

# Rehabilitating Health in the Myanmar Transition

*“This is the time we have been dreaming of for decades.”*



## AUTHORS

J. Stephen Morrison  
RADM Thomas Cullison (USN Ret.)  
Murray Hiebert  
Todd Summers  
Lindsey Hammergren

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*A Report of the CSIS Global Health Policy Center*



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## Introduction

For decades, going back to 1962, when a military junta seized power, the Southeast Asian nation of Myanmar (also called Burma) was one of the world’s most repressive countries. By the late 2000s, the junta held more than 2,000 political prisoners. Living conditions deteriorated under military rule, turning Myanmar into one of the poorest countries in Asia, with fully one-third of its population living in extreme poverty, and only one-quarter with access to electric power.

Yet, from 2011, a historic top-down revolution commenced, politically, economically, and socially—a transformation *The Economist* has called “the most significant event to have taken place in South-East Asia in the past decade.”<sup>2</sup> Exciting efforts are under way from within and without Myanmar to build bridges to the rest of the world. And for the first time in 50 years, outside powers have an opportunity to promote the end of brutality and abuse, encourage peace among the country’s varied ethnic groups, and give Myanmar’s long-suffering people a chance to build new lives.

Health is an area of acute special needs, and also a sector that presents a powerful, timely opportunity to bring about major changes that enhance the lives of millions, integrate society, and help consolidate a fragile transition. Malgovernance has left the health of Myanmar citizens in peril, and left the public health system in a shambles. Life expectancy is among the lowest in the world, while HIV, tuberculosis, and malaria are among the top 10 causes of death. TB and malaria resistance, transnational health threats, are concentrated in Myanmar.

But there is also strong reason for hope; indeed, the pieces are in place to accelerate the rehabilitation of health in Myanmar, if there is a strategic focus, political will, coordinated action, and strengthened partnerships. Child immunization rates have improved. The skeleton of a health system still exists: for example, hospitals, clinics,

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<sup>1</sup> Dr. Thein Thein Htay, deputy minister for health, Naypyidaw, Myanmar, August 7, 2013.

<sup>2</sup> “A Burmese spring,” *The Economist Special Report: Myanmar*, May 25, 2013.

training facilities, and a corps of midwives who can reach far corners. Leadership at the top of the health system appears strong, while those at the helm of Myanmar's transition see the imperative to improve health on an urgent basis.

From August 4–8, 2013, a CSIS Global Health Policy Center delegation traveled to Myanmar to attain a broad overview of evolving government, U.S., and other donor strategies in the health sector and to identify pragmatic, concrete steps to strengthen the U.S. approach. The trip built upon prior CSIS work on how health potentially figures in the U.S. strategic rebalance in Asia, which resulted in late July 2013 in the publication of *A Greater Mekong Health Security Partnership*<sup>3</sup> that argued for strengthening health ties with Myanmar, Cambodia, Vietnam, Thailand, and Laos to manage pandemic threats, control resistant malaria, and improve maternal and child health. The August delegation included J. Stephen Morrison, head of the GHPC; RADM (ret.) Thomas Cullison, USN; Murray Hiebert, deputy director of the CSIS Southeast Asia Studies Chair; Todd Summers, senior adviser at the GHPC and chair of the Strategy, Investment, and Impact Committee of the Global Fund Board of Directors; and Lindsey Hammergren, GHPC program manager.

During its time in Myanmar, the delegation visited health facilities in Yangon and Naypyidaw. It met with a wide variety of public, private, and nonprofit-sector leaders, both local and international. It consulted extensively with U.S. Embassy officials, members of the Myanmar Ministry of Health (MOH), military leaders, aid donors, and health professionals. A preparatory visit to Thailand also included discussions with Thai, U.S., and Australian officials. A full program itinerary can be found in the appendix.

The delegation came away impressed with progress within the health sector, even in the midst of Myanmar's turbulent transition. The MOH's budget is rising, and the ministry is working hard to strengthen itself. The two top international health donors, the Global Fund and the Three Millennium Development Goals (3MDG) Fund, are accelerating their support. The World Bank is nearing conclusion of its health expenditure review, and preparing for a new concessionary facility for Myanmar in 2014 that may include significant health investments. The U.S. mission has established a dynamic team and made health a priority.

The delegation was struck by the mix of excitement and sober realism that surfaced in every discussion of Myanmar's health future. It heard a great deal about exceptional gaps in data, capacity, and budgets; and about difficult cleavages in any consideration of Myanmar's health needs: between rich and poor, urban and rural, and the Burman core versus the ethnic states on the periphery.

Many interlocutors warned that the flood of complex, immediate demands—and countless visitors offering to help—could compromise longer-term priorities. The delegation was also reminded repeatedly that multiple uncertainties surround the overall transition itself: for example, whether it will be possible to navigate the military/opposition divide and Buddhist-versus-Muslim tensions, or to reach a durable resolution with the armed movements in the ethnic states.

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<sup>3</sup> J. Stephen Morrison, Thomas Cullison, J. Christopher Daniel, and Murray Hiebert, *A Greater Mekong Health Security Partnership* (Washington, DC: CSIS, July 2013), [http://csis.org/files/publication/130719\\_Morrison\\_GreaterMekongHealth\\_WEB.pdf](http://csis.org/files/publication/130719_Morrison_GreaterMekongHealth_WEB.pdf).



These real considerations notwithstanding, the delegation heard time and again that health remains a powerful tool that can help stabilize Myanmar's transition and support national integration. The CSIS delegation returned home convinced that the United States is well-positioned to do much good in the health sphere. It recommends that the United States build on its already-impressive record of health support by taking five key steps: strengthen the MOH's strategic planning capacity; put a spotlight on multilateral organizations; make the Global Fund's performance a top priority; initiate U.S.-Myanmar military health collaborations; and launch a U.S. ethnic states health initiative.

## Myanmar's Transition: Treacherous, Surprising, and Hopeful

Myanmar is a Southeast Asian country of 55 million wedged between China, Thailand, Bangladesh, India, Laos, and the Andaman Sea. The United States and much of the western world began imposing economic sanctions on the country following a bloody military crackdown against peaceful protestors in August 1988 in which thousands of civilians were killed.

Momentous political changes in Myanmar jolted into action over two years ago, creating the most significant reboot of the Southeast Asian country's political and economic landscape in the last five decades. Little is known about why 67-year-old Thein Sein, a soft-spoken, somewhat bookish former general and aide to strongman and former head-of-state Than Shwe was chosen in 2011 to be president and allowed to launch democratic changes. It appears that the country's unforeseen turn to sweeping political reforms was prompted by the ruling military elite's recognition that mismanagement and sanctions had left the country isolated, vulnerable, desperately poor, and lagging far behind its neighbors and the broader world according to almost any indicator.

