Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine
Health Policy and Planning 2013;1–9
doi:10.1093/heapol/czt037

Health system strengthening in Myanmar during political reforms: perspectives from international agencies

Isabelle Risso-Gill,[1]* Martin McKee,[1] Richard Coker,[1,2] Peter Piot[1] and Helena Legido-Quigley[1]

[1]London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH, UK and [2]Saw Swee Hock School of Public Health National University of Singapore, MD3, 16 Medical Drive, Singapore 117597, Singapore

*Corresponding author. London School of Hygiene and Tropical Medicine, UK. E-mail: Isabelle.Risso-Gill@lshtm.ac.uk

Accepted 10 May 2013

Myanmar has undergone a remarkable political transformation in the last 2 years, with its leadership voluntarily transitioning from an isolated military regime to a quasi-civilian government intent on re-engaging with the international community. Decades of underinvestment have left the country underdeveloped with a fragile health system and poor health outcomes. International aid agencies have found engagement with the Myanmar government difficult but this is changing rapidly and it is opportune to consider how Myanmar can engage with the global health system strengthening (HSS) agenda. Nineteen semi-structured, face-to-face interviews were conducted with representatives from international agencies working in Myanmar to capture their perspectives on HSS following political reform. They explored their perceptions of HSS and the opportunities for implementation. Participants reported challenges in engaging with government, reflecting the disharmony between actors, economic sanctions and barriers to service delivery due to health system weaknesses and bureaucracy. Weaknesses included human resources, data and medical products/infrastructure and logistical challenges. Agencies had mixed views of health system finance and governance, identifying problems and also some positive aspects. There is little consensus on how HSS should be approached in Myanmar, but much interest in collaborating to achieve it. Despite myriad challenges and concerns, participants were generally positive about the recent political changes, and remain optimistic as they engage in HSS activities with the government.

Keywords Health system, health system strengthening, qualitative research, Myanmar

KEY MESSAGES

- Myanmar's health system is weak and fragile after years of underinvestment and neglect, with the country bearing grave health outcomes.
- Aid interventions have primarily been vertical programmes running independently to the public health system.
- Funding for aid interventions is expected to increase significantly, and new aid partners are looking to enter Myanmar.
- Challenges were identified in engaging with government, due to historical factors and economic sanctions, as well as delivering services due to weaknesses in the health system and government bureaucracy.

- Human resources, data and medical products/infrastructure and logistical challenges were reported by participants. Different agencies raised concerns about finance and governance within the health system; however, there were positive views held on these components as well.
- Aid agencies are generally positive about the ongoing changes, and express both concern and hope regarding the imminent changes.
- All actors cited that despite the rapid speed at which the reforms are taking place, it will be a long time before significant and lasting change is seen within the health system or on the ground.

Introduction

Since voluntarily transitioning from a strict military regime to a quasi-civil government in the 2010 General Election, Myanmar has undergone major political change, indicating strong signals of willingness to re-engage with the international community. Although many former military personnel remain in positions of power, 'an ambitious programme of sweeping reforms' (International Crisis Group 2012) have provided many Western governments with sufficient evidence for them to normalize relations with Myanmar, suspending economic and trade sanctions that had blocked foreign investment and support for development for so many years. Many multinational businesses are now re-engaging or engaging with the country for the first time.

The opening of Myanmar's doors will bring investment to both the private and public sectors, with an expected increase in foreign aid. Economic sanctions had limited aid flows, as had government constraints on foreign agencies operating in Myanmar; Overseas Development Assistance to Myanmar remains significantly lower than to neighbouring countries (World Bank 2012). Decades of underinvestment and neglect of public services have resulted in a fragile and weak health system, reflected in poor health outcomes (WHO 2012a; WHO/UNICEF 2012). Despite being rich in natural resources, Myanmar has high poverty and health indicators. Under-five child mortality rate stands at 62.4/1000 live births, and an estimated maternal mortality rate stands at 200/100 000 live births (World Bank 2012), in both cases, high mortality is due to preventable illnesses (WHO/UNICEF 2012). Although trends show that these rates have decreased in the last decade, they still remain the highest in the region, reflecting the great health needs in the population.

Little reliable information exists on the structure and organization of the health care system [other than Ministry of Health (MoH) documents that omit data or indicators]. Yet Myanmar has many technically sound health policies, but few resources and limited capacity to implement them, a weakness exacerbated by a lack of in-country research or accessible data.

