

## MYANMAR: THE HIV/AIDS CRISIS

### OVERVIEW

HIV prevalence is rising rapidly in Burma/Myanmar,<sup>1</sup> fuelled by population mobility, poverty and frustration that breeds risky sexual activity and drug-taking. Already, one in 50 adults are estimated to be infected, and infection rates in sub-populations with especially risky behaviour (such as drug users and sex workers) are among the highest in Asia. Because of the long lag time between HIV infection and death, the true impact of the epidemic is just beginning to be felt. Households are losing breadwinners, children are losing parents, and some of the hardest-hit communities, particularly some fishing villages with very high losses from HIV/AIDS, are losing hope. Worse is to come, but how much worse depends on the decisions that Myanmar and the international community take in the coming months and years.

The widespread incidence of HIV is a security issue in itself – it can undermine economic, personal and national security.<sup>2</sup> It can also undermine the already weak capacity of the state to govern, threaten security and military structures and have a devastating impact on the economy.

The government in Yangon has been quick to establish a surveillance system and nominal AIDS

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<sup>1</sup> A note on terminology. This report uses the official English names for the country, as applied by the UN, most countries outside the US and Europe and the national government – that is, ‘Burma’ for the period before 1989 and ‘Myanmar’ after 1989. The same criteria are used for other place names such as Rangoon (now Yangon). This should *not* be perceived as a political statement, or a judgement on the right of the military regime to change the names. In Burma/Myanmar, ‘Bamah’ and ‘Myanma’ have both been used for centuries, being respectively the colloquial and the more formal names for the country in the national language.

<sup>2</sup> See ICG Issues Report No. 1, *HIV/AIDS as a Security Issue*, 19 June 2001.

control structures but very slow to take any action that would slow the spread of the virus. The National AIDS Program, while professionally competent, is woefully under staffed and under funded and struggles beneath the weight of its tasks. It gets a little help from international NGOs and more from the United Nations system but the major donors are largely absent.

Recently, there have been signs that the government is crawling out of its deep denial about the true magnitude of the HIV epidemic in Myanmar and is preparing to take real measures to stem its spread. It will not be able to do so, however, without a vast infusion of technical and financial help.

HIV is an unforgiving epidemic: once the initial opportunity for effective prevention is lost and a critical mass of infection builds up, the epidemic assumes a life of its own. Prevention becomes more and more difficult, and care needs begin to swamp health and community services, diverting resources that could otherwise be used for other development priorities. Myanmar stands perilously close to an unstoppable epidemic. However large scale action targeted at helping those most at risk protect themselves could still make a real difference.

Action on the scale necessary will inevitably involve working through government institutions, possibly in partnership with NGOs.<sup>3</sup> The international community, and bilateral donors in particular, should look for ways to channel resources to Myanmar in ways that encourage political commitment and capitalise on the emerging willingness to confront the HIV epidemic.

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<sup>3</sup> For a discussion of the provision of humanitarian aid, see ICG Asia Report No. 32, *Burma/Myanmar: The Politics of Humanitarian Aid*, 2 April 2002.

## I. THE EXTENT OF THE CRISIS

### A. BACKGROUND

“Myanmar is on the brink of a humanitarian crisis”. This was the assessment of nine UN heads of mission in Myanmar in a letter sent in 2001 appealing to their headquarters in New York, Geneva, Vienna and Rome to review their approaches and budget allocations for the country. The letter, entitled “Myanmar: a silent humanitarian crisis in the making”, highlighted the deep concerns over the worsening welfare of the people of Myanmar. It specified an explosive HIV/AIDS problem as a major contributor to the erosion of people’s well-being.

In June 2000, the Joint United Nations Program on HIV and AIDS estimated that over 530,000 people in Myanmar were living with the HIV infection. That translates into one in 50 of the population in the most sexually active age bracket of fifteen to 49. Some 180,000 of those infected were women, and another 14,000 were children. At these levels of infection, the so-far silent epidemic will soon begin to show its face. The number of sick and dying will inevitably multiply rapidly. As the epidemic of HIV gives way to an epidemic of AIDS and then an epidemic of funerals, more and more households will be deprived of their breadwinners. Some 43,000 children under fifteen are already living without their mothers or both their parents because of HIV. Given the sex ratio of infection in the country, it is likely that a great many more have lost their fathers. With around 50,000 new AIDS deaths a year, the total number of children deprived by the virus of a normal family life is rising sharply.