The new quasi-civilian government freed thousands of the country's political prisoners, including Nobel Laureate and opposition leader Aung San Suu Kyi, who had been under house arrest for 16 years. In 2012, Aung San Suu Kyi and her fellow party members won 43 opposition seats in Parliament. Strict press censorship has ended and private newspapers have reopened. Freedom of speech and assembly are beginning to improve.

Recognizing Myanmar's critical geopolitical position between China in the north and east and India and Bangladesh on the west, the United States, the European Union, and other democracies lifted decades of economic sanctions. Foreign companies and investors are entering, eager to capture a slice of the country's largely untapped consumer market and exploit its rich resources.

Meanwhile, Western governments, development agencies, and international financial institutions are establishing aid missions and mounting assistance projects. Thailand and Japan have proposed road and port projects that will connect Myanmar with its neighbors. The United States, Europe, and the United Nations are helping to rehabilitate government institutions, train a competent civil service, and resurrect the health and education systems.

A new sense of hope and optimism fills the air, together with sober recognition of the risks, uncertainty, and turbulence that will likely accompany reform. The government faces acute pressure to quickly bring about concrete benefits in health, education, power,

and employment that will reduce gross inequities and build popular confidence in Myanmar's transition. At the same time, long-term reconstruction priorities must be established and managed effectively, to set Myanmar on a stable, sustainable course.

The CSIS delegation identified three overarching threats to a smooth, successful process of reform.

First, much of what will happen in Myanmar in the coming years will depend on the direction its 350,000-person military takes. The military has dominated political and economic life for half a century. It is the only authoritative functional national institution, yet reviled for its repressive past. Its inner workings remain a black box. No one knows whether the military will allow Aung San Suu Kyi to serve as president if her National League for Democracy wins elections in 2015. Meanwhile, the military reportedly retains active security ties to North Korea, including weapons purchases—a troubling relationship that could jeopardize collaboration with the West.

Second, Myanmar's populous border regions, home to 40 percent of the population, are wracked by ethnic conflict, dating back to 1948 when Myanmar gained independence from the United Kingdom. To varying degrees, these areas remain highly sensitive politically, are often insecure and antagonistic to the central Union government, and are woefully underfinanced. Over the past two years, the government has negotiated ceasefires with all major groups including with the Kachin in the far north, with whom new fighting erupted in 2011. The U.S. Embassy, through the State Department's Bureau of Conflict and Stabilization Operations (CSO) and the U.S. Agency for International Development's (USAID) Office of Transition Initiatives (OTI), is working to track the peace negotiations and support women's groups and other civil organizations. Yet no one knows whether the military will empower senior government negotiators to hammer out a form of federalism that allows a new measure of genuine power- and resource-sharing and makes it possible for Myanmar to transcend its deep history of fragmentation.

A third threat to Myanmar's transition is the communal violence that erupted between Buddhists and Muslims in Rakhine state in the northwest in June and October 2012 and spread to central Myanmar in early 2013. Buddhist mobs, often egged on by radical monks, have committed heinous violence, killed at least 200 Muslims, and burned shops, houses, and mosques. It is estimated that over 200,000 Muslims have been violently displaced. The harshest treatment has been reserved for the Muslim Rohingya, a stateless, vilified minority in the northwest, numbering close to a million, who are not considered citizens under a 1982 law. Observers fear that religious and racial violence could veer out of control in Myanmar's populous core areas and undermine political reform and economic development.

Broad accelerated progress in health—that brings concrete health benefits to people disempowered and marginalized—has the potential to improve equity, raise popular confidence in the transition, and strengthen the security and productivity of families and communities. Over time, health gains can also directly address the key threats to the transition: by correcting the military-civilian imbalance; narrowing the gap between the ethnic states and the rest of the country; and easing sectarian tensions.

# Health Realities: Of Urgent Concern to Myanmar and Beyond

Myanmar's evolving health needs are formidable and complex. The country has the highest rate of malaria infection in Asia,<sup>4</sup> and high incidence of artemisinin-resistant malaria (ARM) concentrated in the border areas of ethnic states. It is also a designated high-burden TB and multidrug-resistant (MDR) TB country.<sup>5</sup> TB prevalence is almost double the regional average and almost three times the global average.<sup>6</sup> Nine thousand new drug-resistant cases are estimated to occur each year, with only 800 patients receiving treatment in 2012.<sup>7</sup> In the absence of quality surveillance and reporting, the true prevalence of drug-resistant malaria and tuberculosis is likely much higher than official figures suggest.<sup>8</sup>

Maternal mortality remains a challenge, complicated by striking regional disparities. While Myanmar has an average maternal mortality rate (MMR) of 200 maternal deaths per 100,000 live births, the MMR in the ethnic states, such as the eastern border region, is estimated to be as high as 721 maternal deaths per 100,000 live births—a rate more comparable to African countries like Cameroon and Liberia than to Myanmar's Mekong neighbors.<sup>9</sup>

Myanmar also faces a growing noncommunicable disease burden. According to the Global Burden of Disease study, stroke is one of the top five leading causes of Disability-Adjusted Life Years (DALYs)<sup>10</sup> in Myanmar; ischemic heart disease, cirrhosis, and chronic obstructive pulmonary disorder also make the top-ten list.<sup>11</sup>

## First Stop: Rehabilitating the Ministry of Health

By any standard, Myanmar's public health system is exceptionally weak. In 2000, the *World Health Report* ranked Myanmar 190 out of 191 member states on overall health system performance and 129 out of 191 on the overall health of its population.<sup>12</sup> In the subsequent decade, prior to the 2011 transition, the ruling regime systematically disinvested in social services, until the public health sector shrank to a mere 10 percent of the health sector itself.

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<sup>4</sup> "Burma: Health Overview," USAID, 2013, [http://www.usaid.gov/sites/default/files/documents/1861/2013\\_BURMA\\_Health\\_FactSheet.pdf](http://www.usaid.gov/sites/default/files/documents/1861/2013_BURMA_Health_FactSheet.pdf).

