Myanmar: Health Care in a Changing National Landscape

Lessons, Challenges and Aspirations on the Way Forward

Report of a Seminar: "Health Care in a Changing National Landscape"

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Overview

On the 30th anniversary of the foundation of the Shoklo Malaria Research Unit (SMRU), a seminar was held on 13-14 December 2016 in Mae Sot, Thailand, to examine the theme, "Health care in a changing national landscape", with a focus on malaria, maternal health and TB/HIV. At a time of critical change, the SMRU anniversary marked an opportune moment to reflect, and look forward, on important issues in national transition in Myanmar at the junction between health, science, economics and politics. Attended by over 200 participants, the meeting represented a diversity of national backgrounds, specialisms and interests. The proceedings were mainly in English, and simultaneous translations were provided in Burmese, Karen and Thai languages. Discussion was under Chatham House Rules,[1] but it was agreed that a position paper would be produced afterwards to summarise the main issues and conclusions during the meeting.

To facilitate debate, panels were held on six themes: the changing landscape, community perspective, medical perspective, funding mechanisms and performances, looking forward, and conclusions. The aim was to promote analyses and ideas that address a number of basic health issues in relation to malaria, maternal health and TB/HIV. Areas of concern included the present status of health delivery, disease trends, community participation, the effectiveness of health-funding strategies, and ensuring that health care reaches to all peoples. Most of Myanmar's population still needs access to proper health care.

No resolutions were passed, and the main conclusions are summarised at the end of this report. But a number of themes emerged that can be highlighted.

- Although there have been significant advances in understanding the importance of health care and its delivery during the past decade, the disease burden and difficulties in health provision are being sustained by a number of detrimental conditions. Key challenges include conflict, community displacement, inadequacies in health access and education, gender inequalities, poor infrastructure, and lack of convergence between different authorities and health providers.

- Despite recent trends in health progress, concerns are not lessening about drug resistance and other challenges in the treatment of malaria, TB and HIV. Much has been gained during recent years, but much could be lost if appropriate policies and effective treatments are not developed. As the disease burden shifts from communicable to non-communicable illnesses, health responses must adapt and, in the case of malaria, the goal should become disease elimination rather than simply disease control.

- Among delivery needs, improved collaboration and partnership are essential between different stakeholders and health providers, including governmental, non-governmental and community-based organisations. International aid

[1] 'When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.' See: https://www.chathamhouse.org/about/chatham-house-rule

agencies should support this but need to be aware of the conflict backdrop. Civil society has a vital role to play, and health should be promoted at the centre of efforts for peace-building and national reform.

- Changes in the national landscape are providing opportunities to broaden the promotion of health rights with the universal goal of 'access to health care for all', but there is much that still needs to be achieved. As socio-political transition continues, a new generation of challenges is emerging that also have negative impact on health, including land loss, environmental degradation, illicit narcotics, corruption, and poor working conditions in mining and other industries.

- Myanmar's health challenges should not be regarded, and cannot be addressed, in international isolation. Myanmar is located in a gateway position on a strategic crossroads in Asia, and continued human flow – whether due to displacement, refugee flight or job migration – confirm the country's front-line position in health challenges in the contemporary world.

- Although international health funds to Myanmar have increased during the past decade, they are now reaching a plateau. On present trends, neither revenue systems nor domestic taxes within Myanmar are likely to be sufficient to sustain progress in key health areas. Meanwhile the future of international health budgets around the country's borders, and in the sub-Asian region more generally, can be considered uncertain. This is extremely worrying in the international fight against malaria, TB and HIV, and in maternal health programmes. There is no room for complacency.

The changing landscape

A recurrent theme during the seminar was the nexus between conflict and health failure. International aid is unlikely to resolve conflict or improve national health by itself, and this creates humanitarian dilemmas over health priorities, where to work and whom to treat. In general, post-conflict transformation is regarded as a more promising platform to support national reform and health progress, but experiences around the world warn that this is not always the case. International aid can serve to support 'power' rather than 'people'. Thus, in seeking to address health needs, much is likely to depend on the political context, societal relations and the inclusion of local communities in health planning and implementation.

In Myanmar, internal conflict and health crises have continued through all political eras since independence, including four different incarnations of government during the past 30 years.[2] This has resulted in a fragmented national landscape where integrated health initiatives have been slow to develop – and have often been impossible. This does not mean that health programmes, if well planned, have not made progress. But the combination of internal conflict and political impasse has

[2] Gen. Ne Win's one-party "Burmese Way to Socialism" (1962-1988); the military State Law and Order Restoration Council (SLORC: subsequently State Peace and Development Council [SPDC], 1988-2011); President Thein Sein's quasi-civilian government of the Union Solidarity and Development Party/Tatmadaw (2011-16); and the civilian-led government of the National League for Democracy ([NLD], 2016-present).

proven a long-term handicap and a cause of failure. Conflict has divided societies, humanitarian emergencies have continued, and health outreach has been limited.

Against this background, understanding about the nature of health challenges within the country has developed only slowly. The scale of socio-economic collapse was first marked in 1987 when Myanmar received a United Nations classification as a 'Least Developed Country' during the last days of Gen. Ne Win's 'Burmese Way to Socialism' that imposed state isolationism. Subsequently, UNICEF promoted support for international aid and conflict resolution in the early 1990s under the slogan 'Myanmar's Silent Emergency'. An ethnic ceasefire programme and spread in non-governmental organisations (NGOs) also gained ground after they were officially allowed to resume in the country from the mid-1990s.

