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Negotiating authoritarian law and (dis)order: medicines, drug shops, and regulators in a poor Yangon suburb

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ABSTRACT

Global health policymakers have identified Myanmar as a source of high drug resistance and informal pharmaceutical markets in need of tighter state regulation. The World Health Organization drafted a Global Action Plan on antibiotic resistance (often referred to as antimicrobial resistance) that seeks to address it. Myanmar is one of over a hundred countries that has followed the World Health Organization's prescription and drafted its own National Action Plan. Through participating in the everyday life of a family pharmacy, we observed that in practice the outcomes of global plans for AMR, such as regulating access to antibiotics, are shaped by people's limited access to affordable health care, low salaries, and the military's authoritarian role in Myanmar politics. We followed how negotiations between state officials and drug vendors evolved towards a mutual understanding (as opposed to following written rules) after a Food and Drug Administration raid, intended to enforce the regulation of the sales of illegal medicines. Rather than uncritically pushing state-centric action, those working to promote the regulation of medicines must attend more carefully to how different modes of political authority and governance, combined with histories of health provision, shape drug policy in practice. Otherwise, they risk contributing, if not intensifying, already existing health and social injustices, whilst also failing to generate their intended outcomes, such as meaningful changes to antibiotic sales and reductions in resistance.

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Introduction

The World Health Organization (WHO) and other global stakeholders increasingly report that antimicrobial resistance (AMR) is an emerging threat to all nation-states. Low- and middle-income countries (LMIC) are frequently singled out as sources of particularly high AMR, commonly attributed to their 'irrational' use of, and the availability of, 'unregulated' antibiotics (Broom et al., 2020a; Holloway et al., 2016; Zellweger et al., 2017). The WHO has developed a Global Action Plan (GAP) on AMR with the goal ' . . . to ensure, for as long as possible, continuity of successful treatment and prevention of infectious diseases with effective and safe medicines' (World Health Organization, 2015, p. 1). Member states are expected to develop their own National Action Plans (NAP) in line with the GAP, following its prescriptions to better surveil, regulate, and rationalise antibiotic usage (World Health Organization, 2015).

Here, we follow Bacchi's approach (Bacchi, 2016) to policy in reading the WHO GAP and NAP as 'reactions to presumed problems', which attempt to dictate how antibiotics and their associated

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peoples should be governed (i.e. globally via the WHO and nationally via state governments) and the expected means to do so (state surveillance, regulation, and stewardship programmes). The WHO AMR GAP acknowledges that nation-states have variable resources available and thus differing abilities to govern antibiotics. This is posed as a particular challenge for many LMIC member-states, where the availability of antibiotics and their 'irrational' uses are shaped through their state-market formations, which in many cases differ from those of high-income countries. Such LMIC member-states may also lack equivalent government infrastructure and investments, as well as having differing degrees of state sovereignty, modes of political governance and means of enacting the rule of law. This raises questions about the success and possible negative consequences of the WHO's apparently default promotion of nation-states as the primary governing bodies through which global health policies, like antibiotic regulations, are expected to be enforced. For example, the WHO AMR secretariat states its support for member states to '[. . .] provide leadership to strengthen medicines regulatory systems at national and regional levels' (World Health Organization, 2015, p. 14)'. This technical language and the WHO's GAP document as a whole promote national regulations as a necessary means for governing antimicrobials while refraining from explicit discussion or prescriptions on political governance, enactment of rule of law and political principles.

We focus on Myanmar, a formally quasi-democratic state that continues to take an authoritarian approach to national security over the health and welfare of its citizens as the recent 2021 military coup amply demonstrates. Prior to the coup, the majority of these citizens were forced to seek health care and medicines through underfunded state facilities, private clinics, pharmacies, and unregulated markets. Similar to the WHO GAP, Myanmar's 2017 draft NAP is a technical policy document that does not describe its form of government, state-market arrangements, or other practices relevant to shaping antimicrobial use (National Action Plan for Containment of Antimicrobial Resistance: Myanmar (NAP AMR), 2017). The document frames AMR in line with the WHO GAP's objectives (The Ministry of Health and Sports, 2018, p. 48) and states that the Myanmar government was at the stage of exploration and initial implementation of laboratory surveillance, AMR awareness, improving hygiene/sanitation and drug regulation, with nationwide scale up due to be completed in 2022. The Food and Drug Administration (FDA) is the actor responsible for aspects of NAP Objective 4 that pertains to the regulation of medicines, including enforcing quality standards of antimicrobials. The draft NAP, however, states that they have 'limited human resources for regulatory enforcement' and 'lack effectiveness at the field level' (National Action Plan for Containment of Antimicrobial Resistance: Myanmar (NAP AMR), 2017, pp. 17, 19). Despite this, the FDA has begun to incorporate antibiotic-related awareness messages into its drug inspections, including warnings like, 'antibiotics should only be sold under a prescription' (Food and Drug Administration, 2020; Shwe Yee San Myint 2014b; The Ministry of Health and Sports, 2018). In this paper, we draw critical attention to examples of how drug regulation is enacted or not in Yangon, the previous capital city, and also the financial and social hub of Myanmar, to highlight some of the consequences of merely translating the WHO's GAP into action without considering how the history of military rule and fragmented state infrastructure in Myanmar shape access and regulation of medicines. We begin with a vignette, of a drug raid in an industrial poor workers' suburb of Yangon.

