

Ceasefires and health: challenges and opportunities for health equity in eastern Burma/Myanmar.

Abstract

From 2011 to 2015, eight separate ceasefires were signed between the Myanmar government and armed groups across eastern Myanmar. Although sporadic fighting continues, this region of the country is receiving both humanitarian and development interventions.

In other contexts, the transition from conflict to post conflict has been accompanied by a transition in donor funds from humanitarian to development programs. This funding transition can impact people's health: analyses of these situations suggest that the nature of aid instruments, donor behavior and politics, and the government's capacity and legitimacy are all determinants of health in transition periods.

The transition in eastern Myanmar is made more complex by the existence of two parallel health systems—one run by the Ministry of Health and one run by a network of ethnic health authorities and community-based providers. Although both sides have indicated their willingness to coordinate and collaborate on health interventions in a process called "convergence," the changing donor environment and gaps in funding could create additional barriers to equitable and universal health service delivery in Myanmar.

This paper describes how the transition from humanitarian aid to development can impact health service delivery in Eastern Myanmar. The paper outlines how the transition creates challenges and opportunities for delivering healthcare, and it makes recommendations on how donors and implementing agencies can best navigate these challenges.

Background

Myanmar has experienced decades of civil war. As elsewhere, the conflict has had negative impacts on the health system and health outcomes. In Eastern Myanmar, conflict impacted health systems and health outcomes, which created wide disparities between this area and the rest of the country (Aye & Lanjouw, 2014). Failure to invest in health services, endemic tropical diseases and human rights violations created the conditions for a chronic humanitarian disaster. Treatable diseases are the leading cause of death, pregnant women and children are malnourished, and tuberculosis and malaria drug resistance is spreading. War related injuries are on the decline, but there is a concern that landmine injuries will increase if populations return to abandoned farmlands.

Table 1: Key health indicators and comparators for Eastern Burma displaced population

	Eastern Burma 2004 ¹	Eastern Burma 2013 ²	Burma (National) ³	3MDG target
Infant Mortality per 1,000 live births (IMR)	91	94.2	40	26
Under 5 Mortality per 1,000 live births (U5MR)	221	141.9	51	38
Maternal Mortality(U5MR) per 100,000 live births (U5MR)	1,000-1,200	721 (2008) ⁴	230	130
Child (U5) malnutrition (%)	15.7	16.8	7.9	21.3
Maternal malnutrition (%)	16.7 (2008) ⁴	11.3		

¹ BPHWT (2004) Chronic Emergency, Mae Sot: Backpack Health Worker Team

² HISWG (2015) The Long Road to Recovery, Mae Sot: Health Information Systems Working group

³ World Bank (2015) Data – Indicators. Available at <http://data.worldbank.org/indicator>

⁴ Parmar PK et al. Health and human rights in eastern Myanmar prior to political transition. BMC

As part of counterinsurgency strategy, the government did not provide health services in Eastern Myanmar and restricted international humanitarian aid to these areas (South, 2011). In response, communities along with health divisions of Non State Armed Groups (NSAGs) developed their own network of community providers, humanitarian financing and expertise. During the last two decades of conflict, NSAGs in conflict areas have had better access and trust of the population to deliver health services compared with the government. The burden of malaria has decreased. Communities now practice healthy behaviours such as exclusive breastfeeding, the average age of first delivery is post-adolescence, and many can access antenatal services and safe delivery (HISWG, 2015).

In Myanmar, healthcare and delivery of other social services by NSAGs has helped them to gain legitimacy. Jolliffe suggests that “Most Myanmar societies are characterized by what social scientists have called ‘patron-client relations’. In such arrangements, those with higher status in a relationship (patrons) are obligated to protect, succor, and effectively make decisions for those with lower status (clients) (Jolliffe, 2014). In return, the latter are expected to remain loyal and to defer almost entirely to their seniors” (Jolliffe, 2014). The Myanmar government historically has given very little attention to social services. Gordon suggests that with the advent of ceasefires that national government has begun using health and other social service delivery to gain political influence in contested areas (Gordon, Cooper-Knock, & Lilywhite, 2015). The ceasefires in Myanmar may have initiated a competition for political influence with social service delivery as one medium.