International relations, however, were deeply divided by 'inside' and 'external' perceptions during the SLORC-SPDC era. While Asian countries preferred 'constructive engagement', Western governments prioritized economic boycotts, support for pro-democracy parties, and humanitarian relief for refugee populations in the ethnic nationality borderlands where conflict still continued. The consequence was that, for many years, the country was treated as an international 'aid orphan', because the international community (notably Western governments) objected to the continuance of military rule and thus provided minimal aid.[3]

Concerns about health conditions did not entirely go away. The increase in refugees and internally displaced persons (IDPs), illicit narcotics[4] and spread of HIV were particular sources of worry.[5] Nevertheless Western aid reluctance continued, highlighted by the 2005 decision of the Global Fund to Fight AIDS, Tuberculosis and Malaria to withdraw from the country. Shortly afterwards, six Western government donors set up the Three Diseases Fund (3DF) that began operation in 2007. Structured to work 'with the government but not through the government', 3DF's ability to work with a diversity of implementing partners saw the Global Fund return in 2009 and a new Livelihoods and Security Trust Fund began operation the same year. If, however, any event was to change international perceptions about the urgency of humanitarian needs, it was the terrible tragedy of Cyclone Nargis in 2008 during which over 140,000 people died.

The stage was thus set for a significant change in international engagement when the government of President Thein Sein assumed office in March 2011. The armed forces, known as the Tatmadaw, continued to be reserved a 'leading role' in national politics, but important changes in Western policies followed a series of reform initiatives by the Thein Sein government, including accommodation with the NLD and a new ethnic ceasefire process. As national transition continued, Western sanctions were largely dropped and a host of new aid programmes started that reached a new high with the assumption to office of the NLD government in March 2016. Within five years, the country appeared to have come a long way and, with embrace

[3] By 2001, official Overseas Development Assistance (ODA) per capita was estimated at just one US dollar per annum as compared with US$ 35 for Cambodia and US$ 68 for Laos.
[4] Myanmar is the world's second largest producer of illicit opium after Afghanistan. A new illegal trade in methamphetamines also developed during the SLORC-SPDC era.
[5] The first HIV sentinel surveillance was in 1992.

of the goal of 'Universal Health Coverage by 2030', Myanmar joined other states on the same international page in seeking to roll out health care to all citizens.

The national picture is by no means even, however. Old problems remain and new risks are arising during a time of uncertain national change. Reliable data is difficult to find as well as correlate in national terms. But, among outstanding challenges, Myanmar continues to have the highest incidence of malaria, TB and HIV in the sub-Asian region (and with attendant problems of drug resistance); it has ASEAN's second highest maternal mortality rate; it stands at 148th out of 188 countries on the 2015 UN Human Development Index; and there are still other life-threatening diseases that are under-reported or under-treated, including dengue fever, Japanese encephalitis, hepatitis, melioidosis, rabies and various waterborne illnesses, such as typhoid and cholera.

As in previous political eras, many of these health crises are being exacerbated by humanitarian emergencies and poor living conditions. In particular, while new ceasefires have come to the Thai borderlands, new conflicts have been breaking out in the Kachin, Rakhine and northern Shan states that had been at relative peace during the SLORC-SPDC era. Presently, there are over half a million IDPs inside the country and at least 200,0000 refugees in neighbouring states (principally in Thailand and Bangladesh), but health difficulties are also being compounded by widespread inequalities in society that, in some cases, are deepening as national transition continues. Women are often worst affected by hardship and conflict in an economy that is 70 per cent agricultural; child labour is still widespread; and land appropriations, the use of illicit narcotics, and unsafe working practices in mining, construction and other industries have been increasing with higher levels of investment.

In the new political climate, recognition of these issues can today be openly discussed, which is an essential step forward. Access to health as a human right is becoming an accepted goal. An important change has been understanding of the challenges of health delivery in conflict settings, a need recognised by a number of international agencies, such as the Three Millenium Development Goal Fund (3MDG: the successor to 3DF), that have promoted 'Do No Harm' policies.[6] At the same time, a previous focus on civil and political rights by democracy reformers has expanded to include the International Covenant on Economic, Social and Cultural Rights, which guarantees that everyone has the right to the 'highest attainable standard of health'. Myanmar is expected to ratify this soon. The need for corporate responsibility is also gaining attention. In these endeavours, civil society and community-based groups have increased in numbers and range, both as humanitarian actors and advocates for national reform. Human rights' protection, however, will require effective actions and tangible reforms that reach to the local peoples – not rhetoric or showpiece projects that are used for self-publicity purposes.

Finally, the backdrop of migration has remained an especially 'haunting spectre' in Myanmar's changing landscape. This reflects a global trend that is predicted to grow during the next 25 years. The life of a migrant is often one of risk, marginalisation and ill-health, raising questions about national security, cross-border operations and

[6] See e.g., http://www.conflictsensitivity.org/do-no-harm-local-capacities-for-peace-project/

the response of health agencies. In Myanmar's case, understanding has been slow to develop that its borderlands to five neighbouring states act as 'gateways', not barriers, to human movement.[7] Thailand alone is home to an estimated three million migrants, both legal and illegal, from Myanmar, and during the past year new refugee crises have occurred due to ethnic conflicts along the Bangladesh, China and Thailand borders, precipitating the flight of a further 100,000 people.

For the moment, there is no indication of imminent peace, reform or refugee resettlement that will achieve sustainable solutions to the health consequences of human displacement and movement. Migrants continue to travel in and out of Myanmar for reasons of employment, security and survival, while a diversity of aid agencies try to address health and humanitarian needs in the field. Even if refugees resettle, migrant mobility is only expected to increase during the next decade, with a raft of infrastructure, energy and industrial schemes now underway in the borderlands. Special Economic Zones with China, India and Thailand are being promoted, and the seminar venue of Mae Sot on the Thailand frontier is vibrant evidence of the pace of transitional change during the past two decades.

Regional responses, therefore, will be essential in addressing Myanmar's health challenges. International language to protect the health rights of individuals can be found in such articles as the ASEAN Vision 2020 and ASEAN Charter: 'One Vision, One Identity and One Caring and Sharing Community'. But, to date, most regional focus has been on the free movement of professionals such as doctors and accountants, while the rights of the marginalised and low-skilled are often ignored.

In summary, although there has been health progress in Myanmar during the past decade, tremendous challenges remain still. The country is still at the beginning of a process of national transition and not at an end. Important opportunities exist but, if momentum is to be sustained, it is essential that reforms address the key political, socio-economic and health issues at the local as well as national levels.

