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ACHIEVING HEALTH EQUITY IN CONTESTED AREAS OF SOUTHEAST MYANMAR

Bill Davis and Kim Jolliffe

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BILL DAVIS AND KIM JOLLIFFE

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ACHIEVING HEALTH EQUITY IN CONTESTED AREAS OF SOUTHEAST MYANMAR

In the context of six decades of ethnic armed conflict in southeast Myanmar, two separate health systems have evolved: one run by the Ministry of Health (MoH) and another run by a collective of community-based organizations and the health departments of ethnic armed organizations. This collective is referred to in this paper as the ethnic and community based health organizations (ECBHOs).¹ These systems are fundamentally different in their service delivery models, human resources, and political affiliations.

Since ceasefires in the region were achieved in 2011 and 2012, the two sides have come closer together, particularly as a result of a “convergence” agenda initiated by ECBHOs to engage the MoH and improve relations. With the inauguration of the new government led by the National League for Democracy (NLD), an unprecedented opportunity has emerged to increase cooperation. Since coming into power, the party’s National Health Network has released a Roadmap Towards Universal Health Coverage in Myanmar, which makes repeated references to the important role played by ECBHOs and the need for greater engagement.²

However, given the continued fragility of the ceasefires, and the inevitably slow pace of reconciliation following decades of war, the ECBHO and MoH systems are likely to remain separate for the foreseeable future, despite their complementary roles. Given that reality, “convergence” activities should be viewed primarily in terms of the need to increase coordination and cooperation between multiple providers to improve health equity, rather than as a way to improve political relations, to drive the peace process, or to push ahead of the peace process, towards full integration of systems.

In particular, it is useful to frame the central agenda for the reform of health care delivery in southeast Myanmar in terms of achieving universal health care (UHC), which has been a stated goal of the Myanmar government in policy documents that date as far back as 1993. The

recently elected NLD has maintained the goal of achieving UHC by 2030, and several international donors are supporting these efforts. This study focuses on the crucial role that ECBHOs have in achieving this goal due to their unique resources, experience, and territorial access. It gives a comparative overview of the two health systems, looks at examples of coordination and joint activities, and provides actionable recommendations for the main domestic and international stakeholders.

ONE: HEALTH AND CONFLICT IN SOUTH-EAST MYANMAR

1.1: A short history

Southeast Myanmar (see map) is a predominantly mountainous region that is populated primarily by ethnic groups with different languages and cultures from the ethnic Bamar population that has tended to control the central government and the military.³ These non-Bamar groups, which include Karen, Mon, Shan, Karenni, Kayan, and multiple other groups and subgroups, are typically described collectively as “ethnic nationalities,” with the term “ethnic” colloquially denoting “non-Bamar.”

Since Myanmar’s independence in 1948, the southeast region has been torn by armed conflicts between the government and multiple ethnic armed organizations (EAOs) calling for greater autonomy in their regions and a more equal stake in national affairs. These conflicts have had significant harmful effects on health in the region, and have led to a deeply fractured governance environment that greatly impacts the ways that healthcare is delivered, and by whom, depending on territory.

Health conditions have firstly been affected by widespread human rights abuses committed by a range of armed actors. In particular, the Myanmar army (*Tatmadaw*) and state-backed militias have been responsible for regular human rights abuses,⁴ and civilian-targeted counterinsurgency campaigns that have caused widespread displacement.⁵ The military government and state-backed militias also placed severe limitations on

¹ The term “ethnic and community-based health organizations” originated in Health Information System Working Group, “The Long Road to Recovery: Ethnic and Community-Based Health Organizations Leading the Way to Better Health in Eastern Burma,” *Reliefweb*, Feb. 27, 2015.

² NLD National Health Network, “Programme of Health Reforms: A Roadmap Towards Universal Health Coverage in Myanmar (2016-2030)” version 1.0 (NLD National Health Network, 2016).

³ Kim Jolliffe, *Ethnic Armed Conflict and Territorial Administration in Myanmar* (The Asia Foundation, 2015).

⁴ For comprehensive documentation of abuses in Karen areas throughout the 1990s and into the 2010s, see the Karen Human Rights Group website, www.khrg.org; see also Amnesty International, *Myanmar: Crimes Against Humanity in Eastern Myanmar* (Amnesty International, 2008), <http://www.amnesty.org/en/library/info/ASA16/011/2008/en>.

⁵ Between 1996 and 2011, an estimated 3,724 villages were destroyed, relocated, or abandoned in the region. IDP numbers in the region soared to over

humanitarian assistance to these areas, and in numerous cases were implicated in harassment, abductions, and killings of ECBHO medics and other staff. Additionally, protracted conflict and longstanding neglect have resulted in poor transportation infrastructure, weak education systems, and poor supply chains for clinics, which have all been documented as detriments to health.

Studies from the southeast over the last decade found that, in addition to direct injuries from land mines and other weapons, households that had experienced forced displacement or other human rights violations had significantly worse morbidity and mortality than households that had not.⁶ A study from 2002 reported higher child mortality rates in conflict-affected areas of the southeast compared to the rest of the country (291 vs. 107 deaths per 1000 live births).⁷ Another study, from 2007, showed that forced displacement increased the odds of households reporting child mortality by a factor of 2.8, and increased the odds of households reporting child malnutrition by a factor of 3.22, compared with households that had not been displaced.⁸

In addition, the main identified causes of mortality were overwhelmingly infectious and easily preventable ailments such as respiratory tract infections, malaria, and diarrheal diseases.⁹ Childhood malnutrition is also disproportionately higher in communities of internally displaced persons (IDPs) in southeastern Myanmar than in the rest of the country: a 2013 survey estimated that 16.8 percent of children under the age of five had moderate-to-severe malnutrition. Another 2013 survey in southeast Myanmar suggests that infant and under-age-five mortality rates are double the national averages and similar to those of Somalia.¹⁰

In 2011 and 2012, a string of ceasefires were achieved between the government and 14 armed organizations, including the Karen Nation Union (KNU), Karenni National Progressive Party (KNPP), Restoration Council of Shan State (RCSS), Karen Peace Council (KPC), the

rebel faction of the Democratic Karen Benevolent Army (DKBA), and three smaller groups with operations in the southeast. On October 15, 2015, eight armed organizations agreed to sign a nationwide ceasefire agreement, alongside the president, commander in chief, and other government officials. Among these armed organizations were the two largest groups in the southeast, the KNU and the RCSS, as well as the DKBA, the KPC, and other, smaller groups operating in the region.