All of this could have been predicted some time ago. The country has actually developed a very good HIV surveillance system. Though HIV infection was probably in Myanmar during the mid-1980s, the first HIV positive case was found in 1988 and the first AIDS case in 1991. To those in the know, data showing alarming rises in HIV prevalence in groups with high risk behaviour such as sex workers, men who have sex with men and injecting drug users have been available since the mid-1990s. Although these data are collected by the government, they are not widely published. The official government position until recently was to claim that reported cases gave a true picture of

the epidemic in the country.<sup>4</sup> In the last decade, the Ministry of Health has reported a cumulative total of 33,553 HIV positive cases and 4,598 AIDS patients, with 1,973 AIDS deaths reported by hospitals in this interval.

The government has recently become more realistic about the threat of HIV. An article in the state-owned *The New Light of Myanmar* daily admitted the problem.<sup>5</sup> In a report in that newspaper, a senior official from the Ministry of Health mentioned for the first time “there are no doubt unreported or undetected HIV infected persons”. In international forums, however, the government continues to insist that Myanmar’s HIV/AIDS problem is not as gloomy as Western experts and the media depict.

### B. WHAT DRIVES HIV INFECTION IN MYANMAR?

Like elsewhere in Southeast Asia, HIV in Myanmar is spread both by injecting drug use and by risky sex, both heterosexual and between men. This is clear from the sentinel surveillance data, which in 2000 showed that the HIV infection rate among injecting drug users (IDUs) was around 60 per cent, a level unchanged for some years. Among sex workers a sharp increase in infection was recorded, from 26 per cent a year earlier to 38 per cent in 2000. Some 12 per cent of male clients at public clinics treating sexually transmitted infections (STIs) tested HIV positive, suggesting that male clients of sex workers are becoming infected with the virus. And evidence that HIV is firmly established in the general population also comes from anonymous testing of pregnant women receiving antenatal care. HIV prevalence in this group – usually considered to be indicative of the low-risk population – averaged 2.2 per cent across the country and in some sites was as high as 5.3 per cent. Among blood donors – generally the lowest risk population of all – HIV prevalence in 2000 crossed the 1.0 per cent threshold, making Myanmar one of only three countries in Asia to have an HIV epidemic considered to be

<sup>4</sup> Even industrialised countries recognise that HIV and AIDS case reporting captures only a fraction of cases. The WHO estimates that developing countries on average report fewer than one in eight of actual cases.

<sup>5</sup> Mya Hein Zin. “Myanmar’s serious all-out efforts against HIV/AIDS: the true picture”, *New Light of Myanmar*, 5-6 October 2001.

“generalised” throughout the population. Men who have sex with men are not included in regular surveillance but ad hoc studies have recorded high rates of infection in this population.

Information from reported cases confirm that injecting drug use is a major engine driving the spread of HIV in Myanmar. Just under a third of cases of both HIV and AIDS recorded so far have been attributed to drug injection, with most of the remainder put down to heterosexual transmission. This probably underestimates homosexual transmission: male-male sex is highly stigmatised, even though it is known to be common at certain temple festivals and in some other settings. Though the men to women ratio among reported cases is still 5:1, the number of infected women has increased in the last three to four years. Geographical mapping of officially reported AIDS cases shows that eastern states/divisions have been hardest hit. The central and delta regions had moderate rates of infection, with the lowest found on the western border.

It is clear that the spread of HIV in Myanmar is the direct consequence of high levels of injecting drug use in some parts of the country and of substantial levels of unprotected sex, particularly in commercial transactions. But what is this behaviour driven by? It is very hard to provide strong scientific evidence for causal linkages between people’s economic, social and cultural situations and their risk behaviour. But it is clear that Myanmar is a country in which most of the classic determinants of risk converge. It is one of the world’s largest producers and exporters of heroin. Inevitably, drugs intended for export leak into the local market. When escapist drugs become available to young people with little education, few job prospects and limited personal freedom, it is hardly surprising that the uptake is high. The hard-line government does not yet take a public health approach to drug injection, however, so access to sterile equipment is limited and sharing rates are high.

Poverty does not just drive people to drugs, it drives them to sex, too, both directly (as a survival mechanism for women) and indirectly (by fostering population mobility, breaking up families and communities, removing people from traditional social controls and sending them in search of easy companionship). Mobility has other another important consequence in the spread of disease: people on the move can easily carry HIV between populations with high risk behaviour in

different corners of the country, as well as across borders.