<sup>5</sup> "Myanmar: Health Profile," World Health Organization, <http://www.who.int/gho/countries/mmr.pdf>.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Betsy McKay, "WHO: Drug-Resistant TB Diagnoses Are Rising," *Wall Street Journal*, October 23, 2013, [http://online.wsj.com/news/article\\_email/SB10001424052702304799404579153310173477306-lMyQjAxMTAzMDIwNDEyNDQyWj-lMyQjAxMTAzMDIwNDEyNDQyWj; Samantha Michaels, "Burma on Track to Reach Tuberculosis Targets: WHO," \*The Irrawaddy\*, October 24, 2013, <http://www.irrawaddy.org/burma/burma-track-reach-tuberculosis-targets.html>.](http://online.wsj.com/news/article_email/SB10001424052702304799404579153310173477306-lMyQjAxMTAzMDIwNDEyNDQyWj-lMyQjAxMTAzMDIwNDEyNDQyWj; Samantha Michaels, )

<sup>9</sup> "Maternal Mortality Ratio," World Bank, <http://data.worldbank.org/indicator/SH.STA.MMRT/countries>.

<sup>10</sup> According to the World Health Organization, "One DALY can be thought of as one lost year of 'healthy' life.... DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences." See [http://www.who.int/healthinfo/global\\_burden\\_disease/metrics\\_daly/en/](http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/).

<sup>11</sup> "2013 Global Burden of Disease (GBD)," Institute for Health Metrics and Evaluation, <http://www.healthmetricsandevaluation.org/gbd>.

<sup>12</sup> World Health Organization (WHO), *The World Health Report 2000: Health System: Improving Performance* (Geneva: WHO, 2000), [http://www.who.int/whr/2000/en/whr00\\_en.pdf](http://www.who.int/whr/2000/en/whr00_en.pdf).

Despite this exceedingly difficult point of departure, many in Myanmar believe recovery is within reach. As Deputy Minister of Health Thein Thein Htay told the CSIS delegation, “This is the time we have been dreaming of for decades.” At the same time, officials, citizens, and expatriate observers are well aware of the formidable challenges ahead—challenges that will require a decade or longer to surmount.

Ethnic states stand largely outside the national system. While some have developed their own parallel health systems, their health needs and capacities are only dimly understood. Ethnic, religious, and political conflicts overlay many of the same regions and populations where infectious diseases flourish, including dangerous, resistant forms of malaria and tuberculosis, where the greatest needs reside in terms of maternal mortality and child survival, and where official capacities are weak. In 110 of Myanmar’s 330 townships, almost all in the ethnic states, the MOH reportedly has had virtually no presence for many years.

Though in the early days of independence the MOH made gains in expanding services to rural and urban populations, decades of neglect under military rule took a heavy toll. Especially in rural areas, shortfalls of doctors, nurses, medical assistants, and midwives steadily worsened over the years. The overwhelming majority of Myanmar’s poor could not access—and still cannot access—the limited services on offer: in the face of co-pay requirements, the absence of any national health insurance coverage, and an overstretched, greatly diminished medical staff that typically works just a few hours per day before turning to private practices on which they rely for survival.

Moreover, those in need are often mobile, moving not only within Myanmar but throughout the region to avoid conflict, seek employment, or obtain affordable services. Large Myanmar refugee populations, most from conflicted ethnic states, reside in neighboring countries, most importantly Thailand and China. (Substantial Muslim refugees from Rakhine state also reside in Malaysia.) Data on these populations is often poor, as is the understanding of when refugees will return home, in what numbers and under what conditions, if the transition achieves a durable peace in the ethnic states.

The current government is trying to bolster Myanmar’s paltry public health investments. As the transition commenced in 2011, Myanmar spent an estimated \$0.60 per person per year on health. In 2012–13, the government quadrupled budget commitments, bringing health up to 3.9 percent of the total national budget. These sudden increases made it possible to raise salaries by 50 percent and to reduce the share of salaries from 75 percent to 30 percent of the total budget. Health budget levels are projected to double in 2014, which would bring Myanmar into closer alignment with the 7–10 percent norm for most fellow states in Southeast Asia.

A major challenge facing the MOH is poor data on health conditions, expenditure, and performance. Some seasoned observers describe the current data as devoid of “authenticity.” The situation should improve over time, however, beginning with the World Bank’s public expenditure reviews of the health, education, and energy sectors, which will be completed by the close of 2013. The USAID-supported Demographic and Health Survey will be completed over the course of 2014; the World Health Organization (WHO), through the western pacific regional office, is carrying out a “health system in transition” assessment; and the WHO Southeast Asia office is helping the government

examine options for universal health coverage. A national census, the first in over half a century, is to be completed in 2014.

Another major challenge is the dramatic asymmetry in Myanmar's health system, 80 percent of which is in the hands of the private sector. That asymmetry is expected to persist, even as public health budgets and external flows rise, and no one yet knows how private health providers, insurance companies, and commodity suppliers will evolve; how their strengths can be tapped for broad public health benefits; or how the MOH, the private sector, and external donor flows will relate to one another going forward.

Given the complexity of these concurrent challenges, the MOH faces a serious risk of overload. Demands are proliferating from multiple directions, and to address immediate as well as long-term problems. There are multiple offers of assistance emanating from donors, nongovernmental organizations, and universities. The Ministry finds itself at the center of acute tensions, rooted in equity concerns: urban versus rural, rich versus poor, Buddhists versus Muslims, citizens in ethnic states versus those residing in the country's wealthier, more accessible, and better served geographic center.

Myanmar has made some recent progress in developing national health plans, setting priorities, and outlining a strategy and milestones for judging progress.<sup>13</sup> But far more work remains to refine those plans and guarantee their quality and credibility. Much more needs to be done to strengthen the MOH's strategic planning and coordination. Since the transition began, the MOH has reached several recent momentous policy decisions without adequate planning, oversight, or transparency, including a massive increase in purchases of medications in 2012–2013. The government has in place plans to attain 80 percent coverage of antiretroviral treatment for people living with HIV by 2016; it remains to be seen if this goal is feasible, and how much direct responsibility for services the MOH can assume, and in what time frame, if it is to lessen reliance on the Global Fund's nongovernmental implementing partners.

## Donors Remain Vital to the Future

USAID estimates that external donor support to health will total \$750 million–\$1 billion over the next five years, and will be fundamental to achieving progress. The World Bank estimates that donor contributions, bilateral and multilateral, will continue to account for 10 percent of the total health sector.