A food and drug administration raid

One morning early in 2019 during our ethnographic fieldwork at *Sein Se Saing* (Sein medicine shop), we noticed several boxes of injectable vitamins were missing. U Kyaw was shifting them and other medicines into a storage space at the back of their shop. U Kyaw and Aunty Moe are a couple that runs their small family-owned business, Sein, without any formal clinical or pharmaceutical credentials, a common practice in Myanmar. News of an FDA inspection was circulating in the neighbourhood. Despite this, Aunty Moe was not anxious, because as she later told us, they had evaded such inspections before, often by closing their shop early. Just as she was preparing *set say* (an assortment

of medicines, usually 3–4 pills per packet), which included antibiotics, for a regular customer, an FDA van arrived and 11 government officials got out and surrounded the entrance of Sein. Without giving her a chance to say anything, an FDA inspector sternly reprimanded her:

> You are mixing drugs? Are antibiotics included in here? [he looked at the packet] … Never sell antibiotics without a prescription. Antibiotic resistance is happening because you are selling them. This was recently announced by MOHS. They are now drawing up the policy … If we see you selling antibiotics after the policy is out, we will put you in jail.

Shortly afterwards, the inspectors started confiscating several boxes of medicines. One of them asked U Kyaw why he had analgesine injections. He answered that it was because the doctors and nurses come to buy them. She responded angrily, almost shouting, 'Watch your mouth, as a health officer we would never buy it from place like this!' While another instructed:

> If people come to buy antibiotics, only sell it to those who bring their prescription books and don't cut up the pills; you must sell them with their packaging. Because you mix medicines, people don't go to clinics and hospitals anymore … When people come to the hospital, they are resistant to the medicines.

The FDA confiscated more than 20 different types of medicines, mostly unregistered medicines, a net worth of approximately 350 USD. After leaving leaflets with instructions on how to sell medicines, they left, leaving Aunty Moe close to tears. Not only was she upset by how these 'young' officials spoke to them, their elders, but also because they had suffered a huge financial loss. Despite what the inspectors had said, Aunty Moe and U Kyaw were left with a sense of confusion and injustice as to why the incident occurred.

For those working in the field of global health, the above encounter may seem to be an example of how state employees can act to regulate the sale of unregistered pharmaceuticals and the unqualified provision of antibiotics. These practices may also be accepted as necessary measures to contribute towards global imperatives to reduce antibiotic consumption, ensure patient safety and medicine quality. Such an uncritical interpretation is problematic for Myanmar, on at least three accounts. First, it fails to engage with how and why the majority of people living in Myanmar access health care and the potential repercussions of clamping down on unregistered medicines. Secondly, it appears ignorant or disinterested in how the Ministry of Health and Sport's (MOHS) (including the FDA) enactment of regulation, like other state agencies in Myanmar, follows a politics of fear and repression that publicly blame and penalise those such as Aunty Moe and U Kyaw for the (dis)functioning and fragmentary nature of health provision and the Myanmar State, more generally. Finally, it fails to engage with how state employees and drug shop vendors attempt to negotiate the enactment of regulation – partly through *nalehmu*, a mutual understanding – so as to minimise disruptions to their work and availability of cheaper medicines, while avoiding directly challenging social hierarchies and inequities. In this paper, we follow the aftermath of the FDA raid and foreground Myanmar's broader history and the WHO's AMR GAP, to elucidate these points.

Myanmar an authoritarian state: fear, rule of law, and Bamar Buddhist nationalism

Research has been conducted on drug resistance in Myanmar since at least the 1970s (R Htun Nyun et al., 1975; Sabai Phyu et al., 2005). In the 2010s, work on AMR was carried out through disease-specific programs (e.g. tuberculosis, malaria) spearheaded by non-governmental organisations and bilateral and multilateral organisations (The Global Fund, 2019; USAID, 2020). Only since the development of the WHO GAP in 2015, however, has antibiotic resistance been framed by the MOHS as a matter of 'national' concern in need of increased regulatory measures. However, to talk of 'national' concern and proposed state-centric solutions in Myanmar is no straightforward matter. While the WHO GAP does not touch directly on the ongoing authoritarian role of Myanmar's military in political governance, state sovereignty, and rule of law, here, we foreground historical and contemporary

aspects of Myanmar that are central to understanding how any NAP, particularly with relation to regulation of antibiotic, (dis)functions in practice (Broom, et al., 2020b), such as in the case of the FDA raid and events that followed it.