Myanmar shares a long border with Thailand and China in the east. Expecting high income and better living conditions in other countries – usually no more than a vain hope – hordes of young people cross these porous borders. Up to a million Myanmar migrants are currently working in Thailand while significant numbers are also working along the borders with southern China and India. Most of these cross-border migrants do not have official papers, which hampers their access to prevention and care services. Their undocumented and illegal status also dramatically increases their vulnerability to exploitation. Many are unable to speak the language of the host country and end up in low paid sex, seafaring or construction work, where they are highly vulnerable to HIV infection and have little or no access to information.

Internal migration is almost as dangerous. With few other opportunities on offer and long running internal conflicts to escape, young people from all over the country, including many from ethnic minorities, are on the move. They are now gathering around the jade, gold and gem mines in the north and east, logging camps in the centre of the country, border trade in the north and east and fishing communities along the coasts. The spread of military commands and battalions across the country contributes to internal migration.

Add to this mix limited access to condoms, poor quality and overpriced treatment for the sexually transmitted infections (STIs) that facilitate the transmission of HIV, massive social stigmatisation of the HIV-affected, tight media censorship, a rhetoric of impeccable national morality that hampers open discussion of HIV-related issues and a government on the defensive against any criticism, and the result is a potent fertiliser for the epidemic.

### C. WHAT DOES THE FUTURE HOLD?

Although not published by the government, its surveillance data provide ample evidence that the estimates of HIV infection in the general population put out by UNAIDS in June 2000 are solid and, if anything, conservative.<sup>6</sup> The rapid increase in infection observed among sex workers

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<sup>6</sup> UNAIDS, Report on Global HIV/AIDS Epidemic, June 2000.

in the late 1990s will inevitably be passed on to clients and their wives and other sex partners unless condom use increases dramatically. Estimates of how high HIV rates could rise with current patterns of risk vary widely and are based on little more than educated guesses. As recently as a decade ago, it was predicted that HIV prevalence in African countries would top out at 9 per cent of the adult population. Now, country after country on that continent is crossing the 25 per cent mark, and in some southern African cities over two-thirds of young women have tested positive for the virus.

Whether Myanmar reaches similar levels depends on patterns of sexual behaviour in the general population, about which virtually nothing is known. In the neighbouring provinces of northern Thailand, HIV prevalence reached 14 per cent before massive government-led prevention campaigns succeeded in forcing it down.<sup>7</sup> It is not inconceivable that similar prevalence levels will be seen in Myanmar. But crystal ball gazing about absolute numbers is futile. The essential point is that HIV prevalence is on the rise in Myanmar, and the higher HIV prevalence rises, the less risk behaviour is needed to continue its increase.

HIV is not like an immunisation program, which can be run into the ground and then built up again when sufficient resources are available. Once the opportunity for successful prevention is allowed to pass and a certain critical mass of HIV-infected people has built up in a population, controlling new infections becomes harder and harder. It also becomes increasingly expensive, not only because prevention interventions have to reach the whole population rather than those most likely to engage in risky behaviour, but also because more infected people mean more sick and dying people to care for and more orphans to support.

## II. WHO IS WHO

### A. GOVERNMENT STRUCTURES

HIV appeared relatively late in Myanmar, and the government reacted very quickly in some areas, principally surveillance. HIV surveillance among high-risk groups in Myanmar started in 1985,

around the same time as some neighbouring countries in the region, and before the first case was even identified. The Disease Control Division of the Department of Health (DOH) has actively carried out regular surveillance among sex workers, drug users and at-risk groups such as long-distance truck drivers since then. Every effort is made to ensure that this surveillance is unlinked and anonymous so that infected individuals do not suffer discrimination.

There was a fairly swift institutional response, too. A multi-sectoral National AIDS Committee (NAC) was formed a year after the first HIV positive case was detected in 1988. The NAC was given the responsibility for formulating and guiding national policies and subsequently creating the National AIDS Programme (NAP) under the Disease Control Division of DOH. Then NAP was given its own administrative structure, budget and staff members, though most of the latter are seconded from other assignments.

The National AIDS Committee (NAC) is a multi-sectoral working body the 27 members of which are high-level officials from government and parastatal NGOs. NAC is chaired by the Minister of Health, with the deputy minister as vice-chair. It consists of seven deputy ministers from the attorney general's office, home affairs, education, labour, immigration, population and information, and border area development. There are also eight directors-general from various departments and seven national NGOs as permanent members. The NAC met only eight times between 1989 and 2001. It was dormant between 1994 and 1998 because the former health minister did not want HIV/AIDS at the top of his agenda. However, the NAC has met annually since 1999.