Multilateral institutions will dominate external flows. The Global Fund to Fight AIDS, Tuberculosis, and Malaria initiated grants to Myanmar in 2004 but stopped abruptly a year later, due to donor concerns about oversight and access.<sup>14</sup> The Fund resumed programs in Myanmar in 2011, and today is the single-largest source of health assistance, providing an estimated \$340 million in the next three years in country programs for

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<sup>13</sup> See "Health in Myanmar 2013," Ministry of Health, <http://www.moh.gov.mm/>; Ministry of Health, *Five-Year Strategic Plan (2011–2015)*, Health Information System, Myanmar, <http://www.moh.gov.mm/file/HIS%20Strategic%20plan%20%282011-2015%29.pdf>; and *Myanmar National Strategic Plan & Operational Plan on HIV and AIDS, 2011–2015*, [http://www.aidsdatahub.org/dmdocuments/NSP\\_Concise\\_2011\\_2015.pdf](http://www.aidsdatahub.org/dmdocuments/NSP_Concise_2011_2015.pdf).

<sup>14</sup> The government of Myanmar implemented new travel procedures that denied unrestricted access and movement in areas where much of the grant work would be occurring. The government also created strict procurement reviews for medical supplies. These new measures rendered it nearly impossible for Global Fund to effectively implement and oversee grant operations in much of the country.

HIV/AIDS, tuberculosis, and malaria, along with an additional \$40 million in that same period toward Myanmar's efforts under the Fund's regional Artemisinin Resistance Initiative (ARI).

At present, the Fund's grants move only through nongovernment channels: Save the Children/UK, for civil society-oriented work; and UNOPS, the United Nations' project management, infrastructure, and procurement agency, for any public-sector work. The Fund enjoys a wide legitimacy, among MOH leadership (even though the government is barred from direct support) as well as among the opposition, but given the Fund's overall funding limitations, it is not likely to expand significantly its Myanmar programs in coming years. The absorptive capacity of the Fund's nongovernmental partners is also a concern. While some civil groups, such as women's and midwives' associations, may be underutilized, other international NGOs are nearing their limit to deliver services. Funding through UNOPS has been essential, but the agency does not yet operate under any imperative to work itself out of a job by building Myanmar's capacity to manage and implement programs.

The departure of the Global Fund in 2005 left a large gap in aid for HIV/AIDS, TB, and malaria. In response, Australia, the Netherlands, Norway, Sweden, the United Kingdom, the European Commission, and later Denmark established the Three Diseases Fund (3DF). In the years 2007–2012, 3DF committed over \$138 million to address HIV/AIDS, TB, and malaria. After the Global Fund resumed activities in 2011, 3DF closed its doors and in 2012 the seven donors established the Three Millennium Development Goals Fund (3MDG), focused principally on maternal, newborn, and child health (MNCH) and health systems strengthening.

Over the next five years, the 3MDG Fund is projected to invest \$300 million toward maternal and child health in Myanmar. Most of that funding will concentrate on local health capacity-building programs in 42 of Myanmar's 330 townships, selected according to their disease burden, poverty, and unfilled need. Additionally, many observers anticipate that Myanmar and the World Bank will reach agreement in the second half of 2014 on an International Development Association (IDA) multiyear facility for future grants and lending. This IDA facility should include health, along with education, energy, and agriculture. If this scenario is realized, the bank could become an important actor in strengthening health financing, human resources, and the MOH's key institutional capacities.<sup>15</sup>

Bilateral donors will also be essential. For 2013–14, U.S. investments in health will be \$20 million per year, drawn from the President's Emergency Plan For AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), and USAID's maternal and child health work. The United Kingdom, Australia, and Japan will be major donors, directly and through the 3MDG Fund. Thailand will play a significant donor partner role, having recently concluded a memorandum of agreement with Myanmar that includes a commitment to

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<sup>15</sup> After a 20-year absence, the World Bank returned to Myanmar in 2012 and established a fully operational office in Yangon in May 2013. Myanmar, an IDA-eligible country, settled its past arrears with the bank in the course of 2012, at the same time that the bank completed a review of overall public-sector finances. Thereafter, in 2013 the bank began public-sector expenditure reviews of the education, health, and energy sectors. The health study should be completed by the end of 2013. As the review was under way, the World Bank announced its first investment project, an interest-free \$140 million loan for a power plant in Mon State.

heightened cooperation in health. China may be seriously engaged in health in the coming years as well, likely with respect to building clinics and hospitals, providing training, and addressing shared regional concerns such as ARI.

## But Can Donors Change Their Modus Operandi?

To be effective, health efforts within Myanmar require access to difficult-to-reach areas and populations and often need to extend across porous borders. In this respect, Myanmar is fortunate to possess a broad range of implementers, including the MOH, international NGOs, quasi-governmental health departments run by the ethnic states, UN agencies, neighboring governments like China and Thailand, grassroots NGOs and health workers, and in certain instances the Myanmar military.

At the same time, Myanmar's diversity of health actors has deprived the MOH of the authority and capacity to set priorities and coordinate. Civil groups are languishing as well, in part because the majority of external resources continue to flow through UN agencies and international nongovernmental bodies.

Until recently, the Global Fund and 3MDG resources were deliberately delinked from the public sector in order to preserve autonomy and distance from the regime and thereby honor international sanctions. These parallel arrangements have carried—and continue to carry—high transaction costs to support the operations of UN agencies and international NGOs.

With the easing of international sanctions and the prospect of national elections in 2015, pressures are mounting on bilateral donors and multilateral agencies alike to reduce their reliance on UN agencies and international NGOs as implementers, and to shift to building the capacities of the Myanmar public health sector and civil-society groups. Government officials and civil leaders both confirmed to the CSIS delegation that they are eager to assume a greater role in working with external partners.

Yet, how Myanmar will move beyond the current parallel system remains unclear. Success will depend on Myanmar leaders and external players working closely together, beginning with agreement on a concrete plan by which UN agencies and international NGOs can expeditiously phase down their direct implementation responsibilities and become sources of finance and technical support to the MOH and civil groups. Devising such a plan will require sustained and detailed strategies that focus systematically on the complex risks and potential tradeoffs inherent in the transition. For instance, if the pace of change is too rapid, that might place too much burden too soon on the MOH and civil groups. Alternatively, if the pace is too slow, that might put too little pressure upon UN agencies and international NGOs to relinquish control and create genuine partnerships.

## The Myanmar Military Cannot Be Ignored

The Myanmar military health system could be a key player in achieving national public health goals, including national efforts to control and eliminate artemisinin-resistant malaria (ARM) and multidrug-resistant tuberculosis (MDR-TB), and to strengthen Myanmar's pandemic preparedness. As a transient population, the military both suffers from infectious diseases and helps transmit them. The Myanmar military could be

motivated and equipped to do far more both for itself and for the broader public health good. If it did, it could also help the transition to a more stable, unified Myanmar. The military's health assets could figure positively in helping support any future negotiated political resolution between the Union government and Myanmar's ethnic states.