The Myanmar public health system is weak and under-resourced, with most ambulatory care being obtained from private sector providers (Myanmar MoH 2012). Out-of-pocket expenditure is one of the highest in the world, at 81% of total health expenditure (World Bank 2012), resulting in high levels of catastrophic health expenditure (Lwin *et al*. 2011). In 2010, <2% of Gross Domestic Product (GDP) was spent on health, equating to US$17 per capita (World Bank), of which almost 70% went towards hospitals. The public healthcare system is, however, highly structured, following the state–district–township government hierarchy and medical officers overseeing all health-related activities in designated areas. There is also an active national network of auxiliary midwives and community health workers, operating in collaboration with village tract health committees, providing prevention and ambulatory care WHO 2007b. Healthcare services at the local level are, however, very under-resourced, and although some areas are supported by international non-governmental organizations (INGOs), they lack the resources to provide effective care.

These changes, coupled with the new opportunities to conduct research in Myanmar, make it an apt time to explore the opportunities to engage in health system strengthening (HSS), now high on the global agenda (Hafner and Shiffman 2012), especially among international agencies working there. There is little literature on the Myanmar health system beyond the standard World Health Organizationn (WHO) reports, which were developed in co-ordination with Myanmar government ministries.

This article aims to capture perspectives on HSS of international agency representatives in Myanmar, with an emphasis on facilitators and challenges, thus capturing an understanding of how current changes are expected to impact the work of international agencies in HSS. This research will also contribute to the literature on Myanmar and HSS more generally.

Conceptualizing health system strengthening

The World Health Report 2000 placed health systems firmly on the international agenda, identifying their core activities as: 'service provision, resource generation, financing and stewardship' (WHO 2000). The subsequent WHO Framework for Action presented a defined set of 'building blocks' that make up the health systems (WHO 2007a), building on the core activities and designed to help clarify the roles and outcomes of a health system. These blocks subsequently led to the extension of health system frameworks to embrace a broader concept of health, with stronger emphases on actors and context (Gilson in Smith and Hanson 2011; De Savigny and Adam 2009; Atun and Menabde in Coker *et al*. 2008). However, while the importance of HSS is now accepted, there is still 'no operational consensus or definition' (Smith and Hanson 2011) of what it involves, with Shakarishvili *et al*. (2011) noting a lack of consensus among actors. De Savigny and Adam (2009) have noted that, 'despite strong global consensus on the need to strengthen health systems, there is no established framework for doing so in developing countries', and even their report lacks a precise definition. Given that the terminology is in widespread use, there is a need to ascertain what those who are engaged in this activity mean by it in each setting. There is, however, some broad agreement on a set of core elements:

changes in the structures of the system that are likely to generate performance gains; what can be done to influence the behaviour and practices of health system agents and how to implement both sets of changes in ways that are most likely to secure intended effects (Roberts *et al*. 2004 in Gilson 2012).

For consistency, the WHO definition of a health system will be employed throughout this article. This is the most widely used definition, although it has also been subject to some criticism (Smith and Hanson 2011).

> A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction. And it needs to provide services that are responsive and financially fair, while treating people decently. (WHO 2012b)

This article will also draw on the WHO health systems building blocks in the structuring of the research: service delivery; health workforce; information; medical products, vaccines and technologies; financing; leadership/governance.

For the purposes of this study, we developed a broad working definition of health systems strengthening as a basis for discussion: 'health system strengthening constitutes changes or influences within or on the health system which are likely to contribute towards improved health of a population'.

Methodology

Semi-structured, face-to-face interviews were conducted with senior staff from international agencies in Yangon, both national and international staff, using an interpretative approach to respect the different realities experienced by research participants (Bowling 2009).

Participants were identified from the international agency contact list produced by the Myanmar Information Management Unit (MIMU 2012). Relevant actors working in health were selected from United Nations agencies, INGOs and donors, resulting in 26 potential agencies. Interviews were scheduled via email. Of the 26 agencies identified, interviews were conducted with representatives from 19 (one agency refused to sign the consent form and has therefore been excluded from the study). Interviews were held at the offices of the agencies in Yangon, Myanmar, in June 2012; all but three were recorded in agreement with the participants.