Myanmar's democratically re-elected government, the National League for Democracy (NLD), has inherited a national territory and state that continues to grapple with the legacies of British colonialism, followed by 50 years of military rule. Many were quick to optimistically laud Myanmar's economic opening up, NLD's 2015 and 2020 election wins, and to support calls for the rule of law as part of democratisation (Cheesman, 2014). As the February 1st military coup demonstrates, the democratisation of Myanmar is fragile. Since the early 1990s, the military imposed and attempted to manage Myanmar's 'transition' to democracy. The result is a 'hybrid regime' (Stokke & Soe Myint Aung, 2020), where the NLD – or any other elected parties – must constantly negotiate with the military that has constitutionally mandated 25% of parliamentary seats, complete operational independence from Myanmar's head of state, Aung San Suu Kyi, and the authority to appoint the heads of three key ministries, Border Affairs, Home Affairs, and Defence (Maung Aung Myoe, 2014). Scholarly analyses draw attention to how the meaning and enactment of politics and the rule of law remain subject to the military's ongoing role in state politics and everyday life (Cheesman, 2014; Prasse-Freeman, 2015). This is not only evidenced by the recent military coup but also in how violence or its threat continues to play a central role in daily life in Myanmar, whether in the civil wars the military is waging with non-Bamar ethnic armed organisations, the exclusion of Rohingya as citizens, or the violent silencing of dissidents. Current enactments of laws and regulations share more in common with Myanmar's military past and its slogan of 'law and order' than rule of law in democratic states where it is ' . . . associated with ideas and practices aimed at substantive [and political] legal equality . . .' (Cheesman, 2014, p. 232). In other words, rule of law continues to serve the military's aspirational order, which prioritises maintaining and expanding their Bamar Buddhist national sovereignty and security for the benefit of a minority of military and other elites (Sanchez, 2020). Meanwhile, Aung San Suu Kyi and the NLD, more generally, have repeatedly attempted to either tacitly or explicitly oppose the military, such as their attempt in 2020 to reduce the military's political power via changing the Constitution. However, in some cases, while referring to national security, rule of law, democracy, and justice, the NLD has also affirmed the military's agenda, such as when Aung San Suu Kyi defended the military in the International Court of Justice in the Hague against accusations of crimes against humanity (Bowcott, 2019).

Many commentators have argued that Myanmar's State as a whole has and continues to give precedence to the expansion and maintenance of its sovereignty, security, and integrity over the fulfilment of universal human rights and equality, improving standards of public health, welfare, and infrastructure for all those that reside within its borders (Oehlers, 2005; Prasse-Freeman & Latt, 2018; Skidmore & Wilson, 2008). While this is most evident for residents of Myanmar living in areas where the military continues to engage in civil wars or in negotiated and forced ceasefires, in many ways it is also the case for the majority of people living in Myanmar. During the military's absolute authoritarian rule (1962–2011), increased investment and development of military resources and institutions paralleled the gradual run-down and fragmentation of state infrastructure and institutions (Oehlers, 2005; Perry, 2007). While this certainly was the consequence of a weak state, scholars have also described not only deliberate negligence (Oehlers, 2005), but the military's active denial of development and improvements to urban settlements and state infrastructure to ensure populations would not come to threaten their pursuit of 'law and order' (Perry, 2007; Sanchez, 2020; Seekins, 2005; Seekins, 2009). The military accompanied such authoritarian means of social control with the threat of violence and state surveillance, all of which served to create a pervasive sense of fear, distrust, and paranoia amongst Myanmar's citizens, as well as the military, civil servants, and state officials themselves (Skidmore, 2003). This continues in varying degrees to the present day, as is evident with the military's recent coup that attempts to silence political dissent and claims for justice through violence.

The legacy of the military's rule has led to public health facilities and state regulatory institutions (like the FDA) that are characterised by corruption and underfunding, lacking all but basic staff, equipment, and consistent supplies of medicines. When patients visit public health facilities, they may have to *gadaw* – pay respect ('special fees') – in order to receive the available medicines or priority clinical appointments, in part as compensation for health staffs' poor salaries. *Gadaw* practices have become an accepted norm for patients to essentially pay for services in the public sector that are otherwise unavailable, contributing to partially privatising the public sector. Furthermore, Myanmar's citizens cope with the shortcomings of state institutions' provision of health care through visiting street vendors and black markets for more affordable medical equipment and medicines (Oehlers, 2005). The lack of a national health insurance means that the majority of health financing occurs through out-of-pocket payments in the private sector (World Health Organization, 2014). In sum, the underfunding and under resourcing of Myanmar's public health infrastructure have created conditions where those already struggling with crippling poverty and low wages often perform *gadaw* practices, simply to access state service, as well as relying on private and poorly regulated provision of basic health care, and safe, quality assured medicines. Combined with the military's ongoing role in everyday life, and a pervasive politics of fear, the majority of Myanmar's citizens are left with limited options, except to cope and make do, or risk being taken before the law; the recent coup makes this all the more evident. Taken together, the coup poses significant challenges to the effective national implementation of global policies, such as the AMR GAP, and how their enactments are experienced by Myanmar's citizens. This paper explores how small drug vendors that provide medicines to Yangon's urban poor, FDA officials, and other state authorities negotiate the enactment of drug regulations, so that the enforcement of laws does not disrupt, at least in the short to mid-term, the sale of unregistered medicines, their livelihoods, and more broadly, Myanmar's 'law and order.'

