

Global Fund withdraws grants to Myanmar

International agencies are scrambling to raise funds to maintain three fledgling health-care projects in Myanmar, after the Global Fund to fight AIDS, Tuberculosis and Malaria withdrew grants to the country in August this year.

Discussions are underway with donors in Norway, Australia, the United Kingdom and Japan to try to secure the survival of a project which began in January to tackle tuberculosis and initiatives in HIV/AIDS and malaria which commenced in April. Collectively the projects were to have received US\$ 98.4 million from the Global Fund over five years, US\$ 11.8 million of which has already been disbursed. WHO is also looking at ways to redistribute existing funding to make money available for Myanmar and the Democratic People's Republic of Korea, (DPR Korea), which has faced similar funding withdrawals from the Global Fund.

"We are doing everything we can to get resources now for Myanmar and DPR Korea. We are promoting horizontal cooperation between WHO country offices, which means that countries like India and Indonesia which have extra funds transfer them to these countries," said Dr Samlee Plianbangchang, Regional Director of WHO's Regional Office for South East Asia.

In the meantime, the United Nations Development Programme (UNDP), the Global Fund's principal recipient in Myanmar, and other agencies are formulating a plan to salvage the remaining US\$ 8.3 million of Global Fund financing already disbursed but not yet put to use and agreement was due to be reached by the end of September. "This is to make sure activities continue until other donors can take over," said Jon Liden, spokesman for the Global Fund. "We feel by leaving behind US\$ 11.6 million, nearly a third of the whole grant, it will cushion the transition."

The plan would cover the costs of these health programmes in Myanmar during a six-month transition to alternative sources of funding for those programmes.

The Global Fund's decision to pull out of Myanmar was unprecedented. Previous withdrawal of funding from DPR Korea was for projects that were not yet underway.

These two plus Cuba, Iran, Sudan and Ukraine are the only countries that are currently subject to the Global Fund's Additional Safeguards Policy which aims to ensure that funding is used for its intended purpose and not to benefit the government.

In nearly half the countries that receive Global Fund grants, the government is not the principal recipient. Myanmar is one of those countries.

"How do you make sure the funds are spent in an accountable way in a country that is notorious for corruption? We spent a lot of time negotiating safeguards

... and set up a system and it worked for the first six to nine months. I was there in late February, it seemed to be going very well," Liden told the *Bulletin*.

However, in July this year the Myanmar government introduced new travel clearance procedures which would effectively deny unrestricted access to areas where Global Fund projects were being implemented. Although the travel restrictions were temporary, they resulted in permanent withdrawal of funding.

"UNDP said they couldn't implement our grants within our safeguards and timescale and they advised us that they should cease to be the principal recipient," said Liden. He denied that the withdrawal was due to political pressure from the United States, the Global Fund's biggest donor. "We felt we had very clear guarantees that all organizations that had been critical of providing a grant to Myanmar could find acceptable. We'd done a lot of ground work with them," he said.

However, the move has raised questions about whether undue political influence has had an impact on the Global Fund's structure which in turn has made it impossible for projects to be implemented in Myanmar. "The real problem is that the fund, the mechanism, lacks the level of flexibility needed to give us time to renegotiate the points. It's more an issue of flexibility," said Charles Petrie, the UNDP's Resident Representative in Myanmar.

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The train from Thazi to Lake Imle in central Myanmar. Remote areas in the country became difficult for international workers to reach after the government imposed travel restrictions this year.

Credit: Agenda-Fototext/K. Desmarowitz

“An environment like Myanmar is complicated, it takes time to get these things through. The time-bound nature is perfectly acceptable but means that the conditions in Myanmar left us in a difficult position to achieve performance target for that period.”

The Global Fund’s Myanmar Country Coordinating Mechanism (CCM), which comprises representatives of government bodies as well as humanitarian organizations, expressed deep regret at the Global Fund’s decision.

“Ever more stringent conditions have been imposed by the Global Fund on the principal and sub-recipients during implementation of approved programmes. Partners have endured these conditions, often with

a sense of humiliation, for the sake of people in need. They have persevered and demonstrated their flexibility in order to make the grant work,” the CCM said in a written statement.

“The conditions imposed by the Global Fund obstructed and undermined our ability to meet performance-based and time-bound targets; while the CCM accepts a safeguard policy to ensure accountability, this policy must be accompanied by more flexible time lines,” the CCM statement said.

Liden, however, denied that the Global Fund had placed any new safeguards or stricter interpretation of safeguards on Myanmar during the implementation period.

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While the full impact of the funding withdrawal remains to be seen, there are also concerns that the Global Fund decision will colour international donors’ view of Myanmar, to the detriment of future humanitarian work there.

“The UN Country Team is unanimous in its view that the termination of the Global Fund grant must not feed impressions that it is impossible to deliver humanitarian assistance in Myanmar,” said Brian Williams UNAIDS country coordinator for Myanmar. “The efforts of the UN Joint Programme on HIV/AIDS since 2003 indeed demonstrate that the delivery of such assistance is possible, with accountability and transparency. Current assistance being provided by the UN in a variety of thematic areas exceeds US\$ 45 million per year. The UN Country Team believes that it can ‘make the money work’ in Myanmar.” ■

Jane Parry, Hong Kong

Emerging diseases fuel health screening

In the Middle Ages seaports put travellers in quarantine for leprosy and plague. Today’s demand for health screening is fuelled by the same fear of infectious disease plus some new factors.

In an age of jet travel and porous borders, a large portion of the world’s population is on the move. But while international law recognizes a person’s right to leave their country, no country is obliged to allow anyone in, and health can be one of the reasons.