The community perspective

Civil society groups are a foremost voice for social change and ensuring that the voice of the vulnerable and most in need is heard. Although often under-acknowledged, community-based initiatives to improve health and livelihoods have continued through all eras of government in Myanmar,[8] and they are an important representation of the ethnic and cultural diversity in the country. Establishing, however, an effective role for community-based organisations (CBOs) in health planning and initiatives has frequently proven difficult, a challenge that continues today.

Discussion during the seminar confirmed the importance of the community viewpoint in the advancement of health programmes. Local community groups are often an early warning of health crises and in the front-line of initiatives to address these challenges. An outbreak of measles in the Naga Self-Administered Zone last year in which 40 people died (mostly children) or cases of leprosy in the Kachin state are reminder of

[7] Bangladesh, China, India, Laos and Thailand.

[8] In earlier decades, activities were often promoted through cultural or faith-based groups because of restrictions on non-governmental organisations.

the gravity of the health situation in remote or conflict-affected areas that are little known in the outside world. As community representatives point out, if the Myanmar state is unable to deliver routine health care, adults and children will continue to die from diseases that are regarded as treatable or preventable in many other parts of the world.

In response to these needs, a growing number of CBOs have developed their own health expertise during the past three decades. In the Thai border region, for example, the Mae Tao Clinic began working from 1988 with refugees and displaced populations before moving on during the 1990s to develop programmes in such fields as family planning, disease surveillance, and access to safe deliveries and emergency obstetrics.[9] A particular focus has been on maternal health, promoting the message that 'reproductive health is more than just a safe delivery'.[10] Other CBOs, such as the Karen Women's Organisation, also help to spread health awareness in conflict-affected areas of the Thai border region. From such beginnings, a network of local CBOs and ethnic health organisations (EHOs) recently came together to produce a 'Health System Strengthening Strategic Plan Eastern Burma: 2016-19'.[11] In addition to humanitarian needs, the plan sought to address the continuing patterns of land loss, militarisation, migration, development projects, resource exploitation, lack of documentation and ethnic inequalities that are principal causes of health failings in this region.

HIV, TB and illicit narcotics are also subjects of special concern among community groups, especially in the northeast of the country. Here the Metta Development Foundation, the country's oldest registered NGO (established 1997), is among a number of community and faith-based groups that have pioneered health initiatives in the field. Nationally, there is a high prevalence of HIV, TB and hepatitis among drug users, but local communities complain that current health responses are inadequate. Despite improvements in medical provision, there is still need for increased Antiretroviral Therapy (ART) and methadone treatments; many drug users are pushed away from accessing harm reduction services, because drugs policy is based on a punitive approach; and women drug users face additional difficulties contacting health services due to stigma and gender discrimination.

Against this backdrop, frustrations are frequently expressed about government failures in health provision and anti-narcotic control. Most obviously, the Pat Jasan movement in the Kachin state has recently promoted vigilante tactics in combatting drug use, and it has taken a collaborative approach among community groups to calm tensions. Compassion, economic alternatives and drug treatment are the most effective in changing social behaviour, but CBOs feel that they are very often left alone in dealing with the health consequence of Myanmar's crises in the front-line.

[9] Initial support came from international NGOs and Thai health officials.

[10] Key issues include: access to a just medical service, safety and dignity, sexual and gender-based violence, access to post abortion care and safe referral, right to choose type of contraception, adolescent and youth health, STI and reproductive health infections.

[11] The implementing partners are: Burma Medical Association, Back Pack Health Worker Team, Committee for Health and Development Network – Karenni, Karen Department of Health and Welfare, Mae Tao Clinic, Mon National Health Committee, Pa-oh Health Working Committee, and Shan State Development Foundation.

Civil society and community leaders therefore believe that it is now imperative for their concerns to be listened to, and their activities to deliver effective outcomes, if national reform is to succeed. Some of the difficulties they face are due to the diversity of 'civil society' groups in the country, which may be based upon ethnicity, profession, gender, faith or other organisational lines. However, their difficulties can also be due to the unwillingness of different authorities and health interests to acknowledge their role on the ground. Community advocates know that 'good governance' is needed for poor people to lead better lives: i.e., taking government out of the loop might improve things in the short-term in some areas (e.g. delivering humanitarian relief), but it does not resolve health challenges that, very often, are underpinned by social, political and economic conditions.

Such criticisms are also pertinent in international aid circles. The increase in foreign aid during the past few years has been welcomed, but many organisations have also brought new challenges in their wake. By overlooking the bigger picture in national reform, not only do they under-estimate the importance of local perspectives and regard CBOs as agencies to 'sub-contract', they also set up complex – and often uncoordinated – programmes that are unlikely to meet their targets. Treating local populations as passive recipients will not lead to sustainable improvements nor national reform.

Further failures can then follow. Experience in Myanmar has shown that the more sophisticated an aid process becomes, the more it may depart from the goal of delivering assistance through local communities in the field. CBOs may also have less access to aid donors who, in turn, have fewer opportunities to profit from local knowledge. Donor practices (e.g. indirect cost or payroll policies) can also corrupt the values and mission of civil society groups, which may experience heavy expenses in delivering programmes that they cannot afford. Furthermore, as 'top-down' thinking dominates, aid programmes will not be designed according to the principles of equity that many donors pledge nor reach out to the poor and vulnerable peoples.

To address such failings, community groups advocate a broad outlook in aid responses. First, the social determinants of health should not be ignored, including local societies, housing, water, livelihoods, food production, working conditions, and environmental conditions. Second, in poor and conflict-affected areas it is misleading to try and separate humanitarian, economic and social issues from the over-arching need for nationwide peace and inclusive reform. And third, 'partnership development' is essential to ensure that communities have a voice and that aid programmes are not imposed from the top by different authorities or international agencies. This, in turn, will mean working with existing health organisations in the field and collaboration with CBOs in health system strengthening and health policy development at the national and state levels of government. Equity, unity and sustainability should be common goals for all.