While the military health system's opacity makes categorical judgments difficult, it reportedly has important assets: in training, research, and service delivery capabilities; skilled personnel; management, data, and procurement systems; and mobility and access to remote populations and territory.

Considerable uncertainty exists regarding Myanmar's actual military health budget, but the military's health infrastructure financing is widely perceived to exceed that of the MOH.<sup>16</sup> Such a reality makes sense, given the military's power and dominance over the past 50 years, and given that the military accounts for a substantial share of the entire national budget (variously estimated at 30 to 40 percent).

The Myanmar Defense Directorate of Medical Services (DMS) adheres to national standards of care and training established by the MOH. It is a unified military health system, led by the director of medical services, Major General Myo Myint Thein, who reports to the commander in chief of the Army through the Adjutant General office. The DMS provides healthcare services to all military branches for active-duty military as well as their families, including parents.

The DMS operates an extensive facility network with numerous hospitals countrywide, including two 1,000-bed, two 700-bed, two 500-bed, and numerous smaller general hospitals; an orthopedic specialty facility; and an obstetric, gynecologic, and pediatric hospital. The 14 field medical battalions assigned to Regional Military Commands around the country provide primary care and preventive medicine services to operational forces, as well as care for some civilians living in more remote areas.

The DMS operates its own training and research facilities. All military physicians train at the Defense Services Medical Academy (DSMA) in Yangon, established in 1992. The curriculum is based upon the same subjects and requirements as civilian medical schools, with the addition of military field training that prepares graduates for their first operational assignment. In the past, Myanmar conscripted military physicians, but now has enough volunteers to fill its requirements. The military medical school classes have decreased in size as retention has improved. At present, the Defense Services Institute of Nursing and Paramedical Science in Yangon trains DMS officers in nursing and ancillary services. The Defense Services Medical Research Center, also located in Yangon, conducts basic science research, including infectious disease risk to Myanmar forces.

Prior to 2004, malaria was the top health problem for troops, but that changed as malaria control measures took effect. Now, with artemisinin resistance on the rise, the Myanmar military is once again on the alert about malaria, but lacks modern diagnostic technology.<sup>17</sup>

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<sup>16</sup> The World Bank, in its ongoing Myanmar health expenditure review, expected to be completed in late 2013, describes the military health budget as a "black box."

<sup>17</sup> In 2007, before Cambodia had declared ARM, a Myanmar military researcher saw a decline in the efficacy of the "per site clearance rate," indicative of artemisinin resistance. Ministry of Health (MOH) research



Myanmar Defense Services (MDS) industry manufactures pharmaceuticals. In 2003, artemisinin combination therapy (ACT) was unaffordable and a decision was taken to rely on MDS-produced monotherapy. In June 2013, the Myanmar military announced it would cease the production and use of monotherapy and convert to ACT. It is hoped that process can be completed in early 2014.

Since 2012, Myanmar military health officials have demonstrated an active interest in creating a new dialogue with the United States and other international and regional actors. In a brief conversation with Department of Defense's Army medical research lab, the Armed Forces Research Institute of Medical Sciences (AFRIMS), in Thailand in October 2012, a senior Myanmar officer outlined the Myanmar military's priority work in HIV/AIDS, TB, and malaria. A Myanmar military representative attended as an observer to the Myanmar Artemisinin Resistance Containment (MARC) meeting in June 2013. Another senior representative attended the Asia-Pacific Military Medicine Conference (APMMC) held in South Korea in July. In the summer of 2013, a representative inquired whether the Myanmar military might be eligible to participate in the Global Fund's \$100 million Artemisinin Regional Initiative. On August 20, several Myanmar military officials joined a trilateral Thai-U.S.-Myanmar session held in Bangkok, focused on military medicine, humanitarian affairs and disaster assistance, and scientific research.

For its part, the United States signaled in early August 2013 that it was prepared to move ahead with military-to-military cooperation in appropriate discrete areas: human rights/rule of law; humanitarian assistance and disaster relief; and health. U.S. officials announced at an early August 2013 press conference in Yangon that the U.S.-based Defense Institute of International Legal Studies (DIILS) would begin rule of law training with the Myanmar military. The first session occurred in September 2013.

## The Stage Is Set for U.S. Leadership in Health

The government and people of Myanmar alike have made clear their intense desire to reengage with the United States—in part as a hedge against China, their primary benefactor over past decades; and also as the most promising path of integration into a globalized world.

After Thein Sein became president, launching reforms and mounting a dialogue with Aung San Suu Kyi, the United States bet conspicuously on the transition. Secretary of State Hillary Clinton visited Yangon in December 2011 and President Barack Obama followed in November 2012. The administration eased sanctions, and sent Derek Mitchell as ambassador to Yangon to lead a young, innovative embassy team. The U.S. Embassy now includes a reopened U.S. Agency for International Development (USAID) mission charged with rapidly putting into motion a two-year \$170 million development program focused on governance reform, human rights, agriculture, and health—all with considerable congressional support.

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departments also in this period found a resistant strain but it was very difficult at that time to measure artemisinin blood levels. The MOH now collaborates with Oxford/Mahidol University in Thailand in this area. A major challenge now is answering the scientific question: what is the genotype in Myanmar? The Myanmar military intends to focus research in this area and will soon begin genotyping.

USAID has been engaged in Myanmar since 2003 through USAID's Regional Development Mission for Asia (RDMA), which developed programs addressing HIV, artemisinin-resistant malaria, and MDR-TB. In the wake of the 2008 Cyclone Nargis, RDMA also oversaw the delivery of basic medical care to internationally displaced persons (IDPs), migrants, and refugees along the Thailand-Myanmar border, supported the UN's work with the government of Myanmar on pandemic influenza preparedness, and contributed over \$84 million in disaster relief funds.

After a 21-year hiatus, USAID reestablished a mission in Yangon in late 2012. Over the course of 2013, responsibility for programming steadily shifted from RDMA to the USAID mission in country. Going forward, USAID intends to prioritize strengthening the management of health commodity supply chains in Myanmar. It invests approximately \$20 million per year in health programs: \$10 million toward HIV/AIDS under PEPFAR; \$6.5 million for malaria under PMI; and \$3.5 million for maternal and child health, through USAID's programs. Approximately half of the maternal, newborn, and child health (MNCH) funding per year is channeled to the 3MDG Fund as a signal of U.S. solidarity.