Methods

This paper draws on ethnographic fieldwork at *Sein Se Saing* and interviews with various people involved in the pharmaceutical sector in Yangon. This approach allowed us to explore not only what people thought about the sale, access, and regulation of medicines, but also how these activities unfold in practice and how they correspond, or not, to Myanmar's drug laws and AMR NAP. As part of participant observation, we also paid close attention to Burmese terms, particularly those related to the negotiation of Myanmar's 'law and order'. We include some of these terms as Burmese transliterations in this text to assist and remind readers that terms cannot be fully understood independent of the contexts and practices in which we observed and heard them.

YKZ and JSB conducted ethnographic fieldwork over nine months (January–September 2019) in various parts of Yangon, including at a small local wet market where Sein was located, and visited two large wholesale markets, and eight pharmaceutical companies. We also followed up some of these businesses' clients, accompanying a few of them in their daily lives, including a clinician, a rural health worker, a nurse aid, a vet, and a rural health assistant. We conducted a series of in-depth semi-structured interviews with Aunty Moe and U Kyaw to supplement our ethnographic observations, to gain a greater degree of reflective discussion of what we observed and heard from them or others, as well as the relevant documents we surveyed (e.g. such as AMR policy and legal documents) (Given, 2008, p.422–423). We interviewed several stakeholders, including two FDA employees, four individuals providing health services (e.g. from non-governmental organisations) in this setting, and six clinicians who worked for the public and private sectors. Interviews lasted between 30 and 120 minutes and focused on understanding participants' lives, their reflections and experiences of laws and regulations, their understandings of health provision, and their awareness of antibiotic use or AMR. We also conducted media and documentary analysis concurrent to our fieldwork on topics related to regulation of medicines and AMR, drawing on various sources including social media sites, libraries, news, and reports. All interviews were conducted in Burmese, and when digitally recorded, were

transcribed, prior to thematic coding and analysis. When participants requested not to be recorded, we took extensive notes instead. YKZ and JSB discussed and reflected on field notes daily, and with CLH every week or two. Data analysis was conducted iteratively alongside fieldwork, allowing themes to be further challenged or corroborated in interviews or observation, as we gradually developed and refined more general or abstracted analytical codes. Throughout our research we prioritised being sensitive to the needs and concerns of our participants and the circumstances in which they lived and worked, and only engaged in interviews and participant observation when consent was granted. In order to protect our participants, we use pseudonyms for people and places. This study obtained ethical approval from the London School of Hygiene and Tropical Medicine.

Sustaining national (dis)order: the national drug law and Yangon's poor

Sein is situated in one of Yangon's large industrial workers' neighbourhoods and has opened 7 days a week from 6 AM to 6 PM for over 15 years. Their customers are a mix of medical professionals buying supplies for their clinics, shops, and practices and residents of the township, most of whom are referred to by development organisations as the urban poor (Azam, 2014). The latter are composed of people who were forcedly displaced and resettled from central Yangon following various development projects or are rural-urban migrants that dramatically increased in number following Cyclone Nargis in 2008. The township where they reside and work is described in popular media as one of Yangon's 'most problematic' townships due to poverty, crime, overpopulation, and lack of state infrastructure (e.g. sewerage and drainage, clean water), which contributes to frequent flooding and spread of infectious diseases (see Supplementary Material, Figures 1 and 2). Almost all of Sein's customers are those who provide care and medicines to the urban poor of Yangon or are the urban poor themselves, subject to various forms of structural violence, including state neglect and market exploitation.

Sein has a registration license from the MOHS, which recognises them as a legal vendor of medicines. While the shop is registered with requisite state authorities, a large portion of the medicines they sell are unregistered with the FDA and are therefore, illegal, according to the updated 2018 National Drug Law (Union of Myanmar, 1992; Union of Myanmar 2018). This states that legal action (up to 7 years of jail or a fine) will be taken against the sale of drugs that are unregistered, fake, and dangerous or 'determined as not fit for utilisation by the Ministry of Health' (The Union of Myanmar, 2018). Although Aunty Moe and U Kyaw – as well as other drug vendors we observed and spoke with – were aware of this law, the fact that they do not literally follow it to the letter is not due to disregard for patient-consumer safety; quite the opposite. Their – and others' – knowledge and ongoing experiences of Myanmar's state repression, violence, and its focus on its security means they do not simply trust that registered medicines are necessarily safer than those that are not. They are aware that not only has the FDA been understaffed and underfunded, limiting their ability to do their work effectively, but the processes of drug registration also lack transparency and are commonly known to require *gadaw* fees. Despite this, Aunty Moe contended that this does not mean that the MOHS is unable to regulate and remove 'dangerous' medicines, as when chloramphenicol pills disappeared from pharmaceutical markets. The director of the FDA and the Department of Fisheries stated that chloramphenicol was not registered for import and was prohibited for use in aquaculture (Shwe Yee San Myint, 2014a). We have not been able to locate publicly available information to corroborate these statements. This reflects a common trope in Myanmar; that being able to know laws and hence, what is illegal or not, is not a citizen's right, or at least, not a self-evident matter. Whether this is intended or not as a means of social control, Myanmar's citizens are kept in the dark about questions of legality, conferring a privilege of power to those with knowledge, potentially enabling them to exercise and enforce laws according to their whims (Cheesman, 2009; Prasse-Freeman, 2015). This also means that state employees can make claims to illegality where such laws may not exist or at least, not strictly in the ways they are articulated in practice. Thus, as Cheesman (2009, 2014) argues, in Myanmar law in practice serves as a means of