Since new ceasefires were signed in the southeast, hope has emerged for significant improvement of health conditions, alongside a set of new challenges. First of all, there have been distinct decreases in certain forms of abuse, despite the persistence of some others and the emergence of new trends in drug-related issues and land confiscation.¹¹ Additionally, the ceasefires have allowed greater space for the MoH and international development partners to reach remote ethnic areas. While this has the potential to improve access to healthcare in the region, it has also further driven fears among some EAOs that the state will manipulate ceasefires to expand its territorial control.

At the same time, ECBHOs have gained more space to operate without harassment from authorities, allowing them to better serve their communities. Furthermore, tentative steps towards greater cooperation between the two systems, and an apparent willingness on the part of the NLD to engage ECBHOs, has provided hope for effective and politically sensitive healthcare arrangements.

1.2: Two health systems in southeast Myanmar

The two health systems in the southeast evolved to serve different types of populations and are thus fundamentally different in structure, workforce, and policy. This section provides an overview of each system, allowing for basic comparison.

400,000, with refugee numbers ranging between 120,000 and 150,000. Thailand Burma Border Consortium, *Displacement and Poverty in South East Burma Myanmar* (Bangkok: TBBC, 2011), 17, <http://burmacampaign.org.uk/images/uploads/TBBC-Displacement-and-Poverty-in-South-East-Burma.pdf>.

⁶ For more on the history and health impacts of the conflict, see: Bill Davis, Andrea Gittleman, Rick Sollom, and Adam Richards, *Bitter Wounds and Lost Dreams: Human Rights Under Assault in Karen State, Burma* (Cambridge, MA, and Washington, DC: Physicians for Human Rights, August 2012), <http://physiciansforhumanrights.org/library/reports/bitter-wounds-and-lost-dreams.html>.

⁷ T. J. Lee, L. C. Mullany, A. K. Richards, H. K. Kuiper, C. Maung, and C. Beyrer, "Mortality rates in conflict zones in Karen, Karenni, and Mon states in eastern Burma," *Tropical Medicine and International Health* 11, no. 7 (2006): 1119-1127.

⁸ Luke C. Mullany, Adam K. Richards, Catherine I. Lee, Voravit Suwanvanichkij, Cynthia Maung, et al., "Population-based survey methods to quantify associations between human rights violations and health outcomes among internally displaced persons in eastern Burma," *Journal of Epidemiology and Community Health* 61, no. 10 (2007): 908-914.

⁹ Lee, et al., "Mortality rates in conflict zones."

¹⁰ HISWG, "The Long Road to Recovery," 25.

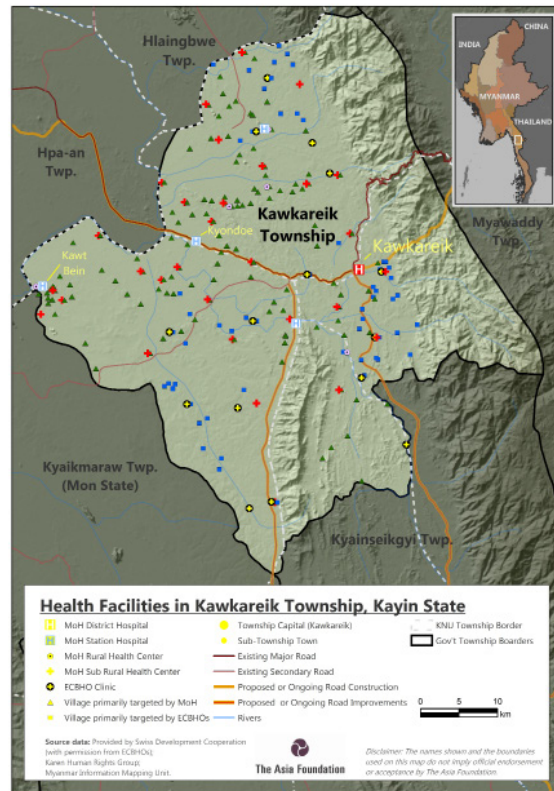
¹¹ Karen Human Rights Group, *Truce or Transition: Trends in Human Rights Abuse and Local Response in Southeast Myanmar Since the 2012 Ceasefire* (KHRG, 2014), 9-10, <http://www.khrg.org/2014/05/truce-or-transition-trends-human-rights-abuse-and-local-response>.

The ethnic and community based health organizations (ECBHOs)

The ECBHOs collectively employ around 3,000 staff, operate 232 clinics and mobile teams in southeast Myanmar (more, nationally), and target a population of around 600,000 people, including IDPs, living in mixed administration areas and areas controlled by EAOs.¹² The combined annual budgets for ECBHOs serving the southeast are over six million USD, including the cost of care and training provided in Thailand.¹³

Although the ECBHO health system targets only a small proportion of Myanmar’s total population, its catchment area encompasses some of the most geographically and politically hard-to-reach places in the country, where health disparities compared with urban areas are most extreme. In terms of achieving UHC, this population is usually the most expensive and the last to get services from government or elsewhere because of the challenges of delivery. However, people living in ECBHO catchment areas already have access to many health services for free, while most of the rest of the country has been paying out-of-pocket for MoH services.

ECBHOs provide care through stationary primary health clinics (PHCs) and mobile teams. PHCs target all surrounding populations who are within four to five hours walk; these target populations range from 2,500 to 10,000 people. PHCs employ from 10 to 40 staff, depending on the size of the catchment area, and they see between 10 and 50 patients per day. Mobile teams comprise three to five medics who provide maternal and child health (MCH), medical care, and health education, plus village health workers and trained traditional birth attendants. The team members live in villages in their catchment areas, which typically comprise about 2,000 people.¹⁴ Some of these clinics and mobile teams are interspersed with each other and also with MoH clinics, as shown in Map 1, as a result of the history of fighting and areas of control. The distribution of ECBHO clinics and mobile teams is shown in Map 1 depending if room for one/two maps 2.