The next stages now are difficult to predict. Many initiatives are underway in different parts of the country. But as an example of the changing landscape, a Health Convergence Core Group was formed among community organisations in 2012 following the ceasefire by the Karen National Union, and a project for health system strengthening was begun in 2015 by eight CBOs and EHOs in eastern Myanmar with a focus on services delivery, governance and human resources for health. Local CBOs

and EHOs in the Karen state have also been involved recently in discussions with Ministry of Health officials about the country's National Health Plan and goals of Universal Health Coverage. Political settlements will be needed for convergence, but such developments can be regarded as a mark of progress.

In contrast, the humanitarian situation is presently urgent in the Kachin and northern Shan states, which were at relative peace under ceasefires agreed during the SLORC-SPDC era. Here the CBO Joint Strategy Team for Humanitarian Response[12] is endeavouring to liaise with governmental, UN and international NGO agencies in initiatives to address the humanitarian needs of more than 100,000 people displaced in conflicts that have revived since the 2011 inception of the Thein Sein government. Humanitarian emergencies also exist in several other borderlands, notably in the northern Rakhine state where Buddhist-Muslim tensions and crises over ethnic identity and citizenship are especially acute. Conflict and population displacement were occurring in the Kachin, Rakhine and Shan states during the seminar and inevitably cast a shadow on hopes and reflections.

Community leaders thus conclude that national transition in Myanmar is now delicately poised. Socio-political changes during the past five years have brought new space and potential for health services to be provided in a more stable and inclusive environment. But community leaders also warn that many communities are yet to see real improvement in the quality of their lives. Conflict is not yet ended; many communities and marginalised populations do not have access to adequate health; and the complexity of health challenges is undiminished.

The medical perspective

The observation, 'so much gained, so much to lose', is a common reflection among health specialists in Myanmar and the region. In recent years, increased health access, medical aid and donor commitment have improved treatments and delivery to more communities. Medical experts, however, are concerned that future progress could be jeopardized by conflict, humanitarian emergencies and policy errors that sustain health failings and national inequalities. As they warn, health advancement in Myanmar is also vital in the global campaigns against malaria, TB and HIV, and health developments in the country continue to have important international ramifications.

The experience of falciparum malaria is a significant case in point. During the past half century, drug resistance has spread from South East Asia, including Myanmar and neighbouring states, to other parts of the world, resulting in the loss of millions of lives globally.[13] Research conducted by SMRU along the Thailand border has shown how quickly resistance can develop to each generation of new drugs. Most recently, there was a dire situation on the Thai-Myanmar border in the 1990s with the spread of resistance to mefloquine, and the crisis was only contained by the potent action of the

[12] Community or faith-based members are: Bridging Rural Integrated Development and Grassroots Empowerment, Kachin Baptist Convention, Kachin Development Group, Kachin Relief and Development Committee, Kachin Women Association, Karuna Mission Social Solidarity, Metta Development Foundation, Shalom Foundation and Wunpawng Ninghtoi.
[13] The highest mortality occurs in Africa.

artemisinins. Since this time, artesunate combination therapies (ACTs[14]), pioneered in Asia, have been used successfully to control and reduce the burden of malaria within the region. ACTs are now used as the standard antimalarial defence in 400 million treatments annually around the world and an estimated three million lives have been saved globally during the past two decades.

This, however, is where the good news ends. Since 2007, artemisinin resistance has been detected, initially in Cambodia and subsequently in parts of Myanmar, Vietnam and northeast Thailand, leading to ACT failure. Five new antimalarial drugs are currently in late development,[15] but they are still several years away from registration, heralding a potential crisis in future malaria treatments. The need for urgent action in antimalarial initiatives was recognised at the 9th East Asia Summit in Myanmar in 2014 where the goal was agreed of an Asia-Pacific 'free of malaria by 2030'. Despite this declared objective, medical specialists warn that there is real risk of international complacency at present. In a policy environment where there are many other aid demands and developing new treatments can be relatively expensive, a belief that falciparum is defeated would be misplaced and dangerous. As disease incidence appears to go down, funding typically starts to go down as well before the disease challenges have been comprehensively addressed. The result could be a new cycle of drug resistance once again emerging, which would have the most catastrophic consequences for Myanmar and around the world.

There is another strategy option. Falciparum malaria needs to be eliminated before it becomes untreatable. Such a goal is ambitious and would need significant up-front investment, requiring access to remote areas and treating malaria that may appear asymptomatic in the local population. However intensive field research by SMRU in areas of the Karen state has shown that this approach can work. The challenge, then, is whether sufficient international and domestic support can be galvanised to roll out this campaign on much larger scale. The window of opportunity could be small. Falciparum malaria is at a historical low in the Greater Mekong Subregion, and there will never be a better moment to seek the elimination of the disease. However it is imperative that this is achieved before it becomes untreatable due to artemisinin and partner drug resistance.

Similar dilemmas exist over the treatment of vivax malaria, which is now the most prevalent form of malaria in Asia. During the past 10 years, research in several parts of the world has demonstrated that the spread and impact of vivax has been greatly under-estimated. It is a difficult disease to treat. The predominant morbidity and mortality of vivax malaria are related to its ability to recur, with different symptoms and cycles in different areas of the world. Vivax is also especially dangerous for children and pregnant women, is associated with anaemia and other diseases, and has cumulative mortality the more it occurs. 'Falciparum kills you quickly, vivax kills you slowly' is the troubling conclusion.