Political influence is not be the sole reason for NSAGs to operate health delivery systems—people who work for Community Health Organisations (CHOs) cite the need for health services in conflict-affected areas as their motivation (Lim, Stock, Shwe Oo, & Jutte, 2013). A report in 2015 suggests they deliver services to over 450,000 people, with 70% of their target group reporting that they rely on the community network as their first source of health care, with only 8% access accessing national programs. Gordon et al suggests that literature on development often frames groups such as these as “incapable of supporting the emergence of positive institutions,” but he cautions that such simplifications do not accurately reflect the complex roles NSAGs play in governance, particularly in

areas where they have been present for a long time. In Eastern Myanmar, opposition groups have had control over (admittedly shrinking) areas for generations. Gordon's research suggests that during transitions in conflict, they may still play significant positive roles in governance and delivery of social services. This may be the case in Myanmar.

From "Conflict" to "Conflict-Affected"

Conflict waned in Eastern Myanmar following a massive offensive by the national army in 2005-2008, and since 2010, with the advent of preliminary ceasefire talks, there has been a reduction in conflict related injuries. The impact of the conflict will persist; there is concern that landmine injuries will increase again as people return to areas abandoned during the conflict. The changes in the epidemiological profile are not only related to the conflict: anecdotally, hypertension, alcohol dependence and methamphetamine use are on the rise and growing in their impact on communities.

Communication links have improved, with rapid increases in mobile phone coverage and ownership of phones. Large areas remain without any coverage. Most villages have no electricity supply, but those that can afford it are purchasing small solar panels. Communities report improvements in transport, both in security and basic roads, and many people travel by motorbike where previously they would have walked. One of the impacts of this is that more people are able to travel for secondary healthcare, but they are paying more for their healthcare. There is apprehension though about major hydropower projects along the Salween River, and there have been outbreaks of violence in these areas (Salween Watch, 2013).

As Eastern Myanmar transitions from humanitarian to development paradigms of aid delivery, financial assistance is in transition from humanitarian development assistance. The existence of two separate health delivery systems run by two states claiming legitimacy in the same areas poses challenges for development work—how to engage with one or both states without triggering conflict, and how to ensure that civilians' right to health is fulfilled. A consortium of CHOs calling themselves the Health Convergence Core Group (HCCG) recognized the changing context and developed a policy model to guide the health development process, which they call "convergence."

The HCCG defines convergence as:

- The systematic, long term alignment of government, ethnic, and community-based health services.
- Increased collaboration between ethnic and community-based health organizations, international donors, INGOs, and NGOs.

With the goals of:

1. Increased access to health care for populations in need
2. Positive impact on peace-building
3. Basic needs and human rights are addressed
4. International partnerships and networking are promoted
5. Recognition and accreditation of ethnic health workers

- 6. Ethnic and community-based health programs are supported and strengthened
- 7. Increased decision-making and power sharing at the state and local level