Figure 1. Informal settlements in the outskirts of Yangon (taken by YKZ).

maintaining a particular order. In the case of medicines, this order determines what medicines are available, where, for whom, and how the state employees classify them, as well as who can afford to purchase and consume them. Hence, any general designation of Sein's sales and its customers' purchases of unregistered medicines and antibiotics without prescriptions as *illegal*, fails to understand how rule of law in Myanmar actually (dis)functions in practice, through its limited investment in quality assurance measures, underpaid staff, and lack of affordable provision of medicines and care to its citizens. Aunty Moe and U Kyaw's distrust of the state is not only is sensitive to this, but is part of sustaining this (dis)order through filling the 'gaps' that national drug laws (re)produce in enabling the classification of medicines and practices as illegal or not in the first place.

Shops like Sein sell unregistered medicines because they are cheaper than medicines registered with the FDA (Shwe Yee San Myint, 2014b). Such medicines are also available elsewhere, such as pharmaceutical chains or in clinics, where customers will also likely be charged a consultation fee of 2–3 USD. The majority of residents in the vicinity of Sein earn 3 or less USD a day through minimum wage jobs or casual labour, and have little choice except to purchase cheaper unregistered

Figure 2. A swamp near Sein (taken by JSB).

medicines. Many state officials are aware of this, albeit not openly. This is the case of medical professionals who refer their patients on to providers like Sein when public health facilities they work in lack the requisite medicines, or they themselves purchase unregistered medicines for their own private practices. One example of the latter is Mya Myint, one of Sein's top customers, a government employed rural health assistant in her village outside Yangon. Her meagre monthly salary at just over 1 lakh (70 USD, roughly the same as factory workers on minimum wage) is barely enough to support herself. Thus, like many other government employees (May Thandar Win, 2016), including medical consultants working in public hospitals, she has had little choice except to start up her own private practice.

Every 1–2 weeks Mya Myint visits Sein to purchase medicines in bulk of up to 5–6 lakhs (350–450 USD), carrying them on her motorbike during her home visits, attending to the elderly, those too sick to leave home or who cannot travel to Yangon or another village for medical attention. For each visit, she charges between 5000 and 10,000 kyats (4–8 USD), almost the same cost as a clinician's consultation fee in central Yangon. From these visits, she says she can earn significantly more than her government salary. Without the likes of Sein and their sale of unregistered medicines, and Mya Myint and her private practice, Yangon's urban poor and those across Myanmar would lack affordable medicines and sufficient earnings. The state's de- and underfunding of public health infrastructure and other state institutions – including salaries, affordable medicines, and transparent processes for regulating them – means that policies such as the National Drug Law actively participate in creating the 'necessity' for shops like Sein to fill such 'gaps' in state provision for Yangon's urban poor. They also contribute to sustaining the distrust Myanmar's people harbour towards laws on paper (many of which they have not seen or heard of) and affect their meaning in everyday encounters.

Negotiating the rule of law: mutual understanding and paying respect

In line with Myanmar's draft AMR NAP, during their unannounced inspections, the FDA has in addition to confiscating unregistered medicines began to reprimand drug shop owners for selling antibiotics without prescriptions. However, legally, the FDA can only take action against the sale of unregistered medicines and not the sale of antibiotics. So, the likes of Sein are confused when they are reprimanded by FDA inspectors for selling antibiotics when it's not currently illegal to the extent of persecution to sell them over the counter without prescription.

Sein received two warning letters stating a mandatory three-month suspension of all operations and a termination of the shop's registration license. U Kyaw and Aunty Moe were very upset and asked a friend, who had also received a warning letter, what he was going to do. Also distressed, he responded: 'If my shop is closed, what are we going to eat and live with? I have to keep it open.' U Kyaw and Aunty Moe then decided to visit the FDA, who denied sending the letters. Later that evening, two other shop owners came to discuss the situation, and speculated on whether the letters were 'fakes' and if someone else in authority, not based in the FDA, had sent them to 'warn us'. Such reflection made it evident that the shop owners were less concerned with the regulations and whether or not they had broken them (selling unregistered medicines or antibiotics without prescriptions), and more concerned with why state officials had specifically targeted and caught them in particular.

All of them knew that state officials were aware of these illegal activities and typically turned a blind eye, so they were convinced that they must have disrespected one of the local authorities, and thus be 'in their bad graces.' After some deliberation, Aunty Moe concluded that they must approach a state official (SO) responsible for overseeing activities in the area. She was convinced that someone was upset because she had not once gone to the public hospital to *gadaw* to the SO. She postulated on several reasons as to why this may be the case.