In its first year, the USAID mission team grew from 6 people to 25. Ambassador Mitchell has designated USAID to be "Embassy Rangoon's development platform." The Centers for Disease Control and Prevention (CDC) recently detailed a staff person to Yangon to work on PEPFAR for six months, and hopes to normalize relations with the MOH through a formal memorandum of agreement that will permit long-term planning and support.

Despite the relative modesty of the U.S. health program in Myanmar, the United States occupies a special leadership role, as reflected by the core donors' mid-2013 decision to appoint the USAID health director, William Slater, to cochair the bilateral donors' health working group. The United States accounts for up to one-third of the Global Fund resources, is the largest World Bank shareholder, and can use its considerable diplomatic clout in Washington, Yangon, and Geneva to advance the Fund's programs. In addition, the United States can draw from several bases of expertise in the region, such as RDMA, the CDC regional office, and the Department of Defense's Army medical research lab, AFRIMS, all based in Bangkok, Thailand.

Premier American universities have also emerged as key actors in expanding U.S. health engagement in Myanmar. In April 2012, the senior leadership of Johns Hopkins University hosted the minister of health and his leadership team for two weeks in the United States. The Myanmar government is enthusiastic about prospects for long-term training and collaborative research enterprises in the United States, and USAID is investing in partnerships with half a dozen leading American universities.

## Recommendations

The CSIS delegation recommends that the United States build on its already-impressive record of health support through the following five steps.

### **1. Strengthen the MOH's strategic-planning capacity.**

The MOH faces a host of pressing needs, and would benefit enormously from a significantly strengthened strategic planning unit, answerable to the minister and his

deputies, that can set priorities and prevent the ministry from becoming overwhelmed. The CSIS delegation recommends that the United States lead in working with the MOH, other donors, and international organizations, to agree on the key steps to bolster that unit's expert capacities and authority.

The strategic planning unit's key functions might include:

- Setting key priorities, timelines, and benchmarks for progress;
- Managing inter-ministerial, donor, and private-sector relations;
- Recruiting young Myanmar talent into the ministry on long-term career paths; and
- Accelerating capacity-building in critical areas such as data, financial management, budgets, personnel, supply chains, and insurance schemes.

Ensuring the legitimacy and success of such an initiative will require quick action, but also need at least a five-year horizon. At least initially, it will likely require a mix of Myanmar talent and expatriate expertise, which in turn will demand flexibility from the MOH in terms of hiring and promotion policies. Key U.S. expert personnel may need to be detailed from the CDC, USAID, and potentially other appropriate agencies. Yet, the unit will succeed only if it is fully desired, owned, and empowered by the MOH leadership and its staff.

## **2. Put the spotlight on multilateral organizations.**

The 3MDG Fund, the Global Fund, and foreseeably the World Bank are the most significant international instruments contributing to Myanmar's health future. Over the next five years, they will account for upwards of \$1 billion in investments in health, representing fully 10 percent of the health sector.

The CSIS delegation recommends that the United States make a concentrated effort to maximize the multilateral potential in Myanmar.

As the largest shareholder in the Global Fund and the World Bank, the United States has significant authority. Though it remains a modest partner in the 3MDG Fund, it can nonetheless use its convening power and good offices, including as chair of the donors health committee, to help bring forward the best multilateral outcomes.

One U.S. priority should be to rally Congress and other donors behind sustained health funding.

Additionally, the United States should push back against any overly cautious tendency by the Global Fund and 3MDG Fund to delay transitioning away from heavy reliance upon UN agencies and international NGOs. Rather, these organizations should be pressed to lean forward, assume some risks, quickly put into place plans and agreed oversight mechanisms, and expedite direct support to both the MOH and Myanmar civil society groups.

Finally, as the World Bank completes its expenditure reviews and works with the Myanmar government to formulate an integrated, multisector and multiyear IDA facility, the United States should ensure that health is a strong priority.

### **3. Give top priority to the Global Fund's performance.**

The CSIS delegation recommends the United States set three clear goals for the Global Fund's role in Myanmar.

- The MOH, donors, and implementing NGOs should formulate detailed transition plans with agreed milestones and metrics. It may take many years for UNOPS and international NGOs to work themselves out of a job, but it is important to start the concrete planning for a phase-down.
- The Global Fund should use its new funding mechanism to strengthen Myanmar's civil society and bolster financing for civil groups. Targets should include midwives and women's associations, including those in ethnic states.
- The Fund should continue supporting and financing of the regional effort to address ARM, while at the same time insisting on a more detailed Myanmar country implementation strategy, including metrics by which progress is to be measured. ARI investments should alleviate other urgent health concerns besides malaria inside Myanmar. In carrying out its country plan under the ARI, the MOH should leverage the technical and logistical capacities of neighboring countries and donors.

### **4. Initiate U.S.-Myanmar military health collaboration.**

The CSIS delegation believes the United States should actively test whether U.S.-Myanmar military-to-military health engagement can be an effective tool to advance Myanmar's national health goals in general and to combat infectious disease in particular. Such health collaborations can also help spur reconciliation and promote stability.

To be sure, there are risks with such an approach, from the uncertainty about the military's current and future role to concerns about sending the wrong signal to Myanmar's citizens and neighbors. Nonetheless, the CSIS delegation believes it is possible to navigate these important concerns, so long as U.S. health-centered overtures to the Myanmar military are understood to be fundamentally humanitarian in nature; explicitly supportive of civilian-led health efforts; and broadly beneficial to Myanmar society and the greater Mekong region.

Three concrete steps could be taken in the near term:

- A series of senior leader and subject-matter expert exchanges could establish a shared, baseline understanding of Myanmar and U.S. military medical capabilities and common interests.
- The U.S. Department of Defense overseas medical research laboratories located in Southeast Asia should expand participation with Myanmar and other Mekong

region countries to address ARM in border areas. These U.S. assets have exceptional scientific research capacities and regional professional networks.

- Recognizing that senior Myanmar military health officials and Ministry of Health officials have expressed a strong interest in U.S. education and training, a relationship should be developed between an American institution such as the Uniformed Services University of the Health Sciences, based in Bethesda, Maryland, and the Myanmar Defense Services Medical Academy (DSMA).

## **5. Launch a U.S. ethnic states health initiative.**

The CSIS delegation recommends the United States launch a five-year ethnic states health initiative in Myanmar, starting with an annual investment of \$20–25 million.