Map 1 – Health Facilities in Kawkaireik

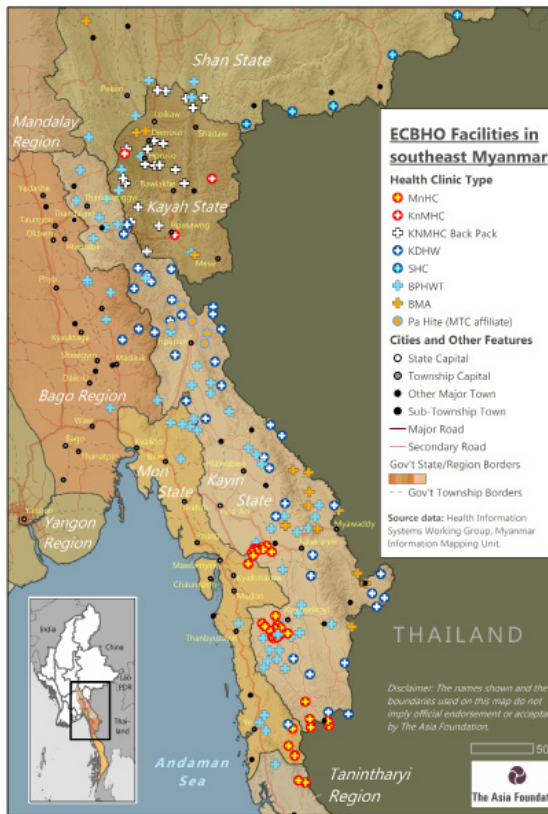
¹² Interview with HISWG senior staff (March 2016). Infrequent data collection and reporting, in- and out-migration, and the challenge of defining catchment areas in the southeast create difficulties in accurately estimating people served by ECBHOs and total staff employed by them.

¹³ Mae Tao Clinic 2014 Annual Report, <http://maetaoclinic.org/publications/annual-reports/>; Karen Dept. of Health and Welfare 2011 Annual Report, <http://kdhw.org/departement/annual-reports/>; Back Pack Health Worker Team 2014 Annual Report, <http://backpackteam.org/?p=417>; interviews with ECBHO senior staff (December 2015-March 2016).

¹⁴ M. Mahn, C. Maung, E. K. Oo, L. Smith, C. I. Lee, E. Whichard, et al., “Multi-level partnerships to promote health services among internally displaced in eastern Burma,” *Global Public Health* 3, no. 2 (2008): 165-186.

¹⁵ S. Low, et al., “Human Resources for Health: Task Shifting to Promote Basic Health Service Delivery Among Internally Displaced People in Ethnic Health Program Service Areas in Eastern Burma/Myanmar,” *Global Health Action* 7 (2014); HISWG, “The Long Road to Recovery,” <http://reliefweb.int/report/myanmar/long-road-recovery-ethnic-and-community-based-health-organizations-leading-way-better>.

¹⁶ Burma Border Guidelines (2007), <http://maetaoclinic.org/publications/burma-border-guidelines/>.



Map 2 – ECBHO Facilities in SE Myanmar

ECBHOs all use similar training curricula and have similar workforce structures that are substantially different from those of the MoH. ECBHOs use cadres of health workers who perform advanced clinical tasks to fill the gaps created by a lack of available doctors and nurses in ECBHO target areas. For example, ECBHO medics, trauma medics, and emergency obstetric care workers can perform amputations and other treatments for war-related injuries, as well as handle complications during childbirth. These are tasks done by doctors and nurses and midwives in the MoH system. ECBHOs argue that this system has been developed to use the human resources available in eastern Myanmar as efficiently as possible to address the most prevalent health problems there.¹⁵ Most ECBHO facilities do not

provide secondary or tertiary care. Clinical diagnostic and treatment protocols specific for morbidities in ECBHO catchment areas are described in the Burmese Border Guidelines, a 300-page manual developed by the Mae Tao Clinic (MTC) with support from international non-governmental organizations (INGOs) and United Nations agencies.¹⁶

ECBHOs face the challenge of making the transition to a system better suited to delivering services in post-conflict areas while maintaining the ability to rapidly revert to their old system if conflict breaks out. Although the ECBHO health system was responsive to conflict situations, this has also created significant challenges for systematic monitoring and evaluation, external evaluations, and other areas of management decision-making. The system that emerged from the conflict environment was one that could respond quickly to ongoing crises, but whose management had little time to work on increasing efficiencies. Security risks during the conflict caused uneven service delivery, and prevented regular travel for public health outreach and education or for health worker refresher trainings, immunization programs, regular supply and supervisory visits to clinics, and regular reporting of health data. All of these areas need strengthening.

ECBHOs rely heavily on international donor funds to run their operations, although EAOs fund some clinics and the central operations costs of their departments, and local donors in communities also contribute. Limited funding has resulted in low salaries for both headquarters and field staff, and this, in addition to other human resource-related factors, has contributed to high turnover of staff, among other structural challenges. More sustainable sources of funding are needed.