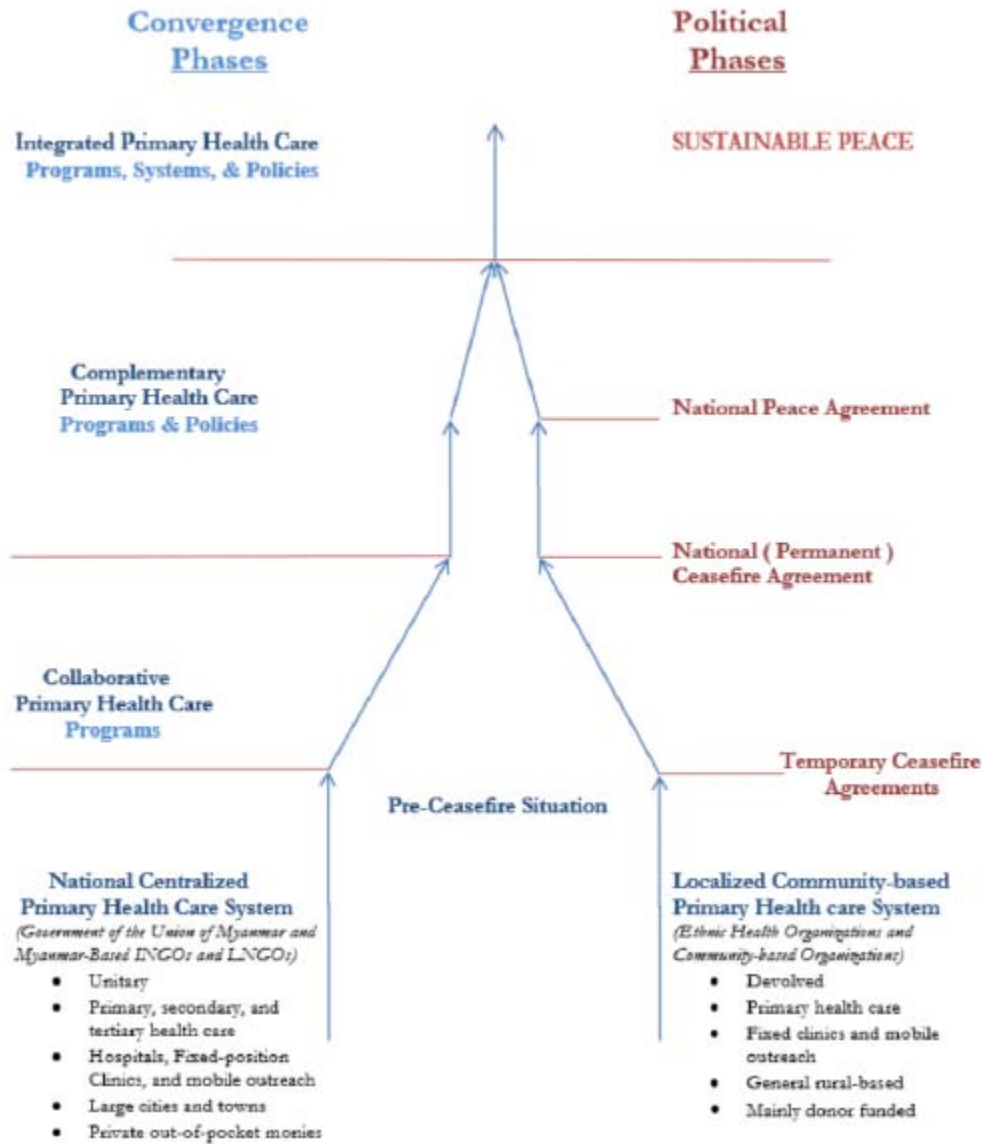


Figure 1: HCCG model for convergence

The HCCG links types of convergence activities to stages of the peace process, which they describe with the “rocketship” model(HCCG, 2013). For example, in a ceasefire situation they state that collaboration on implementing health programs is possible, as the ceasefire negotiations progress to a national ceasefire agreement they say that joint programs and health policies are possible and when a national peace agreement is signed they say that joint programs, policies and health systems are possible. The convergence framework has been used as a policy guide and advocacy tool to promote a decentralized system of healthcare in ethnic areas, to ensure that ethnic peoples maintain some control over their own health services, and in general to help guide the transition process of health service delivery from a conflict –affected area to a post conflict one.

Frameworks

Studies of conflict-affected transitional situations such as the one in Eastern Myanmar suggest several problems can arise in the transition from humanitarian aid to development (Rubenstein, 2009). A central theme that emerges from these studies that is particularly relevant in Eastern Myanmar is the role of development actors in engaging with the state. Engagement can enhance state legitimacy, but it can also lead to inequitable distribution of benefits from development if the state gives preferential treatment to certain groups. This section highlights some challenges in the humanitarian to development transition for Eastern Myanmar.