One scandal they had heard involved Sabai (which also received a warning letter), a large drug shop with multiple branches, whose owner was sued by the FDA and received a jail sentence for having a large stock of unregistered medicines. However, rumour had it, the owner paid 150 lakhs ($10,000) to the SO, which resulted in all the charges being dropped. When they eventually met the SO, they learned that this had actually happened under the previous SO. Despite this, rumours circulated that the current SO had reached a *nalehmu* with Sabai. *Nalehmu* is a discrete, mutual understanding based on relations of mutuality, obligation, and reciprocity that seeks to broker justice often outside the rule of law, whilst leaving intact existing social hierarchies and inequalities (Rhoads, 2020; Roberts, 2020). The outcome of the *nalehmu* was that Sabai would *gadaw* to the SO, and in return they could continue to stock and sell as many illegal medicines as they wanted, unhindered by the potential enactment of the national drug law, so long as they also took precautions to avoid getting caught again.

The current SO was furious with this rumour as it had led to her receiving a warning from her superior. From this, Aunty Moe deduced that the raid had been intended for Sabai and had caught them as collateral damage with their unregistered medicines. She was right, Sabai had to *gadaw* to the SO. Similar to the shame the SO experienced when the rumour circulated about a *gadaw* relationship with Sabai, she was shamed again, this time in front of the inspectors and other state employees when they found unregistered medicines in Sein, a drug shop in an area under her jurisdiction; openly implicating her in allowing illegal activities to take place. Aunty Moe told us that the owner of Sabai, and the SO, came to a *nalehmu*, and the SO warned everyone else, 'If you are selling unregistered medicines, maybe you should do it quietly'. In doing so, the SO recognised Sein and the other drug shops' precarious circumstances, and emphasised that they need to recognise hers too.

Two months later, Sein was back to its pre-raid activities. When we inquired about the penalty from the warning letters, U Kyaw merely responded, 'We have come to a *nalehmu* with the SO.' Despite the raid and the activities that followed, Aunty Moe was not angry with the state officials. She said:

> I don't blame her [SO] too much. It's hard to be a doctor here. You have to work hard and their basic salary is only around 2-3 lakhs [150$/month] and they always have to do overtime. So, they try to get money like this to survive.

Later, we learnt from interviews with our FDA informants that prior to any drug shop raids they have to seek permission from a wide range of state actors, some of whom also participate in their raids. This confirmed Aunty Moe and the other drug shop owners' suspicions that it was the SO and not the FDA, who had sent them the letters.

Evading and breaking the law to broker (in)justice

Reaching a *nalehmu* agreement that involves *gadaw* is one of the ways that Sein and other drug shops negotiate with state authorities to evade the full penalties of the National Drug Law. Preferable to getting caught in the first place, Aunty Moe and U Kyaw employ a number of strategies to evade the authorities. Primary amongst these is receiving notification of raids in advance, so they can close their shop. For Sein, these come from Aunty Moe's brother who works as a state employee or from a phone call from a fellow shop owner. However, when they have insufficient forewarning, like in the raid described earlier, U Kyaw moves any unregistered medicines and others that they are not licensed to sell into hidden storage at the back of their shop. Aunty Moe told us such measures are normal amongst drug shops. A senior member of the FDA attested to such practices in a local news article:

> We try to control the sale of illegal drugs at the market, but we cannot stop all of it. When we go to these shops to inspect for illegal medicines, store owners move their stock before we come. (Shwe Yee San Myint, 2014b)

One of our FDA respondents corroborated this statement by stating that the department lacked staff and budget to do frequent raids and more than one or two antimicrobial awareness raising activities per year. Thus, breaking and negotiating the application of the law through *nalehmu* often is the most practical way for all parties involved to broker relative justice.

A few months later, we witnessed another FDA raid. This time Aunty Moe and U Kyaw were ready. Her brother had already notified them in advance, so they were able to remove their shop sign and close up, leaving what looked like an abandoned roadside cubicle to any passer-by. Meanwhile, U Kyaw stood nearby, listening for any signs of the inspectors coming and going, notifying others of the authorities' intended raid. This time they evaded getting caught and bringing further shame to the SO, fulfilling their part of the *nalehmu* agreement with her. The SO appeared to fulfil her part; they did not receive another warning letter or have to *gadaw*. This allowed vendors to continue to sell unregistered medicines and authorities to continue to conduct their raids in the neighbourhood. Myanmar's national (dis)order is not only sustained by shops like Sein and practices like Mya Myint's, which act as a way to fill the 'gaps' in healthcare provision, but also through state agents like the SO, who actively participate in breaking the law to allow such provision to continue.