There is a further paradox. The only drug to prevent vivax recurrence, primaquine, is also potentially fatal for people with an enzyme deficiency (glucose-6-phosphate dehydrogenase deficiency [G6PDd]). G6PDd also occurs in high prevalences

[14] Combination therapy is the use of multiple antimalarials, with different properties, simultaneously.
[15] Ozonides, spiroindolones, imidazolopiperazines, DSM265, and modified 4-aminoquinolines.

throughout much of the Greater Mekong Subregion and, for this reason, many healthcare policymakers and providers are reluctant to prescribe primaquine as medication. Vivax elimination, therefore, cannot be achieved in isolation if the 'free of malaria by 2030' goals are to be faced up to. Advances can only be made by a combination of actions, including research into drug treatment, reassurance that primaquine saves lives, health systems strengthening, integration of malaria control with management of childhood illness and antenatal care, and sustained political commitment and donor funding.

Tuberculosis is also a major challenge that has been under-estimated in Myanmar and its borderlands. Myanmar is one of the 30 'TB High Burden Countries' in the world, and the disease has a close connectivity with poverty and socio-economic conditions along with multi-drug resistance, HIV and high rates of mortality within the country. Drug treatments, however, started late after decades of state neglect and, although progress is being made, there remain significant gaps between treatments started and successful outcomes. In 2015, the estimated incidence of TB in Myanmar was 365 per 100,000 population as compared with 142 globally, and a mortality rate of 49 per 100,000 as compared with 17 globally. There are, however, concerns that the incidence could be still higher in some areas due to continuing conflicts, internal displacement, and frequent movement or migration among populations that do not have access to health care. In addition, there is stigma associated with receiving, or coming forward, for treatment for TB that is furthered because it frequently co-occurs with HIV.

Such factors compound the difficulties in addressing multi-drug resistance in Myanmar and its borderlands. In consequence, the country faces seemingly impossible challenges to reach the UN Sustainable Development Goals of eliminating TB by 2030. There is an increasing awareness of the extent of the TB crisis in health circles. As with malaria, however, targeted actions are essential at the national and local levels to address the disease across the country. In the case of TB, necessary steps include: improving treatment delivery; identifying more TB cases; intensified analysis (drug resistance, HIV etc.); strengthening TB and HIV integration; greater awareness in the community; and updated and regular reporting. Only by such a combination of initiatives is progress likely to accelerate and be sustained.

Medical opinion is also concerned about health challenges in maternal health, the third field of discussion at the seminar, which has serious implications for child health as well. There remain fundamental difficulties of access and outreach in a country of an estimated 64,000 villages, where conflict and ethnic divisions continue in several areas. There are serious deficiencies in the number of health services and providers in all states and regions, including midwives, nurses, obstetricians and clinical departments. National data is unreliable, with considerable variations in health conditions around the country. But with the majority of birth deliveries at home, Myanmar has one of the highest infant and maternal mortality rates in the world. Despite recent progress, the 2014 maternal mortality rate was officially put at 282 per 100,000 live births as compared with an average of 140 in other South East Asia countries, and the under-five mortality rate at 72 per 1,000 live births as compared with 30 in the same range.

To try and address these failings, various national initiatives are underway, spearheaded by the Five-Year Strategic Plan for Reproductive Health (2014-18). But medical specialists agree with community opinion that long-term focus and initiatives are needed at the local levels if national headway is to be made. Progress continues to be impeded by such basic causes as inadequacies in health access, finance, knowledge, infrastructure, staffing, research and harmonisation in data and activities. It is vital therefore that health systems are strengthened in quality, networking and access. Key areas for attention include safe motherhood, birth spacing, advocacy, education and capacity-building.

With these needs in mind, recent trainings have been initiated by Ministry of Health officials with CBO health workers from the Karen state and other ceasefire areas (see 'The community perspective' above). All parties regard this as a positive step. As CBOs point out, the Five-Year Strategic Plan calls for engagement with communities in health promotion, incorporating gender perspectives, inclusion in humanitarian settings, and the adoption of a strategy for nationwide implementation. The challenge now is how to put these policy objectives into practice.

Funding mechanisms and performances

During the past decade, the international aid profile of Myanmar has changed from marginalisation and politicised discussion to one where such leading donors as the Global Fund, World Bank, European Union (EU), UK Department for International Development (DFID) and United States Agency for International Development (USAID) are seeking to work with the government, UN agencies, international NGOs, local NGOs and other partners to address health challenges within the country. Health planning and analysis have not been easy in earlier decades due to political conflict, societal divisions and international isolation. There is a general consensus, however, that important progress has been made during the past four years, and the key now is that the opportunities for greater health understanding and delivery are matched to population needs, disease trends and national realities. To meet these goals, the monitoring of funding mechanisms and performances are a critical indicator in assessing the achievements of health planning, expenditure and outcomes.

At present, a diversity of external aid donors and health providers are continuing operations in Myanmar and its borderlands. Health attention generally focuses around the sustainable development goals of the World Health Organisation that seeks 'Universal Health Coverage by 2030', and this vision is incorporated in the new National Health Plan (2017-21) of the Ministry of Health and Sports. Recent progress on the national scale is suggested by the burden of disease shifting from communicable to non-communicable illnesses (e.g. diabetes, heart ailments). However medical opinion is still widespread that many of the 2030 targets will be hard to reach, indicating a 'direction rather than destination'. Blatant humanitarian crises and health disparities remain throughout the country, including rural-urban, state-region, conflict-ceasefire, and among different nationality groups. As an example of the dilemma in reaching national targets, one of the Universal Health Coverage goals is: 'Everyone has access to the health services they need, without suffering financial hardship when paying for it.' But this is presently impossible. Of

the six methods of health financing,[16] 'out of pocket' remains the most common in Myanmar and a perennial cause of inability to gain adequate health treatment.

International donors and aid agencies therefore need to be aware of the need for transparent goals and strategies in the financing and monitoring of health programmes. To address these challenges, two underlying policies have been promoted. The first is adherence to the principles of 'do no harm' and 'conflict sensitivity'.[17] These are supported by many aid agencies in conflict-affected countries around the world and have been promoted in Myanmar by such NGOs as Save The Children and the multi-donor 3MDG fund, which has developed principles for aid engagement.[18] Among key elements: health interventions should not undermine peace initiatives; health should bring people together and facilitate dialogue between different actors in the conflict landscape; programme interventions must be carefully tailored; gender sensitivity should be integral in peace initiatives; coordination mechanisms need to be established with different stakeholders; and programme competition must be avoided.