Ministry of Health

The MoH system employs large numbers of workers, but these numbers are still inadequate to ensure service

¹⁷ Myanmar Ministry of Health, “Health Statistics 2014” (2015), <http://www.moh.gov.mm/file/HEALTH%20STATISTICS.pdf>.
¹⁸ World Bank, *Myanmar Public Expenditure Review* (World Bank, September 2015), 59, http://www-wds.worldbank.org/external/default/WDSContentServer/WDS/IB/2016/03/15/090224b0842014db/1_0/Rendered/PDF/Realigning0the0c0expenditure0review.pdf.
¹⁹ WHO Global Health Expenditure Database, <http://www.who.int/health-accounts/ghed/en/>.
²⁰ World Health Organization, *The World Health Report 2000. Health Systems: Improving Performance* (Geneva: WHO, 2000), http://www.who.int/whr/2000/en/whr00_en.pdf.
²¹ Than Tun Sein, et al., “The Republic of the Union of Myanmar Health System Review,” Asia Pacific Observatory on Health Systems and Politics, *Health Systems in Transition* 4, no. 3 (2014): 163.
²² “The Republic of the Union of Myanmar, The Population and Housing Census of Myanmar, 2014 Summary of the Provisional Results,” (Department of Population, Ministry of Immigration and Population, 2014), <http://countryoffice.unfpa.org/myanmar/drive/SummmmaryoftheProvisionalResults.pdf>.
²³ Than Tun Sein, et al., “Myanmar Health System Review,” 150.
²⁴ Myanmar Ministry of Health, *Myanmar Healthcare System: Health in Myanmar 2014* (Ministry of Health, 2014), <http://www.moh.gov.mm/file/MYANMAR%20HEALTH%20CARE%20SYSTEM.pdf>.
²⁵ NLD National Health Network, “Roadmap Towards Universal Health Coverage.”

coverage that meets WHO standards. In 2014, the Ministry of Health operated 988 hospitals, 348 MCH centers, 87 primary and secondary care centers, and 1,684 rural health centers. It managed 13,000 doctors, 30,000 nurses, 22,000 midwives, and 11,000 other health workers.¹⁷

For decades, Myanmar's military governments underfunded the MoH. In 2011, shortly before the country implemented health reforms, it was spending only about 0.3 percent of GDP on health, about \$1.60 per person.¹⁸ The result was a systemic weakening of the entire health system: human resources development, supply chains, data collection and management, and clinical and preventive services were affected. The low government funding resulted in high costs for consumers, and had the effect of boosting the private sector as doctors opened their own clinics that were perceived as being of better quality. A decade after this trend toward privatization began, Myanmar had one of the highest percentages in the world of health expenses paid out-of-pocket by individuals.¹⁹ In 2000, the last year for which rankings are available, the WHO ranked Myanmar's health system as 190th out of 191 countries.²⁰

There is also a wide gap in service provision between urban and rural areas. The MoH long prioritized building secondary and tertiary care centers in urban areas over providing basic care in rural areas, and it focused on training doctors and nurses over basic health staff.²¹ By the 2010s, half of the country's health workers were located in urban areas, while 70 percent of the population lived in rural areas.²² Meanwhile, regular rotation of health staff in and out of rural postings, "led to lack of understanding of the local situation and the community, reducing trust of, and rapport with, the local community."²³

Today, the MoH leadership is tasked with reviving this system, and its resources are expanding. Over the last five years, the previous government increased spending on health from 1.0 to 3.4 percent of government expenditures, and from 0.2 to 1.0 percent of GDP.²⁴ Foreign aid in the health sector has increased steadily since 2010. In its Roadmap Towards UHC, the NLD

laid out plans to reduce out-of-pocket expenses from about 60 percent to 25 percent of total health expenditures, and to make up for the difference with a significant increase in government spending, as well as some increase in external funding.²⁵

²⁶ HCCG, Presentation to UNHCR, Yangon, Myanmar (June 2014).

²⁷ HCCG, "Community Health: We Care for Our Own," *Myanmar Times*, March 29, 2016, <http://www.mmtimes.com/index.php/opinion/19702-community-health-we-care-for-our-own.html>.

²⁸ This diagram is available on the HISWG website, http://hiswg.org/?page_id=3473.

²⁹ HCCG, "Statement of Burma Health Reform Seminar," March 30, 2016, Mae Sot, Thailand, <http://www.burmapartnership.org/2016/03/statement-of-burma-health-system-reform-seminar/>.

³⁰ Center for Strategic and International Studies, "Working Together to Eliminate Malaria in Myanmar," Conference Statement (Washington, DC: CSIS, Aug 3, 2015). http://csis.org/files/attachments/150804_Myanmar_Conference_Statement.pdf.

TWO: “CONVERGENCE” OF THE MOH AND ECBHOS

2.1: The Health Convergence Core Group (HCCG) agenda

When bilateral ceasefires were signed in 2012, political space opened up for increased engagement between MoH and ECBHOs. Accordingly, ECBHOs formed the Health Convergence Core Group (HCCG) and initiated a discussion about how the two systems might be able to increase cooperation and coordination by laying out a policy for “convergence,” aimed at bringing the two systems incrementally closer together in line with stages in the peace process. By 2014, the term “convergence” was featuring in health programme and strategy documents of major INGOs, intergovernmental banks, and United Nations agencies.

This was a crucial development, both politically and particularly from a practical standpoint. Across southeast Myanmar, the two systems’ catchment areas are intertwined and frequently overlap. At the same time, both health systems have strengths and weaknesses and are adjusting to political changes. The MoH has more available resources, but it has multiple priorities and currently does not have a strong presence in rural areas of the southeast. ECBHOs, on the other hand, have developed their system specifically to deliver services in rural, conflict-affected areas, but there are gaps in the package of services they can provide. Attempts to improve coordination and cooperation will be crucial to reaching mutual health goals.

“Convergence” is defined by the HCCG as “the systematic, long-term alignment of government, ethnic, and community-based health services,” with a focus in the short term on “consultation and coordination between ECBHOs, MoH, and INGOs.”²⁶ HCCG’s policy and principles revolve around the central desire for a federal system of government and extensive devolution of healthcare responsibilities to the states and regions.²⁷ They lay out a model for bringing the two systems closer together incrementally, increasing collaboration in line with progress in the peace process. This basic concept is demonstrated visually in the policy’s “rocket ship” diagram.²⁸ This proposed sequencing is largely due to a hesitancy among ECBHOs to change their modes of operations too quickly, as the ceasefires remain far from guaranteed.