Tensions between humanitarian and development actors are not uncommon during transitions. Humanitarian actors, operating on principles of neutrality, impartiality, and independence may avoid engagement with state (and non-state) actors if they feel the state is an inefficient partner in service delivery or, more importantly, if the state is engaged in human rights abuses or is using aid to reward or punish different groups (Cliffe & Petrie, 2007). Development actors, on the other hand, tend to engage in state-supporting activities, per development principles. Tensions arise when the state is engaging in human rights abuses or otherwise encouraging an unfair distribution of aid for political reasons. In Myanmar, the situation is further complicated by the presence of non-state armed groups and their affiliated CHOs that claim (and have) governing legitimacy over segments of the population. These CHOs have been engaged for decades in humanitarian and development work, supported by international bilateral and multilateral donors. As parts of eastern Myanmar transition from relief to development assistance, the presence of multiple state actors has created potential for conflict, i.e. if both state and nonstate actors claim to be legitimate governments, then development actors must decide which one(s) to engage with and support. If multiple groups are supported by development actors, then there is potential to exacerbate conflict by supporting two legitimate states in the same overlapping area. On the other hand, as Jolliffe notes, supporting one state actor over another could also trigger conflict (Jolliffe, 2014).

This dilemma is especially relevant in the health sector. Health system strengthening has emerged as an essential component to post-conflict development assistance. It has been employed by major bilateral donors active in Myanmar, such as USAID and DFID, as well as disease or intervention-specific global initiatives like GAVI and Global Fund. The World Bank alone has committed \$200 million towards achieving universal health coverage by 2030 (World Bank, 2014). It involves strengthening coordination, planning, management and organization of the health system. Increasingly, health interventions in fragile states are being assessed on their transformative potential for peace and state-building (Philips & Derderian, 2015). However, in contexts such as Eastern Burma, where the state has been absent and is unable to provide services, the health system is under the authority of non-state actors.

In Eastern Myanmar, problems may arise because these interventions are based on the assumption that provision of health services is a driver of political processes (peace talks, state legitimacy/strengthening), instead of a product of them. Development actors have recognized the risk of ignoring NSAGs and their affiliated CHOs, and Myanmar government officials have warned INGOs not to

encroach on CHO territory without permission. In 2014 Joliffe rightly warned that failure to recognize CHO authority could exacerbate conflict (Joliffe, 2014). However, his guidance has perhaps inadvertently led to donors and implementers simultaneously respecting and strengthening the health systems of two separate states. Although this is in line with HCCG's guidelines at the current stage of the peace process, there is risk that placing too much focus on state legitimacy via health delivery areas and supporting two separate systems could result in promoting health inequity between populations living in different catchment areas.

Further complicating the situation in Eastern Myanmar is the growing popularity of "health as a bridge to peace" programs¹. These programs purport those activities that health delivery systems will encourage parties to conflict to work more closely together and promote a cooperative relationship. Globally there is scant evidence that health interventions lead to state stabilization. Rubenstein claims that "The contributions of health services to the achievement of stabilisation are unclear at best, especially in the short time frames anticipated for such interventions, and they are assumed or asserted but rarely explained or justified." He further states that state political priorities may conflict with equitable delivery of health services, and that "health as a bridge to peace" programs have potential to do more harm than good (Rubenstein, 2009).

An examination of the Accra Accord also highlights this dilemma. The Accra Accord and Busan Principles for Development offer guidance on partnership for development assistance in fragile states. The Accra agenda emphasizes the use of *country systems* for aid delivery (UNCTAD, 2008). A *country system* does not exclude multiple providers, but it was followed by the Busan and Dili Declarations that explicitly take on Peace and State Building Goals. But as Philips observes, fragile states are defined by being *unwilling* or *unable* to meet their obligations to communities. Thus if state building, or peace is the objective of health programs, there is an inherent conflict of interest and risk that building the national health services might be prioritized over more immediate and effective service delivery. As part of the aid-effectiveness agenda, health interventions in fragile states are assessed on their transformative potential for peace and state-building (Philips, 2015). Given the historical context of counterinsurgency policies against ethnic and political opposition groups in Eastern Myanmar, there is risk that opposition areas will not receive an equitable share of development assistance. The presence of multiple state actors creates potential for conflict, i.e. if both state and nonstate actors claim to be legitimate governments, then development actors must decide which one(s) to engage with and support. If multiple groups are supported by development actors, then there is potential to exacerbate conflict by supporting two legitimate states in the same overlapping area.