The second policy seeks to support health integration by 'pooled funding' among the major donors and collaboration among the different health stakeholders. Convergence rather than divergence is the aim, and the current funding landscape generally reflects these health perspectives. Of the donor financing mechanisms, the main multi-laterals in Myanmar are the Global Fund, GAVI (Global Vaccine Alliance), World Bank, and the World Health Organisation and other UN agencies. Of the bi-laterals, the largest programme is the 3MDG, which is supported by Australia, Denmark, EU, Sweden, Switzerland, United Kingdom and United States. Like the Global Fund programme, the 3MDG has been designed to perform with different partners, including the Ministry of Health, UN agencies, international NGOs, local NGOs and CBOs. Other governmental donors also pursue similar goals, including Japan and Canada.

Many problems, however, remain with regard to funding mechanisms and performances. Health aid may well reach a highpoint during 2017, with several bilateral donors reportedly poised to exit from health in the next year, including Australia, Denmark and the EU. This does not mean that total international aid will decrease, but that donor funding is likely to be spent in different areas and under different criteria. In operational terms, it is intended that 3MDG will transform into a new five-year health initiative, while there will be new funding opportunities with the Global Fund, GAVI, Global Financing Facility and the World Bank. However, in terms of sustainability and meeting health needs, serious shortfalls are likely to occur.

In this respect, Myanmar faces many of the classic dilemmas of emerging states in conflict and post-conflict transition. Self-sufficiency and a lack of dependence on external donors can be regarded as strengths in domestic health systems. Isolation, however, has its limitations, and the advent of external aid can allow low-income countries to provide access to needed services that they would not otherwise be able to afford (e.g., for the treatment of malaria, TB and HIV). At the same time, international aid also comes with new challenges, and an increase in foreign support

[16] Tax-financed, national health insurance, private health insurance, out of pocket, external and community-based insurance.
[17] http://www.conflictsensitivity.org/do-no-harm-local-capacities-for-peace-project/
[18] See e.g., http://www.3mdg.org/sites/3mdg.org/files/publication_docs/lessons_learned_report.pdf

can put serious strain on national and local systems. In particular, external aid can disrupt service delivery where domestic capacity is constrained; it can expose the need for harmonization and equity in national priorities; and both programme and financial sustainability become difficult when funding begins to run down.

These financial dimensions are especially acute in Myanmar at present. Health progress has become dependent on external funds, but there is little indication that sufficient funds will be raised by the government, whether through domestic taxes or reform of the revenue systems, to fulfil budgets in the future. Although increases have been made in national health funding since 2013, general government health expenditure as a share of government spending is calculated at just 3.6 per cent as compared to 6.1 per cent in Cambodia. Other sources of external funding might be available, such as the World Bank, but this provides soft loans that need to be paid for.

In consequence, the need is now urgent to replace external funding and develop concrete strategies to mobilize financial resources. However, this will not be easy, and it will require serious debate and decision-making over health policies during a delicate time in state transition. Myanmar remains at a stage where balance is needed between continuity and change in service delivery and building health systems; where isolated and poor communities still need to be reached; and where political and conflict-related constraints obstruct health initiatives in different parts of the country.

In the short-term, the impact of financial limitations may be reduced by some pragmatic measures. There needs, for example, to be greater alignment and harmonization between different authorities and health providers; new donors may be identified and incorporated; there should be closer involvement with the private sector; and participation by civil society and CBOs can become more effective. But, ultimately, the consensus is widespread that only greater health priority and increased expenditure at the governmental level will support progress towards the 2030 Universal Health Coverage goals.

Failure to address the funding crisis could also have implications for peace and reform efforts within the country. During the past four years, health has been an important element in trust-building programmes in the peace process initiated by President Thein Sein, and this is a development that the NLD government and other stakeholder parties have pledged to continue. Ethnic and community-based groups have long maintained their own health programmes in and around areas administered by ethnic armed organisations. However, as national transition continues, local groups are concerned that they could be squeezed out as the focus of external donors switches to standardisation and collaboration with government priorities and systems rather than with the health needs and structures in the local communities.

In many borderlands, local health initiatives are already facing financial shortfalls, and the peace process future is very difficult to predict. Conflict is presently continuing in the Kachin, Rakhine and northern Shan states, and the government's Nationwide Ceasefire Agreement is still incomplete. Furthermore, even if nationwide peace is achieved during the cycle of the present parliament (2016-20), the funds required to support peace and post-conflict transformation will be huge – and this is during a time when national health funding is already constrained. At a minimum,

over 200,000 refugees might need to be resettled from neighbouring countries and an estimated 500,000 IDPs in the borderlands as well.

To date, many local health organisations have responded creatively to the changing landscape by networking and changing their methods of operation. In ceasefire areas, focus is being given to cooperation with national health programmes. In recognition of looming need, a multi-donor Peace Support Fund was also set up in 2014, with funds from the governments of the UK, Australia and Sweden, and which seeks to coordinate with local activities already underway.[19] This could become a major conduit for external aid in the future. However, for the moment, while peace and reform impasse continues, the strategy and ownership of aid programmes in conflict areas are controversial and fundamental details are yet to be agreed.

Finally, in any analysis of funding mechanisms and performances, questions need to be asked about the quality of data, the trends in performance, and the implications for policy planning and rejecting corruption. In particular, although health data is growing, it can be difficult to assess. Major differences can occur as to whether the data is looking at 'output' rather than 'impact'; whether it acknowledges uncovered areas and borderland conflicts; which regions, systems and histories are being assessed; and it needs to be acknowledged that health situations are sometimes worst in places from which there are no data. There are also concerns that too many health agencies and providers perennially go through funding cycles of seeking new resources but without delivering on promised goals. The lack of reliable data is partly a cause. However institutional self-interest is also a major challenge and, with major funds being committed in the international aid world,[20] complacency or a lack of focus in meeting health ambitions are not acceptable.