HCCG policy calls for ECBHO structures and systems to remain intact throughout the process of incremental

convergence, and argues that outside actors should continue to support both the ECBHOs and the evolution of a federal, decentralized system of health services, rather than simply strengthening the central government system. To this end, the HCCG asserts that government must involve ECBHOs in decision-making processes, and that international development actors should continue financial and technical support to ECBHOs, while securing their approval before working in their areas.²⁹

2.2: Examples of convergence activities

Since the 2011 and 2012 ceasefires, key convergence activities have included:

- Increased engagement and sharing of information about their systems, policies, and strategies, through formal meetings, a number of seminars hosted by ECBHOs, and one workshop hosted by the NLD. Such engagements have greatly improved mutual understanding, and have been instrumental in creating space for the other activities listed here.
- Joint trainings, including auxiliary midwife training hosted by MoH and attended by the Backpack Healthworker Team.
- Limited progress towards accreditation of ECBHO health workers, which has been noted as a priority in the NLD’s Roadmap Towards UHC.
- A dialogue between ECBHOs, the former government, the NLD, and defense services, convened in Washington, DC, to develop a joint strategy for the eradication of malaria by 2030. A joint statement was released stating that “success [in eliminating malaria] requires expanded cooperation.”³⁰
- In 2015, a detailed mapping of a small area of mixed health coverage was undertaken by MoH and numerous Karen ECBHOs as part of a Swiss-funded primary health care project, in Kawkaeik Township, Kayin State. One component of the project involved mapping MoH and ECBHO clinics, locations of community health workers, and catchment areas, to ensure that everyone in the township had health coverage.

THREE: ASSESSING CONVERGENCE AND IDENTIFYING STEPS FORWARD

The term “convergence” has different meanings for different actors. Although the HCCG has laid out detailed policies on its views of convergence, these sometimes leave a lot of room for interpretation.

It is the view of the authors that convergence should be approached (and understood) first and foremost in terms of health equity rather than in terms of politics and the peace process. Social services and politics are inextricably linked in southeast Myanmar, but convergence activities should be planned, prioritized, and evaluated based on what will achieve equitable services in ECBHO and MoH catchment areas, rather than on what will improve political relations or drive the peace process. Inevitably, however, such an approach still depends on international aid actors maintaining a conflict-sensitive and “politically smart” approach.

Given the challenges of delivering health services in this area, both systems have significant contributions to make in reaching the government’s goal of universal health care. The MoH has authority as the health agency of the national government, with the attendant domestic and international financial and technical support. It has many more resources than ECBHOs, but it also has a much larger system and a more geographically and socially diverse catchment area, and thus it has more problems to address. In other countries, rural and remote areas like southeast Myanmar are often the last to receive UHC interventions because of the difficulty of delivering services there.

ECBHOs can therefore play a crucial role in improving national coverage and health outcomes, particularly by delivering services in hard-to-reach areas where the MoH has little or no presence, and by engaging in wider reform efforts. ECBHOs use local human resources, which helps to circumvent language and cultural barriers and increase trust among local populations. They have decades of experience working on health in this region, and have developed their own diagnosis and treatment guidelines for endemic morbidities and mortalities, as well as training programs based on international standards but customized for the region. Furthermore, there remain numerous territories that only ECBHOs can reach, due to EAO and *Tatmadaw* restrictions on

MoH services.

Due to the fractured governance environment and the inevitably slow pace of political reconciliation, MoH and ECBHO systems will remain separate entities for some time. In the near term, convergence activities will primarily focus on enhancing coordination to ensure equitable service delivery, reducing overlap and gaps in services, and avoiding counter-productive strategies.

In contrast, it is unhelpful and unrealistic to view convergence as primarily about bringing the two systems together to create a single entity as soon as possible. Assertions that “parallel” MoH and ECBHO systems are inefficient and problematic suggest that there should be one combined system in southeast Myanmar. Although having separate systems with overlapping catchment areas presents certain challenges to maximizing efficiency, it is the current political and practical reality. Both ECBHO and MoH resources are needed to maintain and expand coverage in southeast Myanmar. The presence of multiple health service providers in the same area is common in other contexts. Indeed, in terms of achieving UHC, most countries use different providers, specialized to reach different populations or provide different services, as a way of *increasing* efficiency.³¹

The government has a responsibility, not simply to invest in its own delivery capacity, but to create a policy and legal framework that provides universal health services of the highest quality as affordably as possible. ECBHOs should be seen as crucial partners in this project due to their unique resources, experience, and territorial access, allowing the government to better monitor the country’s actual progress towards domestic and international development targets. The overall strategy of the NLD’s Roadmap Towards UHC is largely consistent with this approach, and reflects a positive shift towards relying on multiple providers to provide health services to all.

For their part, ECBHOs should make certain that their own convergence policies and efforts are conceived to ensure health equity. They should continue to develop strategies that leverage their unique capacity to reach rural populations, while pursuing all options to complement the government system where it will serve beneficiaries. ECBHOs should understand that the government has a democratic mandate from the people, and should respect the legitimacy of the MoH as the

³¹ Daniel Cotlear, Somil Nagpal, Owen Smith, Ajay Tandon, and Rafael Cortez, *Going Universal: How 24 Developing Countries are Implementing Universal Health Coverage Reforms from the Bottom Up* (Washington, DC: World Bank, 2015), 146, <http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up>.

country's primary provider of health services, despite the crucial role that ECBHOs continue to play. Given the MoH's much wider mandate, ECBHOs should recognize that adapting their own strategies to harmonize with those of the government will often be the best approach, with no implication of inferiority.

For international actors supporting health, this perspective will require a slightly different interpretation of some key development principles regarding local ownership of development strategies. Where there are multiple health systems due to a fractured governance environment, the most politically sensitive way to work is to collaborate with all who are contributing to positive health outcomes. Ideally, the peace process will clearly define the governance roles of the state and EAOs, but thus far, the "interim arrangements" in the nationwide ceasefire agreement remain vague, and many EAOs have not yet signed on. Until these ambiguities can be formally resolved, donors should provide evenhanded support to both the government and EAOs to the extent that each is able to deliver quality health services in the most efficient way.