The interview guide was developed following a literature review and drew on other studies that are similar in method and subject (Grundy *et al*. 2009; Ejaz *et al*. 2011) as well as the WHO building blocks (WHO 2007a). Given the context of the reforms, the questions followed chronologically the past, present and future contexts. We also drew from Walt and Gilson's policy analysis triangle, which identifies context, processes, content and actors (Walt and Gilson 1994). Open, neutral questions with familiar language were used to encourage conversation around defined topics.

Interviews focused on agencies' experiences and perspectives of HSS activities; successes and challenges in implementing health activities and changes and expectations concerning the political reforms. All interviews were recorded, transcribed and then inductively coded line-by-line using NVivo 9.2 software (apart from the three that were not recorded, whose notes were written up and then transcribed). Initial index codes were drawn from the question themes, with further emergent codes and sub-codes added as appropriate. When new codes were developed, all transcripts were reviewed to see whether the new codes were also relevant. This resulted in an index of 24 main codes, with 59 sub-codes. Some codes were used to categorize agencies (e.g. according to their scope of work or objectives), while others were developed to group shared perspectives on HSS and related topics. When completed, codes were reviewed for high density, importance and relevance to the research question, which led to the identification of key themes presented in the findings.

We used a mix of deductive and inductive methods. Since a variety of frameworks was reviewed in developing this research we included some themes identified from the literature (e.g. service delivery, health workforce, medical products and information), although most emerged from inductive analysis as we allowed for open interpretation of the data and logical categorization of topics. To mirror the interview structure, the WHO building blocks were drawn on to structure the findings, with an emphasis on service delivery as the area where international agencies have most involvement. However, we recognized the limitations of the building block framework and through thematic analysis we identified additional themes related to behaviour, values and ideas.

We have organized this article around three main areas with nine sub-themes: HSS in Myanmar (understanding HSS; shifting away from parallel systems; momentum behind HSS), facilitators and challenges to HSS (barriers to service delivery; health workforce, medical products and information; and bureaucracy) and changes and future expectations (recognition of change; transitioning through the reforms; harmonization and mindfulness).

This research was approved by the Ethics Committee at the London School of Hygiene and Tropical Medicine. Confidentiality and anonymity was assured to all participants of the study, using information sheets and consent forms. Due to ethical constraints, permission was granted only to interview participants within the scope of their international agency, whose headquarters are outside of Myanmar; no Myanmar entities (Myanmar government, private sector or non-governmental organisations) participated in the study. The study objectives account for this limitation. All identifiers have been removed to maintain confidentiality.

Findings

Health system strengthening in Myanmar

Understanding health system strengthening

As noted earlier, little consensus exists on what HSS is in theory or practice (Shakarishvili *et al*. 2011; Smith and Hanson 2011). Although participants were not asked directly what they understood HSS to be, the questions around how agencies approached the topic demonstrated a range of understandings.

When asked how their agency prioritized HSS in their mission, 9 of 15 who responded reported it as a strategic

objective ('it's what we do' I18). Other respondents described it as a means to an end; 'it's the only way to get there . . . (our) objective is better health' (I14).

Most agencies cited the WHO definition of HSS, although some cited their own agency's models. Agencies that have HSS as a strategic objective commented on the lack of true understanding of it among health actors, in both agencies and government.

> Few (agencies) actually do health system strengthening in its true sense. There are lots of meetings about it but little understanding. (I06)

Some agencies saw direct provision of services as a contribution to strengthening the health system as it provided services that would not have otherwise existed. However, others regarded this more as supporting or 'propping up' the health system, by providing services in lieu of the MoH, not strengthening it (I06).

A key question is whether such diverse views matter. A few participants expressed concern about a lack of understanding of HSS by government, evident at regional level with anecdotes of local health departments requesting donations of technical equipment and infrastructure for activities labelled as HSS, showing an understanding of HSS that is more tangible than strategic. Another participant simply said, 'if the person in the driving seat doesn't know that concept or have an inclusive idea of what health system strengthening means then there may be some issues' (I17). Since the principle governance role of a health system is commonly held by the government, a practical and strategic understanding of HSS is needed for it to be truly realized.

Most agencies regarded HSS as strengthening of the public health sector, referring to examples of their work to strengthen the public health services and capacity at regional level or mainstreaming their services within the formal health structure. A few agencies, however, considered it more holistically, including the private sector and civil society.

> People rarely consider the private sector when they think about health system strengthening. It's always about the public sector, when in Myanmar, 80% of health services come through the private sector . . . the private sector should have a place at the table. (I18)

With such high out-of-pocket expenditure and limited public sector capacity, the private sector is an essential part of the health system, yet it often lies outside of the many agencies' mandate and is overlooked.