Money in itself, therefore, is not the solution. Although increased donor funding is welcome and new opportunities for health outreach should be taken, improvements in funding mechanisms and the monitoring of performances are essential if sustainable progress is to be made. This will require considerable attention. Data collection has to be improved to reflect national realities; national reforms are essential in finance and health; and programmes have to be developed by collaborative inter-actions between different authorities and health stakeholders that reach to the roots of challenges and not simply deliver impacts that have been short-term in far too many cases in the past.

Looking forward and conclusions

No resolutions were passed at the end of the meeting, but there was discussion on looking forward and conclusions. In general, there was consensus about the key health challenges. The main points of reflection were over clarifications as to how health progress can be advanced in a landscape where conflict has continued, political

[19] http://www.peacesupportfund.org

[20] In 2015, total ODA was recorded at US$ 131.4 billion, 40 per cent of which goes to multilateral organisations including the UN and Global Fund. UN member states are expected to contribute 0.7 per cent of gross domestic product, but only six major donor countries are presently meeting this commitment. The 0.7 per cent figure was first pledged in a 1970 UN General Assembly resolution and reiterated in the UN Millennium Development Goals. Myanmar was placed at 136th of 176 countries in the 2016 Corruption Perceptions Index of Transparency International.

reform is still in early stages, and there are many different stakeholders and health interests. In many countries, national diversity is not unusual. In Myanmar's case, however, addressing health needs is complex in the field, and initiatives towards national convergence and inclusion are very new.

Two constant refrains from the seminar were that peace is essential and that opportunities for health progress must be taken. While reality suggests that 'Universal Health Coverage by 2030' is unlikely, these are still important goals that all parties can aspire to if progress is to be achieved in 'mainstreaming' health for all. To assist national healing, a number of steps can be taken by all stakeholders and parties. Recommended policies include: conflict sensitivity and 'do no harm' principles; improving access to Public Health Care and the Essential Package of Health Services; health service collaboration and coordination; setting common goals; support and backing from the leaderships of the different authorities; protection of the health and livelihood rights of all people; and the development of short term and long term plans that pay cognizance to the processes of peace and national reform.

Health progress, however, is unlikely to be smooth or easy to incorporate within one national plan in different parts of the country. Serious problems remain and new challenges, such as land and livelihood loss, are emerging that underpin health deficiencies for marginalised communities. Health initiatives therefore need to be prioritised for the most needy and vulnerable populations. Displacement and migration are also significant features of Myanmar's health landscape, and special attention needs to be paid to population movements within the country as well as to and from neighbouring states.

In addressing health challenges, the participation of civil society and community-based groups is essential. Partnership will be vital, ensuring that the government and international agencies do not provide only 'top-down' programmes. CBOs can also play an important role in cross-border collaboration with neighbouring countries over issues such as migrants, protection of the work force and special economic zones. But for the community voice to be effectively heard, dialogue needs to be increased between different stakeholders, including governmental, non-governmental and civil society groups. Through such discussion, common health goals can be agreed; funding and health plans can be harmonised; and priorities and strategies can be developed in line with existing structures, strengths, weaknesses, lessons and achievements.

Dialogue alone, however, is not sufficient, and tangible actions will be needed that guarantee real inclusion. At the local level, priority needs to be given to: empowering village and township health committees; strengthening the participation of women, youth and community representatives; promoting health security among displaced and mobile populations; developing standard operation procedures; and developing capacity-building, leadership and management.

At the national level, community representation will be important in health system strengthening, policy development and rolling out the new National Health Plan. There must be adherence to the principles of equity and protection; health delivery should be delivered with appropriate focus on ethnic nationalities and poorly-serviced areas; there should be equitable allocation of health resources, including in planning,

recruitment, training and accreditation; there must be no 'out of pocket expenses' that cause financial distress; and there needs to be protection in key social areas, including for women, labour and the environment.

Greater recognition should also be paid by international donors and health providers to the role of NGOs, CBOs and 'national responders' in ensuring that health delivery is focused and close to the needs of communities on the ground. Many health organisations, such as the Global Fund, include a platform for civil society voices, but representation needs to become more effective in the coming years. At the recent World Humanitarian Summit in Istanbul, member state donors, NGOs and UN agencies drew up important goals to support closer inter-action between donors, communities and locally-based groups; these are targets that can be supported in Myanmar.[21]

In health delivery terms, the seminar recognised that a defining moment of opportunity, and also risk, has now been reached in the three areas of particular focus in discussion: malaria, TB/HIV and maternal health. This requires serious consideration in both domestic and international circles with regards to health planning and priorities in the years ahead.

In the case of both falciparum and vivax malaria, it needs to be asked whether the treatment of malaria is going 'forwards or backwards'. In particular, despite the effectiveness of combination therapy treatments for falciparum malaria during the past 20 years, warning signs of drug resistance have already appeared, and there are many poor, marginalised and conflict-affected areas in the world from which drug resistance can rapidly spread in the future. Due to its disease prevalence and location, Myanmar will remain a country for front-line attention. Disease trends will continue to be monitored, and it is intended to roll out further a programme of public health worker provision at the village level that has been successful in addressing falciparum malaria during the past two years. However it needs to be stressed that no replacement treatments for the ACT are yet in prospect – and this must be a matter of global concern.

Similar concerns also exist about vivax malaria, both in Myanmar and risk areas in the rest of the world. Efforts to address morbidity and mortality need to be stepped up for a disease that has been significantly under-estimated in the past. Concerns about primaquine as a medication must also be resolved, and this will require further research and international commitment.