In particular, ECBHOs are a mainstay of support for some of the country's hardest-to-reach and most vulnerable populations. During conflicts or other humanitarian crises, they are the providers of critical emergency assistance. ECBHOs, which are particularly reliant on donor funds, should be considered high-value health partners that can reach vulnerable populations at relatively low cost and have the potential to connect those populations with more advanced government services in a conflict-sensitive way. In the near term, donors should develop instruments to provide consistent and stable systems-strengthening support to ECBHOs, both to maintain and improve the care that they provide, and to ensure their readiness should conflict return.

Government recommendation #1: The government should view ECBHOs as crucial partners in achieving UHC, due to their unique resources, experience, and territorial access.

ECBHO recommendation #1: ECBHOs should continue their concerted efforts towards convergence with the MoH, and should frame those efforts as having the primary aim of improving health equity.

International aid community recommendation #1: In

the near term, supporting both MoH and ECBHO systems is politically and programmatically necessary to ensure that all people have access to health services. International aid community recommendation #2: In particular, instruments should be developed to provide stable, long-term, systems-strengthening support for ECBHOs to stabilize and improve care for hard-to-reach and vulnerable populations in southeast Myanmar.

3.1: Overcoming barriers to cooperation and trust building

There remain various difficulties in building trust between the two systems and achieving greater cooperation and coordination. As the NLD's Roadmap Towards UHC states, "Critical will be to establish a process of constructive dialogue and confidence building."³² This section explores the main hurdles in this area and provides recommendations.

The need for formal recognition of ECBHOs

Mistrust between ECBHOs and the MoH remains high as a result of decades of civil war. In particular, the lack of legal recognition of ECBHOs as health providers, and their links to EAOs that have long been on the list of "unlawful associations," have greatly hindered cooperation between the two systems. Not only have ECBHO staff always operated under risk of arrest, but MoH staff engaging in coordination activities with ECBHOs have also long run the risk of being punished by their superiors or other agencies of government.

EAOs pushed consistently for the aforementioned "interim arrangements" in the nationwide ceasefire agreement (NCA) to recognize, in the period prior to a political settlement to the conflict, their role in governance and providing development and other services. While the final NCA text provides some protection of their health services from explicit government repression, it fails to provide them with clear authority. Furthermore, these provisions only apply to groups who sign the NCA, so they hinge on the political status of groups, rather than on what is best for the provision of health services.

Encouragingly, the NLD's Roadmap Towards UHC represents a key advance in this direction, frequently referring positively to the roles of "ethnic health

³² NLD National Health Network, "Roadmap Towards Universal Health Coverage," 24.

organizations.”³³ The government should solidify this recognition, by clearly referring to the roles of ECBHOs in legislation, in a presidential notification, or in formal MoH policy. This recognition would ideally state that ECBHOs are important providers of health services in the country; that they can receive funds from local and international sources; and that the MoH should coordinate its health activities with them and consult them on matters of health policy and strategy. While this recognition should not be contingent on specific forms of registration, it could be a useful first step towards greater regulation.

Government recommendation #2: Provide firm recognition to ECBHOs, ideally in legislation or presidential notification.

The need for greater government commitment to cooperation with ECBHOs

For ECBHOs, convergence is a central component of their policy and planning for the future, as they are regularly confronted with ceasefire developments, donor pressures, and new international partners. They are also constantly assessing the risks of modifying their health systems to operate in peacetime when a return to conflict is still possible. For the MoH, however, convergence with ECBHOs is one of a myriad of challenges, and although some national and state-level officials have been willing to engage with ECBHOs, such relations do not seem to be a high priority.

While it is a formal part of ECBHO policy to engage the state, the former government did not explicitly lay out any official position or agenda for engaging ECBHOs. Therefore, the relationship between ECBHOs and the MoH has not been formalized, and successful engagement has relied heavily on specific individuals in the MoH. This problem is made worse by the consistently high turnover of MoH staff, as it usually takes MoH officials a long time to become sensitized to the ECBHO system.

The new government should therefore take steps to develop a clearer policy on convergences, and make engagement with ECBHOs a key responsibility for relevant MoH staff. This policy should fully institutionalize MoH’s relations with ECBHOs, so that engagement does not depend primarily on personal relationships. The NLD’s Roadmap Towards UHC states

the need to establish a “communication and coordination mechanism,” which could include both Union-level and local-level bodies. Importantly, it should include all significant providers of health services, and should not be restricted to those connected to NCA signatories or to any other political category. Additionally, the MoH should make efforts to avoid high turnover of staff in states/regions and townships where ECBHOs are operating and where greater coordination is necessary.

Government recommendation #3: Develop clearer policies and positions on convergence, and create an institutional agenda to cooperate and coordinate more effectively with ECBHOs.

Government recommendation #4: Particularly in areas where ECBHO relations are important, develop policies to reduce the rate of turnover in MoH staff.

Uncertainty in the peace process among ECBHOs

ECBHOs’ confidence in the peace process and democratic reforms is essential to their willingness to engage with the government. ECBHOs’ trust in the government is increasing, but not enough time has passed for them to forget the last 60 years of conflict. ECBHOs understand that increased engagement with the MoH is going to happen, but in order to manage risks, they want it to happen on their terms and their timeline. Different organizations see this process differently, and relationships between MoH and the health departments of EAOs often depend on relations between that EAO and the government.

ECBHOs have been wary to adapt their operations too fast, or to become reliant on relations with MoH, until there is a sustainable peace. In programs, they have preferred a step-by-step approach in which they are able to assess the conflict situation continuously and to delay or alter implementation if they feel the risk is unacceptable. For example, senior Burma Medical Association (BMA) and MTC leaders have been reluctant to close cross-border supply lines and source their medicine and equipment in Yangon. Development actors have expressed frustration at this sometimes seemingly noncommittal attitude of ECBHOs and the delays it introduces to development projects. But development actors should respect ECBHO perceptions of risk to their operations, and work with them to design

³³ The NLD Roadmap refers generally to “ethnic health organizations” or “EHOs.” By their own definition, “EHO” refers just to the health departments of EAOs, and not to local NGOs like MTC, BMA, and BPHWT; hence the preference for “ECBHO” in this report.

conflict-sensitive interventions. Overall, where political risk remains, all stakeholders should see resilience to shocks and crises as a crucial feature of ECBHO delivery models.

