolute position either for or against aid is not appropriate, carefully targeted aid can be effective, even in Myanmar.

The NLD’s position on humanitarian aid is absolute, because it is a political issue. Although the goal of the NLD’s platform is to end the suffering caused by military rule, it is foremost a political agenda that places development as a secondary issue.\(^\text{64}\) Whatever the intent, the reality is that the NLD’s policy – or at least the interpretation of it by aid donors, political activists and other observers – has greatly politicised the issues of investment in and humanitarian aid to Myanmar, and contributed to cutting off sources of external aid that might have helped compensate for the lack of regime interest in the social sectors. The confidence building talks between the SPDC and Aung San Suu Kyi provided some governments and international organisations with the opportunity to partially resume or increase humanitarian aid to Myanmar, although this trend was halted following the re-arrest of Aung San Suu Kyi in May 2003.

Conclusion

The problems facing the health system in Myanmar are rooted in the historical development of the country, the prevailing political culture, the current political system and, most of all, the underdevelopment of the country. This situation is not going to be rectified merely by modifications in health policy under the current government, or in the event of a political transition.

This chapter has outlined the political and economic context that has a direct bearing on the health status of the country and the government’s attempts to improve it. The historical analysis revealed a health system shaped by state ideology. The combination of the dominance of the military regime’s security agenda over social development in the last four decades, which has been exacerbated by economic transition, and the impact of sanctions against

\(^{64}\) A similar argument is made by Steinberg (2001b: 65). However, in recent years the NLD has become more willing to engage in discussion about humanitarian aid with diplomats and aid workers. After Aung San Suu Kyi’s release from her second period of house arrest, in 2002, she visited a number of INGO, bilateral and UN projects in the country, indicating a willingness to explore the issues further.
Myanmar, have resulted in the political incapacity of the Myanmar state in regards to health.

Over the long-term, this incapacity of the state has contributed to the impoverishment and low health status of a large part of the population, a situation which the government has a self-imposed obligation, but limited ability, to address. The changing role of the state during economic transition leaves it not only less inclination, but also less ability to adopt a major role in health promotion as it cedes control in this area to the private sector and communities.

In addition to the uncertainty of the transitional period, the use of health as a political tool - the humanitarian aid debate – is a key factor in contributing to the continued underdevelopment and increasing inequity of the state. In this context, the support of the international community for the NLD’s call for a ban on international assistance also forms a major constraint on improving the health of the Myanmar nation. At the same time, the international organisations working within the country negotiate the highly political context of aid to provide much needed support to the health sector.

The next chapter examines how the public health sector operates within these structural constraints. It provides a cross-sectional view of the state, examining the health system from its operation at the highest point in the government hierarchy to the lowest levels, and societal influences on health care services, which reveal how political incapacity contributes to reducing state incapacity.