In the near term, the initiative's core aim would be to actively support the peace process. Over the longer term, it would help lay the foundation for sustainable health capacity in these critically important communities.

Core goals might include:

- Systematically expand knowledge of the health status, needs, and health capacities in the ethnic states.
- Provide technical and other forms of capacity-building support to ethnic state health departments and civil organizations, including women's organizations.
- Prepare contingency plans for different future scenarios, including mass refugee returns in the event of a durable negotiated agreement.

While this initiative would require close diplomatic consultations to secure the Myanmar government's active support, the United States could move quickly to realize the concept, drawing on expertise within the U.S. mission, as well as CDC and USAID expertise in the Bangkok regional offices.

## **Closing Thoughts**

The CSIS delegation remains quite optimistic about the opportunity present today in Myanmar to achieve rapid and meaningful improvements in the health of Myanmar citizens. With sufficient will, finances, and the benefit of a smart, disciplined strategy that insists above all on rehabilitating Myanmar capacities, it is possible to reduce gross inequities, rehabilitate faith in the public health system, consolidate the transition, and help integrate society. Success will of course require stamina, patience, realism, adaptability, and risk-taking, especially in addressing the huge gaps in the ethnic states. It will be essential to continue leaning forward even in the midst of the many rough and often unforeseen setbacks that emanate inevitably from a turbulent historic transition like that under way in Myanmar.

Luckily, a dynamic U.S. leadership in health is welcome, essential, and already much in evidence in Myanmar, grounded in hope and innovation. Looking ahead, the United States will get its best results in health if there is continued high-level political backing,

matched by sustained financial support. It can accelerate health gains by strengthening the government's strategic planning capacity, pressing for the best possible performance by the Global Fund and an expanded role by the World Bank, extending the reach of U.S. programs into the ethnic states, and testing what is possible in military-to-military collaborations. Back home in Washington, there will be great benefits also to intensifying the dialogue on health with those in the executive branch and Congress who remain keen to see the Myanmar transition succeed.

# Appendix. Travel Itinerary

## CSIS Team

Dr. J. Stephen Morrison  
RADM Thomas R. Cullison, MD (USN Ret.)  
Murray Hiebert  
Todd Summers  
Lindsey Hammergren

**Thursday, 1 August, 2013**

**Bangkok, TH**

**1100–1200 U.S. Embassy to Thailand**

Colonel Des Walton, Defense Attaché; Colonel William Geesey, Commander, AFRIMS; Colonel Julia Lynch, Deputy Commander for Science, AFRIMS; Rick Switzer Department of State, Environment, Science, Technology, and Health (ESTH); Joe Bagga-Taves Department of State (ESTH); Aaron Schubert, USAID Regional Team Leader for HIV and TB; Maj. Ravi Baldarom

**1400–1500 Center for Disease Control and Prevention, Thailand**

Mitch Wolfe, Country Director

**Friday, 2 August, 2013**

**Bangkok, TH**

**1030–1130 Thailand Ministry of Foreign Affairs**

Tanee “Khun” Sangrat, Director, Division 2, Department of East Asian Affairs, Ministry of Foreign Affairs

**1330–1430 AusAID Regional Health Adviser**

Michael O’Dwyer, Health Sector Specialist

**1500–1600 Thailand Ministry of Health**

Dr. Suwit Wibulpolprasert, Senior Adviser in Disease Control; Dr. Churnrurtai “Boom” Kanchanachitra, Vice President for Collaboration and Networking at Mahidol University

**Monday, 5 August, 2013**

**Yangon, MM**

**0830–1000 USAID**

David Leong, Deputy Mission Director; William Slater, Director of the Office of Public Health; ThuVan Dinh, Health Adviser; Dr. Mya Sapal Ngon,

Health Program Manager; Henry Miller, Program Manager, TDY from Washington

**1000–1100 Senior Defense Official and Defense Attaché**

Colonel William Dickey

**1130–1330 Lunch with Ambassador and Deputy Chief of Mission**

Ambassador Derek Mitchell and DCM Virginia Murray

**1530–1630 Meeting with NLD National Health Network**

Dr. Tin Myo Win, Chair of NLD, Aung San Suu Kyi's PolAd & personal physician; Dr. Mya Thaw (Vice Chair) Retired Rector Institute of Dental; Dr. Khine Khine Mar (Psychiatrist) Head of CME Committee; Dr. Shawe Pone (Management) Head of Committee

**1700–1800 Meeting with Serge Pun & Associates**

Serge Pun, Chairman

**1900–2100 Working Dinner with International NGOs**

Chris White, Population Services International (PSI) Country Rep; Frank Smithuis, Medical Action Myanmar; Parsa Sanjana, Deputy Director Program Implementation, Save the Children; Vickie Hawkins, Deputy Head of Mission, MSF

**Tuesday, 6 August, 2013**

**Yangon, MM**

**1030–1130 Myanmar Development and Research Institute (MDRI)**

Zaw Oo, Director of MDRI & EcoAd to President Thein Sein; Dr. Kyaing Kyaing Sein, MD, MPH, Director of Administration; Dr. Tin Maung Than, Director/Senior Research Fellow

**1200–1300 Lunch with Chief Political Adviser to President Thein Sein**

KoKo Hlaing

**1330–1430 3MDG Fund**

Dr. Kyaw Nyut Sein, Sr. National Adviser; Dr. George Ionita, Head of Program Management Unit, 3MDG Fund

**1500–1600 Local NGOs**

Daw Khin Ni, Assistant Project Manager at Yatana Myitta; New Zin Win, Dr. Nyan Tun, Pyigy-Khin; U Aung Khin, U Soe Aung, Myanmar Health



Assistant Association (MHAA); U Khin Win, Phoenix Association

**1630–1730 UK Department for International Development**

Dr. Louise Mellor, Health Adviser; Dr. Mya Maw, Health Programme Manager

**1900–2100 Working Dinner with International Groups**

Eamonn Murphy, UNAIDS; Dr. Paul Sender, Director of the Three MDG Fund, managed by UNOPS Myanmar; Dr. Yin Yin Htun Ngwe, 3MDG Fund

**Wednesday, 7 August, 2013**

**Naypyidaw, MM**

**1030–1130 Ministry of Health, Deputy Minister for Health**

Dr. Thein Thein Htay

**1130–1200 Ministry of Health, Department of Medical Science**

Dr. Than Zaw Myi, Director General

**1330–1500 Ministry of National Defense, Medical Corps**

Professor Major General Myo Myint Thein, Director of Medical Services (Surgeon General); Colonel Tin Maung Hlaing, Commandant, Defense Services Medical Research Centre; Lt. Col. Zaw Myo Han, Directorate of Medical Services