International aid community recommendation #3: When working with ECBHOs, allow them to assess their own risks of cooperation and coordination with government, and prioritize maintaining resilience.

The politics of healthcare expansion

Another challenge to building trust is the push by government and EAOs alike to expand the catchment areas of their systems. With ceasefires restricting their ability to use combat troops to mark territories, both sides have done so more subtly by providing social services, including healthcare.³⁴ ECBHOs, human rights groups, and women's groups have complained of new government clinics and schools being built in areas influenced or controlled by EAOs, fearing that this could trigger conflict and mistrust.³⁵ As argued in a 2014 Asia Foundation study, government expansion of social services that undermines EAO social service structures has the potential to damage confidence in the peace process and usurp ethnic people's aspirations for autonomy and self-determination.³⁶

ECBHOs have also begun to expand coverage to areas they were forced to evacuate after *Tatmadaw* offensives in the mid-2000s, where the delineation of authority often remains contested. Senior leaders have said they feel it is still their responsibility to deliver health services to the people in these areas.³⁷ But a push for more clinics could easily outpace the rate at which health workers can be trained and at which appropriate systems can be developed to support these clinics. This risks reducing quality of service delivery, while resources might be better used to strengthen services to existing target populations. Such expansion could also create barriers to cooperation if each side is competing for territory.

The territorial claims of EAOs and government are extremely fluid, ceasefires have failed to establish clearly demarcated territories, and competing health services continue to overlap. Given the slow pace of the peace

talks and the long list of issues to address, it is not practical to assume that the *Tatmadaw* and EAOs will be able to demarcate territories or agree on exact catchment areas for social service provision in the near future. Alternative, temporary solutions for resolving the territory issue are needed until a final decision is agreed upon in peace treaties.

A "communication and coordination" mechanism, as recommended in the NLD's Roadmap Towards UHC, could be used to address these issues of coverage, and would ideally be empowered to make final decisions. It might not be realistic, however, for such a body to clearly delineate all coverage areas down to the village level. Rather, the emphasis should be on achieving a basic level of coordination and cooperation in the shared interest of improving health equity overall, while recognizing that a degree of overlap is likely to continue.

Government and EAO/ECBHO recommendation #1: Areas of government and EAO control should be established through the ceasefire and political dialogue processes, not by establishing social services.

Government and EAO/ECBHO recommendation #2: In lieu of peace agreements that formally delineate areas of control, a "communication and coordination mechanism," as recommended in the 2016 NLD health roadmap, could be established to pursue formal discussions and decision-making about catchment areas for health services.

3.2: Key areas for convergence activities

In addition to the core areas of relationship-building, there are a range of areas for convergence activities that this study identified as of particular value and importance. These are: sharing information and mapping coverage, countering infectious diseases, patient referrals from ECBHOs to MoH facilities, accreditation of health workers, and health financing.

Sharing information and mapping coverage

Trust between ECBHOs and the government is increasing, and as it does, more joint activities will

³⁴ Stuart Gordon, Sarah Jane Cooper-Knock, and Louis Lilywhite, *Dynamics of Provision of Health Services by Non-State Armed Groups* (CAERUS, 2015), <http://www.caerus-info.eu/Portals/10/Docs/Deliverables/CAERUS-D2.2-Dynamics%20of%20provision%20of%20health%20services%20by%20non-state%20armed%20actors-250315.pdf>.

³⁵ Interviews in Mae Sot, Thailand, with KWO (Dec. 11, 2015), BPHWT (Dec. 8, 2015), MTC and BMA (Dec. 4, 2015). See also "The sensitivities of Ministry of Health expansion" in Section 2.4.

³⁶ Kim Jolliffe, *Ethnic Conflict and Social Services in Myanmar's Contested Regions* (The Asia Foundation, June 2014), 27-29.

³⁷ Interviews in Mae Sot, Thailand, with BMA (Dec. 4, 2015), BPHWT (Dec. 8, 2015), IRC (Dec. 11, 2015).

become possible. In the meantime, continued information sharing at various levels between ECBHOs and MoH is of great importance to building trust and understanding. Joint mapping exercises are useful to identify areas of no coverage, avoid overlap and duplication of services, identify key areas for joint projects and programs, and build strategies for reaching the most underserved.

Even where lack of trust still inhibits information sharing, independent data collection and mapping exercises by MoH or ECBHOs could help to prevent delays in future joint projects that will require coordination. ECBHOs have expressed interest in securing international assistance for such activities, so that they can have data ready to share with the MoH when the time is right. Less intricate information-sharing activities and seminars, like those hosted many times by HCCG, and by NLD in December 2015, also build trust, and should be recognized as worthwhile convergence activities.

Government and EAO/ECBHO recommendation #3: Each system should explore options for both separate and joint activities, such as mapping, health systems assessment, and policy development, that will facilitate cooperation in the future and could strengthen coordination of catchment areas.

Government and EAO/ECBHO recommendation #4: General information-sharing activities and seminars should also be continued in order to build relationships, trust, and broader understanding between the two systems.

International aid community recommendation #4: International aid actors should support MoH and ECBHOs to continue information-sharing activities at various levels.

Countering infectious diseases

Coordination is required to combat diseases like malaria and lymphatic filariasis, transmitted by mosquitoes, that are not isolated in geographic areas or by borders. Interventions to control these diseases typically need to be implemented across wide regions and require coordination among multiple health agencies and

implementing actors.

In southeast Myanmar, coordination between MoH and ECBHOs is crucial for eliminating artemisinin-resistant malaria, a strain that has developed resistance to one of the most effective treatments. Artemisinin-resistant malaria was first reported along the Thai-Myanmar border in 2012,³⁸ and if not eliminated, it could spread to other regions. Led by INGO and university researchers, coordination is ongoing between MoH and ECBHOs to map populations, determine the prevalence of malaria and artemisinin-resistant malaria, and treat individuals and entire villages as needed.