Although there is not yet consensus on a definition of HSS, agencies and government are becoming more familiar with the concept of working in a more integrated way. With the reforms and changing aid environment in Myanmar, HSS will likely be integrated into many health activities, highlighting a 'need to make everyone speak the same language' (I17) before moving forward.

Shifting away from parallel systems

Almost all participants expressed a desire to shift away from parallel systems and vertical programming, which is how many international agencies currently operate, instead moving towards more integrated systems so as not to bypass existing health structures entirely. One reason for this approach is that it 'was the only way to do it' (I12) referring to the government's lack of co-operation or ability to provide basic services in many regions. However, the main contributing factor to the parallel system has been the sanctions, as most international agencies in Myanmar are dependent on funding from donors who stipulate that funds could not be used in transactions with government bodies under the sanctions ruling.

> Sanctions are a major part of it, because you can't give your money to the government. So you talk about health system strengthening, when there is nothing to strengthen if you can't give your money to it. That's a major impediment. (I12)

Many other agencies described how their activities have been limited by strict donor conditions as well as a degree of external pressure to not engage with government from an ideological stance. Agencies also saw how formerly strong government bodies have been weakened as a consequence of underinvestment and their duplication by international agencies, with a few agencies presenting the example of the UN and Global Fund replicating the role of drug procurement, leading to the demise of a once-functioning government drug procurement system.

Although sanctions against Myanmar have just been suspended, existing grants, including Global Fund and pooled-funding initiatives such as the new Three Millennium Development Goal (3MDG) Fund (2012), were developed under the sanctions and therefore have considerable restrictions on working with government, '(pushing) towards vertical programmes, creating silos' (I04).

One participant (I15) described 'a broader recognition that vertical approaches on the three diseases weren't helpful' and that 'a more systematic approach is needed', a sentiment shared by some other actors who felt that the three diseases interventions should be more integrated, while recognizing the role this parallel approach has had in improving partner co-ordination on this topic through various committees and initiatives. Despite this a few agencies also reported that some programmes would remain as parallel systems until there is capacity to integrate them in the health system.

Momentum behind health system strengthening

Almost all participants spoke of the growing attention to HSS, referring to it as the new 'buzz word' both globally and in Myanmar. Hill *et al*. (2011) attribute the growth in HSS thinking to the increased number of new and different actors in global health, the rise in joint-funding initiatives and transition to more targeted programmes as well as increased 'recognition of the need to support health systems more broadly'. Some participants commented that it had come about simply because 'it can be done now' (I07), while in the past it was more challenging, and others shared that 'without a strengthened health system, it is not possible to move further forward' (I05).

Many donor–recipient agencies saw the growing emphasis on HSS as donor-driven, although there were mixed feelings over whether the push was coming from donors or as a donor response to international agencies. A few participants also commented on the donor-led shift from humanitarian aid towards longer term development, encouraging the health community to concentrate on sustainable, integrated programming.

Many agencies have noticed encouraging signs that the government is open to closer co-operation and change:

> I think system strengthening is recognised by government as needed. At [a government-led strategy meeting in February 2012], the government basically said 'everything needs to be reformed, so you can choose your sector and topic' . . . someone said, 'we need to reboot'. (I01)

Support and encouragement for a system strengthening approach seems to have developed organically in response to the reforms, the suspension of sanctions and also recognition that there is a better way of facilitating health activities than through vertical programming.

Facilitators and challenges to health system strengthening

Barriers to service delivery

Despite willingness to work towards more integrated health programming, there are grave concerns over its applicability in practice, due to the challenges agencies face in delivering health services. Aside from sanctions and limited funding, participants commonly found gaining access to those areas in greatest need obstructed, either physically or bureaucratically. Poor transport infrastructure as well as security concerns in conflict areas often prevented agencies from accessing these areas; some agencies talked of having 'to suspend or downsize activities as a consequence of conflict' (I11), although most agencies are not allowed to work in conflict areas.

Most participants reported the main constraint to access as gaining permission to work in certain places. As an interviewee stated:

> With policies and procedures, they are not facilitating easy access to Myanmar. To come in now as an NGO, it takes a year . . . Even for a field visit, it takes a month for authorisation (for international staff). (I01)

Slow bureaucratic processes have caused a few agencies to return funds to donors after not being able to gain permission to work in particular regions. International staff also face travel and visa restrictions.