**Thursday, 8 August, 2013**

**Yangon, MM**

**0800–0900 MOH Site Visit at Tharketa Specialist Hospital (HIV ART site)**

Dr. Thaung Aye, Medical Superintendent; Dr. Sabai Phyu, Consultant; USAID Office of Public Health Team (William Slater, ThuVan Dinh, Henry Miller)

**0900–1000 Site Visit to the Medecins du Monde ART Clinic**

Dr. Thin Thin Thwe, Project Medical Coordinator; Dr. Dorian Job, Country Health Director; Dr. Theingi Aye, Township Coordinator, MSF- Holland; USAID Office of Public Health Team (William Slater, ThuVan Dinh, Henry Miller)

**1100–1130 Tour of Sun Quality Health Clinic**

Dr. Aye Aye Mu, Owner of Clinic; Dr. Hla Myo Kyaw, HIV Program Director, Population Services International (PSI); Dr. Myat Min Zaw, HIV Program Manager, PSI; USAID Office of Public Health Team (William Slater, ThuVan Dinh, Henry Miller)

**1200–1300      Tour of PSI Targeted Outreach Program (TOP) Centre**

Anne Lancelot, TOP Centre Director; Nay Oo Lwin, Program Manager; Dr. Hla Myo Kyaw, HIV Program Director, PSI; Dr. Myat Min Zaw, HIV Program Manager, PSI; USAID Office of Public Health Team (William Slater, ThuVan Dinh, Henry Miller)

**1430–1530      Health Development Partners Roundtable**

Amber Cernovs, First Secretary-Health, AusAID; Dr. Louise Mellor, Health Adviser, DFID; Eamonn Murphy, Country Coordinator, UNAIDS; Jason Eligh, Country Manager, UNODC; Dr. Paul Sender, Director of the Three MDG Fund; Dr. Sanjay Mathur, Director, UNOPS-Myanmar; Hnin Hnin Pyne, Senior Human Development Specialist, The World Bank; Dr. Hla Hla Aye, Assistant Representative, UNFPA; Anne Hassberger, First Secretary of the Swiss Confederation; Marinus H. Gotink, Chief, Young Child Survival and Development Section, UNICEF; USAID Office of Public Health Team (William Slater, ThuVan Dinh, Henry Miller)

**1600–1700      Outbrief with Embassy Front Office**

Ambassador Derek Mitchell; Colonel William Dickey; Chris Milligan, USAID Mission Director; William Slater; ThuVan Dinh; Henry Miller

# About the Authors

**J. Stephen Morrison, Ph.D.**, is senior vice president and director of the Global Health Policy Center at CSIS. With support from the Bill and Melinda Gates Foundation, other foundation and corporate contributors, the Center advances a long-term strategic U.S. approach to global health, cultivates new global health champions, enriches our understanding of the security and foreign policy dimensions of global health, and links Washington-based work to emerging policy expertise in key developing and middle income countries. Dr. Morrison writes widely, testifies before Congress, has directed several high-level task forces and commissions, and is a frequent contributor in major media on U.S. foreign policy, global health, Africa, and foreign assistance. He served for seven years in the Clinton Administration, four years as committee staff in the House of Representatives, and taught for twelve years as an adjunct professor at the Johns Hopkins School of Advanced International Studies. He holds a Ph.D. in political science from the University of Wisconsin and is a magna cum laude graduate of Yale College.

**Rear Admiral Thomas Cullison, Medical Corps, (USN Ret.)** is a senior adviser at the Uniformed Services University of the Health Sciences Center for Disaster and Humanitarian Assistance Medicine and senior medical adviser for the CNA Institute for Public Research. He has been actively involved in international health engagement and health policy issues since retiring from the U.S. Navy in 2010, following a 38-year career culminating in service as deputy surgeon general. He first served as a Navy line officer, participating in riverine diving and salvage operations in Vietnam. Dr. Cullison graduated from Indiana University School of Medicine and is board certified in orthopedic surgery. He held numerous clinical and operational leadership positions including fleet surgeon, U. S. Pacific Fleet; command surgeon, U.S. Pacific Command; and medical officer of the Marine Corps. His Navy command tours included commanding officer, Naval Hospital Camp Lejeune, and commander, Naval Medical Center Portsmouth (Virginia)/Navy Medicine East. Disclaimer: The views expressed are those of the author and do not necessarily represent those of the Uniformed Services University of the Health Sciences or the Department of Defense.

**Todd Summers** is a senior adviser to the CSIS Global Health Policy Center, which he joined in September 2012. His primary focus is on international financing for global health, especially the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and serves as chair of its board's Strategy, Investment, and Impact Committee. In addition to work as an independent consultant, Summers has previously served with the ONE Campaign, the Bill & Melinda Gates Foundation, and the Clinton administration, for which he served as deputy director of the White House Office of National AIDS Policy. In his personal capacity, he serves as president of the U.S. Fund for the Global Fund and board treasurer of AVAC. He holds a B.A. cum laude in religion from Middlebury College in Vermont.

**Murray Hiebert** is a senior fellow and deputy director of the Sumitro Chair for Southeast Asia Studies at CSIS. Prior to joining CSIS, he was senior director for Southeast Asia at the U.S. Chamber of Commerce in Washington. Earlier he worked as a journalist in the *Wall Street Journal's* China bureau, where he covered trade issues. Prior to his posting to Beijing, he worked for the *Wall Street Journal Asia* and the *Far Eastern*

*Economic Review* in Washington. Earlier he was based in Kuala Lumpur, Hanoi, and Bangkok for the *Far Eastern Economic Review*. Mr. Hiebert is the author of two books on Vietnam, including *Chasing the Tigers* (Kodansha, 1996).

**Lindsey Hammergren** is a program manager and research assistant in the Global Health Policy Center at CSIS, where she researches and writes about the intersections of health and security, health in Southeast Asia, and other topics. Prior to joining CSIS, Ms. Hammergren worked for Booz and Company helping to reshape the strategies of Fortune 500 health care companies to adapt to the changing domestic health environment as a result of the Patient Protection and Affordable Care Act. She is a graduate of American University.





1616 Rhode Island Avenue NW | Washington DC 20036  
t. (202) 887-0200 | f. (202) 775-3199 | [www.csis.org](http://www.csis.org)

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