Patient referrals from ECBHOs to MoH facilities

Coordination is also required to ensure that patients treated at ECBHO primary health clinics or by mobile teams can be referred quickly and efficiently to secondary or tertiary facilities if advanced care is needed. ECBHO clinics historically have referred patients to facilities in Thailand such as Mae Tao Clinic, clinics in refugee camps, or Thai hospitals. Many ECBHO clinics are located along the Thai border, making referrals to Thai facilities logistically easy. But for clinics located further inside Myanmar, time and travel costs can put Thai facilities out of reach.

The ceasefire and subsequent lifting of restrictions on movement in the southeast have created opportunities to refer patients to MoH hospitals, which are sometimes more accessible than those in Thailand. This will become increasingly important if refugee camps and their clinics in Thailand are closed. Encouragingly, the NLD's Roadmap Towards UHC repeatedly references the need for strengthening referrals between different types of providers, including ECBHOs.³⁹ Specific challenges include creating mechanisms for clinic payments, standardizing reimbursement for transport, and mutually developing referral forms and protocols for clinical meetings between ECBHOs and MoH to discuss patient cases (especially for causes of death).

Government and EAO/ECBHO recommendation #5: Countering infectious diseases and establishing mechanisms for patient referrals should be considered key areas for systematic coordination.

³⁸ Aung Pyae Phyo, et al., "Emergence of artemisinin-resistant malaria on the western border of Thailand: a longitudinal study," *The Lancet* 379, no. 9830 (Apr. 5, 2012): 1960-66, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)60484-X/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60484-X/abstract).

³⁹ NLD National Health Network, "Roadmap Towards Universal Health Coverage," 20.

Accreditation of ECBHO health workers

The former government's reluctance to accredit ECBHO health workers was a significant obstacle to building trust and formalizing relations. Accreditation is important to navigate the barriers imposed by the Unlawful Association Act, and even more so as a sign of government respect for the capacity of ECBHOs and their staff. Efforts to promote accreditation can also help to build trust and respect between ECBHOs and MoH, and thus also promote cooperation. Indeed, such efforts will be crucial in the long term for the state to fulfill its responsibility to ensure the quality of services being provided by ECBHOs.

Encouragingly, the NLD's Roadmap Towards UHC acknowledges the need to improve accreditation and licensing procedures, specifically recognizing that ECBHOs and other actors (such as the private sector) will be crucial to its efforts to achieve maximum coverage.⁴⁰ The roadmap recommends the establishment of an independent body to accredit health workers from outside of government as well as public and private pre-service training institutions. This opens up the possibility, not just for existing ECBHO health workers to be accredited, but also for their training institutions to offer formally recognized training in the future.

It is important that the government recognize that ECBHOs already have a system of training and accreditation in place, perhaps unlike those of some private, single-clinic providers, but based on the delivery models needed to reach their target populations. Retraining all 3,000+ ECBHO workers to fit the cadres currently defined by the MoH would be inefficient and politically impossible, and other approaches should be considered. The accreditation body should therefore work closely with ECBHOs to better understand their current training and staffing methods.

Government recommendation #5: Develop a process for accrediting ECBHO health workers, in coordination with the ECBHOs.

Health Financing

Coordination between MoH and ECBHOs could contribute to more sustainable health financing if the

MoH or another government body were able to begin funding some ECBHO activities. The NLD National Health Network raised this possibility in its March 2016 policy document, as part of its plans to establish a "single purchaser" body in government that, like the social security board, can purchase services from a range of available providers on behalf of the population.⁴¹

This may be neither possible in the near term, nor immediately required for health equity as long as donors are able to support both the MoH and ECBHOs. But in the long term, health financing would be more stable if the government and EAOs were able to pool resources and align financing channels to utilize all available public revenues. Discussions with some ECBHO leaders, however, suggest that they see accepting resources from the national government as a threat to their autonomy and a risk of getting drawn into the centralized government health system that is antithetical to their philosophy of health services delivery. They may also perceive a risk in becoming dependent on government, making it harder to re-establish old donor channels should ceasefires break down or resources be later withheld for political or other reasons. Nonetheless, it is crucial that all stakeholders begin discussing financing models for the future.

Government and EAO/ECBHO recommendation #6: If the government undertakes reforms of the country's health financing mechanism to allow government to fund other providers (as laid out in the NLD's Roadmap Towards UHC), dialogue should begin between government and ECBHOs about potential future funding from the former to the latter.

ECBHO recommendation #2: ECBHOs should initiate internal policy dialogue on securing more sustainable sources of financing, and particularly on the possibility of, and the preconditions for, accepting government funding.

International aid community recommendation #5: When developing funding strategies, donors should prepare to maintain parallel financing channels for ECBHOs for at least five years, due to the inevitably slow pace of the peace process and the ongoing potential for renewed conflict.

⁴⁰ NLD National Health Network, "Roadmap Towards Universal Health Coverage," 9.

⁴¹ NLD National Health Network, "Roadmap Towards Universal Health Coverage," 26-28.

FOUR: KEY QUESTIONS AND FURTHER READING

Discussion Questions

- Given the inevitable continuation of separate healthcare systems in southeast Myanmar in the near term, what areas of coordination and cooperation are most crucial to achieving health equity?
- How can communities' priorities be assessed more effectively to determine which health provider they prefer and how they view the strengths and weaknesses of the two systems?
- How can both systems be better assessed in terms of quality of services and approval ratings?
- Could joint strategies be developed by MoH and ECBHOs for convergence, or, more generally, for increasing coordination and cooperation between the two systems?
- What indicators could be used to effectively design and monitor convergence programs that contribute health equity in conflict-sensitive ways?
- How can ECBHOs become officially recognized partners in the pursuit of UHC while maintaining independence from the MoH?
- Given the many political and constitutional hurdles that remain before a political settlement to conflicts can be realized, how can sustainable financing models for ECBHOs be developed?
- What role can peace agreements play in sustaining and strengthening health-sector cooperation in the meantime?

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