Under the guidance and policy matrix of NAC, the National AIDS Program (NAP) was formed as a unit inside Ministry of Health (MOH). In Myanmar, as in most countries, the rhetoric of multisectoralism is maintained in the face of a different reality: though various ministries and departments are included in NAC, all HIV related activities are referred back to the doctors at the NAP. In other words, most of the work is still done by the Ministry of Health.

NAC receives policy guidelines from the National Health Committee (NHC), a supreme decision making body on all health matters in Myanmar, which includes twelve government ministers and is chaired by Secretary One of the State Peace and

<sup>7</sup> Ministry of Public Health, Thailand, Projections for HIV/AIDS in Thailand 2000-2020. March 2001.

Development Council (SPDC). Perhaps the single most important indicator of the government's increasing realism about the country's HIV epidemic is that the National Health Plan, which sets the agenda for health over a five-year period, currently ranks HIV/AIDS as the nation's third most important health challenge, after malaria and tuberculosis (TB).

Along with multisectoralism goes the rhetoric of decentralisation, another favourite of UNAIDS and other international agencies. Like other countries, Myanmar obediently formed State/Divisional and Township-level AIDS committees. And like other countries, these local bodies, designed to bring decision-making closer to "the community", do little more than commemorate World AIDS Day once a year. In practice, HIV/AIDS prevention and control is a highly centralised activity, led by the NAP in the Ministry of Health.

Perhaps surprisingly in such a constrained environment, the National AIDS Program is staffed by professionals of international-level competence and real dedication. The problem is that there are far too few of them, and they have virtually no funds. These limitations notwithstanding, the NAP has gone further than most far better resourced countries in many areas.

For example, program managers were quick to recognise the importance of tracking risk behaviour as a way of planning and monitoring effective HIV prevention programs. With no outside help and a budget of just a few thousand dollars, they designed and implemented the first round of behavioural surveillance in 2001, covering 27 townships. Like much of the HIV-related activity in Myanmar, this surveillance was carried out through 39 public AIDS/STI teams with 375 staff members working in 27 townships. These teams form the frontline of STI/HIV/AIDS prevention and control as well as the platform for collaboration and coordination with other sectors.

Major NAP activities include advocacy, blood safety, sentinel surveillance, STI management and care, prevention of mother-to-child HIV transmission, promotion of 100 per cent condom use among sex workers and clients, HIV education in schools, collaboration and coordination with NGOs, research, and monitoring and evaluation activities. Given the limited budget and human resources, the NAP has a far higher work load than it can cope with.

## B. UN AGENCIES

In the absence of any significant bilateral and multilateral donors, the UN system in Myanmar is the principal source of external funding for HIV/AIDS prevention and control efforts. UN agencies working for HIV/AIDS prevention and care are: the United Nations Development Program (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Health Organization (WHO) and United Nations Drug Control Programme (UNDCP). All UN agencies are coordinated through UNAIDS.

A significant achievement of the UN agencies is the two-year work plan – UN Joint Plan of Action on HIV/AIDS – the product of an intensive planning process in which all participated. The aim is a more co-ordinated approach, but this is not as easy as it sounds. This is in part because different agencies implement their activities through different mandates and working styles. Some agencies such as WHO and UNDCP work very closely with government ministries (Health, Home Affairs and Police). Others are forbidden by mandate to work directly with the government, instead delivering services directly to the communities using a parallel system as well as staff (e.g. UNDP). Some agencies like UNICEF and UNFPA work with government, NGOs and communities.

How close or distant to government does not really matter since all UN agencies receive hot and cold treatment from time to time, especially from the Ministry of Health. Tension always mounts when UN bodies publish statistics or data that might be interpreted as "critical" of Myanmar. The World Health Report 2000 and UNAIDS report 2000 are cases in point. Although products of the global headquarters of WHO and UNAIDS respectively, the publication of these two documents set back activities at a country level considerably. The UN tries to tread carefully around sensitive issues in Myanmar, often taking a low-profile approach that allows it to move work forward at the field level. In consequence, it has been criticised by the outside world for not being vocal enough in influencing HIV/AIDS policy formulation and for its poor advocacy record with the government.