While access is difficult in certain regions, a few agencies work through local NGOs and community-based organisations (CBO) to access difficult areas, showing that it is possible and reporting positive stories through work with local actors.

A challenge mentioned in all interviews was how overall weakness in the health system makes sustainable health programming much harder to realize. As one participant said, 'here you had the final result of decades of not investing in the health system' (I12), noting the poor quality of both public health services and infrastructure. Consequently, some agencies described the underutilization of public services and expressed concern about heavy reliance on self-medication from the private sector, which contributes to high out-of-pocket payments as well as drug resistance.

Health workforce, medical products and information

The inadequacy of appropriate resources within the health system was noted by most agencies, and in particular human resources. Many areas have a low health staff/patient ratio, more due to the lack of paid positions than lack of employable staff. Many health workers are 'inadequately trained' or 'stretched to the limit' (I01). Although some agencies identified some 'very talented' and motivated staff, underinvestment in the sector, an absence of career development pathways and inadequate remuneration mitigates against nurturing a skilled and motivated workforce.

The Global Fund and other international partners are reported to facilitate access to drugs and vaccines, as well as support public health worker training activities through fund flow mechanisms. However, they are unable to donate directly to the public health system; vaccination campaigns and health services are therefore implemented through UN agencies and INGOs because the public sector lacks the capacity to absorb donations.

> MoH has been struggling for funds and resources, because it is one of the lower priorities in the government. Whilst there is a willingness to do better, they just didn't have the resources. (I10)

One agency noted that the government does not have a way of collecting or managing revenue to fund the health system, as such an approach or system has not existed in functioning capacity within the government for decades. However, as with human resources, it is not a lack of resources but an inability to manage what is available.

Use of health data has also been a major challenge. Myanmar has not had any Demographic and Health Surveys or censuses in recent years, and routine collection of data from health facilities is also impractical due to the underutilization and imbalanced distribution of services.

> There's a lack of information on what the true situation is on the ground . . . on which to base good decisions . . . it's hard to set priorities when you don't have data to base it on. (I15)

Agencies have been constrained in collecting their own data. With funding expected to rise in Myanmar, the government is seen to have recognized the need to improve data management to aid prioritization in reform of the health system.

Bureaucracy

Although the government has formally changed, agencies noted how many former officials remain in powerful regional positions, with some reported to be obstructive to development. Many participants found them distrusting of international partners, and 'extremely cautious . . . conservative . . . worried

and protective of everything' (I17). While most agencies voiced respect for the new Minister of Health, they also spoke of other decisions within the government being 'personality-driven':

> Policy changes are very individually motivated. It's not based on WHO or best practices, just on someone's gut feeling. (I18)

It seems that this varies greatly, with agencies having positive experiences implementing work in one township but unable to work in another one. Participants shared their frustration that regional decision-makers are still crippled by the legacy of strict hierarchical structures, saying, 'even if the ''Iron Hand'' isn't holding then down anymore, they still have that mentality' (I10). With limited decision-making capacity and a very 'stereotyped thinking' or 'military discipline' (I09) among government staff, it is widely believed that a change in the mind-set of government staff is needed, but this will take time to achieve.

Equally, some agencies reported positive changes within regional authorities that are taking advantage of their new autonomy; issues that had been regarded as too sensitive to discuss openly are now on agendas.

Another prevalent theme was the perception of the government's desire to remain in control and to be seen to be competent in providing for the people, as one participant shared, 'the government always wants to be seen as strengthened enough . . . taking care of their people, competent . . . they don't like to see [NGOs] doing a lot of things' (I14). Some agencies believed that many restrictions on their work are to prevent them from witnessing situations that would undermine the government's competency; this is also why little research is permitted to be conducted in Myanmar. HSS initiatives are thought to highlight weakness in the government's ability to oversee the health system.

In contrast, a few agencies see the control exhibited by the government positively, saying, 'it can be refreshing to see a government which is controlling a lot of aspects' (I14) as opposed to other countries where they are more corruptible. Another participant recognized that the government 'have the reason for being cautious, dealing with UN, INGOs, donors, after all these years' (I05). Despite myriad complex challenges faced by agencies in their work, there are also many successes, reflected in their activity reports. Agencies are able to overcome barriers and work within the constraints. It seems that the greatest issue is simply the overall weakness of the health system so that it is hard to know where to start:

> The system is in disarray . . . it's from top to bottom that you are looking at health system strengthening . . . reform . . . revitalisation. (I01)

The government has previously been reluctant to address these weaknesses, and instead is 'trying to cover up their lack of capacity' (I12); however, now the government seems to be willing to address them and work with international agencies. There is still a degree of apprehension as they loosen their control, as expected after a sustained and rigid regime, but this offers hope for real change.