Myanmar, meanwhile, will remain of particular health concern as one of 30 'TB High Burden Countries' in the world. Although awareness of socio-economic factors that underpin poor health is growing, the TB challenge is likely to remain enhanced because of its close association with multi-drug resistance, HIV, high rates of mortality and other socio-economic factors. Similarly, serious worries will continue about maternal and child health care due to widespread hardship and social

[21] These included: providing 25 per cent of humanitarian funding to local and national responders as directly as possible by 2020; making greater use of funding tools, such as UN-led and NGO-led pooled funds, that increase assistance delivered by local and national responders; removing barriers that prevent donors partnering with national responders; enhancing the institutional capacities of national responders; and increasing support to national coordination mechanisms.

deprivation within the country, with official mortality and morbidity rates likely to remain higher than other states in the region. Unofficial rates are likely to remain even higher in marginalised and hard-to-reach areas.

In looking forward to the future, many health specialists are concerned about balancing health needs and perspectives. In some regards, the recent shift in the national burden from communicable to non-communicable illnesses can be seen as evidence of advances in disease treatments and increased health access, but there are worries that this can also lead to complacency about underlying health needs and challenges. With increased medical provision, some of the easiest statistical improvements have been made, but health systems and outreach are not yet in place to ensure that progress will be sustained. Furthermore there are also less-targeted diseases, such as dengue fever, melioidosis, rabies, typhoid, cholera and hepatitis, which remain matters of serious concern. As socio-political transition continues, the relative rise in non-communicable illnesses may not necessarily represent progress in the state of the nation's health, but rather greater recording of other health challenges, including diabetes and heart disease, that had most likely been previously under-estimated.

In the short-term, improvements can be made in many health areas by effective policies and planning, strengthening health systems, the smart use of resources, and greater collaboration and networking among different stakeholders and health actors. For example, there needs to be greater advocacy, disease awareness and development of safe and reliable treatments in the campaigns to eliminate falciparum malaria and fight vivax malaria. At the same time, the Five-Year Strategic Plan for Reproductive Health (2014-18) covers many key commitments in health planning, system strengthening, capacity-building and networking in seeking national convergence in providing health access to all. Targets to lower maternal and child mortality rates by 2030, as well as eliminate malaria, TB and AIDS, are included in the UN Sustainable Development Goals that Myanmar has endorsed. However, important as these objectives are, there is little expectation of achieving health progress on such a scale until greater priority is given to health and synergy reaches to all parts of the country. The difficulty of present challenges should not be underestimated. Good intentions need to progress to implementing health improvements that can be sustainable, particularly in the poorest and most vulnerable communities.

To address these challenges, three inter-related requirements stand out for policy attention: there must be improved planning, data and financing for health programmes. In planning terms, despite recent progress, there still needs be greater understanding of health realities in different parts of the country, the importance of raising the health bar on what should and can be done, and the risks in policy-makers setting out, and then hiding behind, long-term health targets that will never be met. The need for national refocusing has increased the urgency that disease elimination rather than disease control should be considered the primary goal. New approaches could be especially timely in the case of falciparum malaria, which research shows can be eliminated by targeted programmes. Similar awareness, however, needs to be galvanised for other treatable and preventable illnesses, including TB and HIV, which remain prevalent in the country and, like malaria, are health crises of global concern.

Serious failings are likely to continue to occur unless improvements are made in both the analysis and funding of health programmes. During a time of fast-moving change in national politics, many steps are needed. Research and data collation need to be strengthened; there should be greater focus on understanding impacts rather than outputs; and monitoring and evaluation should seek to ensure that programmes are being appropriately designed and delivered in the field. International agencies can play an important role in this. Better communication is essential between health stakeholders and providers, and the gap needs to be closed between policy-makers and health researchers to quicken the speed and impact of decision-making. But with external funding reaching a peak, the long-term financing of Myanmar's national health plans will still be problematical.

The country is therefore likely to face a continuing funding crisis in the years ahead. On current trends, nothing like the scale of the necessary funding will be achieved, whether through domestic taxes or revenue systems; hence 'out of pocket' expenditure will remain the most common form of health payment. Some savings can be made by improved planning and cost-efficiency measures, but this will still leave serious deficiencies unless there are major structural reforms in national financing. This raises questions as to where reform advocacy will come from. Myanmar faces major reform challenges, and it will be difficult for the health voice to be heard in a congested field. If steps are not taken within government, it is likely that the pressure for increased health funding can only be triggered by public representation and activism.

In any discussion of health funding, scrutiny also needs to be paid to the role of external donors and health providers. As foreign aid budgets constrict around the world, health planning and implementation risks are being confounded by bureaucracy, late responses, and institutional self-interest. Improved structures need to be established to ensure that international funds are maximized for health delivery rather than salaries, cars, accommodation and other extraneous expenses. Maintaining programmes or institutions that do not deliver fitting results also supports corruption. Many international organisations seek to pay attention to this. However, there is also advocacy for a changed donor architecture and support for locally-led working methodologies, with donors reviewing their mandates and revising their funding strategies to put more emphasis on community needs and inclusion.

Despite these challenges, the seminar finished on a positive note about the many opportunities ahead for promoting health. Daunting tasks obviously remain, but achievements during the past few years provide confidence that solutions exist to many of the present health needs, as long as opportunities are taken and appropriate policies developed. Certainly, great ambition and commitment to health progress were expressed at the seminar.

An important caveat, however, should be articulated. Despite encouraging trends, concerns remain that the country may still be at a 'tipping point' between 'emerging democracy' and 'continued militarisation'. This is evident in ethnic conflicts that continue to flare in several borderland regions and also in the new 'hybrid' government that includes both NLD and military representatives. For this reason, the achievement of nationwide peace and transition towards a decentralised form of national government are still regarded as essential. Without these two benchmarks of

change, political impasse and national fragmentation will continue, and this will impact negatively on aspirations for national reform.

Health therefore has a central role to play in national transition and building a better future for Myanmar's peoples. Health progress is a key indicator of national reform and an essential element in the achievement of peace and stability. During the last few years, hopes have been engendered by greater health focus in peace and reform discussions. It is vital that this momentum continues. The experiences of the past three decades have shown that health initiatives must be inclusive and not the cause of new divisions or disparities within the country. In the coming years, this will require a continued demonstration of the government's commitment to health and a real sense of community ownership by the people.