### **C. NON-GOVERNMENTAL ORGANISATIONS (NGOs)**

There are very few international NGOs (INGOs) in Myanmar, and only ten of them are active in HIV/AIDS prevention and care. They have been able to pilot a range of important activities such as condom social marketing, behaviour change, and innovative communication approaches i.e. use of traditional theatrical troupes. In addition, INGOs are reported to be effective in targeting vulnerable and at-risk groups to whom the government and national NGOs have no access.

Though INGOs are reported to be effective, their geographical as well as population reach is very limited. Most INGOs working in Myanmar operate under memorandums of understanding with the government which specify their permitted work very carefully and limit their geographic reach. They are often confined to specific, targeted geographical areas, usually along the Thai or Chinese borders. Basically three different types of INGOs are working in HIV prevention and care in Myanmar (1) HIV/AIDS within the framework of development (development NGOs like SC-UK, World Vision and CARE (2) Service delivery types (e.g. PSI, Médecins du Monde, MSF – Holland), and (3) Technical NGOs like the Population Council.

There is a fair degree of competition between INGOs, for geographical dominance, staff recruitment and funds, and they often fail to coordinate with others working in the same field. If there were stronger collaboration and cooperation between INGOs, their impact would be greater. In addition, several INGOs are still in the phase of “raising awareness” about HIV. Few have moved very far down the road of providing the services and the skills that would allow people to act on the information to protect themselves from HIV.

Many INGOs are financed on condition that their activities do not in any way benefit the existing political leadership. This has led them to sign a joint declaration that they will not collaborate with government structures in any material way. Since most of their contact is with the NAP technical department, which is staffed by public health professionals rather than political appointees, it is not clear how these restrictions actually contribute to the overall goal of increasing the welfare of the people of Myanmar.

National NGOs also exist, although they are not truly independent of government. They have been called government organised NGOs (GONGOs) or project organised NGOs (PONGOs). The most significant GONGOs are the Myanmar Red Cross Society (MRCS), the Myanmar Maternal & Child Welfare Association (MMCWA) and the Union Solidarity and Development Association (USDA). They have a large number of branches as well as members reaching down to the grass roots.

PONGOs are mainly established by UNDP, whose mandate strictly bars it from working with the government or GONGOs. A few women’s groups have been established and sustained by UNDP projects to carry out activities at community level.

### **D. OTHER SECTORS**

Most HIV/AIDS prevention and control activities are financed and implemented by the NAP. A few other ministries have activities for HIV/AIDS prevention but most merely participate in either NHC or NAC as dormant members. The Ministry of Railways and Inland Transport is one of the very few active ministries in HIV/AIDS prevention. The ministries of labour, home affairs, social welfare, and transport initiated some work place HIV/AIDS prevention activities. It seems, however, that their activities are always blocked either by lack of funding or political support. The private sector is in many cases struggling to keep its head above water economically and has not expressed any interest in joining work on HIV prevention.

## **III. RESPONSES**

### **A. THE GOVERNMENT**

On paper, the government’s response to the epidemic has been adequate, at least in terms of setting up the structures popular with international agencies. However, in practice the response has been constrained by high-level policy ambivalence, the limitation of a medical model perspective, and shortages of human, technical and financial resources.

The higher political level made HIV/AIDS a sensitive subject since the beginning of the epidemic. It is often considered to be associated

with illicit or illegal sexual and drug related behaviour, to the exclusion of other routes of transmission. This has led to HIV becoming understood or coded as “the virus of immorality”, the notion being that HIV/AIDS is a marker of illicit, Western cultural influence and wrongdoing.

Until recently, national HIV/AIDS policy boiled down to a continued denial of the magnitude of the epidemic. Flowing from this denial came stringent control over the use of mass media, foot-dragging about promoting condom use, reluctance to help people with high-risk behaviour and a preference for moralistic pronouncements and measures. And government put its money where its mouth was: the purse strings stayed shut, and the AIDS program remained woefully understaffed.

Recently, there has been something of a shift. First, HIV/AIDS was elevated to third place as a priority disease in the National Health Plan (1996–2000). Secondly, the government has joined in several high-level meetings on HIV and signed major regional and international declarations (through ASEAN, the UN General Assembly Special Session on AIDS, a ministerial meeting at the Melbourne AIDS conference, etc). These may seem like small steps but in the opaque world of Burmese politics, where the rhetoric of “self-reliance” has long eclipsed any possibility of constructive international cooperation, they are significant.