From 1960 to 1990, immigration medical screening for public health reasons became less a government priority with advances in the treatment of infectious disease, according to the International Organization for Migration (IOM). But since 1990, there has been a renewed interest in such screening because of the re-emergence of diseases, such as tuberculosis, combined with unprecedented population movement and a widening gap in countries’ health standards. But while some screening has proved effective, other forms raise questions as to the ethical and practical limits of such measures.

Countries use several kinds of health screening to detect conditions such as tuberculosis and sexually transmitted diseases that may pose a public health

risk and conditions, such as heart disease, to avoid a burden on the host country’s health services.

The 1969 International Health Regulations (IHR), which were revised this year, limit the health screening measures, which countries can apply, to short-term visitors who pose an immediate risk of spreading a disease.

The IHR, however, allow countries to apply additional health screening measures to people seeking long-term residence, recognizing the potential burden a sick person could have on the new country’s health services.

For this reason, there are no limitations on a country’s right to demand health information of those seeking residence, while they are limited in what they can ask of short-term visitors.

Health screening of tourists and other short-term visitors is therefore rare and came to the fore during the Severe Acute Respiratory Syndrome (SARS) crisis in 2003, when thermal scanners — in addition to pre-arrival health questionnaires — were used to detect passengers with a fever at airports across South-East Asia.

Countries such as Argentina and Brazil, far from the epicentre of the outbreak in Asia, also adopted temporary measures by screening passengers arriving from Canada with a written questionnaire and a short interview. “The booths for screening are still in place but no screening is currently being carried out,” said Colin Isaacs of the Canadian Institute for Business and the Environment, who frequently travels to

the two countries.

Similar health screening measures have been considered in the event of an avian influenza outbreak among humans, but according to WHO are un-

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Jacqueline Weekers, Senior Migration Health Advisor at the International Organization for Migration.

likely to be effective because pandemic influenza is considered more difficult than SARS to control.

"If only a few countries are affected, travel-related measures, such as exit screening for persons departing from affected areas, might delay international spread somewhat but cannot stop it," states a 2005 WHO report entitled: *Avian influenza: assessing the pandemic*. The report adds: "When large numbers of cases occur ... entry screening at airports and borders will have no impact".

Tough anti-SARS measures raised questions about civil rights but were welcomed in the face of a frightening new disease. Some people even volunteered to go into quarantine.

In contrast, many international public health experts agree that barring people with HIV from entering a country is ineffective in preventing spread of the virus and discriminatory. This dual argument was summed up in a joint 2004 UNAIDS and IOM statement concluding: "HIV/AIDS-related travel restrictions have no public health justification".

There are three main reasons for this: HIV is present in every country; it is impossible to close borders effectively and permanently; and travel restrictions may encourage visitors to enter or remain illegally, making HIV prevention even more difficult.

Yet the last two decades have seen a rise in the number of countries that impose travel restrictions on people with HIV. A 1999 study by the German nongovernmental organization Deutsche AIDS Hilfe found that 101 of 164 countries surveyed imposed some form of HIV-related travel restrictions.

These come in a number of forms, such as mandatory HIV testing for people seeking entry to the country and these invariably apply to short- and long-term visitors, including students, workers,



Indonesian Health Department officer setting up a body temperature scanner in May 2003 to detect fever in passengers at the height of the SARS crisis at Soekarno-Hatta Airport, Jakarta.

Keystone/EPA/A.Rante

refugees and immigrants.

Jacqueline Weekers, Senior Migration Health Advisor at the IOM, said that positive screening results do not necessarily bar entry. For example, some countries, such as the United States, accept certain categories of applicants who test HIV positive through pre-departure screening. These applicants may be accepted on humanitarian grounds or allowed to apply for a waiver, which can permit them to travel after they receive health education and counselling.

A small but unknown proportion of some 17.2 million refugees and 80.9 million economic migrants undergo some form of health screening, according to the IOM.

Australia, Canada, New Zealand and the United States have for decades required health screening of long-term visitors before arrival. Now European countries are following suit.

The United Kingdom announced a new immigration pre-entry health screening programme for tuberculosis initially to be implemented this month in four countries: Bangladesh, Sudan, Thailand and the United Republic of Tanzania.

“ It remains to be proven that pre-departure screening really works without infringement of human rights or encouragement of behaviour that would tend to hide the presence of disease; especially in the case of illnesses such as TB where diagnosis of active disease is often far from straightforward. ”

Paul Sommerfeld, Chair of TB Alert, a UK charity.

"TB is a growing problem in the UK and the new scheme is aimed at tackling this problem. This is not a new concept and other countries such as the USA, Australia, Canada and New Zealand already insist on long-term migrants undergoing a health check," said a government statement.

The UK pilot programme is significant, signalling a shift away from health screening for tuberculosis (TB) on arrival which came to be regarded as ineffective and expensive. The new approach also avoids language problems and long waiting times for tests.

The IOM assists 10 countries with pre-departure health assessments to detect diseases that could pose a public health risk or an excessive burden on the receiving country. "Pre-departure health assessments ... help receiving countries prepare their health services for the new arrivals, as they may not be used to recognizing or treating certain ... diseases," Weekers told the *Bulletin*.

But some experts question whether such pre-departure checks are effective in preventing the spread of disease or can be ethical in practice.

Paul Sommerfeld, Chair of TB Alert, the UK's national TB charity, said: "It remains to be proven that pre-departure screening really works without infringement of human rights or encouragement of behaviour that would tend to hide the presence of disease; especially in the case of illnesses such as TB where diagnosis of active disease is often far from straightforward". ■

Prakash Khanal, *London*