Conclusion

The WHO prescribes nation-states as those responsible for translating its AMR GAP policies into action, particularly the regulation of access, use, and quality of antibiotics. Our ethnographic exploration of drug regulation in practice pushes back against the sufficiency of such technical prescriptions (e.g. reduce illegal sales of antibiotics) to effectively achieve the National Drug Law and NAP AMR's apparent intended ends. We demonstrate this by contextualising our empirical findings through historical and contemporary aspects of Myanmar daily life. Shops like Sein's sale of unregistered medicines and Mya Myint's private medical practice provide where the Myanmar state does not. FDA and other state authorities, and drug shop vendors, are well aware of the limits of the Myanmar state's health-care infrastructure, inadequate investment in drug quality assurance and low employee salaries. They understand that the *illegal* sale of medicines is necessary because of the state's lack of provision of affordable medicines but also to sustain the livelihoods of the likes of U Kyaw and Aunty Moe, as well as to supplement state officials' own meagre salaries. They all also know that not only does the state lack infrastructure to effectively enact regulations according to the letter of the drug law but also, when attempts are made to enforce it, they typically end up serving the military and state authorities' interests over Myanmar's citizens' health and welfare. Hence, as we have described, distrust of Myanmar's state and fears of its authorities are commonplace, an ongoing legacy of the military's authoritarian approach to governing everyday life in Myanmar, as amply evidenced in the recent coup. So, drug vendors, the FDA, and other state officials discreetly negotiate

the enactment of drug laws through fragile *nalehmu* and *gadaw* practices to maintain a semblance of following the rule of law to the letter, while avoiding bringing shame to more senior state officials and openly challenging Myanmar's 'law and order'. In doing so, they find ways to cope and make do with the little they have, while brokering small acts of justice through ensuring Yangon's poor continue to have access to affordable medicines. We therefore call for those working to promote the regulation of medicines, such as antibiotics, to attend more carefully and explicitly in policy design and implementation not only to a state's infrastructural abilities to enact laws but also its political priorities, approaches to political governance, and the relevant effectiveness of its state-market arrangement to the provision of affordable quality assured health care. In Myanmar, this means questioning the effectiveness and harm of promoting a state-centric approach, such as the regulatory aspects of its AMR NAP, as well as considering cautious engagement and decentralised work with the many non-state 'experts' that are already in place (e.g. civil society and other ethnic minority organisations, local researchers). If not, they may run the risk of contributing to, if not intensifying, already existing health disparities and social injustices whilst also failing to generate intended outcomes, such as meaningful changes to antibiotic sales and reductions in resistance.

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References

Azam, A. (2014). Health Care for the urban poor in Myanmar. *Hera: Right to health and development*. https://careersdocbox.com/70229855-Nursing/Health-care-for-the-urban-poor-in-myanmar-assessment-to-identify-the-scope-of-problem-and-intervention-options-consultancy-mission-report.html

Bacchi, C. (2016). Problematizations in health policy: Questioning how "problems" are constituted in policies. Sage Open, *6*(2). 1-16. https://doi.org/10.1177/2158244016653986

Bowcott, O. (2019, December 11). Aung San Suu Kyi tells court: Myanmar genocide claims 'factually misleading'. *The Guardian*. https://www.theguardian.com/world/2019/dec/11/aung-san-suu-kyi-tells-icj-myanmar-genocide-claims-factually-misleading

Broom, A., Kenny, K., Kirby, E., George, N., & Chittem, M. (2020a). Improvisation, therapeutic brokerage and antibiotic (mis) use in India: A qualitative interview study of Hyderabadi physicians and pharmacists. *Critical Public Health*,*30*(1), 16–27. https://doi.org/10.1080/09581596.2018.1516032

Broom, A., Kenny, K., Prainsack, B., & Broom, J. (2020b). Antimicrobial resistance as a problem of values? Views from three continents. *Critical Public Health*,*6*(2), 1–13. https://doi.org/10.1080/09581596.2020

Cheesman, N. (2009). Thin rule of law or un-rule of law in Myanmar? *Pacific Affairs*, *82*(4), 597–613. https://doi.org/10.5509/2009824597

Cheesman, N. (2014). What does the rule of law have to do with democratization (in Myanmar)? *South East Asia Research*, *22*(2), 213–232. https://doi.org/10.5367/sear.2014.0203

Food and Drug Administration. (2020). *Regulations [webpage]*. Ministry of Health and Sports, Republic of the Union of Myanmar. https://www.fda.gov.mm/?p=4481

Given, L. M. (2008). *The Sage encyclopedia of qualitative research methods*, (pp. 422–423). Sage Publications.

Holloway, K. A., Rosella, L., & Henry, D. (2016). The impact of WHO essential medicines policies on inappropriate use of antibiotics. *Plos One*, *11*(3), e0152020. https://doi.org/10.1371/journal.pone.0152020

Htun Nyun, R., Aung-Than-Batu, H., N.,Tin, F. U. T., Myint, T., & Kyi, K. K. (1975). Chloroquine-resistant malaria in Burma. The Journal of Tropical Medicine and Hygiene, 78 (8), 186–189. PMID: 128638. https://europepmc.org/article/med/128638

Maung Aung Myoe, (2014). The soldier and the state: The Tatmadaw and political liberalization in Myanmar since 2011. *South East Asia Research*, *22*(2), 233–249. https://doi.org/10.5367/sear.2014.0205

National Action Plan for Containment of Antimicrobial Resistance: Myanmar (NAP AMR). Ministry of Health and Sports, Republic of the Union of Myanmar. (2017). apps.who.int/datacol/answer_upload.asp?survey_id=666&view_id=722&question_id=13163&answer_id=19958&respondent_id=249312

Oehlers, A. (2005). Public health in Burma: Anatomy of a crisis. *Journal of Contemporary Asia*, *35*(2), 195–206. https://doi.org/10.1080/00472330580000131

Perry, P. J. (2007). *Myanmar (Burma) since 1962: The failure of development*. Ashgate Publishing, Ltd.