Perhaps most importantly, in a rare interview with the *Myanmar Times* in January 2001, Secretary One of the State Peace and Development Council, Lt. General Khin Nyunt, highlighted the importance of fighting HIV/AIDS in Myanmar. “HIV/AIDS is a national concern”, the general was quoted as saying “If we ignore it, it will be the scourge that will destroy the entire race”. He quickly followed, however, with the other side of the coin, noting that Myanmar is a conservative and religious society, and it is against national culture to promote condoms in public. He did, however, mention that there were other means to get the message across.<sup>8</sup>

The ambivalence demonstrated in this interview has paralysed policy. The dilemma on HIV/AIDS policy seems to be rooted in a battle of hard-liners and moderates inside the SPDC. Ministries like

Health and Education, under the Secretary One, who chairs the National Health and Education committees, are keen to respond to the growing epidemic (though at their own pace and intensity). Ministries like information and social welfare, on the other hand, resist most forms of constructive collaboration. Whether a significant increase in resources associated with HIV interventions would sway the hard-liners into a more cooperative mood is open to speculation.

## B. THE INTERNATIONAL COMMUNITY

Policy contradictions are not the monopoly of Yangon. The international community, too, speaks out of both sides of its mouth. Led by London and Washington, it accuses Yangon of not doing enough to control the spread of HIV infection. This accusation is not without some justification but it could also be levelled at Zimbabwe, Kenya, Botswana or any number of other countries into which the U.S., for example, is pouring tens of millions of dollars to fight HIV. In Myanmar, there has until recently been little or no willingness to use assistance to persuade the regime to take a more proactive approach to HIV prevention and care.

This decision is clearly based on a far wider set of political imperatives than the HIV situation alone can answer for. But as was pointed out earlier, the epidemic waits for no person, whatever his or her political leaning. The military government in Yangon has shown a willingness to begin addressing the epidemic. The SPDC is a highly prickly government, and high-profile international accusations of deliberate fixing of the numbers (such as those levelled recently by a senior U.S. epidemiologist during international AIDS events) do not move the agenda forward. In other words, on this issue, the stick does not work. Incentives may be more effective.

This may be easier since ASEAN has become worried enough about HIV to put it on the collective regional agenda. This gives relative liberals in Yangon a convenient face-saving way of keeping HIV activities on the boil at home.

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<sup>8</sup> His statement does not seem to have dampened the success of Population Services International in beginning to promote a subsidised, high quality condom using classic and extremely high-profile advertising methods

## C. THE OPPOSITION

The political opposition inside Myanmar, led by Aung San Suu Kyi, has a very strong voice in dialogue with potential donor nations, and deservedly so. It has until recently opposed most forms of development aid, arguing that it ultimately benefits the military regime. Recently, however, opposition leaders have become more flexible in their thinking about funding of basic health and welfare services such as immunisation and primary health, which are delivered directly to beneficiaries.

In a meeting with European Union officials recently, Aung San Suu Kyi said that she saw HIV as less of a priority than other primary health interventions. Diplomats from neighbouring Asian countries, on the other hand, report that the opposition leader has repeatedly cited HIV as an important common concern. One thing is clear: future leaders of Myanmar, whatever their political persuasion, will have to cope with the consequences of the HIV epidemic. The more successful the country is in braking the spread of HIV now, the less the future impact will be. Less HIV-related illness, death and family breakdown means that future governments working to reconstruct the country will have more to invest in other basic areas of welfare and development.

## D. AUSTRALIA

Myanmar has very limited access to Official Development Assistance (ODA) and does not benefit from any assistance of the international financial institutions. This has left it with a huge gap in infrastructure facilities and financial capital. The total ODA currently provided to Myanmar is around U.S.\$1.0 per capita compared with U.S.\$35 for Cambodia and U.S.\$68 for Laos (1997 figures). This very low level of ODA fails to cover the minimum for basic humanitarian needs.

Myanmar's government expenditure on health care in 1999 was two billion kyat (U.S.\$3 million approximately) – a per capita expenditure on health care of U.S.\$0.60. The World Bank's recommended minimum is twenty times that amount. As much as 70 per cent of the budget goes to recurrent costs such as staff salaries and maintenance, leaving very little for other health care expenditures. NAP's budget for 1999 was 24

million kyat (U.S.\$30,000). Total UN system and INGO support to the National Program is U.S.\$3.0 million, which is 100 times the NAP's budget.

Because these budgets are so paltry, the argument usually shifts into "scarce resources" mode. Equally important health interventions get traded off against one another in the interests of making inadequate resources go further. However, while there will never be enough money for all that is needed, the people of Myanmar should not be in the position of seeing a penny split seven ways to preserve fragments of their health, when seven pennies would be well within the budget of bilateral and multilateral donors.