¹See, for example, [Astrid Zwegnert](http://www.reuters.com/article/2014/12/18/us-peace-myanmar-health-idUSKBN0JW0AW20141218) (2014) Fight against malaria unites old foes in Myanmar. Reuters. Available at www.reuters.com/article/2014/12/18/us-peace-myanmar-health-idUSKBN0JW0AW20141218; Peter Biro (2014) In eastern Myanmar, former enemies join forces for health care. Irrawaddy. Available at <http://www.irrawaddy.org/contributor/ethnic-state-former-enemies-join-forces-health-care.html>

Shifting the development focus from state building to health equity

An alternate approach to the state-building through health systems building, which seems to be ongoing in eastern Myanmar, is to focus health efforts on promoting equity. As in other fragile contexts, conflict is a determinant of health. The World Bank has identified it as a barrier for development, partly as a reflection on those countries that have made the least progress towards their Millennium Development Goals (World Bank, 2011). In South Eastern Myanmar, infant mortality has remained high (91 for every 1,000 live births in 2004, compared to 94 in 2013 (HISWG, 2015)), while in Central Burma it has reportedly fallen (52 in 2004 to 40 in 2013 (World Bank, 2015)), if not reaching its MDG target of 26. In Bornemisza et al's framework for conflict affected settings, factors that influence equity include displacement, gender, financial barriers, and a lack of capacity or political will for policies that address equity. Strategies include strengthening pro-equity policy and planning functions, building *both state and non-state provider capacity* [authors emphasis] to provide services, reducing participation and access barriers for excluded groups (Bornemisza, Ranson, Poletti, & Sondorp, 2010).

The Union government has acknowledged the existence, and the need to address, inequity in health outcomes; in fact, the 2008 Myanmar Constitution guarantees all citizens the right to healthcare (GoM, 2008). However, it has framed these inequities in terms of a rural-urban divide (MNPED, MOH and UNICEF, 2011) and not necessarily a conflict/non-conflict divide or one defined by ethnicity. This limits interventions that address this divide to measures that address geographic barriers. With the new government in 2011, the concept of universal health coverage (UHC) and social protection was back on the policy agenda. It is unclear if the revived interest in equity will be translated into meaningful practice. 'Health for all' has been a catchphrase of the MoH throughout the past decades, and national health policy and planning over the past two decades focused strongly on strengthening and expanding hospitals.

Discussion

A challenge for development actors in Eastern Myanmar is how to support health programs and simultaneously respect the Union and NSAG government role. The health convergence model gives some guidance on this, but it may be misleading if it is assumed health can be a driver of peace (or conflict). An alternative approach to health service delivery in Eastern Myanmar is to focus on maintaining health equity and guaranteeing rights. Support of community delivery through CHOs may be one way to do this.

What the convergence model does suggest is that health delivery and policy activities might be possible at different stages of the peace process. This is as prescriptive and detailed as the model gets, there is no description of what the final health policies and systems might look like, and there is no description

of any end product. That the model is vague and only outlines a process is likely intentional, as multiple variables relating to politics and the peace process cannot be predicted or addressed before they arise.²

Although convergence policy is intended to be vague to allow for adaptation and responsiveness, one drawback of the vague descriptive nature of convergence model and the “rocketship” diagram are that they also allow for misinterpretation. For example, the two halves of the rocket ship that depict the MOH and ethnic health systems as two parallel systems may suggest that these systems do not overlap in terms of geographical catchment areas or interaction outside of official HCCG-sanctioned activities. The pointed tip of the rocket ship suggests that there is some endpoint or final goal of the process, and the links to stages of the peace process may suggest that health could be a driver for this process. None of these is entirely true today.