Changes and future expectations

Recognition of change

The changes in the political landscape are undeniable and are acknowledged by all interview participants. However, the degree to which the changes are reaching the development arena is debatable. Almost all agencies recognize the changes as the start of a new positive era, reporting better dialogue with government bodies; however, most agencies still maintain an air of 'cautious optimism' (I01). While some operational restrictions are easing, other administrative processes are reported to have become stricter and more bureaucratic (e.g. registration, travel permission), with examples that are more fitting with the old regime than the new one.

> The government is somehow addressing the low-hanging fruit . . . addressing the major obstacles for the world stage, for the sanctions to be lifted. (I01)

While the government has taken some large steps in reform, some see it more as 'window-dressing' (I14), and are not yet convinced that the changes will take effect throughout the system:

> The political will is there but how will they manage this when they don't have the capacity to manage this transformation from military rule to parliamentary democracy? (I01)

Some agencies also raised concerns over the government's leadership capacity, yet conversely other agencies are embracing the leadership shown by the MoH, such as the increase in government spending on health—from 1 to 4% of government expenditure of GDP (Myanmar MoH 2012)—is seen as a real commitment to change. Yet all agencies remain uncertain of the government's capacity to fulfil their promises of reforms.

Transitioning through the reforms

In discussing the transitional process, agencies voiced different concerns (including many challenges mentioned above) as well as their views of what conditions are necessary for a successful transition. With the easing of sanctions, new actors are already trying to enter the country, putting further pressure on the bureaucratic systems and government staff. Many participants predicted a 'tsunami' of NGOs and companies entering the country, and questioned the government's capacity to manage the new actors' needs and interests, particularly given the current level of bureaucracy involved in working with international actors. In contrast, a few agencies were doubtful that there would be a flood of agencies, because government control would not allow them to enter without authorization. Either way, it was acknowledged that more international agencies are likely to enter the country.

Many concerns surrounded the government's absorptive capacity, both financially and operationally. There is concern that, 'the government are not prepared for the amount of money coming in' (I09), and this might increase corruption within the government, which is currently reported to be relatively low. It is also recognized that 'everyone wants the attention and time of the key people, but they are only a few

people and they are overwhelmed' (I05), indicating the strict hierarchical structure of government. As seen in other countries, it is thought that this might 'overpower them and derail all the good work by overwhelming the process' (I05). Many actors cautioned of 'the risk of becoming another Cambodia or Kenya' (I08), used as examples of how countries can be overwhelmed by influxes of aid. Some actors suggested that the Myanmar government learns from other countries undergoing reforms.

A common theme throughout was that of time. On the one hand, some participants spoke of the speed at which the recent reforms happened: 'It's all very fast (the reforms)... they've opened the flood gates but the filters don't seem to quite be in place' (I01). Participants voiced concerns over the fast pace of the changes, and how they too are struggling to adapt to the new circumstances, particularly regarding the fiscal reforms. On the other hand, almost all agencies emphasized the long time that is needed for the changes to effect any meaningful impact. Of institutional change, 'it will take a generation' (I01); of strengthening system capacities: 'we are talking in years to come' (I08); direct bilateral funding is 'still a long way off' (I09). The general sentiment is that movement is afoot but it will take a long time. Meanwhile, international agencies will be watchful of the progress, and hoping to see co-ordinated moves towards a successful transition.

Harmonization and mindfulness

Looking reflexively at their own involvement in HSS, most agencies voiced an eagerness for closer and more thoughtful co-ordination with government bodies. They sought a more harmonized approach, saying that, 'each side needs to learn how to better work together' (I01), in a way that 'doesn't overshadow national initiatives, and doesn't create the dependency that you see in so many places' (I07). Some agencies mentioned the Paris Declaration (Development Assistance Committee, 2008) as a tool to guide collaboration and ensure alignment with government objectives. Many agencies believed that the MoH should be taking a stronger governance role, recognizing its need for external support but also to be empowered in decision-making.