In primary health care, immunising a child is as important as prevention and treatment of tuberculosis. But in Myanmar's precarious epidemic situation, deciding to jettison HIV interventions in favour of more politically acceptable programs such as immunisation is simply not an option. Unless money is found for this (as well as for all basic primary healthcare packages), an out-of-control HIV epidemic will rapidly reverse all achievements made by other projects in a very short time, and for generations, regardless of who is in power.

Though limited resources are made available for Myanmar by donor communities, Australia has begun to show leadership in the funding of HIV/AIDS interventions. While there are political constraints to bilateral aid to Myanmar, Australia has recognised that addressing the epidemic can not wait. Therefore, it has started to fund Myanmar's HIV/AIDS prevention and care programs through various channels such as the government, UN, INGOs and national NGOs.

## IV. INCREASING ACTIVITY

After his first visit to Myanmar in April 2001, Professor Paulo Sergio Pinheiro, the UN Human Rights Rapporteur, said, "There are several signs that indicated evolution leading to an eventual political opening". Those signs are even more manifest six months after Professor Pinheiro's remarks, as indicated by the pace of visits, which seems to grow day by day. Many different groups have used HIV/AIDS, a humanitarian emergency, as an entry point to resume long pending talks with the government and other development partners.



In recent months, the following activities have provided evidence that donor nations and the government are tiptoeing towards a more proactive and productive partnership against HIV. These visits indicate that at least the issue is being discussed. However, discussion is, of course, no substitute for action against HIV.

- After the EU Troika's visit, two teams of experts representing the EU visited Myanmar for three weeks during June 2001 for situation assessment and analysis. Soon after that a first tranche of two million euros was given to four INGOs for HIV/AIDS, primary health care, and water and sanitation. More EU personnel have been coming and going during these months, and another tranche of humanitarian aid is in the pipeline for HIV/AIDS.
- The top official of the International Organisation for Population Movement (IOM) was in Myanmar during July 2001 for initial talks on HIV/AIDS and mobility issues.
- Two UNAIDS experts and one UNICEF/FHI person came to Myanmar to strengthen the blood product and behavioural surveillance systems.
- The deputy executive director of UNAIDS Geneva was in Myanmar during October 2001 with a team that was welcomed not only by the Health Ministry but also by other ministries involved in HIV/AIDS prevention.
- Thai Prime Minister Thaksin Shinawatra's government, which follows a robust, commerce-driven engagement policy, resumed a joint border HIV, TB and Malaria program. A high-level meeting and health exhibition took place in Tachileik in September 2001.
- UNAIDS experts visited Myanmar to work on estimates in October 2001.
- An AusAid team visited Myanmar during September and October 2001 to explore possibilities to work in HIV/AIDS and nutrition.
- Other teams from the UK's DFID, the EU, Norway, Sweden and Switzerland were in Myanmar during 2001 just to carry out on-the-ground work.

- Several occasions have shown the Myanmar government's high-level commitment to HIV/AIDS work, such as the UNGASS meeting, the ASEAN taskforce meeting in Yangon, Ministerial consultations in Melbourne, and the ASEAN heads of government meeting in Brunei.

## V. CONCLUSION

It is in the clear interests of Myanmar and all its neighbours that the HIV epidemic be brought under control as quickly as possible. Available epidemiological data suggest that the country is already close to the "tipping point". This is the point at which the critical mass of infection becomes so great that the epidemic is self-sustaining in the general population, even if risk behaviour in sub-populations with the highest risk, such as drug injectors and sex workers, is significantly reduced.

However other countries in the region, notably Thailand and Cambodia, have demonstrated that concerted, national-scale intervention at this stage can succeed in controlling the epidemic. Ultimately, averting a catastrophic generalised epidemic reduces the strain that HIV puts on other health and social services, not to mention families, communities and the nation as a whole. Wise investment in this area is, therefore, essential in order to protect the success of other initiatives in health and development.

This begs the question: what is wise investment? There is much debate about the key to successful HIV prevention and care programs. However, it is clear that the small handful of countries that have succeeded have been governed by two principles, namely pragmatism and working on a large scale.

There are now indications that at least some important factions within the government of Myanmar are willing to take a pragmatic approach to the epidemic. Whether they will gain the upper hand over more conservative elements remains to be seen. What is absolutely clear, however, is that the resolve of those who would like to avert the impending HIV crisis will never be tested without more pragmatism on the part of international donors.