During the conflict political analysts conceptualized areas of control in Eastern Myanmar in to three categories: “white” zones, where the Union government had complete control, “brown” zones, where the Union government had control, but a strong underground resistance was present, and “black” zones, where ethnic armed groups had control and Union government was not present. Although some maps attempt to show these areas at different times during the conflict, in reality the “front lines” or borders between the zones of control were difficult to define, and areas of control shifted as Tatmadaw offensives pushed NSAGs into rural and jungle areas, and establishing administrative control in towns. Thus these territories shifted constantly, resulting in significant overlap between CHO and MOH service delivery areas. Today, efforts to map health services in Eastern Myanmar have revealed heterogeneous distribution of MOH and CHO clinics, with several instances in Karen state of both CHO and MOH clinics in the same village. More often, villages will have access to a community clinic, while in the towns there are government hospitals or private practitioners.

This geographical distribution of clinics has allowed for some “consultation and coordination” activities to take place before codified into any model or principles. For example, on a very local level arranging referrals between government and CHO clinics was not uncommon. These activities went on without formal processes or MOUs or deals brokered by development actors.

The HCCG rocket ship model defines a hierarchy of activities that could be possible under certain circumstances. Because it ends in a point, it seems to suggest that this is the goal, some kind of defined and final combined health system. This assumption is unfounded. The HCCG at its most specific talks about “joint systems, policies and programs,” when a national peace accord is signed, but it may not necessarily mean that HCCG is striving for this, and it does not specify what these policies and systems look like.

The links between permissible convergence activities shown in the rocket ship and the peace process may imply that health programs can somehow drive the peace process-- that “health is a bridge to peace.” As discussed earlier, there is no evidence that suggests health programs can drive peace processes. This is also likely true in eastern Myanmar. Although two governments are interacting in

²For example, a draft discussion paper on decentralisation options was circulated HCCG (2013) A federal devolved health system for Burma/Myanmar, and is now available at www.hiswg.org

peace negotiation and also on health consultation and coordination activities, the same people are not involved in the same processes. In fact, the two points in the proposed peace deal between KNU and Union government that address health issues have been consistently tabled from discussion. That peace is linked to health may in fact delay delivery of health services that require a high degree of cooperation between the MOH and CHOs, because individuals working on both sides are concerned about upsetting their superiors in the government.

When development actors apply the above misconceptions to convergence, there is risk of poor program planning, which can shift the focus of health development to a driver of peace and not on improving health inequity. Alternatively, now that restrictions on movement are lifted the two parallel (but overlapping) systems may evolve into a system of complementary providers, with decentralized regulation and more options for healthcare and some competition for better services-free and local, or fee-for-service advanced care. In some ways this is already happening. For example, in conflict and isolated areas of Eastern Myanmar, Backpack Health Worker Teams (BPHWTs) work in partnership with local authorities, ethnic or government, in the design and delivery of basic primary health services. This is a “community system strengthening approach”, focusing on capacity building and human and financial resources, that Global Fund suggests can “play a full and effective role alongside health and welfare systems” (Global Fund, 2011). As a multi-ethnic community organization, BPHWT is able to engage with vulnerable communities and react quickly to community needs. In areas outside the reach of the national health and welfare system, it is the primary provider. Supporting providers such as these extends coverage of essential health programs, addressing barriers of exclusion such as displacement and ethnicity in a sustainable manner.

The partnership with the BPHWT and the Phlon Education Department Development Unit (PEDU) offers a blueprint for success. BPHWT, a CHO historically serving conflict-affected populations, is now providing training and supplies to Auxillary Midwife (AMWs) in a government controlled area. The program was initiated by a local CBO PEDU, who were concerned by the absence of trained birth attendance due to a lack of government resources and services in the area. Trainers include BPHWT trainers, State Health Department trainers, and government retirees. The training includes a three month internship at the Mae Tao Clinic Reproductive Health Department, a clinic serving mobile populations on the Thai side of the border(BPHWT, 2015).