> We want to make sure that we do it responsibly. And for us, that vision must include MoH because they should be ultimately responsible. But we also understand where their limitations are, and their infrastructure has been deprived for so many decades. (I10)

This may seem to contradict earlier comments about the government's control, but in fact highlights a desire to see the Ministry take on the stewardship role over the health sector. Many of the participants talked of accountability to the government, 'it's our international responsibility to co-ordinate ourselves better' (I10). Many also spoke of hope: for legitimate change, for positive relations with government, for improved health outcomes.

> There is a definite hope in the air, of positivity that things are changing, there is a movement forward that's palpable everywhere. (I10)

Despite concerns about the government's managerial capacity, there is a genuine belief among international agencies that it can achieve a successful transition, conditional upon the right support and if done in a timely manner. Many agencies did not expect to see the reforms that are currently taking place in Myanmar, and feel a growing optimism as they have transitioned the critical point at which it is impossible for the government to backslide.

Discussion

We report the views of representatives of international agencies in Myanmar about the ongoing changes as well as the operational context of implementing health programmes. These findings are unique in that such research has not been undertaken there before, and also due to the timeliness of the interviews: capturing these perspectives at the beginning of the transitions.

The perceptions of HSS in Myanmar are intrinsically linked to what has been and will be possible in light of the changes, what agencies still hope might happen and what they realistically expect in the future. In such a challenging and controlled working context, these perspectives vary between resoundingly positive to negative, with a dichotomous undercurrent of cynicism about the existing working conditions on one side and an optimistic hopefulness regarding future possibilities on the other. All agencies acknowledged the myriad challenges they face in their working environment and the need for investment in the fragile health system. There was consensus, even from the most cynical participants, that the political reforms so far are legitimate, although some remain sceptical about how they might develop. There are frequent concerns about the impact of new actors working in Myanmar, as well as a communal sense of hope that true change will come into effect, resulting in improved health outcomes from a strengthened health system.

Among the themes raised in the interviews, participants showed a 'systems thinking' approach (De Savigny and Adam 2009) and reflected on the WHO building blocks framework in their commentary, identifying successes and weaknesses of the functionality of the blocks within the Myanmar context. Challenges were found in all six components, particularly with service delivery and also with issues related to human resources, data and medical products/infrastructure and their impact on service delivery. Different agencies raised concerns about finance and governance within the health system but some had positive views about these components. Many agencies saw leadership lying within the MoH, and sensed that the MoH too sought this, promoting positive hopes for health systems governance as well as control over the incoming aid. There were also strong expectations for increased funding for the health sector, through multilateral pooled funding mechanisms and private sector investments, although more complex cost sharing and bilateral funding initiatives were understood to still be far off. Should the Ministry indeed adopt a stronger governance role, it is hoped that they would be in a position to manage the incoming resources and provide the oversight needed to improve capacity of other components of the health system. Although it was not possible to explore the

perspectives of the government in this research, the perception by agencies of the government always wanting to be in control would suggest that they would seek to adopt this leadership position.

While it is important to keep HSS on the agenda, it is crucial that the facilitating and challenging components beyond the WHO building blocks—including behaviour, values and ideas—are acknowledged and addressed. The government has maintained an obstructive and controlling role until now, which has restricted access by many aid agencies. They are now at partial liberty to shift away from this system—an unnatural transition for many—but inconsistencies will remain until bureaucrats throughout the hierarchy understand the nature of this change and are comfortable with this new approach. Weaknesses in the Myanmar health system are rarely due to lack of know-how but mostly due to the strict control and austerity that the social sector has faced. Myanmar is a potentially rich country, and—with support—is capable of bolstering its infrastructure and workforce, should it realign its priorities. The new reforms suggest that such a shift is likely, which will likely resonate not just in health but across the society as a whole. As a society in transition, a lesson learned from HSS initiatives in Cambodia (Grundy *et al*. 2009) shows that efforts should be made to ensure that new health policies are designed to be responsive to the needs and changes in society, and that ownership of these reforms is built by the Myanmar government. It is hoped that aid agencies will be able to engage with these developments, as a way to build a dialogue with government partners, and also to overcome challenges in their service delivery.