Myanmar needs far more resources if it is to mount an effective response to HIV. And it needs to work

on a scale that far surpasses the capacity of existing non-governmental organisations. Working with NGOs alone is not an option if enough interventions are to be carried out to make any real difference. Apart from anything else, NGO-heavy funding is likely to create jealousies within the government and increase its obstruction. Like it or not, working effectively against HIV in Myanmar means working in substantial part through government institutions.

The good news is that the most relevant of those institutions – the public health infrastructure including the National AIDS Program – is in the hands of competent professionals who have demonstrated their willingness to work hard to deliver services to the most at-risk populations. Public health professionals in government have established good working relationships with NGOs and international organisations, though they have often been obliged to fly below the radar of the political bosses to do so.

It should be possible for the international community to capitalise on these informal partnerships by finding creative ways of funding

HIV-related interventions in Myanmar. A possible procedure would be to provide bilateral financial support for government-NGO partnerships in quantities large enough to create an incentive for politicians to embrace those partnerships. Funding of regional initiatives in cooperation with neighbouring provinces in Thailand and China may also be productive.

HIV in Myanmar is an issue that simply cannot be put on the back burner until the political situation improves or a more amenable regime is in power. Unless radical action is taken now to turn the tide, a humanitarian disaster whose effects will be felt for generations is inevitable.

It is by no means certain that attempts to work constructively with the government to avoid this disaster will succeed. But it is absolutely certain that the country cannot stem the tide without immediate, substantial and sustained financial and technical support for HIV prevention activities. Every effort must be made to encourage constructive engagement to this end.

**Bangkok/Brussels. 2 April 2002**

## APPENDIX A

### ABOUT THE INTERNATIONAL CRISIS GROUP

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The International Crisis Group (ICG) is a private, multinational organisation committed to strengthening the capacity of the international community to anticipate, understand and act to prevent and contain conflict.

ICG's approach is grounded in field research. Teams of political analysts, based on the ground in countries at risk of conflict, gather information from a wide range of sources, assess local conditions and produce regular analytical reports containing practical recommendations targeted at key international decision-takers.

ICG's reports are distributed widely to officials in foreign ministries and international organisations and made generally available at the same time via the organisation's Internet site, [www.crisisweb.org](http://www.crisisweb.org). ICG works closely with governments and those who influence them, including the media, to highlight its crisis analysis and to generate support for its policy prescriptions. The ICG Board - which includes prominent figures from the fields of politics, diplomacy, business and the media - is directly involved in helping to bring ICG reports and recommendations to the attention of senior policy-makers around the world. ICG is chaired by former Finnish President Martti Ahtisaari; former Australian Foreign Minister Gareth Evans has been President and Chief Executive since January 2000.

ICG's international headquarters are at Brussels, with advocacy offices in Washington DC, New York and Paris. The organisation currently operates field projects in more than a score of crisis-affected countries and regions across four continents, including Algeria, Burundi, Rwanda,

the Democratic Republic of Congo, Sierra Leone, Sudan and Zimbabwe in Africa; Myanmar, Indonesia, Kyrgyzstan, Tajikistan, and Uzbekistan in Asia; Albania, Bosnia, Kosovo, Macedonia, Montenegro and Serbia in Europe; and Colombia in Latin America.

ICG also undertakes and publishes original research on general issues related to conflict prevention and management. After the attacks against the United States on 11 September 2001, ICG launched a major new project on global terrorism, designed both to bring together ICG's work in existing program areas and establish a new geographical focus on the Middle East (with a regional field office in Amman) and Pakistan/Afghanistan (with a field office in Islamabad). The new offices became operational in December 2001.

ICG raises funds from governments, charitable foundations, companies and individual donors. The following governments currently provide funding: Australia, Canada, Denmark, Finland, France, Germany, Ireland, Japan, Luxembourg, the Netherlands, Norway, the Republic of China (Taiwan), Sweden, Switzerland and the United Kingdom. Foundation and private sector donors include the Ansary Foundation, the Carnegie Corporation of New York, the Ford Foundation, the William and Flora Hewlett Foundation, the Charles Stewart Mott Foundation, the Open Society Institute, the Ploughshares Fund and the Sasakawa Peace Foundation.

April 2002



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**All ICG reports are available on our website [www.crisisweb.org](http://www.crisisweb.org)**