Prasse-Freeman, E. (2015). Conceptions of justice and the rule of law. In D. I. Steinberg (Ed.), *Myanmar: The dynamics of an evolving polity* (pp. 89–114). Lynne Rienner.

Prasse-Freeman, E., & Latt, P. W. (2018). Class and inequality. In A. Simpson, N. Farrelly, & I. Holliday (Eds.), *Routledge handbook of contemporary Myanmar* (pp. 404–416). Routledge.

Rhoads, E. (2020). Informal (Justice) brokers: Buying, selling and disputing property in Yangon. In H. M. Kyed (Ed.), *Everyday justice in Myanmar: Informal resolutions and state evasion in a time of contested transition* (pp. 283–315). Nias Press.

Roberts, J. L. (2020, November 17). Nalehmu urbanism: The informal, intimate and relational economies of Yangon Street Vending. https://www.lse.ac.uk/seac/events/2020/seminar-roberts

Sabai Phyu, Thandar Lwin, T., Ti Ti, Win Maung, Win W. Mar, San S. Shein, & Grewal, H. M. (2005). Drug-resistant tuberculosis in Yangon, Myanmar. *Scandinavian Journal of Infectious Diseases, 37*(11–12), 846–851. https://doi.org/10.1080/00365540500265065

Sanchez, J. (2020). Blinded like a state? Urban sanitation, improvement and high modernism in contemporary Myanmar. *Political Geography*, *82*, 102255. https://doi.org/10.1016/j.polgeo.2020.102255

Seekins, D. (2009). State, society and natural disaster: Cyclone Nargis in Myanmar (Burma). *Asian Journal of Social Science*, *37*(5), 717–737. https://doi.org/10.1163/156848409X12474536440500

Seekins, D. M. (2005). Burma and US sanctions: Punishing an authoritarian regime. *Asian Survey*, *45*(3), 437–452. https://doi.org/10.1525/as.2005.45.3.437

Shwe Yee San Myint. (2014a, July 21). Call for action on use of drugs in fish farming. *Myanmar Times*. https://www.mmtimes.com/national-news/11096-call-for-action-on-use-of-drugs-in-fish-farming.html

Shwe Yee San Myint. (2014b). Mingalar market, an illegal medicine cabinet.*Myanmar Times*. https://www.mmtimes.com/national-news/11439-mingalar-market-an-illegal-medicine-cabinet.html

Skidmore, M. (2003). Darker than midnight: Fear, vulnerability, and terror making in urban Burma (Myanmar). *American Ethnologist*, *30*(1), 5–21. https://doi.org/10.1525/ae.2003.30.1.5

Skidmore, M., & Wilson, T. (2008). *Dictatorship, disorder and decline in Myanmar*. ANU Press.

Stokke, K., & Soe Myint Aung.(2020). Transition to democracy or hybrid regime? The dynamics and outcomes of democratization in Myanmar. *The European Journal of Development Research,* 32, 274–293. https://doi.org/10.1057/s41287-019-00247–x

The Global Fund. (2019). Focus on regional artemisinin-resistance initiative (RAI). https://www.theglobalfund.org/media/6509/publication_regionalartemisininresistanceinitiative_focuson_en.pdf

The Ministry of Health and Sports. (2018). First national multisectoral steering committee meeting combating AMR Myanmar [report]. http://mohs.gov.mm/Main/content/publication/antimicrobial-resistance-first-national-multi-sectoral-steering-committee-meeting-for-combating-antimicrobial-resistance

The Union of Myanmar. (1992). *National drug law*. Ministry of Health, Republic of the Union of Myanmar. http://www.fdamyanmar.gov.mm/wp-content/uploads/2018/01/Regulations-on-National-Drug-Law-min.pdf

The Union of Myanmar. (2018). *Amendment of the national drug law*. Ministry of Health and Sports, Republic of the Union of Myanmar. https://www.fda.gov.mm/?p=166

USAID. (2020). *U.S. President's Malaria Initiative Burma Malaria Operational Plan FY 2020*. United States Agency for International Development. https://www.pmi.gov

May Thandar Win (2016, September 19). The great medical brain drain. *Frontier Myanmar*. https://www.frontiermyanmar.net/en/the-great-medical-brain-drain/

World Health Organization (2014). *The Republic of the Union of Myanmar health system review*. World Health Organization. https://iris.wpro.who.int/handle/10665.1/11354

World Health Organization. (2015). *Global action plan on antimicrobial resistance*. World Health Organization. https://www.who.int/antimicrobial-resistance/global-action-plan/en/

Zellweger, R. M., Carrique-Mas, J., Limmathurotsakul, D., Day, N. P. J., Thwaites, G. E., & Baker, S., & Southeast Asia Antimicrobial Resistance Network. (2017). A current perspective on antimicrobial resistance in Southeast Asia. Journal of Antimicrobial Chemotherapy, 72(11), 2963–2972. https://doi.org/10.1093/jac/dkx260