Formally defining geographic catchment areas may stifle consumers’ options for health providers and continue to place focus on service delivery as a proxy for state legitimacy and that health catchment area is equivalent to state territory. A policy of geographically separating service providers may also force out some services that are better delivered by one side or the other for example, village-based workers or access to secondary/ tertiary care facilities. For example, the Karen Human Rights Group (KHRG) reported that with increased freedom of movement after the ceasefire, villagers in some areas could choose whether to go to CHO or Mohr health facilities (KHRG, 2014). Several factors influenced this decision, including the perception that Mohr services were expensive and often not open, but CHO services were free but sometimes “under-resourced.” KHRG further notes that villagers tend to prefer government services for serious illnesses, but use a combination of government, CHO and for-profit facilities for less serious health problems. Until more agreements are made on how to ensure coverage

between the Mohr and CHOs, formalizing catchment areas might be best left alone, except to ensure that everyone has access to services from at least one provider (KHRG, 2014, pp. 127-128). Formalizing geographic catchment areas might force some providers out, and limit choices of providers and therefore risk creating inequity, if not all providers are equal.

Unofficial convergence going on at the very local level seems to be done only in the interest of promoting individual health through referrals and data sharing, etc. Local-level health actors likely have no other agenda, especially since they would likely be punished by superiors for doing these activities without higher-level clearance. Defining catchment areas may stifle these activities, as might highlight them as convergence “successes,” if this would make Mohr and CHO providers on the local level reluctant to continue these practices. Stopping referrals or other activities done in the interest of promoting health could have negative impacts on the health of the population and could possibly lead to inequitable service delivery.

The misconception that health is a bridge to peace, when this is applied to programming decisions, may also drive inequity. Impatient actors in peace and development work may place unreasonable timelines on convergence-related health projects in attempts to use health to drive the peace process. They also may use inappropriate indicators for health programs, such as those focused on convergence activities rather than health outcomes in attempts to measure progress towards peace. These risks shifting the development focus away from health outcomes and equity, and health inequities may not receive the attention or interventions they need.

Eastern Myanmar has had 30 years of humanitarian financing, during which time the humanitarian response has evolved. During the conflict, there has been some continuity between humanitarian aid and development programming as delivered by community-based providers. For example, despite ongoing conflict, the existence of secure administrative satellite offices across the border has allowed for technical support to local governance and health information systems (HISWG, 2015) that would usually be supported only in a development context. Thus the humanitarian space has allowed for, and community actors have demanded, a flow between relief and development in practice, if not in funding flows. Frustratingly, new funding flows are less flexible and less reliant on the indigenous monitoring mechanisms, and the availability of core funding for primary healthcare is drying up, with new funding streams for vertical programs with limited geographical coverage. During both conflict and transition, investment in community based service provision allows for the development of basic services in neglected areas. Supporting local authorities in the development of regulatory capacity enhances preparedness. Conversely, engaging in health interventions conditional on the peace process risks creating conditions on health service provision that neglects the most conflicted affected areas, and investing in inappropriate, substandard or inefficient service providers.

Conclusion

As long as health services are tied to political legitimacy and health service catchment areas are a proxy for political territory, health sector development will not be able to ensure equitable health services for

the population. Donors and implementers need be cognizant of this in order to find ways to avoid inadvertently creating disparities. A possible way forward is to acknowledge both the gaps and the overlaps in service and coverage that exist in Eastern Myanmar and focus instead on activities that would help to reduce health disparities. In the early stages of transition, this could include: determining what services would be included in a basic package of health services and ensuring this is available in all areas of Eastern Myanmar; donors funding MoH and NSAGs to decide on a more mixed system of service provision; and identifying new roles for community-based organizations working as service providers in partnership with national, state and local authorities, regulating policy and funding.

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