One weakness in employing the building blocks framework is that it does not account for the interplay of actors in HSS. As noted in the interviews, many of the decisions made are personality driven, both on the side of the government, but also within UN agencies, donors and NGOs. While the government certainly holds power over aid operations—at both state and township levels—it is also weak in resources, both financially and managerially, and is likely to take advantage of any resources on offer. Within the context of sanctions and shift to a more development-focused approach, the few international donors present in Myanmar have transitioned towards pooled-funding initiatives—Three Diseases Fund and the new Three Millennium Development Goal (3MDG) Fund—as well as co-ordinating with the recently returned Global Fund. In a situation with limited funding options, these donors have significant influence over the health agenda, preparing the way for bilateral donors, as well as helping the government to prioritize. HSS is on the donor's agenda—featuring in funds from Global Alliance for Vaccines and Immunisation (GAVI Alliance), Global Fund and the new 3MDG Fund. Donors are reported to be 'quite responsive' to partners' feedback, and it seems that they are keen to champion the key components of the Paris Declaration as they explore new strategies for funding. At the time of writing, it is too soon after the suspension of sanctions to see how donors will approach this new era of funding opportunities. Equally, it will be interesting to see how other actors, old and new, enter discussions. The previously repressed civil society and the unregulated private sector both have prime roles to play, if they receive appropriate support and guidance.

Both the literature and this research present a lack of consensus on a definition of HSS at both a global and local level (Bowling 2009; Smith and Hanson 2011). While agencies differ in their understandings of the phenomenon, many hold opinions on critical conditions for implementing HSS. These include promoting government leadership, inter-agency collaboration and co-ordination and the harmonization and alignment of stakeholder objectives. Agencies are keen for these principles to be followed throughout the reforms.

Limitations and strengths of the study

The main limitation in this study is that only representatives from international agencies participated, mostly from UN agencies and NGOs, restricting the scope to their perceptions of HSS. Perspectives from a wider range of stakeholders, including Myanmar public and private actors, would have allowed the paper to present a more holistic and accurate view of the phenomenon. With limited literature existing on HSS in transitional contexts, a more balanced study would have added more to the literature base, although this article also shows that studies in complex contexts are possible. The perspectives of the Myanmar government, particularly the MoH, would greatly complement this paper's findings, and could perhaps focus more on realistic strategies and potential outcomes than personal perspectives and speculation. Although such engagement was not feasible for this study, it is hoped that this article will promote the topic of HSS in Myanmar and that engagement with the government would be possible for future research, further contributing to the knowledge base of HSS in countries in transition.

A further limitation was that, for most agencies, only one participant was interviewed, so responses risk being more idiosyncratic and perhaps failing to reflect the considered views of the agency. Equally, the level of experience in Myanmar varied between participants, which may skew the degree to which they had felt or noticed changes.

The provision of a detailed account of how HSS is understood and operationalized by representatives of international agencies in Myanmar during a time of transition is the strength of this study. To our knowledge, this is the first primary data collection of HSS undertaken within the Myanmar context and it also represents one of the few examples that present the HSS perspective of UN agencies, donors and NGOs (Pfeiffer *et al*. 2008; Grundy *et al*. 2009; Tin *et al*. 2010; Ejaz *et al*. 2011; Newbrander *et al*. 2011). This article also expands our understanding of the practical application of the WHO buildings blocks in HSS, highlighting the need to incorporate the ideas, values and behaviours of the actors involved in the analysis and policy making process.

Conclusion

While Myanmar continues to be a complex country for aid agencies to work in, with great health needs, the political changes seen in the last 2 years appear to be sustained and promoting a social agenda. New reforms continue to surprise all parties in their speed and progression but the legacy of the previous autocratic regime lives on through administrative

bureaucracy and obstructive control. This could take a generation to overcome. Changes in restrictions on international agencies continue to attract new actors, bringing with them much needed resources for development. Concerns abound over the government's capacity to absorb the influx of resources, and as well as what may be the consequences of mismanaged resources. However, there is a growing hope and cautious optimism that health activities in Myanmar can have greater impact and improve health outcomes.

With little objective literature available on Myanmar's health system, as well as the lack of literature on how a HSS approach can be used in health reforms, there is a need for further research on both these subjects. With the recent lightening of censorship within Myanmar and increased engagement with the global community, it may now be possible to undertake research to gain a more accurate picture, without which is it impossible to create realistic and effective plans for strengthening the Myanmar health system.

Acknowledgements

We are grateful to all the individuals and agencies that agreed to be interviewed for this study.

Funding

Funding was received from the London School of Hygiene and Tropical Medicine's Trust Fund, which covered the researcher travel costs.

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